



**BOARD OF REGISTERED NURSING  
NURSING PRACTICE COMMITTEE**

**2015/2016 GOALS AND OBJECTIVES**

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**GOAL 1**            **In support of the consumers' right to quality care, identify and evaluate issues related to registered nursing tasks being performed by unlicensed assistive personnel.**

Objective 1.1      Take an active role in activities conducted by other agencies and organizations related to unlicensed assistive personnel.

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**GOAL 2**            **Promote patient safety as an essential and vital component of quality nursing care.**

Objective 2.1      Engage and dialogue with recognized national experts in supporting patient safety in what individuals and organizations have done and what remains to be done. For example, just culture and root cause analysis, failure mode and effect analysis, human factor and systems factor.

Objective 2.2      Monitor patient and resident safety activities as a component of quality nursing care such as health care errors, competency, patient outcomes, stakeholders, nursing shortage, ethics, lifelong learning, nursing standards, licensure, safety legislation, and magnet hospitals.

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**GOAL 3**            **Develop and implement processes for the Board to interact with stakeholders to identify current trends and issues in nursing practice and the health care delivery system.**

Objective 3.1      Actively participate with other public and private organizations and agencies involved with health care to identify common issues and to promote RN scope of practice consistent with the Nursing Practice Act and ensuring consumer safety.

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**GOAL 4**            **Identify and implement strategies to impact identified trends and issues.**

Objective 4.1      Provide timely written and/or verbal input on proposed regulations related to health care policies affecting nursing care.

Objective 4.2      Collaborate with the Education/Licensing Committee on educational issues/trends and the Legislative Committee on legislation pertaining to nursing practice.

Objective 4.3      Review and revise current BRN advisory statements and recommend new advisory statements as needed to clarify standards of nursing practice.

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**GOAL 5**      **Develop and implement processes for the Board to interact with stakeholders to identify and evaluate issues related to advanced practice nursing and to promote maximum utilization of advanced practice nursing.**

Objective 5.1      Support and promote full utilization of advanced practice nurses.

Objective 5.2      Monitor trends and growing opportunities for advanced practice nursing in areas of health promotion, prevention, and managing patients through the continuum of care.

Objective 5.3      Actively participate with organizations and agencies focusing on advanced practice nursing.

Objective 5.4      In collaboration with the Education/Licensing Committee remain actively involved in facilitating communication and work in progress for education/certification function and communication with advanced practice educational program directors, professional organizations, state agencies and other groups.

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

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**AGENDA ITEM:** 10.2  
**DATE:** April 2, 2015

**ACTION REQUESTED:**       **Information:** Community Paramedicine Pilot Project: A Model for Integrating Emergency and Primary Care- five different concepts at twelve project sites throughout California

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

**BACKGROUND:**

Office of Statewide Health Planning and Development (OSHPD), Health Workforce Pilot Project HWPP # 173 program, Community Paramedicine  
The project has an Advisory Committee and a Council of Advisors; the Advisory Committee (comprised of 13 members) and Council of Advisors (5 subject matter experts). Major responsibilities include participation and attendance at meetings, advisement on the efficacies of training, competence and the collection of data, review and advisement of project protocols related to triage and patient safety, participation and attendance at site visits, and advisement on evaluation of project reports as needed. Both groups will make recommendations on various aspects of the project. The Advisory Committee has voting ability while the Council of Advisors does not.

The following information is as a result of the meeting minutes published by OSHPD December 8, 2015 including PowerPoint presentations-

**Phase I:**

Pilot Project Concepts:

- Transport patients with specified conditions to alternative locations other than acute care emergency departments (Los Angeles, Carlsbad, Orange Counties)
- Alternative Destination Behavioral Health Issues to Mental Health Facilities (Stanislaus County)
- Frequent 9-1-1 Users, address needs by helping access primary care, social, or psychological services (City of San Diego, Alameda County)
- Post Discharge Support short term home follow-up care for recently discharged from hospital with increased risk of return to ER or readmission to acute referral by hospital, clinic, or medical provider (Solano, Alameda, Butte, San Bernardino, Orange, and Los Angeles Counties)
- TB Directly Observed Support, TB Specialty Clinic (Ventura County)
- Hospice Support to improve care and service to hospice patients who have activated 9-1-1 system. Provide comfort care using patient's own comfort care kit and supplemental medications until hospice clinicians can take over care (Ventura County)

Pilot Project Partners: See Attachment

**Phase II:**

Community Paramedicine “Core” Education Plan will be coordinated and delivered by the UCLA Center for Prehospital Care using affiliated faculty made up of nurses and physician Educators (didactic and clinical January 13, 2015- February 19, 2015). The curriculum was developed by Community Healthcare and Education Cooperative (CHEC). The curriculum was reviewed and approved by EMSA Curriculum Advisory Review Committee.

Community Paramedicine Site Specific Training (didactic and clinical) approved curricula will be taught locally by physicians and nurse educators with experience in emergency medicine and Public Health (March 2015-April 2015)

Numbers of individuals or groups will complete both statewide and local training and be considered “Community Paramedics.”

**Phase III:**

Employment and Intervention Phase where pilot projects begin employment/interventions phase following completion of Core and Site Specific Training (May/June 2015-November 2015)

**History:**

HWPP #173 Community Paramedicine is sponsored by the California Emergency Medical Services Authority (EMSA) and will be testing five different concepts at twelve project sites throughout California. The five concepts include alternate destinations, post-discharge follow-up, 9-1-1 frequent users, direct observed treatment of tuberculosis, and hospice patient support.

Community Paramedicine: *A Promising Model for Integrating Emergency and Primary Care*, report was prepared for the California HealthCare Foundation and California Emergency Medical Services Authority (EMSA). Grant funded by California HealthCare Foundation (Grant Number 17119, Regents of University of California). The organization providing leadership and support is UC Davis Institute for Population Health Improvement.

