

**BOARD OF REGISTERED NURSING**  
**Nursing Practice Committee**  
**Agenda Item Summary**

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**AGENDA ITEM:** 10.1  
**DATE:** November 5, 2015

**ACTION REQUESTED:** Review and Comments on Proposed Language for Article 8 Standards of Nurse Practitioner Practice: Office of Administrative Law's pre-notice public discussion.

**REQUESTED BY:** Trande Phillips, RN, Chair Nursing Practice Committee

**BACKGROUND:**

The Board of Registered Nursing directed staff to initiate the Office of Administrative Law's pre-notice public discussion\* as a preliminary activity before starting the formal rulemaking process for Article 8 Standards for Nurse Practitioners proposed regulation.

Article 8 Standards for Nurse Practitioner regulations were primarily adopted between 1979 – 1985. The 1979 – 1985 context and content in Article 8 Standards of Nurse Practitioner are no longer relevant in the areas of Definitions, Categories, Holding Out as NP, Evaluation of Credentials, and Standards of Education.

As a result, the Nursing Education Consultants developed a comprehensive review of nurse practitioner practice, education, and regulation for Article 8 Standards for Nurse Practitioner that is intended to provide clarity in definitions, categories, NP use of title, and Standards of Education. Attached is the regulation proposal.

The following organizations are in agreement with updating Article 8 Standard for Nurse Practitioners, as specified, at the October 8, 2015 Practice Committee meeting, attached letters

**California Action Coalition**

Susan Philips DNP, RN, FNP-BC and Garret Chan, Ph.D., RN, ACNP-BC  
Co-Lead Workgroup #1 Removing Practice Barriers

**California Association for Nurse Practitioners**

Donna Emanuel DNP, RN, CNS, FNP-BC  
President

**California Hospital Association**

BJ Bartleson, RN, MSN NEA-BS  
Vice President, Nursing and Clinical Services

**Association of California Nurse Leaders**

Patricia McFarland, MS, RN, FAAN  
CEO, Association of California Nurse Leaders

**Western University of Health Science- Education Perspectives**

Karen Hanford, EdD, MSN, FNP  
Dean, College of Graduate Nursing

The following organization is opposed, as specified, with updating Article 8 Standard for Nurse Practitioners at the October 8, 2015 Practice Committee. See attached letter.

**California Nurses Association**

Donald W. Nielsen  
Director, Government Relations

The board invites interested parties to submit information/responses regarding the Nurse Practitioner proposed regulation to the following Nursing Practice Committee and Board at the following meeting:

January 14, 2016 3:00 – 4:30 pm – Practice Committee  
Northern California location to be determined  
February 11, 2016 – Board Meeting – North  
March 16, 2016 – Practice Committee – South  
April 14, 2016 – Board Meeting – South

Staff requests responses that will be presented at the above committee meetings be submitted prior to the meeting at the address below. In addition, any interested parties who are unable to attend one of the above meetings but wishes to provide information/responses may send your written information to:

Janette Wackerly RN, BSN, MBA  
Board of Registered Nursing  
1747 North Market Blvd., Ste. 150  
Sacramento, CA 95834

**NEXT STEPS:** Place on Board agenda.

**PERSON TO CONTACT:** Janette Wackerly, MBA, BSN, RN  
Supervising Nursing Education Consultant  
916.574-7686  
[janette.wackerly@dca.ca.gov](mailto:janette.wackerly@dca.ca.gov)

**BOARD OF REGISTERED NURSING**

**Adoption and Revision 1480-1486 in Article 8 of**

**Title 16 of the California Code of Regulations**

Proposed changes are designated by single underline and ~~strikeout~~.

1 **1480. Definitions**

- 2 (a) "Nurse practitioner" means a an advanced practice registered nurse who meets board  
3 certification requirements and ~~who~~ possesses additional advanced practice educational  
4 preparation and skills in physical diagnosis, psycho-social assessment, and management of  
5 health-illness needs in primary health care, and/or acute care that meet board standards and who  
6 has been prepared in a program that conforms to meets the board standards, ~~as specified in~~  
7 ~~Section 1484."~~
- 8 (b) "~~Primary health care~~" is ~~that which occurs when a consumer makes contact with a health care~~  
9 ~~provider who assumes responsibility and accountability for the continuity of health care~~  
10 ~~regardless of the presence or absence of disease.~~ "Primary care" means the comprehensive  
11 continuous care provided to patients, families and the community. Primary care focuses on basic  
12 preventative care, health promotion, disease prevention, health maintenance, patient education  
13 and the diagnoses and treatment of acute and chronic illnesses in a variety of practice settings.
- 14 (c) "Clinically competent" means ~~that one~~ the individual possesses and exercises the degree of  
15 learning, skill, care and experience ordinarily possessed and exercised by a member of the  
16 appropriate discipline in clinical practice: of the appropriate discipline.
- 17 (d) "~~Holding oneself out~~" means ~~to use the title of nurse practitioner.~~
- 18 (e) "Acute care" means the restorative care provided by the certified nurse practitioner to patients  
19 with rapidly changing, unstable, chronic, complex acute and critical conditions in a variety of  
20 clinical practice settings.
- 21 (f) "Advanced health assessment course" means the knowledge of advanced processes of collecting  
22 and interpreting information regarding a patient's health care status. Advanced health assessment  
23 provides the basis for differential diagnoses and treatment plans.
- 24 (g) "Advanced pathophysiology course" means the foundational knowledge of physiological  
25 disruptions that accompany a wide range of alterations in health.
- 26 (h) "Advanced pharmacology course" means the integration of the advanced knowledge of  
27 pharmacology, pharmacokinetics, and pharmacodynamics content across the lifespan and  
28 prepares the certified nurse practitioner to initiate appropriate pharmacotherapeutics safely and  
29 effectively in the management of acute and chronic health conditions.
- 30 (i) "Nurse practitioner curriculum" means a curriculum that consists of the graduate core; advanced  
31 practice registered nursing core, and nurse practitioner role and population-focused courses.
- 32 (j) "Advanced practice registered nursing core" means the essential broad-based curriculum  
33 required for all nurse practitioner students in the areas of advanced health assessment, advanced  
34 pathophysiology, and advanced pharmacology.
- 35 (k) "California based nurse practitioner program" means a board approved academic program  
36 meeting nurse practitioner state certification criteria that's physically located in California. The  
37 program is accredited by a nursing organization recognized by the United States Department of

38 Education or the Council of Higher Education Accreditation that offers a graduate degree or  
39 graduate level certificate to qualified students.

- 40 (l) “Clinical practice experience” means the supervised provision of direct patient care in the  
41 clinical setting that provide for the acquisition and application of advanced practice nursing  
42 knowledge, skills and competencies.
- 43 (m) “Direct supervision” of Students means ~~the~~ a clinical preceptor or the faculty member is  
44 physically present at the practice site where the patient/client is located. The clinical preceptor  
45 and/or faculty member retains the responsibility for patient care while overseeing the student.
- 46 (n) “Lead nurse practitioner educator faculty” refers to a licensed Nurse Practitioner faculty member  
47 who is responsible for developing, and implementing the curriculum, policies and practices for a  
48 nurse practitioner program.
- 49 (o) “Major curriculum change” means a substantive change that results in a refocus of purpose and  
50 objectives ; or a substantive change in program structure or method of clinical or institutional  
51 delivery, or clinical hours and content.
- 52 (p) “National Board Certification” means current certification as an ~~an~~ **advanced certified** nurse  
53 practitioner in a role and population focus through testing accredited by the national commission  
54 on certifying agencies or the American Board of Nursing Specialties, as approved by the board.
- 55 (q) “Nurse practitioner program director” means the individual responsible for administration,  
56 implementation, and evaluation of the nurse practitioner program and the achievement of the  
57 program objectives in collaboration with program faculty.
- 58 (r) “Non-California based ~~graduate~~ nurse practitioner programs” means an academic program  
59 accredited by a nursing organization recognized by the Unites States Department of Education or  
60 the Council of Higher Education Accreditation that offers a graduate degree or graduate level  
61 certificate to qualified students and does not have a physical location in California.

62  
63 Authority cited: Sections 2715, 2725(c), 2725.5, 2835.5, 2836, 2836.1, Business and Professions Code.  
64 References: Section 2834 and 2836.1, Business and Professions Code.

#### 65 66 **1481. Categories of Nurse Practitioners**

67 ~~A registered nurse who has met the requirements of Section 1482 for holding out as a nurse practitioner,~~  
68 ~~may be known as a nurse practitioner and may place the letters "R.N., N.P." after his/her name alone or~~  
69 ~~in combination with other letters or words identifying categories of specialization, including but not~~  
70 ~~limited to the following: adult nurse practitioner, pediatric nurse practitioner, obstetrical-gynecological~~  
71 ~~nurse practitioner, and family nurse practitioner.~~

- 72 (a) Categories of nurse practitioners shall include, but are not limited to:
- 73 (1) Family/individual across the lifespan
- 74 (2) Adult-gerontology; primary care or acute care
- 75 (3) Neonatal
- 76 (4) Pediatrics; primary care or acute care
- 77 (5) Women’s health/gender-related
- 78 (6) Psychiatric- ~~Mental Health/mental health-(across the lifespan)~~
- 79 (b) A registered nurse who has been certified by the board as a nurse practitioner may be known as  
80 an advanced practice **registered** nurse and may place the letters APRN-CNP after his/her name or  
81 in combination with other letters or words that identify the population focus.

84 Authority cited: Sections 2715, 2835.5, 2836, Business and Professions Code. Reference: Sections 2834  
85 and 2836, 2836.1 and 2837, Business and Professions Code.

86 Note: Authority cited: Section 2715, Business and Professions Code. Reference: Sections 2834 and  
87 2836, Business and Professions Code.