For any additional information, please contact Kristen Widdifield at OSHPD (916) 326-3718

**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

<b>Project #</b>	<b>Lead Agency</b>	<b>LEMSA</b>	<b>Pilot Concept</b>	<b>EMS Providers</b>	<b>Partners</b>
<b>CP001</b>	<b>UCLA Center for Pre Hospital Care</b>	<b>Los Angeles</b>	<b>Alternate Destination</b>	<b>Santa Monica, Glendale &amp; Pasadena Fire Dept's</b>	<b>Glendale Memorial Hospital, Huntington Medical Foundation Urgent Care Center, Kaiser Permanente, Pasadena Public Health Department UCLA Health System</b>
<b>CP002</b>	<b>UCLA Center for Pre Hospital Care</b>	<b>Los Angeles</b>	<b>Post Discharge Follow Up (CHF)</b>	<b>Burbank &amp; Glendale Fire Dept's</b>	<b>Providence St. Joseph's Medical Center</b>
<b>CP003</b>	<b>Orange County Fire Chief's Assoc</b>	<b>Orange County</b>	<b>Alternate Destination</b>	<b>Fountain Valley, Huntington Beach &amp; Newport Beach Fire Dept's</b>	<b>Covenant Health Network, Kaiser Permanente, Memorial Care Health System, University of California, Irvine Center for Disaster Medical Sciences</b>
<b>CP004</b>	<b>Butte County EMS</b>			<b>Butte County EMS, Inc</b>	<b>Enloe Medical Center</b>
<b>CP005</b>	<b>Ventura County EMS Agency</b>	<b>Ventura</b>	<b>Directly Observed Treatment of TB</b>	<b>AMR Ventura, Gold Coast Ambulance &amp; LifeLine Ambulance</b>	<b>Ventura Public Health Department</b>

<b>Project #</b>	<b>Lead Agency</b>	<b>LEMSA</b>	<b>Pilot Concept</b>	<b>EMS Providers</b>	<b>Partners</b>
<b>CP006</b>	<b>Ventura County EMS Agency</b>	<b>Ventura County EMS Agency</b>	<b>Hospice Support</b>	<b>AMR Ventura</b>	<b>Assisted Hospice Care of Ventura</b>
<b>CP007</b>	<b>Alameda County</b>	<b>Alameda County</b>	<b>Post Discharge Follow Up (CHF) &amp; Frequent 911 Callers</b>	<b>Alameda City Fire Department</b>	<b>Kaiser Permanente – Alameda County Medical Center</b>
<b>CP008</b>	<b>San Bernardino County Fire Department</b>	<b>Inland Counties Emergency Medical Agency</b>	<b>Post Discharge Follow up</b>	<b>San Bernardino County Fire Department</b>	<b>Arrowhead Regional Medical Center – San Bernardino County Department of Public Health</b>
<b>CP009</b>	<b>Carlsbad Fire Department</b>	<b>San Diego County EMS Agency</b>	<b>Alternate Destination</b>	<b>Carlsbad Fire Department</b>	<b>Kaiser Permanente</b>

<b>Project #</b>	<b>Lead Agency</b>	<b>LEMSA</b>	<b>Pilot Concept</b>	<b>EMS Providers</b>	<b>Partners</b>
<b>CP010</b>	<b>City of San Diego</b>	<b>San Diego County EMS Agency</b>	<b>Frequent 9-1-1 Callers</b>	<b>San Diego City Fire Department &amp; Rural Metro Corporation</b>	<b>San Diego Health and Human Services Agency, San Diego State Institute of Public Health, SDSU School of Social Work, UCSD Department of Preventive Medicine, UCSD Department of Emergency Medicine, Hospital Association of San Diego and Imperial Counties</b>
<b>CP012</b>	<b>Mountain Valley EMS Agency</b>	<b>Mountain Valley EMS Agency</b>	<b>Alternate Destination Mental Health</b>	<b>AMR Stanislaus County</b>	<b>Sutter Health Memorial Medical Center, Stanislaus County Behavioral Health and Recovery Services</b>
<b>CP013</b>	<b>Medic Ambulance – Solano</b>	<b>Solano County EMS Agency</b>	<b>Post Discharge Follow Up</b>	<b>Medic Ambulance – Solano</b>	<b>Kaiser Permanente</b>

# OSHPD Office of Statewide Health Planning and Development

## Healthcare Workforce Development Division

400 R Street, Suite 330  
Sacramento, California 95811-6213  
(916) 326-3700  
Fax (916) 322-2588  
www.oshpd.ca.gov



### Office of Statewide Health Planning and Development (OSHPD) Health Workforce Pilot Projects (HWPP) Program HWPP #173 Community Paramedicine Advisory Committee Meeting Notes

The HWPP #173 Advisory Committee meeting was scheduled on December 8, 2014 from 9:00am-4:00pm at the Office of Statewide Health Planning and Development (OSHPD) in Sacramento, California in Conference Room 471.

#### Welcome

Liz Martin, Healthcare Workforce Development Division Access to Care Section Chief, welcomed the meeting attendees, OSHPD staff and public guests. She also thanked them for their participation in the first Health Workforce Pilot Project #173 Community Paramedicine Advisory Committee meeting. Ms. Martin acknowledged that Linda Onstad-Adkins was serving as Acting Deputy Director in the absence of Lupe Alonzo-Diaz during her maternity leave.

Ms. Martin introduced HWPP #173 Community Paramedicine which is sponsored by the California Emergency Medical Services Authority (EMSA) and will be testing five different concepts at 12 project sites throughout California. The five concepts include alternate destination, post-discharge follow-up, 911 frequent users, direct observed treatment of tuberculosis and hospice patient support. She highlighted the department approval by OSHPD Director, Bob David, on November 14, 2014. Liz provided an overview of the day's proposed activities and further explained that the meeting will be focused on gathering input from the Advisory Committee and Council of Advisor members on data evaluation.

#### Overview of the HWPP Program

Ms. Martin noted historical highlights of HWPP including the program's inception in the early 1970's and explained how it provides the opportunity for healthcare-related organizations to demonstrate, test and evaluate new or expanded roles for healthcare professionals or new healthcare delivery alternatives before changes are made in law. Further, HWPP could be sponsored by hospitals or clinics, non-profit educational institutions or government agencies engaged in health or education activities. She concluded that the overall purpose of HWPP is to test healthcare strategies related to scope of practice, new concepts regarding health professional classifications, healthcare delivery strategies during periods of health professional shortage crisis and better access to healthcare.

Ms. Martin walked through the milestones of the application process for HWPP #173 Community Paramedicine to date. These included:

Milestone	Date
Application Submission	December 28, 2013
45-Day Public Comment	February 14 - March 30, 2014
Addendum Submission	June 9, 2014

Public Hearing	June 30, 2014
Public Hearing Transcript Distributed	October 13, 2014
OSHPD Project Approval	November 14, 2014

With regard to next steps, Ms. Martin explained the three major phases of this project to be data collection, training and employment utilization. She emphasized that the project would be evaluated on an ongoing basis by OSHPD with the number one priority of oversight to be patient safety. Additionally, she explained that the program staff would evaluate patient satisfaction, health outcomes and systems delivery efficacy.

Review Advisory Committee and Council of Advisors Roles and Responsibilities

Ms. Martin provided a summary of the Roles and Responsibilities for both the Advisory Committee (comprised of 13 members) and Council of Advisors (5 subject matter experts). Major responsibilities of both groups include participation and attendance in meetings, advisement on the efficacies of training, competencies and the collection of data, review and advisement of project protocols related to triage and patient safety, participation and attendance in site visits, advisement on evaluation of project reports as needed, and advisement of project issues, if they arise.

Both groups will provide recommendations to OSHPD on various aspects of the project and operate from a collaborative decision-making process. The only difference is that the Advisory Committee has a voting ability and the Council of Advisors does not. The recommendations that come from the both committees are considered advisory in nature to the program staff. OSHPD will consider these suggestions when making all final decisions.

Introductions

Ms. Martin asked all members of the Advisory Committee and Council of Advisors to introduce themselves to the group and share their interest in the project. A round table was completed where each person had the opportunity to share this information. It was also requested that a roster of all member names with contact information be provided following the meeting.

Presentation of HWPP #173 - EMSA

Dr. Howard Backer, Director of the California Emergency Medical Services Authority and Lou Meyer, Project Manager, conducted a thorough power point presentation of HWPP #173 Community Paramedicine. An electronic copy can be found attached, but the major discussion topics of their presentations included:

- Role of EMSA and the California EMS system
- Explanation of “Community Paramedicine”
- Need for HWPP #173 Community Paramedicine
- Explanation of five project concepts
- Project partners
- Project timelines

Presentation of Data Collection Frequency - UCSF

Dr. Janet Coffman, the project’s independent evaluator, conducted a thorough power point presentation on the current data collection elements proposed for the project as well as the methodology for obtaining such information. An electronic copy can be found attached, but the major discussion topics of her presentation included:

- Evaluation Plan Overview
- Data Components
- Data Collection Methods
- Data Collection Timeline

At the conclusion of the presentation, Dr. Coffman and Dr. Backer clarified the types of patient data which would be collected in response to questions raised by the committee members. Ms. Widdifield further added that both representatives would be available during the break-out sessions for consultation as needed.

### Break-Out Sessions

The Advisory Committee and Council of Advisor members sat together in groups of four or five individuals. Each group worked together to discuss the five concepts presented by EMSA including alternate destination, post-discharge follow-up, 911 frequent users, direct observed treatment of tuberculosis and hospice patient support. Specifically, they were given 45 minutes to discuss 1-2 concepts at a time and complete the following instructions:

1. Identify the data elements or outcomes that you would like to see captured by EMSA.
2. Once all data elements or outcomes have been captured, work as groups to identify the top five elements that you feel are most important to this project and put a star next to those five.
3. Explain how you would like to see your top five data elements or outcomes captured. There should be at least one methodology for each of the five items.

Each subsequent table built on the recommendations presented by the previous groups(s) so the information collected is a culmination of all discussion items. The comments regarding data elements or outcomes they would like to see captured by EMSA are summarized as follows:

### **Alternate Destination**

- Patient's source of admission (where they were picked up)
- Chief complaint for calling 911
- Identification of social issues or additional circumstances that prompted the 911 call
- Identification of the patient's injury or illness after being treated in an urgent care clinic (final disposition of the patient)
- Would like to see a clear definition of "adverse outcomes" added to protocols
- Number of patients admitted to an ER after treatment at an urgent care center
- Total time needed for patient disposition in the urgent care clinic AND at the ER if transferred later
- Number of patients who were declined by the receiving site
- Reasons why patients were declined by the receiving site
- Name of sites who denied the alternate transport
- Number of patients who declined treatment in the pilot program
- Reasons why patients declined treatment in the pilot program
- Identification of the chief complaint for those patients being transferred directly to an ED
- Assessment of the patient's ability to access primary care
- Amount of additional time spent on scene due to alternate destination
- Wait time at the urgent care clinic
- Would like to know if alternate destination patients are also considered to be 911 frequent users
- Monitor the specific medical discharge diagnosis
- Should consider "focused hot spotting" where preventative medicine could have helped in cases where there may be a high number of calls for a specific site's illnesses
- Behavioral health patients should receive a suicide assessment
- Behavioral health patients should receive detox if needed
- Track 5150 frequency
- Assess the global impact on patient's being seen in the ER