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89 **1482. Requirements for ~~Holding Out As a~~ Certification as a Certified Nurse Practitioner.**

90 ~~The requirements for holding oneself out as a nurse practitioner are:~~

91 (a) ~~Active, valid, licensure license~~ as a registered nurse in California; and

92 (b) One of the following:

93 (1) ~~Successful completion of a program of study and national certification as recognized by the board~~  
94 ~~and which conforms that meets to board standards as set forth in this article;~~ or

95 (2) ~~Certification by a national or state organization whose standards are equivalent to those set forth in~~  
96 ~~Section 1484; in the role and population focus through testing accredited by the national commission on~~  
97 ~~certifying agencies or the American Board of Nursing Specialties, as approved by the board and as set~~  
98 ~~forth in this article;~~ or

99 (3) ~~A nurse who has not completed a~~ an academically affiliated nurse practitioner program of study  
100 ~~which meets board standards as specified in Section 1484,~~ shall be able to provide evidence of having  
101 completed equivalent education and supervised clinical practice as set forth in this article.

102 (A) ~~Documentation of remediation of areas of deficiency in course content and/or clinical experience,~~  
103 ~~and~~

104 (B) ~~Verification by a nurse practitioner and by a physician who meet the requirements for faculty~~  
105 ~~members specified in Section 1484(e), of clinical competence in the delivery of primary health care.~~

106 (4) Graduates from a nurse practitioner program in a foreign country shall meet the requirements as set  
107 forth in this article. The applicant shall submit a credentials evaluation through a board approved or  
108 directed service demonstrating education equivalency to a Master's or Doctoral degree in Nursing.

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110 Note: Authority cited: Section 2715, Business and Professions Code. Reference: Sections 2835 and  
111 2836, Business and Professions Code.

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113 **1483. Evaluation of Credentials**

114 An application for evaluation of a registered nurse's qualifications ~~to hold out to be certified as a~~  
115 Certified Nurse Practitioner shall be filed with the board on a form prescribed by the board and shall  
116 be accompanied by the fee prescribed in Section 1417 and such evidence, statements or documents as  
117 therein required by the board. ~~to conform with Sections 1482 and 1484.~~

118 Certified Nurse Practitioner application shall include submission of the following information:

119 (a) Name of the graduate nurse practitioner program or post-graduate nurse practitioner program.

120 (b) Official transcript documentation with the date of graduation or post-graduate program  
121 completion, nurse practitioner population foci, credential conferred, and the specific courses  
122 taken to provide sufficient evidence the applicant has completed the required course work  
123 including the required number of supervised direct patient care clinical practice hours.

124 (c) Students who graduate from a board approved nurse practitioner program shall be considered  
125 graduates of a nationally accredited program if the program held national nursing accreditation at  
126 the time the graduates completed the program. These program graduates are eligible to apply for  
127 nurse practitioner certification with the board regardless of the program's current national  
128 nursing accreditation status.

129 The board shall notify the applicant in writing that the application is complete and accepted for filing; or  
130 that the application is deficient and specify what additional information is required within 30 days from  
131 the receipt of an application. A decision on the evaluation of credentials shall be reached within 60 days  
132 from the filing of a complete application. The median, minimum, and maximum times for processing an  
133 application, from the receipt of the initial application to the final decision, shall be 42 days, 14 days, and  
134 one year, respectively, and take into account Section 1410.4 (e) which provides for abandonment of  
135 incomplete applications after one year.

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137 Authority cited: Sections 2715 and 2718, Business and Professions Code. Reference: Sections 2815 and  
138 2835.5, Business and Professions Code.

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140 **1483.1 Requirements for Nurse Practitioner Education Programs based in California.**

141 (a) The nurse practitioner programs shall:

142 (1) Be an academic program approved by the board and is accredited by a nursing organization  
143 recognized by the United States Department of Education or the Council of Higher Education  
144 Accreditation that offers a graduate degree or graduate level certificate to qualified students.

145 (2) Provide the board evidence of initial accreditation within 30 days of the program receiving this  
146 information from the institutional accreditation body.

147 (3) Provide the board evidence of ongoing continuing nurse practitioner program accreditation  
148 within 30 days of the program receiving this information from the national nursing accreditation  
149 body.

150 (4) Notify the board of changes in the program's institutional and national nursing accreditation  
151 status within 30 days.

152 (b) The board may grant the nurse practitioner program initial and continuing approval when the board  
153 receives the required accreditation evidence from the program.

154 (c) The board shall retain its authority to monitor, regulate and change the approval status for board  
155 approved nurse practitioner programs at any time. If the Board determines the program has not provided  
156 necessary compliance evidence to meet board regulations irrespective of institutional and national  
157 nursing accreditation status and review schedules.

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159 Authority cited: Section 2715, Business and Professions Code. Reference: Sections 2785, 2786, 2786.5,  
160 2786.6, 2788, 2798, 2815 and 2835.5, Business and Professions Code.

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162 **1483.2 Requirements for Reporting Nurse Practitioner Program Changes.**

163 (a) A board approved nurse practitioner program shall notify the board within thirty (30) days of the  
164 following changes:

165 (1) A change of legal name or mailing address prior to making such changes. The program shall file its  
166 legal name and current mailing address with the board at its principal office and the notice shall provide  
167 both the old and the new name and address as applicable.

168 (2) A fiscal condition that adversely affects students enrolled in the nursing program.

169 (3) Substantive changes in the organizational structure affecting the nursing program.

170 (b) An approved nursing program shall not make a substantive change without prior board notification.

171 These changes include, but not limited to:

172 (1) Change in location;

173 (2) Change in ownership;

174 (3) Addition of a new campus or location.

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Authority cited: Section 2715, Business and Professions Code. Reference: Sections 2785, 2786, 2786.5, 2786.6, 2788, 2798, 2815 and 2835.5, Business and Professions Code.

**§ 1484. Standards of Nurse Practitioner Education.**

The program of study preparing a certified nurse practitioner ~~shall meet the following criteria:~~

(1) Be approved by the board.

(2) Be consistent with the curriculum content to support nurse practitioner core competencies as specified by National Organization of Nurse Practitioner Faculties and the Curricular Leadership Committee for the population foci as recognized by the board. ~~shall meet the following criteria:~~

(a) Purpose, Philosophy and Objectives, and Learning Outcomes

~~(1) have as its primary purpose the preparation of registered nurses who can provide primary health care;~~

~~(2) have a clearly defined philosophy available in written form;~~

~~(3) have objectives which reflect the philosophy, stated in behavioral terms, describing the theoretical knowledge and clinical competencies of the graduate.~~

(1) The purpose for preparation of the graduate nurse practitioner providing primary care and/or acute care services to one or more of the population foci.

(2) Written program materials shall reflect the mission, philosophy, purposes, and objectives of the program and be available to all students.

(3) Learning outcomes for the nurse practitioner Program are measurable and reflect assessment and evaluation of the theoretical knowledge and clinical competencies required of the graduate.

(b) Administration and organization of the nurse practitioner program:

~~(1) Be conducted in conjunction with one of the following:~~

~~(A) An institution of higher education that offers a baccalaureate or higher degree in nursing, medicine, or public health~~ A college or university that prepares nurse practitioners at the master's degree or higher is accredited by a nursing organization that is recognized by the United States Department of Education or the Council of Higher Education Accreditation that offers a graduate degree or graduate level certificate to qualified students

~~(B) A general acute care hospital licensed pursuant to Chapter 2 (Section 1250) of Division 2 of the Health and Safety Code, which has an organized outpatient department. Prepare graduates to be eligible for national certification as an advanced nurse practitioner in a population focus through testing accredited by the National Commission on Certifying Agencies or the American Board of Nursing Specialties, as approved by the board.~~

(2) (1) Have admission requirements and policies for withdrawal, dismissal and readmission clearly stated and available to the student in written form.

(3) (2) Have written policies for clearly informing applicants of the academic status of the program.

(4) (3) Provide the graduate with official evidence indicating that he/she has demonstrated clinical competence in delivering primary health care and has achieved all other objectives of the program. meet the curriculum requirements in effect at the time of enrollment.

~~(5) (4) Maintain systematic, retrievable records of the program including philosophy, objectives, administration, faculty, curriculum, students and graduates. In case of program discontinuance, the board shall be notified of the method provided for record retrieval. The nurse practitioner program shall maintain a method for retrieval of records in the event of program closure.~~

(5) (5) Provide for program evaluation by faculty and students during and following the program and make results available for public review. The nurse practitioner program shall have and implement a written total program evaluation plan for improvement.

221 (6) The nurse practitioner program shall have sufficient resources to achieve the program objectives.  
 222 ~~(c) Faculty There shall be an adequate number of qualified faculty to develop and implement the~~  
 223 ~~program and to achieve the stated objectives.~~  
 224 (1) There shall be an adequate number of qualified faculty to develop and implement the program and to  
 225 achieve the stated objectives.  
 226 ~~(4) (2) Each faculty person shall demonstrate current competence in the area in which he/she teaches.~~  
 227 (3) There shall be a lead nurse practitioner faculty educator who meets the faculty qualifications for the  
 228 population focus/foci tracks and nationally certified for the population focus program track he/she  
 229 serves as the lead faculty.  
 230 (4) Faculty who teach in the nurse practitioner program shall be educationally qualified and clinically  
 231 competent in the same population foci as the theory and clinical areas taught. Faculty shall meet the  
 232 following requirements:  
 233 (a) Hold an active, valid California registered nurse license;  
 234 ~~(b) (c) (3) Faculty in the theoretical portion of the program must include instructors who hold a Master's~~  
 235 ~~or higher degree in the area in which he or she teaches. Have a Master's degree or higher degree in~~  
 236 ~~nursing;~~  
 237 (c) Have at least two years of clinical experience as an nurse practitioner, CNM, CNS, or CRNA within  
 238 the last five (5) years and consistent with the teaching responsibilities;  
 239 (5) Faculty teaching in clinical courses shall maintain currency in clinical practice.  
 240 (6) Each faculty member shall assume responsibility and accountability for instruction, planning and  
 241 implementing the curriculum, and evaluation of students and the program.  
 242 (7) Interdisciplinary faculty who teach non-clinical nurse practitioner nursing courses, such as but not  
 243 limited to, pharmacology, pathophysiology, and physical assesment, shall have an active, valid  
 244 California license issued by appropriate licensing agency and an advanced graduate degree in the  
 245 appropriate content areas taught.  
 246 (d) Director  
 247 ~~(1) (e)(2) The director or co-director of the program shall: The nurse practitioner program director is~~  
 248 ~~responsible and accountable for the nurse practitioner program within an accredited academic institution~~  
 249 ~~including those functions aligned with program and curricular design and resource acquisition and~~  
 250 ~~allocation and shall meet the following requirements:~~  
 251 ~~(A) Be a~~ Hold an active, valid California registered nurse license  
 252 ~~(B) Have earned hold a master's or a doctoral higher degree in nursing or a related health field from an~~  
 253 ~~accredited college or university;~~  
 254 ~~(C) Have had one academic year's experience, within the last five (5) years, as an instructor in a school~~  
 255 ~~of professional nursing, or in a program preparing nurse practitioners~~  
 256 (D) Be certified by the board as an advanced nurse practitioner and nationally certified as advanced  
 257 nurse practitioner in one or more population foci;  
 258 (E) The director shall have sufficient time dedicated for the administration of the program.  
 259 (F) The director, if he/she meets the requirements for the certified nurse practitioner role, may fulfill the  
 260 lead nurse practitioner faculty educator role and responsibilities.  
 261 (e) Clinical Preceptors in the nurse practitioner program shall  
 262 ~~(1) (e)(4) A clinical-instructor preceptor shall hold active-licensure valid, California license to practice~~  
 263 ~~his/her respective profession and demonstrate current clinical competence.~~  
 264 ~~(2) (e)(5) A clinical preceptor instructor shall participate in teaching, supervising and evaluating~~  
 265 ~~students, and shall be appropriately matched with the content and skills being taught to the students.~~