- Assess whether the volume of 911 calls has increased as a result of the pilot program because patients can get easier access to an urgent care center
- Cost of care for patient going to an alternate destination
- Similar concepts should develop shared knowledge of evidence-based, collaborative “best practices” since different jurisdictions may be making different decisions when working independently
- Track the payor source
- Patient satisfaction surveys

### **Post-Discharge Follow-Up**

- Patient’s source of admission (where they were picked up)
- Discharge disposition of all pilot program participants
- Comparison of 30-day readmission for the general population versus the inclusion group of pilot program participants with the same chronic conditions
- How many contacts/visits were needed with each patient
- Would like to know how Community Paramedics will ensure patient understanding of discharge plans, instructions on prescribed medications, and their after-care plan
- Number of patients referred to a social services agency or to a primary care physician after they were discharged
- Comparison of the ER medical records of participants prior to and after their enrollment in the pilot program
- Would like to know if the patient was referred for a clinic visit afterwards and if so, what was the result of the clinic visit in comparison to the original assessment?
- Recommend doing a “social element assessment” survey which would be inclusive of factors such as whether a patient lives alone or with family, identification of their source of care, analysis of their IADL (Instrumental Activity of Daily Living), housing stability, support system, etc.
- Patient satisfaction surveys

### **Frequent 911 users**

- Would like to see a clear definition of a “frequent 911 user.” There is a recommendation to adopt the definition included in CP010 for all frequent 911 user sites.
- Chief complaint for the patient calling 911(i.e. meals, medication, etc.)
- Patient’s comorbid conditions besides the chief complaint identified during their ER visit (i.e. medical or social issues)
- Patient’s language preference when receiving their healthcare information to ensure health literacy
- Patient’s source of admission (where they were picked up) and where they were returned to after receiving medical care – i.e. homeless center, public housing, the street, etc.
- Would like to know if the patients were given a clear discharge plan after their ER visit
- Number of patients referred to a social services agency or to a primary care physician after they were discharged
- Number of participants that stopped calling 911 but showed up in the ER instead as a result of the pilot program
- Number of times a follow-up is done with frequent users who have stopped calling 911
- Need data on whether there is a decrease in the number of Emergency Department visits or a decrease in the number of 911 calls to determine whether the pilot program is making a difference
- Need to develop a standardized plan for reporting adverse outcomes

- Patient satisfaction surveys

### **Direct Observed Treatment of Tuberculosis**

- Cost of Community Paramedic and entire crew to go out to patients
- Number of patients that were intended to find versus the number of patients they were able to find
- Treatment time/duration
- Location of treatment (i.e. home, assisted living, farm worker, homeless, etc.)
- Reasons why a scheduled day for observed treatment was missed and why
- Methodology of how Community Paramedics will ensure they complete all visits during their shift
- Compliance rate versus number of patients refusing care
- Identification of side effects in protocols and how to treat
- Would like to know how many patients responded to treatment and if they did not, were protocols changed?
- Would like to know how situations are handled on weekends when public health nurses do not work
- Would like to know what educational materials regarding the importance of medication usage are provided to patients when they deny treatment
- Would like to know who at the health facility is providing tuberculosis care and patient oversight (i.e. public health nurses, MDs, etc.)
- Would like to know if home visits ever result in an ER transport
- Reasons why patients fall out of the pilot program
- How the pilot program affects compliance with medication usage
- Cost savings with pilot program
- Patient satisfaction surveys to include language communication

### **Hospice Patient Support**

- Number of hospice patients enrolled in the pilot program
- Number of 911 calls made for patients enrolled in the pilot program
- Should discuss whether all hospice patients should be identified and enrolled in a health record system
- Reason for the 911 call beyond the chief complaint
- Would like to know if the family called hospice
- Would like to know if hospice responded to the 911 call
- If the family contacted hospice, what instructions did they receive, if any?
- Would like to know if a Community Paramedic or a regular Paramedic responds to the 911 calls
- Would like to know whether the Community Paramedic was able to keep the patient at home or if they had to transport them
- Would like to know if families can use the patient's care kits
- Is there an Advanced Directive or POLST (Physician-Ordered Life Sustaining Treatment) in place?
- Would like to know if patients were:
  - Transported to an ER and admitted OR
  - Transported and treated OR
  - Transported to a hospice inpatient facility
- Disposition data from community paramedics, hospitals, hospice and the families
- Cost of transporting the patient
- Patient and family satisfaction surveys

### Report-Out from Break-Out Sessions

A single representative from each of the three groups reported major highlights from the discussion of each concept. All comments have been captured in the detailed break-out section of the notes.

### Opportunity for Public Comment

There were no public comments made.

### Follow-Up Items

Kristen Widdifield will complete these follow-up items:

- Distribute a roster of all Advisory Committee and Council of Advisors members
- Develop meeting notes and provide absent members the opportunity to provide input
- Distribute finalized meeting notes
- Distribute a monthly report template for Advisory Committee input via e-mail
- Meet with EMSA to discuss implementation of OSHPD's recommended patient outcome data elements to be added to the project
- Develop a summary for Advisory Committee and Council of Advisors members to outline the patient outcome data which was approved
- Complete travel expense claims for Advisory Committee and Council of Advisors members

The meeting was adjourned at 3:00pm.

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

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**AGENDA ITEM:** 10.3

**DATE:** April 2, 2015

**ACTION REQUESTED:** Information: Status of Certified Nurse Midwives Association bill to remove supervision

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

**BACKGROUND:** CNMA President Linda Walsh requested presentation of CNMA Bill. Bill language attached; no bill number assigned.

**RESOURCES:**

**NEXT STEPS:** Board

**FISCAL IMPACT, IF ANY:** None

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

## LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, \_\_\_\_\_.

General Subject: Healing arts: certified nurse-midwives: scope of practice.

(1) Existing law, the Nursing Practice Act, provides for the licensure and regulation of the practice of nursing by the Board of Registered Nursing and authorizes the board to issue a certificate to practice nurse-midwifery to a person who meets educational standards established by the board or the equivalent of those educational standards. The act makes the violation of any of its provisions a misdemeanor punishable upon conviction by imprisonment in the county jail for not less than 10 days nor more than one year, or by a fine of not less than \$20 nor more than \$1,000, or by both that fine and imprisonment.

This bill would additionally require an applicant for a certificate to practice nurse-midwifery to provide evidence of current advanced level national certification by a certifying body that meets standards established and approved by the board. This bill would also require the board to create and appoint a Nurse-Midwifery Advisory



Council consisting of certified nurse-midwives in good standing with experience in hospital and nonhospital practice settings, a nurse-midwife educator, as specified, and a consumer of midwifery care. This bill would require the council to make recommendations to the board on all matters related to nurse-midwifery practice, education, and other matters specified by the board, and would require the council to meet regularly, but at least twice a year.

(2) The act authorizes a certified nurse-midwife, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn, and provides that the practice of nurse-midwifery constitutes the furthering or undertaking by a certified person, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal.

This bill would delete those provisions and would instead authorize a certified nurse-midwife to manage a full range of primary health care services for women from adolescence beyond menopause, including, but not limited to, gynecologic and family planning services. The bill would authorize a certified nurse-midwife to practice in all settings, including, but not limited to, a home. This bill would declare that the practice of nurse-midwifery within a health care system provides for consultation, collaboration, or referral as indicated by the health status of the client and the resources of the medical personnel available in the setting of care, and would provide that the practice of nurse-midwifery emphasizes informed consent, preventive care and early detection



and referral of complications to a physician and surgeon. This bill would authorize a certified nurse-midwife to provide peripartum care in an out-of-hospital setting to low-risk women with uncomplicated singleton-term pregnancies who are expected to have uncomplicated birth.

(3) The act authorizes a certified nurse-midwife to furnish and order drugs or devices incidentally to the provision of family planning services, routine health care or perinatal care, and care rendered consistently with the certified nurse-midwife's educational preparation in specified facilities and clinics, and only in accordance with standardized procedures and protocols, as specified.

This bill would delete the requirement that drugs or devices are furnished or ordered in accordance with standardized procedures and protocols. The bill would authorize a certified nurse-midwife to furnish and order drugs or devices in connection with care rendered in a home, and would authorize a certified nurse-midwife to directly procure supplies and devices, to order, obtain, and administer drugs and diagnostic tests, to order laboratory and diagnostic testing, and to receive reports that are necessary to his or her practice as a certified nurse-midwife and that are consistent with nurse-midwifery education preparation.

(4) The act also authorizes a certified nurse-midwife to perform and repair episiotomies and to repair first-degree and 2nd-degree lacerations of the perineum in a licensed acute care hospital and a licensed alternate birth center, if certain requirements are met, including, but not limited to, that episiotomies are performed pursuant to protocols developed and approved by the supervising physician and surgeon.



This bill would also authorize a certified nurse-midwife to perform and repair episiotomies and to repair first-degree and 2nd-degree lacerations of the perineum in a patient's home, and would delete all requirements that those procedures be performed pursuant to protocols developed and approved by the supervising physician and surgeon. The bill would require a certified nurse-midwife to provide emergency care to a patient during times when a physician and surgeon is unavailable.

This bill would provide that a consultative relationship between a certified nurse-midwife and a physician and surgeon by it self is not a basis for finding the physician and surgeon liable for any acts or omissions on the part of the certified nurse-midwife. The bill would also update cross-references as needed.

(5) Because the act makes a violation of any of its provisions a misdemeanor, this bill would expand the scope of an existing crime and therefore this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.



93837

02/21/15 09:49 AM  
RN 15 07129 PAGE 1

An act to amend Sections 2725.1, 2746.2, 2746.5, 2746.51, 2746.52, 4061, 4076, and 4170 of, and to add Section 2746.6 to, the Business and Professions Code, relating to healing arts.



150712993837BILLMA78

## THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 2725.1 of the Business and Professions Code is amended to read:

2725.1. (a) Notwithstanding any other ~~provision of law~~, a registered nurse may dispense drugs or devices upon an order by a licensed physician and surgeon or an order by a certified nurse-midwife, nurse practitioner, or physician assistant issued pursuant to Section 2746.51, 2836.1, or 3502.1, respectively, if the registered nurse is functioning within a licensed primary care clinic as defined in subdivision (a) of Section 1204 of, or within a clinic as defined in subdivision (b), (c), (h), or (j) of Section 1206 of, the Health and Safety Code.

(b) No clinic shall employ a registered nurse to perform dispensing duties exclusively. No registered nurse shall dispense drugs in a pharmacy, keep a pharmacy, open shop, or drugstore for the retailing of drugs or poisons. No registered nurse shall compound drugs. Dispensing of drugs by a registered nurse, except a certified nurse-midwife who functions pursuant to ~~a standardized procedure or protocol described in~~ Section 2746.51 or a nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, shall not include substances included in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code). Nothing in this section shall exempt a clinic from the provisions of Article 13 (commencing with Section 4180) of Chapter 9.