266 (3) Clinical preceptor means a health care provider qualified by education, licensure and clinical  
267 competence in assigned population focus/foci to provide direct supervision of the clinical practice  
268 experiences for a nurse practitioner student.  
269 (4) Clinical preceptor functions and responsibilities shall be clearly documented in a written agreement  
270 between the agency, the preceptor, and the nurse practitioner program including the clinical preceptor's  
271 role to teach, supervise and evaluate students in the nurse practitioner program.  
272 (A) Clinical preceptor is oriented to program and curriculum requirements, including responsibilities  
273 related to supervision and evaluation;  
274 (B) Clinical preceptors shall be evaluated by the program faculty at least every two (2) years.  
275 (f) ~~Curriculum~~ Students shall hold an active, valid registered nurse California license to participate in  
276 nurse practitioner program clinical experiences.  
277 (g) ~~(d)~~ Nurse Practitioner Curriculum:  
278 The nurse practitioner program curriculum shall meet the standards set forth in this Section, be  
279 congruent and consistent with national standards for graduate and nurse practitioner education, including  
280 nationally recognized core role and population focused competencies and be approved by the board.  
281 (1) The program shall include all theoretical and clinical instruction necessary for to enable the graduate  
282 to provide primary health care for persons for whom he/she will provide care. the graduate in one or  
283 more population foci.  
284 (2) The program shall provide evaluation evaluate of previous education and/or experience in primary  
285 health care for the purpose of granting credit for meeting program requirements, when applicable.  
286 (3) Training for practice in an area of specialization shall be broad enough, not only to detect and control  
287 presenting symptoms, but to minimize the potential for disease progression. The curriculum shall  
288 provide broad educational preparation including a graduate core; **advance practice registered nursing**  
289 **nurse practitioner** core, the nurse practitioner core role competencies, and the competencies specific to  
290 the population focus/foci.  
291 (4) Curriculum, course content, and plans for clinical experience shall be developed through  
292 collaboration of the total faculty. The program shall prepare the graduate to be eligible to sit for a  
293 specific national nurse practitioner population foci certification examination consistent with educational  
294 preparation.  
295 (5) Curriculum, course content, methods of instruction and clinical experience shall be consistent with  
296 the philosophy and objectives of the program. The curriculum plan evidences appropriate course  
297 sequencing and progression, this includes, but is not limited to:  
298 (A) The **advance practice registered nursing -nurse practitioner** core courses (advanced health  
299 assessment, advanced pharmacology, and advanced pathophysiology) are completed prior to or  
300 concurrent with commencing clinical course work.  
301 (B) Instruction and skills practice for diagnostic and treatment procedures shall occur prior to  
302 application in the clinical setting.  
303 (C) Concurrent theory and clinical practice courses in the population focus/foci emphasize the  
304 management of health-illness needs in primary and/or acute care.  
305 (D) The **majority** of the supervised direct patient care precepted clinical experiences shall be under the  
306 supervision of the certified nurse practitioner.  
307 (6) Outlines and descriptions of all learning experiences shall be available, in writing, prior to  
308 enrollment of students in the program. The program shall meet the minimum clinical hours of supervised  
309 direct patient care experiences as specified in current nurse practitioner national education standards.  
310 Additional clinical hours required for preparation in more than one population foci shall be identified  
311 and documented in the curriculum plan for each population focus/foci.

312 (7) The curriculum shall include content related to California Nursing Practice Act, Business &  
313 Professions Code, Division 2, Chapter 6, Article 8, Nurse Practitioners and California Code of  
314 Regulations Title 16, Division 14, Article 7 Standardized Procedure Guidelines and Article 8 Standards  
315 for Nurse Practitioners, including, but not limited to:  
316 (A) Section 2835.7 of Business & Professions Code Authorized standardized procedures;  
317 (B) Section 2836.1 of Business & Professions Code Furnishing or ordering of drugs or devices by nurse  
318 practitioners.  
319 ~~(7)~~ (8) The program may be full-time or part-time and shall be comprised of not less than thirty (30)  
320 semester units, (forty-five (45) quarter units), but must be congruent and consistent with national  
321 standards for graduate and nurse practitioner education, which shall include theory and supervised  
322 clinical practice.  
323 (8) The course of instruction shall be calculated according to the following formula:  
324 (A) One (1) hour of instruction in theory each week throughout a semester or quarter equals one (1) unit.  
325 (B) Three (3) hours of clinical practice each week throughout a semester or quarter equals one (1) unit.  
326 (C) One (1) semester equals 16-18 weeks and one (1) quarter equals 10-12 weeks.  
327 (9) The course of instruction program units and contact hours shall be calculated using the following  
328 formulas:  
329 (A) One (1) hour of instruction in theory each week throughout a semester or quarter equals one (1)  
330 unit.  
331 (B) Three (3) hours of clinical practice each week throughout a semester or quarter equals one (1) unit.  
332 Academic year means two semesters, each semester is 15-18 weeks; or three quarters, each quarter is  
333 10-12 weeks.  
334 (10) (9) Supervised clinical practice shall consist of two phases:  
335 (A) Concurrent with theory, there shall be provided for the student, demonstration of and supervised  
336 practice of correlated skills in the clinical setting with patients.  
337 (B) Following acquisition of basic theoretical knowledge prescribed by the curriculum the student shall  
338 receive supervised experience and instruction in an appropriate clinical setting.  
339 (C) At least 12 semester units or 18 quarter units of the program shall be in clinical practice.  
340 (11) (10) The duration of clinical experience and the setting shall be such that the student will receive  
341 intensive experience in performing the diagnostic and treatment procedures essential to the practice for  
342 which the student is being prepared.  
343 (12) (11) The program shall have the responsibility for arranging for clinical instruction and supervision  
344 for the student.  
345 (12) The curriculum shall include, but is not limited to:  
346 (A) Normal growth and development  
347 (B) Pathophysiology  
348 (C) Interviewing and communication skills  
349 (D) Eliciting, recording and maintaining a developmental health history  
350 (E) Comprehensive physical examination  
351 (F) Psycho-social assessment  
352 (G) Interpretation of laboratory findings  
353 (H) Evaluation of assessment data to define health and developmental problems  
354 (I) Pharmacology  
355 (J) Nutrition  
356 (K) Disease management  
357 (L) Principles of health maintenance

- 358 ~~(M) Assessment of community resources~~  
359 ~~(N) Initiating and providing emergency treatments~~  
360 ~~(O) Nurse practitioner role development~~  
361 ~~(P) Legal implications of advanced practice~~  
362 ~~(Q) Health care delivery systems~~  
363 ~~(13) The course of instruction of a program conducted in a non-academic setting shall be equivalent to~~  
364 ~~that conducted in an academic setting.~~

365  
366 Authority cited: Sections 2715, 2835.5, 2835.7, 2836, 2826.1, Business and Professions Code.  
367 Reference: Sections 2835, 2835.5, 2835.7, 2836, 2836.1, 2836.2, 2836.3, 2837, Business and  
368 Professions Code.

369  
370 **1485. Scope of Practice**

371 Nothing in this article shall be construed to limit the current scope of practice of the registered nurse  
372 authorized pursuant to the Business and Professions Code, Division 2, Chapter 6. The nurse practitioner  
373 shall function within the scope of practice as specified in the Nursing Practice Act and as it applies to all  
374 registered nurses.

375  
376 Authority cited: Section 2715, Business and Professions Code. Reference: Sections 2834 and 2837,  
377 Business and Professions Code.

378  
379 **1486. Requirements for Clinical Practice Experience for Nurse Practitioner Students Enrolled in**  
380 **Out of State Nurse Practitioner Programs.**

- 381 (a) The out-of-state nurse practitioner Program requesting clinical placements for program students in  
382 clinical practice settings in California shall:  
383 (1) Obtain prior board authorization;  
384 (2) Ensure students have successfully completed prerequisite courses and are enrolled in the nurse  
385 practitioner Program;  
386 (3) Secure clinical preceptors who meet board requirements;  
387 (4) Ensure the clinical preceptorship experiences in the program meet all board requirements and  
388 national education standards/competencies for the nurse practitioner role and population focus/foci;  
389 (5) Demonstrate evidence the curriculum includes content related to legal aspects of California certified  
390 nurse practitioner laws and regulations.

- 391 (6) Notify the board of pertinent clinical placement changes within 30 days.  
392 (b) The board may withdraw authorization for program clinical placements in California, at any time.