(c) ~~Nothing in this~~ This section shall not be construed to limit any other authority granted to a certified nurse-midwife pursuant to Article 2.5 (commencing with Section



2746), to a nurse practitioner pursuant to Article 8 (commencing with Section 2834), or to a physician assistant pursuant to Chapter 7.7 (commencing with Section 3500).

(d) ~~Nothing in this~~ This section shall not be construed to affect the sites or types of health care facilities at which drugs or devices are authorized to be dispensed pursuant to Chapter 9 (commencing with Section 4000).

SEC. 2. Section 2746.2 of the Business and Professions Code is amended to read:

2746.2. (a) Each applicant shall show by evidence satisfactory to the board that he or she has met the educational standards established by the board or has at least the equivalent thereof. The board is authorized to appoint a committee of qualified physicians and nurses, including, but not limited to, obstetricians and nurse-midwives, to develop the necessary standards relating to educational requirements, ratios of nurse-midwives to supervising physicians, and associated matters thereof, including evidence of current advanced level national certification by a certifying body that meets standards established and approved by the board.

(b) The board shall create and appoint a Nurse-Midwifery Advisory Council consisting of certified nurse-midwives in good standing with experience in hospital and nonhospital practice settings, a nurse-midwife educator who has demonstrated familiarity with consumer needs, collegial practice and accompanied liability, and related educational standards in the delivery of maternal-child health care, and a consumer of midwifery care. The council shall make recommendations to the board on all matters related to nurse-midwifery practice, education, and other matters as specified by the board. The council shall meet regularly, but at least twice a year.



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SEC. 3. Section 2746.5 of the Business and Professions Code is amended to read:

2746.5. (a) ~~The certificate to practice nurse-midwifery authorizes the holder, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family planning care, for the mother, and immediate care for the newborn. holder to manage a full range of primary health care services for women from adolescence to beyond menopause. These services include, but are not limited to, primary health care, gynecologic and family planning services, preconception care, care during pregnancy, childbirth, and the postpartum period, immediate care of the newborn, and treatment of male partners for sexually transmitted infections. A certified nurse-midwife is authorized to practice in all settings, including, but not limited to, private practice, clinics, hospitals, birth centers, and homes.~~

(b) ~~As used in this chapter, the practice of nurse-midwifery constitutes the furthering or undertaking by any certified person, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal. All complications shall be referred to a physician immediately. The practice of nurse-midwifery does not include the assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any version. within a health care system provides for consultation, collaboration, or referral as indicated by the health status of the patient and the resources and medical personnel available in the setting of care. When providing peripartum care in out-of-hospital settings, the certified nurse-midwife~~



shall only provide care to low-risk women with uncomplicated singleton-term pregnancies who are expected to have an uncomplicated birth. The practice of nurse-midwifery care emphasizes informed consent, preventive care, and early detection and referral of complications to physicians and surgeons. While practicing in a hospital setting, the certified nurse-midwife shall collaboratively care for women with more complex health needs.

~~(e) As used in this article, "supervision" shall not be construed to require the physical presence of the supervising physician.~~

~~(d)~~

~~(c) A certified nurse-midwife is not authorized to practice medicine and surgery by the provisions of this chapter.~~

~~(e)~~

~~(d) Any regulations promulgated by a state department that affect the scope of practice of a certified nurse-midwife shall be developed in consultation with the board.~~

SEC. 4. Section 2746.51 of the Business and Professions Code is amended to read:

2746.51. (a) Neither this chapter nor any other provision of law shall be construed to prohibit a certified nurse-midwife from furnishing or ordering drugs or devices, including controlled substances classified in Schedule II, III, IV, or V under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code), when all of the following apply:

~~(1) The the drugs or devices are furnished or ordered incidentally related to the provision of any of the following:~~



(A)

(1) Family planning services, as defined in Section 14503 of the Welfare and Institutions Code.

(B)

(2) Routine health care or perinatal care, as defined in subdivision (d) of Section 123485 of the Health and Safety Code.

(C)

(3) Care rendered, consistent with the certified nurse-midwife's educational preparation or for which clinical competency has been established and maintained, to persons within a facility specified in subdivision (a), (b), (c), (d), (i), or (j) of Section 1206 of the Health and Safety Code, a clinic as specified in Section 1204 of the Health and Safety Code, a general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code, a licensed birth center as defined in Section 1204.3 of the Health and Safety Code, or a special hospital specified as a maternity hospital in subdivision (f) of Section 1250 of the Health and Safety Code.

(4) Care rendered in a home pursuant to subdivision (a) of Section 2746.5.

~~(2) The drugs or devices are furnished or ordered by a certified nurse-midwife in accordance with standardized procedures or protocols. For purposes of this section, standardized procedure means a document, including protocols, developed and approved by the supervising physician and surgeon, the certified nurse-midwife, and the facility administrator or his or her designee. The standardized procedure covering the furnishing or ordering of drugs or devices shall specify all of the following:~~

~~(A) Which certified nurse-midwife may furnish or order drugs or devices.~~



~~(B) Which drugs or devices may be furnished or ordered and under what circumstances:~~

~~(C) The extent of physician and surgeon supervision.~~

~~(D) The method of periodic review of the certified nurse-midwife's competence, including peer review, and review of the provisions of the standardized procedure.~~

~~(3) If Schedule II or III controlled substances, as defined in Sections 11055 and 11056 of the Health and Safety Code, are furnished or ordered by a certified nurse-midwife, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician and surgeon. For Schedule II controlled substance protocols, the provision for furnishing the Schedule II controlled substance shall address the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.~~

~~(4) The furnishing or ordering of drugs or devices by a certified nurse-midwife occurs under physician and surgeon supervision. For purposes of this section, no physician and surgeon shall supervise more than four certified nurse-midwives at one time. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include all of the following:~~

~~(A) Collaboration on the development of the standardized procedure or protocol.~~

~~(B) Approval of the standardized procedure or protocol.~~

~~(C) Availability by telephonic contact at the time of patient examination by the certified nurse-midwife.~~

(b) (1) The furnishing or ordering of drugs or devices by a certified nurse-midwife is conditional on the issuance by the board of a number to the applicant who has



successfully completed the requirements of paragraph (2). The number shall be included on all transmittals of orders for drugs or devices by the certified nurse-midwife. The board shall maintain a list of the certified nurse-midwives that it has certified pursuant to this paragraph and the number it has issued to each one. The board shall make the list available to the California State Board of Pharmacy upon its request. Every certified nurse-midwife who is authorized pursuant to this section to furnish or issue a drug order for a controlled substance shall register with the United States Drug Enforcement Administration.