393  
394 Authority cited: Section 2715, Business and Professions Code. Reference: Sections 2729, 2835, 2835.5  
395 and 2836, Business and Professions Code.



October 8, 2015

Janette Wackerly, MBA, BSN, RN  
Nursing Education Consultant  
Board of Registered Nursing

Dear Ms. Wackerly,

The California Action Coalition applauds the efforts of the Board and staff in amending the outdated nurse practitioner regulations. We have submitted proposed language changes previously, however, given the new format and additional proposed language, we are submitting a new document for the Board's review and consideration.

Following review of the latest draft presented by the Nursing Education Consultant APRN Workgroup (4 OAL Proposal Form 1480-1486 2015 06 09 2015 07 31 Numbered), we have a request for the following amendments with rationale:

**1. Section 1480 Definitions**

- a. The California Action Coalition supports amendments of this section as drafted with the request for the following changes as specified below:
  - i. **Line 43 (m) "Direct Supervision of Students"** means ~~the~~ a clinical preceptor or faculty member is physically present at the practice site where the patient/client is located. The clinical preceptor and/or faculty member retains the responsibility for patient care while overseeing the student.  
*Rationale: The CAC believes we should specify who must be directly supervised to avoid confusion.*
  - ii. **Line 52 (p) "National Board Certification"** means current certification as an ~~advanced~~ certified nurse practitioner in a role and population focus through testing accredited by the national commission on certifying agencies or the American Board of Nursing Specialties, as approved by the board.  
*Rationale: In an effort to standardize terminology, we do not want confusion to occur among "advanced nurse practitioner" and "certified nurse practitioner"*

**2. Section 1481 Categories of Nurse Practitioners**

- a. The California Action Coalition supports amendments of this section as drafted with the request for the following changes as specified below:
  - i. **Line 78 (6) Psychiatric-Mental Health (across the lifespan)**  
*Rationale: Maintain consistency with accepted national title*
  - ii. **Line 79 (b)** A registered nurse who has been certified by the board as a nurse practitioner may be known as an advanced practice registered nurse and may place the letters APRN-CNP after his/her name or in combination with other letters or words that identify the population focus.

*Rationale: To maintain consistency with legal titling and to avoid confusion.*

**3. 1482 Requirements for ~~Holding Out As a~~ Certification as a Certified Nurse Practitioner**

- a. The California Action Coalition supports amendments of this section as drafted with the request for the following changes as specified below:
  - i. **Lines 89-98 & Lines 102-108:** The California Action Coalition supports the recommended changes as printed.
  - ii. **Lines 99-101 (3)** The California Action Coalition does not support this statement and recommends deletion.

*Rationale: This regulatory amendment would potentially authorize physician assistants and physicians to be certified as nurse practitioners in this state; however, individuals without a MS in Nursing or Doctoral degree in nursing would not be authorized to sit for a national nurse practitioner certification examination and therefore could not be credentialed as a nurse practitioner. The CAC understands the disconnect between B&P Code Sections 2836 (a) and 2835.5 (d)(1-3); however, given the prevailing and most recent legislative update to Section 2835.5, this could be easily rectified in board-sponsored or supported clean-up legislation.*

**4. 1483 Evaluation of Credentials**

- a. The California Action Coalition supports amendments of this section as drafted.

**5. 1483.1 Requirements for Nurse Practitioner Education Programs based in California**

- a. The California Action Coalition supports amendments of this section as drafted.

**6. 1483.2 Requirements for Reporting Nurse Practitioner Program Changes.**

- a. The California Action Coalition supports amendments of this section as drafted.

**7. Section 1484 ~~Standards of~~ Nurse Practitioner Education:**

- a. The California Action Coalition supports amendments of this section as drafted with the request for the following changes as specified below:

- i. **Lines 203 – 207 (B)** A general acute care hospital licensed pursuant to Chapter 2 (Section 1250) of Division 2 of the Health and Safety Code, which has an organized outpatient department. Prepare graduates to be eligible for national certification as an advanced nurse practitioner in a population focus through testing accredited by the National Commission on Certifying Agencies or the American Board of Nursing Specialties, as approved by the board.

*Rationale: Maintain consistency with titling.*

- ii. **Line 237 (c)** Have at least two years of clinical experience as an nurse practitioner, CNM, CNS, or CRNA within the last five (5) years and consistent with the teaching responsibilities;

*Rationale: CNMs and CNSs have valuable knowledge and skills to share with NP students and may be qualified to teach clinical courses where appropriate to their education and expertise, such as women's health and mental health. CRNAs have valuable knowledge and skills to share with NP students and may be qualified to teach clinical courses where appropriate to their education and*

*expertise in acute care NP programs. Given the tremendous shortage in qualified nursing faculty, we would like to avoid limiting nursing faculty with appropriate training, experience, and expertise.*

- iii. **Lines 242-244 (7)** Interdisciplinary faculty who teach non-clinical nurse practitioner nursing courses such as but not limited to, pharmacology, pathophysiology, and physical assessment, shall have an active, valid California license issued by appropriate licensing agency and an advanced graduate degree in the appropriate content areas taught.

*Rationale: We want to avoid limiting interdisciplinary faculty where their education, skills, and expertise provide a rich learning experience.*

- iv. **Lines 285-288 (3)** Training for practice in an area of specialization shall be broad enough, not only to detect and control presenting symptoms, but to minimize the potential for disease progression. The curriculum shall provide broad educational preparation including a graduate core; advanced practice registered nursing ~~nurse practitioner~~ core, the nurse practitioner core role competencies, and the competencies specific to the population focus/foci.

*Rationale: Consistent use of regulatory definitions as defined above.*

- v. **Lines 296-297 (A)** The advanced practice registered nursing ~~nurse practitioner~~ core courses (advanced health assessment, advanced pharmacology, and advanced pathophysiology) are completed prior to or concurrent with commencing clinical course work.

*Rationale: Consistent use of regulatory definitions as defined above.*

- vi. **Lines 302-303 (D)** The majority of the supervised direct patient care precepted clinical experiences shall be under the supervision of the certified nurse practitioner.

*Concerns: Where it is ideal for the majority of supervised direct patient care precepted clinical experiences should be under the supervision of a CNP, this may not be feasible in rural and underserved areas where provider availability is limited. Consider revising.*

- vii. **Lines 316-318 (7) (8)** The program may be full-time or part-time and shall be comprised of not less than thirty (30) semester units, (forty-five (45) quarter units), but must be congruent and consistent with national standards for graduate and nurse practitioner education, which shall include theory and supervised clinical practice.

*Concerns: Consider the added text. This minimum total program requirement was established prior to a required standard of academic preparation. Academic institutions should weigh in on whether current criterion is too low based on accreditation standards for NP programs and should provide recommendations a careful focus on competency standards. It is clear that current California criterion for minimum clinical practicum hours (540) meets and exceeds the national standard (500).*

**8. 1486 Requirements for Clinical Practice Experience for Nurse Practitioner Students Enrolled in Out of State Nurse Practitioner Programs.**

- a. The California Action Coalition supports amendments of this section as drafted.

**9. Grandfathering language to be added:**

- a. The California Action Coalition requests careful review of proposed language and discussion with stakeholders to ensure grandfathering language is added to appropriate sections. This will ensure the new regulatory requirements do not disenfranchise currently licensed/certified nurse practitioners or education programs.

We applaud the BRN's efforts to bring NP standards and regulations into alignment with today's practice environment and the California Action Coalition, with vast expertise in NP practice and education, continue to partner in this effort.

Respectfully submitted

Susanne J. Phillips, DNP, RN, FNP-BC  
Co-Lead, Workgroup #1: Removing Practice Barriers  
California Action Coalition  
sjphilli@uci.edu

Garrett Chan, Ph.D, RN, ACNP-BC, CNS, FAAN  
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California Action Coalition  
Gchan\_rn@me.com



**CALIFORNIA ACTION COALITION**

Advancing Health In California

October 8, 2015

Janette Wackerly, RN, MBA  
Nursing Education Consultant  
Board of Registered Nursing

Dear Ms. Wackerly,

Below you will find our testimony presented October 8, 2015 during the Nursing Practice Committee Meeting in Santa Ana, CA. The CAC would like to thank the members of the Board and the Board Staff for their interest in amending outdated regulations pertaining to NP education.

Good afternoon Chair Phillips, members of the Nursing Practice Committee. I am Dr. Susanne Phillips, a Clinical Professor and a family nurse practitioner at UC Irvine, where I have been a nurse educator for nearly 20 years.

I am here today on behalf of the California Action Coalition, as the Co-Lead for Recommendation #1, to remove all barriers to full practice authority for California's nurses. The California Action Coalition supports the BRN's work to update the 35-year-old nurse practitioner regulations pertaining to definitions and categories of NPs, "Holding-Out" as a NP, evaluation of credentials, as well as the standard of NP education. As a nurse practitioner and nurse educator in the UC System approaching 20 years, as well as a former member & President of this Board, I have seen first-hand the importance of updated regulatory guidance in defining the practice of, credentialing, and training our registered nurses (RNs) and advanced practice registered nurses (APRNs). In an effort to support the movement toward full practice authority for all nurses in the State of California, it is imperative that our regulations reflect accepted national standards and mandate uniform comprehensive, high quality training.

We have done good work over the years by moving NP education to academic institutions. All NP education in California is now completed at the Master's degree or higher level as a result of legislation sponsored by Assemblyman Todd Spitzer (AB 2226) signed in 2004, amending Business & Professions Code Section 2835.5, mandating that NPs enter into practice with a minimum of a Master's degree in nursing. Unfortunately, other related nurse practice act statutes such as Business & Professions Code Section 2836 (a), added in 1977, were not deleted or amended following that legislation. This is unfortunate; however, I can attest, having been closely involved with the legislation at the time, it was simply an oversight, not a meaningful omission. We now have an opportunity to "clean-up" this issue, given the standard of academic preparation for all nurse practitioners. During several Nursing Practice Committee Meetings, board members have also questioned the need for national certification as a requirement for NPs to enter into practice in California, stating that because it was not included in the 2004 Spitzer legislation, the legislature did not want that standard here in California. I refute that idea, as I personally drafted the language in AB 2226 (Spitzer) and although national certification language was included in early drafts, it was removed due to political opposition, not as a

matter of policy opposition by the author, sponsor, or the legislative body at large. In fact, there was considerable discussion of placing that language in a future bill.