(2) The board has certified in accordance with paragraph (1) that the certified nurse-midwife has satisfactorily completed a course in pharmacology covering the drugs or devices to be furnished or ordered under this section. The board shall establish the requirements for satisfactory completion of this paragraph.

~~(3) A physician and surgeon may determine the extent of supervision necessary pursuant to this section in the furnishing or ordering of drugs and devices.~~

~~(4) A copy of the standardized procedure or protocol relating to the furnishing or ordering of controlled substances by a certified nurse-midwife shall be provided upon request to any licensed pharmacist who is uncertain of the authority of the certified nurse-midwife to perform these functions.~~

~~(5)~~

~~(3)~~ Certified nurse-midwives who are certified by the board and hold an active furnishing number, who are currently authorized through standardized procedures or protocols to furnish Schedule II controlled substances, and who are registered with the United States Drug Enforcement Administration shall provide documentation of



continuing education specific to the use of Schedule II controlled substances in settings other than a hospital based on standards developed by the board.

(c) Drugs or devices furnished or ordered by a certified nurse-midwife may include Schedule II controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) ~~under the following conditions:~~

~~(1) The when the drugs and devices are furnished or ordered in accordance with requirements referenced in paragraphs (2) to (4), inclusive, of subdivision (a) and in paragraphs (1) to (3), inclusive, of subdivision (b).~~

~~(2) When Schedule II controlled substances, as defined in Section 11055 of the Health and Safety Code, are furnished or ordered by a certified nurse-midwife, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician and surgeon.~~

(d) Furnishing of drugs or devices by a certified nurse-midwife means the act of making a pharmaceutical agent or agents available to the patient in strict accordance with a standardized procedure or protocol. Use of the term "furnishing" in this section shall include the following: patient.

~~(1) The ordering of a drug or device in accordance with the standardized procedure or protocol:~~

~~(2) Transmitting an order of a supervising physician and surgeon.~~

(e) "Drug order" or "order" for purposes of this section means an order for medication or for a drug or device that is dispensed to or for an ultimate user, issued by a certified nurse-midwife as an individual practitioner, within the meaning of Section



1306.03 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription of the supervising a physician; (2) all references to “prescription” in this code and the Health and Safety Code shall include drug orders issued by certified nurse-midwives; and (3) the signature of a certified nurse-midwife on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

(f) A certified nurse-midwife is authorized to directly procure supplies and devices, to order, obtain, and administer drugs and diagnostic tests, to order laboratory and diagnostic testing, and to receive reports that are necessary to his or her practice as a certified nurse-midwife and consistent with nurse-midwifery education preparation.

SEC. 5. Section 2746.52 of the Business and Professions Code is amended to read:

2746.52. (a) Notwithstanding Section 2746.5, the certificate to practice nurse-midwifery authorizes the holder to perform and repair episiotomies, and to repair first-degree and second-degree lacerations of the perineum, in a licensed acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, and in a licensed alternate birth center, as defined in paragraph (4) of subdivision (b) of Section 1204 of the Health and Safety Code, but only if all of the following conditions are met: and in a home pursuant to subdivision (a) of Section 2746.5.

(a) The supervising physician and surgeon and any backup physician and surgeon is credentialed to perform obstetrical care in the facility.





SEC. 6. Section 2746.6 is added to the Business and Professions Code, to read:

2746.6. A consultative relationship between a certified nurse-midwife and a physician and surgeon shall not, by it self, provide the basis for finding a physician and surgeon liable for any act or omission of the certified nurse-midwife.

SEC. 7. Section 4061 of the Business and Professions Code is amended to read:

4061. (a) ~~No~~ A manufacturer's sales representative shall not distribute any dangerous drug or dangerous device as a complimentary sample without the written request of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7. However, a certified nurse-midwife who functions pursuant to ~~a standardized procedure or protocol described in~~ Section 2746.51, a nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, a physician assistant who functions pursuant to a protocol described in Section 3502.1, or a naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, may sign for the request and receipt of complimentary samples of a dangerous drug or dangerous device that has been identified in the standardized procedure, protocol, or practice agreement. Standardized procedures, protocols, and practice agreements shall include specific approval by a physician. A review process, consistent with the requirements of Section 2725, 3502.1, or 3640.5, of the complimentary samples requested and received by a nurse practitioner, certified nurse-midwife, physician assistant, or naturopathic doctor, shall be defined within the standardized procedure, protocol, or practice agreement.

(b) Each written request shall contain the names and addresses of the supplier and the requester, the name and quantity of the specific dangerous drug desired, the



name of the certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor, if applicable, receiving the samples pursuant to this section, the date of receipt, and the name and quantity of the dangerous drugs or dangerous devices provided. These records shall be preserved by the supplier with the records required by Section 4059.

(c) Nothing in this section is intended to expand the scope of practice of a certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor.