It is both a professional and regulatory responsibility to ensure our nurse practitioners are educated in institutions held to the highest, most up-to-date standards of patient safety and quality, as well as held to minimum competency standards as new graduates. Not only have we seen an evolution of NP practice settings, but state and federal payers have mandated through regulation, advanced education and national certification. For instance, to be credentialed and reimbursed as a recognized independent provider for both Medi-Cal and Medicare, a NP must have graduated from a nationally-accredited Master's- or Doctoral-degree program and be nationally certified in one of the recognized NP population specialties. This supports alignment of NP education regulations with Medi-Cal (Title 22) and Medicare regulations.

California licenses & certifies over 20,000 active nurse practitioners; the largest numbers of NPs in the country are actively practicing in our state and the vast majorities are working in small private and community-based practices. In fact, the largest individual employers of NPs in the state, Kaiser and the UC system, employ less than 20%. Those systems provide an infrastructure of support for nurse practitioners as their practice evolves; however, most NPs in our state do not practice in those settings; they are working in small practices, side-by-side with physician partners, and we have a social and ethical responsibility to ensure they are universally prepared to deliver high quality care. The CAC understands that there are sensitive issues surrounding compact language. We are not in a position to take a stand on that issue and our support of this process has to do with ensuring California's regulatory standards meet or exceed national standards. Current language is far below the national benchmark.

We applaud the BRN's efforts to bring the NP education regulations into alignment with today's practice environment and the California Action Coalition, with vast expertise in NP education, continue to partner in this effort.

Respectfully submitted

Susanne J. Phillips, DNP, RN, FNP-BC  
Co-Lead, Workgroup #1: Removing Practice Barriers  
California Action Coalition  
sjphilli@uci.edu

Garrett Chan, Ph.D, RN, ACNP-BC, CNS, FAAN  
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POWER IN PRACTICE



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October 8, 2015  
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Louise R. Bailey, MEd, RN, Executive Officer  
Janette Wackerly, RN, MBA, Nursing Education Consultant  
Ms. Trande Phillips, RN, Board Member and Chair, Nursing Practice Committee

**Re: Support Adopted Revisions of Proposed Language for Article 8 Standards of Nurse Practitioner Practice**

Dear California Board of Registered Nursing:

On behalf of the California Association for Nurse Practitioners (CANP) we greatly appreciate the work of the California Board of Registered Nursing in their review and consideration to adopt revisions to **Proposed Language for Article 8, Section 1480 – 1484, Standards of Nurse Practitioner Practice, Title 16 of the California Code of Regulations**, and applaud your efforts to modernize and update language that reflects current nurse practitioner (NP) practice. CANP is the only professional NP organization that represents and advocates for more than 18,000 practicing NPs statewide on policy and practice issues. We strongly believe an educated and competent NP workforce, reflected in certifying standards, will ensure that the health care needs of the population are safely met. With the addition of millions of newly insured Californians entering the health care system under the Patient Protection and Affordable Care Act (PPACA), NPs play a critical and necessary role in serving the present and future health care needs in this effort.

Over 205, 000 NPs practice nationwide that contribute to the health care system. Many of the revisions as identified outline requirements in licensure, accreditation, certification, and education that have been adopted by several states with others proposing legislation and rules change to move closer to compliance. This alignment offers benefit to consumers, employers, NP educational programs, legislators, regulators, and present and future NPs, providing a clear understanding of their role, preparation, training, and scope of practice, and upholds public protection and accountability to the standards for practice.

As previously noted, Article 8 *Standards for Nurse Practitioner* regulations were primarily adopted between 1979 – 1985. However, the 1979 – 1985 context and content in Article 8 Standards of Nurse Practitioner are no longer relevant in the areas of Definitions, Categories, Holding Out as NP, Evaluation of Credentials, and Standards of Education. Following review of the latest draft presented by the Nursing Education Consultant APRN Workgroup, we concur

with the request for “amendments with rationale” and the recommended changes, deletions and additions, as thoughtfully detailed in the document. CANP agrees that the amendments here provide clarity in definitions, categories, NP use of title, and Standards of Education that reflect the practice of nurse practitioners today.

We remain confident that the CA-BRN is amenable to revisiting antiquated regulations of the past, update regulations that reflect current practice, and as always, offer our assistance to the board during this ongoing endeavor.

The revisions to sections 1480 –1486 in Article 8 of Title 16 of the California Code of Regulations is a forward step in California and will ensure educational standards and competence for the future practice of NPs, providing uniformity in the regulations.

We appreciate your consideration of our comments and thank the board for their continued work on this important area of our APRN practice.

Respectfully,

A handwritten signature in black ink that reads "Donna Emanuele". The signature is written in a cursive style with a large initial 'D' and 'E'.

Donna Emanuele, RN, MN, CNS, DNP, FNP-BC, FAANP  
President, CANP



**CALIFORNIA  
HOSPITAL  
ASSOCIATION**

*Providing Leadership in  
Health Policy and Advocacy*

October 8, 2015

Janette Wackerly, RN,BSN, MBA  
California Board of Registered Nursing  
Janette.wackerly@dca.ca.gov  
1747 North Market Blvd., Suite 150  
Sacramento, CA 95834

BY ELECTRONIC CORRESPONDENCE

**RE: PRE-NOTICE PUBLIC DISCUSSION FOR CALIFORNIA CODE OF  
REGULATIONS, TITLE 16, ARTICLE 8, SECTIONS 1480-1486, STANDARDS  
FOR NURSE PRACTITIONERS PROPOSED REGULATIONS**

Dear Ms. Wackerly:

The California Hospital Association (CHA), the largest professional hospital trade association in the nation, is the statewide leader representing the interests of hospitals and health systems in California with the legislature, the administration and regulatory agencies. CHA's vision is an optimally healthy society, where every Californian has equitable access to affordable, safe and high-quality health care. On behalf of its more than 400 member hospitals and health systems, CHA respectfully offers the following comments for consideration for the "pre-notice public discussion" period prior to the opening of the formal rulemaking process for Title 16, Article 8, Standards for Nurse Practitioners.

Advanced practice registered nurses (APRN), including their ability to practice to the full extent of their education and training, are key in the state's ability to improve access to care and promote delivery system transformation. More than 2.7 million additional California state residents who have enrolled in Medi-Cal since its expansion do not have access to services that could be provided by APRNs. It is imperative that nurse practitioners are well educated and competent to provide care, and that their professional competencies and state mandated regulations reflect contemporary practice.

Present standards for nurse practitioner regulations were adopted between 1979 and 1985. Much of Article 8 is no longer relevant, and in need of updates to definitions, categories, nurse practitioner use of title and standards of education. The Board of Registered Nursing (BRN) Nurse Practice Committee (NPC), comprised of board staff, has proposed changes reflective of current APRN practice based on foundational work of the *2008 National Council of State Board's of Nursing (NCSB) Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education*, a pivotal document that provides guidance for all states to adopt uniformity in the regulation of APRN roles. In 2008, awareness of the important role the APRNs play in improving access to high-quality, cost effective care grew nationally. However, the lack of common definitions regarding APRN roles, increasing numbers of nursing specializations and

debates on appropriate credentials and scope of practice, along with lack of uniformity in educational and state regulations, have limited patients' access to APRN care. The APRN consensus model document addresses these issues, and has been used both nationally and by the NPC as a springboard for necessary changes to California's outdated APRN regulations.

CHA supports raising APRN certifying standards to include the NPC's recommendations, such as certification and examination by an accredited certifying organization as outlined in suggested revision of Section 1482 Requirements for Certification as a Certified Nurse Practitioner, consistent with the APRN consensus model. This requirement currently applies to nurse anesthetists in California but not APRNs, making California one of only four states that does not require passage of a national certification exam for an APRN to enter into practice. This certification ensures that APRNs have the minimum level of knowledge needed to provide quality care to the public.

CHA strongly endorses this certification process to not only ensure competency, but also to help streamline the credentialing process so that APRNs can enter the workforce more quickly. Only nationally-certified APRNs are qualified to bill for Medicare services. Medi-Cal allows nationally certified APRNs to bill for certain services. This certification would allow APRNs to provide critical health care services in medically underserved areas of our state.

In addition to the APRN consensus model, the NPC based its proposed changes to the regulations on qualified organizational standards such as those from the National Organization for Nurse Practitioner Faculties and the National Task Force — the same standards used by accreditors reviewing nurse practitioner programs across the country. In the interest of being consistent and current with national accrediting standards, CHA strongly supports the changes suggested throughout the proposed regulations.

Significant health care changes drive the need to improve access to care through modernization of the regulations guiding professional practice. CHA firmly believes that the NPC-proposed changes are in the best interests of Californians, and encourages the California Board of Registered Nursing to fully endorse these changes through the formal rulemaking process.

CHA appreciates the opportunity to comment on proposed changes to Title 16, Article 8, Standards for Nurse Practitioners. If you have any questions or require additional input, please do not hesitate to contact me at [bjbartleson@calhospital.org](mailto:bjbartleson@calhospital.org) or (916) 552-7537.

/s/

BJ Bartleson, RN, MS, NEA-BS  
Vice President, Nursing and Clinical Services

cc: Louise Bailey, Med, RN, Executive Officer, BRN  
Michael Jackson, MSN, RN, CEN, MICN, President, BRN

BJB:rf



# Association of California Nurse Leaders

*A professional nursing organization that develops nurse leaders, advances professional practice, influences health policy and promotes quality and patient safety.*

October 5, 2015

Janette Wackerly, BSN, MBA, RN,  
Supervising Education Consultant  
Board of Registered Nursing  
1747 North Market Boulevard, Suite 150  
Sacramento, CA 95834

## **Regarding: Support of proposed adoption and revision of 1480-1486 in Article 8 of Title 16 of the California Code of Regulations**

Dear Mrs. Wackerly,

The Association of California Nurse Leaders (ACNL) is the voice for nursing leadership in our state representing nurse leaders in service and academia. Our membership is in **support** of the proposed revisions to Sections 1480-1486 in Article 8 of Title 16 of the California Code of Regulations.

ACNL is the largest state chapter of the American Organization of Nurse Executives with approximately 1400 members. ACNL's mission is to develop nurse leaders, promote professional nursing practice, influence health policy and promote quality health care and patient safety. For more than 35 years we have had an excellent working relationship with the Board of Registered Nursing (BRN) and staff. We respect the work the Board has done and continues to do to protect the public by regulating the practice of registered nurses. The proposed revisions supports the Board's mission.

An estimated five million Californians will be newly insured under health reform, and nurse practitioners (NPs) are critical in providing health care for this population. We need to ensure that nurse practitioners are well educated and competent to provide the best possible health care for our citizens.

ACNL supports the additional prerequisite for national certification and examination by an accredited certifying agency as a requirement for certification as a nurse practitioner in California. The examination requirement currently applies to nurse anesthetists in California and, we are asking that the same requirement apply to nurse practitioners. California is only one of four states which currently does not require passage of a nurse practitioner certification exam to enter into practice. ACNL supports the inclusion of appropriate grandfathering language as to not disenfranchise currently practicing NPs.

The examination ensures that recent nurse practitioner graduates have the minimum level of knowledge needed to safely enter into practice, and that they are competent to provide the best possible care for California residents. ACNL believes the requirement would also help streamline credentialing processes so NPs may enter the workforce more quickly. The proposed regulation would also facilitate reimbursement through full credentialing in programs such as

Medicare, Medi-Cal, Tricare and others, so NPs may effectively provide critical health services in medically underserved areas of our state.

The Association of California Nurse Leaders believes these regulatory updates are the next step in enhancing nurse practitioners' ability to effectively serve millions of Californians who will need health services under the Affordable Care Act (ACA). We hope the California Board of Registered Nursing will join us in supporting this important initiative on behalf of California's advanced practice nurses.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Patricia McFarland". The signature is fluid and cursive, with a long, sweeping underline that extends to the right.

Patricia McFarland, MS, RN, FAAN  
CEO, Association of California Nurse Leaders

cc. Louise Bailey, Med, RN, Executive Officer BRN  
Michael Jackson, MSN, RN, CEN, MICN, President, BRN

**Board of Registered Nursing**

Karen Hanford EdD, MSN, FNP

Dean, College of Graduate Nursing

Western University of Health Sciences

October 8, 2015

Educational Perspective in Support of the New Proposed Language for APRN Regulations.

The new APRN proposed regulations is needed to assure that APRN education meets standards of quality in education and graduates are competent to practice (protect the public) in CA. APRN national certification can serve as a benchmark and measure of student competency. I am an educator with over 30 years' experience and 20 years as a Family Nurse Practitioner. I am the founding Director for Western University of Health Sciences MSN/FNP program (1997) and have served as the founding Dean for the College of Graduate Nursing for 18 years. All of our Master's and Doctoral programs are BRN approved and CCNE accredited. It is imperative for CA to advance the APRN regulations to include national certification. Program effectiveness, transparency to consumers, and prospective students is required by multiple state and national entities. These include the Council of Higher Education (CHEA), Western Assoc of Senior Colleges and Universities (WASC), professional nursing accreditation (NLN, CCNE) and the Department of Education (state and national).

Fact

CA is **one of three states** that does not require national certification to practice as an APRN. This is an embarrassment in the academic community nationally. SON in CA cannot benchmark effectiveness of our programs to our professional accrediting bodies and students who are applying to APRN programs are not informed.

Nationally transparency for outcomes of schools is the norm. Schools are required to report outcome data, graduation rates, pass scores, etc. on their website. This is being driven by the Dept. of Education and the federal government due to concerns regarding student debt. Institutions must be accountable to the communities they serve, and students must make informed decisions when selecting a school.

Having benchmark data would actually assist the BRN to monitor NP outcomes and focus efforts to underperforming schools, similar to how schools are monitored by NCLEX pass rates. The blue print for the two APRN certification exams can be viewed on the website for each entity. The exams are very rigorous.

Cost Issues – if an APRN is not certified then there are less employment opportunities as you must be nationally certified to serve populations of patients (Medicare and Medical). Billing for services provided by APRN's to these populations is limited if they are not nationally certified. This is critical as

NP's care for the most vulnerable. If clinics are not able to secure sufficient funding, then our safety net clinics will not be sustainable.

Graduates would not be able to practice out of state. Why would our standards be less than other states?

Public Safety – would only be enhanced if all APRN's were held to a standard. The BRN does not have the resources to be experts in all APRN programs. National certification can assist the BRN as does NCLEX scores.

Recently the CACN surveyed all APRN schools of nursing on whether they felt CA schools should require national certification. Ninety (90%) of all schools supported national certification for APRN's. This survey was conducted by Dr. Lucy Huckabee at CSULB.

**My second comment** is in regards to the proposed standards by the APRN sub-committee and I find that the new regulations to be an improvement **except:**

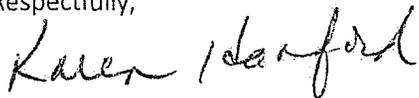
The one proposed regulation states the majority of preceptorship should be with NP's.

We do not have an adequate preceptor base to exclude MD's and DO's. We are moving healthcare towards a patient centered IP team and we need collaboration with all members of the healthcare team.

In addition, we need to increase the number of NP's to meet the healthcare needs of our nation.

Thank you for the time to review my public comments to the Practice Committee regarding the proposed new regulations.

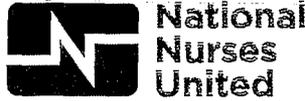
Respectfully,

A handwritten signature in cursive script that reads "Karen Hanford".

Karen Hanford EdD, MSN, FNP



CALIFORNIA  
NURSES  
ASSOCIATION



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August 31, 2015

Trande Phillips, RN  
Chairperson, Nursing Practice Committee  
California Board of Registered Nursing  
P.O. Box 944210  
Sacramento, CA 94244-2100

**RE: August 6, 2015 Draft Revisions to CCR, Title 16, Article 8, Sections 1480-1484 – OPPOSE**

Dear Ms. Phillips,

Thank you for the opportunity to provide comments on the regulatory proposal to update the Nurse Practitioner (NP) standards (California Code of Regulations Title 16, Article 8, §§ 1480-1484), as prepared by the Nursing Education Consultants for the BRN's Nursing Practice Committee meeting on August 6, 2015. The California Nurses Association (CNA) represents over 90,000 Registered Nurses (RNs) in California, many of whom are Advanced Practice Registered Nurses (APRNs) and RNs seeking to become APRNs. As such, we have a vested interest in both current and future APRN regulations, and appreciate your consideration of our comments.

As you are aware, CNA took an oppose position to the previous version of the draft regulations as discussed at the January 8, 2014 Nursing Practice Committee meeting. Regrettably, the revisions to the previous language do not adequately address our concerns. As such, CNA maintains its opposition to the proposed regulatory changes. Our opposition is based on five key concerns: (1) the proposed regulations are inconsistent with current statutes; (2) the proposed regulations will lead to an abdication of the Board's authority and responsibility to regulate NPs and NP education programs; (3) these regulations will dramatically increase costs for NPs; (4) we are concerned that the Board lacks the authority to promulgate these regulations; and (5) the proposed regulations put California on track to adopt compact licensure, which CNA strongly opposes.

**(1) The Board cannot promulgate the proposed regulations because they are inconsistent with current statutes:**

Government Code § 11349.1(a)(4) prohibits an agency from promulgating regulations which contradict or are inconsistent with an existing statute. CNA is concerned that several key provisions of the proposed regulations are inconsistent with current statutes. The first such provision is the requirement for all NPs to be nationally certified in order to practice. When it was introduced, AB 2226 (Spitzer 2004) would have amended Business & Professions Code § 2835.5 to add a fourth requirement mandating that all NPs seeking initial qualification on and after January 1, 2008 "[p]resent documentation of initial certification that he or she has been granted a nurse practitioner credential by a national certification organization

*recognized by the board.*" The bill was quickly amended to eliminate the requirement that NPs be credentialed by a national certification organization. After the amendment, the bill was passed by the legislature.

The fact that the legislature passed AB 2226 only after amending it to eliminate the national certification requirement strongly indicates that the legislature specifically disapproved of that language, and that the law should be interpreted to exclude that provision. This analysis of legislative history amounts to a rule of statutory interpretation, which is supported by ample California case law.<sup>1</sup> Given this rule of statutory interpretation, the regulations currently under consideration by the Board are in conflict with the Business & Professions Code. Thus, by requiring national certification as a condition of NP qualification, the Board may be proposing language that would violate Government Code § 11349.1(a)(4), which requires regulations to be consistent with existing statute. It is inappropriate for the Board to attempt to impose by regulatory fiat the precise requirement that was rejected by the Legislature not long ago.

CNA is also concerned that, by requiring national certification as a condition of practice, the Board is imposing a *de facto* requirement for a master's degree in nursing, which would directly conflict with existing law. The previous draft regulations presented to the Board on January 8, 2014, contained language in § 1482 *Requirements for Nurse Practitioner Certification*, which would have required NPs to have a "master's degree in nursing or a higher degree in nursing." This requirement was in direct conflict with B&P Code § 2835.5 (amended by AB 2226 in 2004), which states that, on and after January 1, 2008, an applicant for initial qualification as an NP must "possess a master's degree in nursing, a *master's degree in a clinical field related to nursing*, or a graduate degree in nursing." In our previous opposition letter, CNA argued that, because the draft required a "master's degree in nursing or a higher degree in nursing," but did not allow for "a master's degree in a clinical field related to nursing," the regulations directly conflicted with an existing statute and thus would violate the Government Code.

In the most recent discussion draft, presented to the Board on August 6, 2015, it appears that the requirement for NPs to have a master's degree in nursing has been removed from § 1482. While we appreciate these changes in their attempt to conform to the B&P Code, there are still two underlying problems that have not been resolved. First, in the latest draft regulations, § 1484 *Standards of Nurse Practitioner Education* requires NP programs to be "[a] college or university that prepares nurse practitioners at the master's degree or higher," whereas the current regulations allow for "[a]n institution of higher education that offers a baccalaureate or higher degree in nursing, medicine, or public health."

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<sup>1</sup> See, for example, *Prospect Medical Group Inc. v. Northridge Emergency Medical Group* (2006, 2<sup>nd</sup> Dist.) 136 Cal.App.4th 1155, 1169-70 ("[T]he Legislature's omission of a provision from the final version of a statute which was included in an earlier version 'constitutes strong evidence that the act as adopted should not be construed to incorporate the original provision.');" *People v. Goodloe* (1995, 1st Dist.) 37 Cal.App.4th 5433, 555 ("The evolution of a proposed statute after its original introduction in the Senate or Assembly can offer considerable enlightenment as to legislative intent. Generally the Legislature's retraction of a specific provision which appeared in the original version of an act supports the conclusion that the act should not be construed to include the omitted provision.);" *Wilson v. City of Laguna Beach* (1992, 4th Dist.) 6 Cal.App.4th 543, 555 ("The rejection [by the Legislature] of a specific provision contained in an act as originally introduced is most persuasive that the act should not be interpreted to include what was left out.")

Second, national certification companies like the American Nurses Credentialing Center (ANCC) and the National Certification Corporation (NCC) *do* require a master's, postgraduate, or doctoral degree from an NP program, and the draft regulations require national certification. Taken together, this implies that the regulations as proposed contain a *de facto* requirement for a master's degree or higher in nursing and do not allow for a master's degree in a *clinical field related to nursing*. As we stated in our previous comments, this *de facto* requirement conflicts with B&P Code § 2835.5 and lacks the flexibility that the Legislature intended when it passed AB 2226.

**(2) The proposed regulations will lead to an abdication of the Board's authority and responsibility to regulate NPs and NP education programs:**

CNA opposes the proposed regulations because they privatize a state responsibility and give undue authority to private, national certification corporations outside California. In the current proposal, certification by a national certification/accreditation company becomes a requirement for qualification to practice as an NP (as opposed to current regulations, in which certification is not mandatory, but is just one of several pathways to Board approval). In addition, accreditation becomes required for all NP education programs. Under the B&P Code § 2835, the Legislature gave the BRN the statutory authority to establish standards for NPs to practice in this state. By requiring NPs to be certified by national certification agencies, the Board is essentially handing over this responsibility and authority to private entities. We urge the Board to refrain from ceding power, responsibility, and authority to regulate nursing practice to a private enterprise.

In essence, this change allows national certification/accreditation corporations to dictate APRN standards to the state of California. Going forward, the BRN would have no control, input, or oversight over the contents of the certification examinations or accreditation standards. A state board cannot impose requirements on a private accrediting agency. The entities which provide national certification and accreditation, such as ANCC and NCC, do not operate with transparency and have no duty to accept input from the BRN regarding the content of their examinations, to notify the BRN when the content changes or share the nature of those changes. Furthermore, there is no way for the BRN to verify the examination's reliability in measuring competency or preparedness for current practice standards. Whether the BRN agrees with the content of these examinations and the philosophies of these accrediting agencies as they stand *today* is beside the point, because they are subject to change at any time without the insight and oversight of the Board members and staff.

The move to shift control away from the state board and towards private entities will not be limited to the advanced practice arena. If the Board allows this shift to occur, the same changes will be suggested next for other APRNs, and then for all RNs and RN programs. By ceding this authority, the BRN will become little more than a "rubber stamp" for the decisions made by private entities outside the state of California, whereas once it had genuine control over the regulation of the profession. This shift severely diminishes the Board's ability effectively to regulate the nursing profession within the state, to protect public safety, and to maintain its own high standards. The BRN retains some of the highest standards for practice in the

country; once these are replaced with a uniform national standard, the standards are likely to fall to the “lowest common denominator” seen in other states.

At the end of the day, these national credentialing and accreditation businesses are just that—businesses. The BRN has a statutorily mandated purpose, which is to protect the public. Indeed, § 2708.1 of the B&P Code mandates that protection of the public must be the Board’s highest priority, and that “[w]henver the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.” Private credentialing companies have no such mandate. Their overriding interest is not solely to maintain the integrity of the profession or the safety of the public, but to maximize the business interests of the corporation.

CNA contends there is an inherent conflict of interest where the company issuing credentials has a business interest in handing out more credentials, since the more people and institutions it approves, the more it can collect in certification, accreditation, and renewal fees. This is a conflict of interest that would harm both nurses and the public. CNA is also concerned that there was a conflict of interest at play in the development of these proposed regulations, since the Consensus Model for APRN Regulation, which provides the foundation for the current proposal, was developed by a workgroup which included the certification corporations themselves—business entities with a clear self-interest in requiring national certification for all NPs and accreditation for all NP programs. Indeed, more than 20% of the members of the APRN Consensus Process Work Group represented private accrediting bodies that stand to benefit financially from the implementation of this new regulation and both of the nursing accreditation bodies currently recognized by the US Department of Education had representatives on the committee that drafted the Consensus language.

Despite their nonprofit status, the national certification organizations charge very significant fees for the testing and certification services they provide (and pay their executives very handsome compensation packages). They are not organized and tax qualified as charitable or educational institutions under Internal Revenue Code (IRC) § 501(c)(3), but rather, as “business leagues” under § 501(c)(6). Reg. 1.501(c)(6)-1 defines a business league as

*“an association of persons having a common business interest, whose purpose is to promote the common business interest and not to engage in a regular business of a kind ordinarily carried on for profit. Its activities are directed to the improvement of business conditions of one or more lines of business rather than the performance of particular services for individual persons.”*

At their core and by definition, these institutions are designed to promote their own business interests, not necessarily the health, safety, or welfare of the public.

CNA recognizes that a new section has been added to the most recent draft proposal—§ 1483.1 *Requirements for Nurse Practitioner Education Programs Based in California*—in which language has been added to state that:

*“[t]he Board shall retain its authority to monitor, regulate and change the approval status for board approved nurse practitioner programs at any time. If the Board determines the program has not provided necessary compliance evidence to meet board regulations irrespective of institutional and national nursing accreditation status and review schedules” [sic.]*

We assume that this language is attempting to maintain the authority of the Board, despite the addition of the national accreditation requirement for all NP programs. While we appreciate the inclusion of this language, we do not think it goes far enough in protecting the Board’s role. By requiring all NP programs based in California to be accredited by national accreditation companies over which the Board has no input, oversight, or control, the Board is ceding too much of its statutory responsibility and authority to private companies. It is clear from the NCSBN’s *Preferred Future for Prelicensure Nursing Program Approval* guide that the ultimate goal of this agenda is significantly to minimize the role of state boards in the initial and continuing approval of nursing education programs. Although the plan is not to eliminate the state boards all together, their role would be limited mostly to enforcement, while the bulk of the oversight and approval responsibilities would belong to the private accreditation companies. Again, given that the Board has a statutory mandate to protect the public, while the accreditation companies are motivated primarily by their own business interests; this is a shift that should be of grave concern to the Board members and the public alike.

**(3) These regulations will dramatically increase costs for NPs, leading to a decrease in diversity in the field:**

CNA objects to the national certification requirement because it will impose on NPs an unnecessary and unfounded obligation to pay additional sums of money to a private enterprise in order to practice in this state. The requirement that all NPs must be credentialed by a national accreditation agency will make it significantly more costly and cumbersome for NPs to practice in California. As an example, to be certified by ANA/ANCC, an NP must pay \$395 for the certification exam and \$350 every 5 years for the renewal. This added expense will likely discourage RNs from becoming NPs, inhibit upward mobility for nurses from lower economic backgrounds, and discourage diversity in the field. Additionally, these prices are subject to change at any time, and the Board will have no control over such changes. At a time when the Board is already considering raising licensure fees in order to cover its own costs, it seems especially unjust to require NPs to hand over more money to a private enterprise.

Furthermore, despite the costly nature of this requirement, there is no evidence that requiring NPs to obtain national certification will lead to any additional protection for the public. To our knowledge, there is no credible quantitative, qualitative, or even anecdotal evidence demonstrating that such “certified” practitioners are more competent than those without national certification, or that national certification of NPs is correlated in any way with enhanced patient safety or improved patient outcomes. Given that this requirement would dramatically increase the cost of obtaining education and licensure as an NP, the lack of evidence of any benefit is troubling to say the least.

**(4) CNA is concerned that the Board lacks the authority to promulgate these regulations:**

Government Code § 11349.1(a)(2) requires an agency to have statutory authority to adopt, amend, or repeal a regulation. Without a statute enabling it to do so, CNA strongly questions whether the Board has the authority to promulgate new regulations requiring national certification as a prerequisite to practicing as an NP. California Business and Professions Code (B&P) § 2835 confers authority on the Board to establish the “standards and qualifications” required to practice as an NP in California. However, in § 2835.5, the statute lays out three specifically enumerated requirements for initial qualification on or after January 1, 2008:

- (1) Hold a valid and active registered nursing license issued under this chapter;*
- (2) Possess a master's degree in nursing, a master's degree in a clinical field related to nursing, or a graduate degree in nursing; and*
- (3) Satisfactorily complete a nurse practitioner program approved by the board.*

It is not clear whether the statute grants the Board authority to go beyond these statutory requirements by requiring national certification for all NPs.

**(5) These regulations will put California on track to adopt compact licensure, which CNA strongly opposes:**

The foundation for the recommended changes currently under consideration is the *Consensus Model for APRN regulation*, a document prepared by the National Council of State Boards of Nursing (NCSBN, Inc.) in conjunction with other professional organizations. CNA does not support the NCSBN's Consensus Model, in part due to its stated goal of allowing for “mutual recognition [of NPs] through compact.” CNA strongly opposes compact licensure due to a multitude of concerns, which have largely been shared by the Board. Amongst other reasons, CNA is concerned that compact licensure is likely to erode disciplinary procedures, public safety, educational standards, and continued competence.

- a. **Disciplinary Procedures:** The Board is empowered to discipline RNs and APRNs with licenses issued by the Board. Currently, only nurses with licenses issued by the Board are allowed to practice in California. Participating in the Compact would restrict the Board's ability to discipline or address complaints regarding RNs and APRNs practicing in California under licenses from other Compact states outside California.
- b. **Public Safety:** Currently several Compact states do not require licensees to undergo criminal background checks and fingerprinting before obtaining a license. Under the Compact, nurses from those states would be allowed to practice nursing in California under licenses from their home states.
- c. **Educational Standards:** Educational requirements vary widely from state to state. If California became part of the Compact, the Board would be forced to recognize licenses issued by states that do not conform to California's stringent educational standards. Thus, NPs from other states may effectively be held to a lower standard than NPs from our own state.
- d.

Trande Phillips, RN - Chairperson, Nursing Practice Committee  
California Board of Registered Nursing  
August 31, 2015  
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- e. **Continued Competence:** Continuing education requirements also vary widely from state to state. Some states have little to no continuing education requirement for license renewal. Under Compact licensure, the nurse is only required to meet the continued competence requirements in his or her home state, not in the state where s/he practices. Thus, if California became part of the Compact, nurses who have not met California's strict standards would still be able to practice here.

As Californians are gaining broader access to our health care system through the Patient Protection and Affordable Care Act, NPs and other APRNs will continue to be key providers of primary and specialty care. For this reason, it is vitally important that the Board act deliberately and methodically in order to protect the public interest and its own role in the regulation of this profession. We hope that the board will take these concerns into consideration and vote to oppose these regulatory changes at this time.

Thank you for your time and consideration.

Sincerely,

CALIFORNIA NURSES ASSOCIATION/  
NATIONAL NURSES UNITED



Donald W. Nielsen  
Director, Government Relations

cc: Cynthia Cipres Klein, RN, Nursing Practice Committee Member, BRN  
Elizabeth Woods, RN, FNP, MS, Nursing Practice Committee Member, BRN  
Michael Jackson, MSN, RN, CEN, MICN, Nursing Practice Committee Member, BRN  
Louise Bailey, RN, Executive Officer, BRN  
Janette Wackerly, RN, MBA, Nursing Education Consultant, BRN

**BOARD OF REGISTERED NURSING**  
**Nursing Practice Committee**  
**Agenda Item Summary**

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**AGENDA ITEM:** 10.2  
**DATE:** November 5, 2015

**ACTION REQUESTED:** Consideration for Appointment to the Nurse-Midwifery Committee

**REQUESTED BY:** Trande Phillips, RN, Chairperson

**BACKGROUND:**

In accordance with B & P Code Section 2746.2, the Board of Registered Nursing is responsible for appointing persons to serve on the Nurse-Midwifery Committee. The Nurse-Midwifery Committee is composed of direct practice nurse- midwives one each from northern and southern California, a nurse midwife engaged in nurse-midwifery education, one public member who has been a consumer of nurse midwifery practice and an obstetrical physician with knowledge of nurse midwifery-practice.

**POSSIBLE APPOINTMENTS**

Below are the names of the candidates who can be considered for appointment to the Nurse-Midwifery Committee.

<u>NAME</u>	<u>TITLE</u>	<u>Location</u>
Karen Ruby Brown	RN, CNM	San Diego -Southern
Karen Roslie	Public Member	Encinitas- Southern
Lin Lee	RN, CNM	Los Altos- Northern
Stuart Fischbein	MD	Los Angeles- Southern
Rachael Latta	RN, CNM	Santa Rosa- Northern
Naomi E. Stotland	MD	San Francisco- Northern
Anne Galko	RN, CNM	Oakland- Northern
BJ Snell	RN, CNM	Cota De Caza- Southern
Susan Stone	RN, CNM	Sacramento- Northern
Candace Curlee	RN, CNM	Encinitas- Southern
Christina Choi	RN, CNM	Woodland hills- Southern
Linda Church	RN, CNM	Orange- Southern
Yolanda Estremera	Public Member	San Jose- Northern
Jane Finney	Public Member	Cupertino- Northern
Susan Fischer Wilhelm	Public Member	Sacramento-Northern

**THE BOARD MADE THE FOLLOWING MOTIONS ON SEPTEMBER 3, 2015**

Nurse-Midwifery Committee be composed of

- One direct practice nurse-midwife from northern California
- One direct practice nurse mid-wife from southern California
- One nurse-midwifery educator
- One public member who is a consumer of nurse-midwifery services; and
- One obstetrical practicing with experience working with nurse-midwives- total of five members on the Committee.

Nurse Midwifery Committee should have membership with staggered terms for two direct practice nurse mid-wives. One direct practice nurse-midwife would be a term of two years and one direct nurse-midwife would be a term of three years. The other three members would have staggered terms of two years.

Nurse-midwifery committee will meet twice a year.

**NEXT STEP:**

**PERSON TO CONTACT:**

Janette Wackerly, MBA, BSN, RN  
Supervising Nursing Education Consultant  
(916) 574-7686

**BOARD OF REGISTERED NURSING**  
**Nursing Practice Committee**  
**Agenda Item Summary**

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**AGENDA ITEM:** 10.3  
**DATE:** November 5, 2015

**ACTION REQUESTED:** Review and vote on whether to approve: Physician Orders for Life Sustaining Treatment, POLST Signed By Nurse Practitioner and Physician Assistant under the Supervision of the Physician.

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

**BACKGROUND:**

AB 637, (Campos) Chapter 217, enacted during the 2015 legislative session (Chaptered 8/17/15), amends Section 4780 of the Probate Code, relating to resuscitative measures: Physician Orders for Life Sustaining Treatment (POLST) forms. This amendment authorizes the signature of a nurse practitioner or a physician assistant acting under the supervision of the physician and within the scope of practice authorized by law, to create a valid POLST form.

Existing law defines a request regarding resuscitative measures to mean a written document, signed by an individual, as specified, and the physician, that directs a health care provider regarding resuscitative measure, and includes a POLST form. Existing law requires a physician to treat a patient in accordance with the POLST form and specifies the criteria for creation of the POLST form, including that the form be completed by a health care provider based on the patient or his or her legally recognized health care decision maker.

Additional information regarding this can be found at the legislative information website at [http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab\\_0601-0650/ab\\_637\\_bill\\_20150817\\_chaptered.pdf](http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_0601-0650/ab_637_bill_20150817_chaptered.pdf)

and the BRN website at [www.rn.ca.gov/regulations/np.shtml](http://www.rn.ca.gov/regulations/np.shtml).

**NEXT STEPS:** Place on Board agenda.

**PERSON TO CONTACT:** Janette Wackerly, MBA, BSN, RN  
Supervising Nursing Education Consultant  
916.574-7686 [janette.wackerly@dca.ca.gov](mailto:janette.wackerly@dca.ca.gov)

## **Nurse Practitioner: Physician Orders for Life Sustaining Treatment (POLST)**

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Legislation enacted during 2015 session

AB 637, (Campos) Chapter 217 an act amend Section 4780 of the Probate Code, relating to resuscitative measures: Physician Orders for Life Sustaining Treatment forms.

The amendment to Section 4780 of the Probate Code authorizes the signature of a nurse practitioner or a physician assistant acting under the supervision of the physician and within the scope of practice authorized by law to create valid POLST form.

Existing law defines a request regarding resuscitative measures to mean a written document, signed by an individual, as specified, and the physician, that directs a health care provider regarding resuscitative measure, and includes a Physician Orders for Life Sustaining Treatment form (POLST form). Existing law requires a physician to treat a patient in accordance with the POLST form and specifies the criteria for creation of the POLST form, including that the form be completed by a health care provider based on the patient or his or her legally recognized health care decisionmaker.

The People of the state of California do enact as follows:

### **SECTION 1.**

Section 4780 of the Probate Code is amended to read:

(a) As used in this part:

(1) "Request regarding resuscitative measures" means a written document, signed by (A) an individual with capacity, or a legally recognized health care decisionmaker, and (B) the individual's physician, that directs a health care provider regarding resuscitative measures. A request regarding resuscitative measures is not an advance health care directive.

(2) "Request regarding resuscitative measures" includes one, or both of, the following:

(A) A prehospital "do not resuscitate" form as developed by the Emergency Medical Services Authority or other substantially similar form.

(B) A Physician Orders for Life Sustaining Treatment form, as approved by the Emergency Medical Services Authority.

(3) “Physician Orders for Life Sustaining Treatment form” means a request regarding resuscitative measures that directs a health care provider regarding resuscitative and life-sustaining measures.

(b) A legally recognized health care decisionmaker may execute the Physician Orders for Life Sustaining Treatment form only if the individual lacks capacity, or the individual has designated that the decisionmaker’s authority is effective pursuant to Section 4682.

(c) The Physician Orders for Life Sustaining Treatment form and medical intervention and procedures offered by the form shall be explained by a health care provider, as defined in Section 4621. The form shall be completed by a health care provider based on patient preferences and medical indications, and signed by a physician, or a nurse practitioner or a physician assistant acting under the supervision of the physician and within the scope of practice authorized by law, and the patient or his or her legally recognized health care decisionmaker. The health care provider, during the process of completing the Physician Orders for Life Sustaining Treatment form, should inform the patient about the difference between an advance health care directive and the Physician Orders for Life Sustaining Treatment form.

(d) An individual having capacity may revoke a Physician Orders for Life Sustaining Treatment form at any time and in any manner that communicates an intent to revoke, consistent with Section 4695.

(e) A request regarding resuscitative measures may also be evidenced by a medallion engraved with the words “do not resuscitate” or the letters “DNR,” a patient identification number, and a 24-hour toll-free telephone number, issued by a person pursuant to an agreement with the Emergency Medical Services Authority.