SEC. 8. Section 4076 of the Business and Professions Code is amended to read:

4076. (a) A pharmacist shall not dispense any prescription except in a container that meets the requirements of state and federal law and is correctly labeled with all of the following:

(1) Except when the prescriber or the certified nurse-midwife who functions pursuant to ~~a standardized procedure or protocol described in~~ Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6 orders otherwise, either the manufacturer's trade name of the drug or the generic name and the name of the manufacturer. Commonly used abbreviations may be used. Preparations containing two or more active ingredients may be identified by the manufacturer's trade name or the commonly used name or the principal active ingredients.

(2) The directions for the use of the drug.



(3) The name of the patient or patients.

(4) The name of the prescriber or, if applicable, the name of the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6.

(5) The date of issue.

(6) The name and address of the pharmacy, and prescription number or other means of identifying the prescription.

(7) The strength of the drug or drugs dispensed.

(8) The quantity of the drug or drugs dispensed.

(9) The expiration date of the effectiveness of the drug dispensed.

(10) The condition or purpose for which the drug was prescribed if the condition or purpose is indicated on the prescription.

(11) (A) Commencing January 1, 2006, the physical description of the dispensed medication, including its color, shape, and any identification code that appears on the tablets or capsules, except as follows:

(i) Prescriptions dispensed by a veterinarian.



(ii) An exemption from the requirements of this paragraph shall be granted to a new drug for the first 120 days that the drug is on the market and for the 90 days during which the national reference file has no description on file.

(iii) Dispensed medications for which no physical description exists in any commercially available database.

(B) This paragraph applies to outpatient pharmacies only.

(C) The information required by this paragraph may be printed on an auxiliary label that is affixed to the prescription container.

(D) This paragraph shall not become operative if the board, prior to January 1, 2006, adopts regulations that mandate the same labeling requirements set forth in this paragraph.

(b) If a pharmacist dispenses a prescribed drug by means of a unit dose medication system, as defined by administrative regulation, for a patient in a skilled nursing, intermediate care, or other health care facility, the requirements of this section will be satisfied if the unit dose medication system contains the aforementioned information or the information is otherwise readily available at the time of drug administration.

(c) If a pharmacist dispenses a dangerous drug or device in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include on individual unit dose containers for a specific patient, the name of the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a



standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6.

(d) If a pharmacist dispenses a prescription drug for use in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include the information required in paragraph (11) of subdivision (a) when the prescription drug is administered to a patient by a person licensed under the Medical Practice Act (Chapter 5 (commencing with Section 2000)), the Nursing Practice Act (Chapter 6 (commencing with Section 2700)), or the Vocational Nursing Practice Act (Chapter 6.5 (commencing with Section 2840)), who is acting within his or her scope of practice.

SEC. 9. Section 4170 of the Business and Professions Code is amended to read:

4170. (a) ~~No~~A prescriber shall not dispense drugs or dangerous devices to patients in his or her office or place of practice unless all of the following conditions are met:

(1) The dangerous drugs or dangerous devices are dispensed to the prescriber's own patient, and the drugs or dangerous devices are not furnished by a nurse or physician attendant.

(2) The dangerous drugs or dangerous devices are necessary in the treatment of the condition for which the prescriber is attending the patient.

(3) The prescriber does not keep a pharmacy, open shop, or drugstore, advertised or otherwise, for the retailing of dangerous drugs, dangerous devices, or poisons.

(4) The prescriber fulfills all of the labeling requirements imposed upon pharmacists by Section 4076, all of the recordkeeping requirements of this chapter,



and all of the packaging requirements of good pharmaceutical practice, including the use of childproof containers.

(5) The prescriber does not use a dispensing device unless he or she personally owns the device and the contents of the device, and personally dispenses the dangerous drugs or dangerous devices to the patient packaged, labeled, and recorded in accordance with paragraph (4).

(6) The prescriber, prior to dispensing, offers to give a written prescription to the patient that the patient may elect to have filled by the prescriber or by any pharmacy.

(7) The prescriber provides the patient with written disclosure that the patient has a choice between obtaining the prescription from the dispensing prescriber or obtaining the prescription at a pharmacy of the patient's choice.

(8) A certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, a nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, a physician assistant who functions pursuant to Section 3502.1, or a naturopathic doctor who functions pursuant to Section 3640.5, may hand to a patient of the supervising physician and surgeon a properly labeled prescription drug prepackaged by a physician and surgeon, a manufacturer as defined in this chapter, or a pharmacist.

(b) The Medical Board of California, the State Board of Optometry, the Bureau of Naturopathic Medicine, the Dental Board of California, the Osteopathic Medical Board of California, the Board of Registered Nursing, the Veterinary Medical Board, and the Physician Assistant Committee shall have authority with the California State Board of Pharmacy to ensure compliance with this section, and those boards are



specifically charged with the enforcement of this chapter with respect to their respective licensees.

(c) "Prescriber," as used in this section, means a person, who holds a physician's and surgeon's certificate, a license to practice optometry, a license to practice naturopathic medicine, a license to practice dentistry, a license to practice veterinary medicine, or a certificate to practice podiatry, and who is duly registered by the Medical Board of California, the State Board of Optometry, the Bureau of Naturopathic Medicine, the Dental Board of California, the Veterinary Medical Board, or the Board of Osteopathic Examiners of this state.

SEC. 10. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.



Ms. Louise R. Bailey, MEd, BSN, RN  
Executive Officer  
California Board of Registered Nursing  
PO Box 944210  
Sacramento, CA 94244



March 5, 2015

ATTN: Nursing Practice Committee

Dear Ms. Bailey and Committee Members,

My name is Linda Walsh (CNM, MPH, Ph.D., FACNM) and I am the President of the California Nurse Midwives Association. Thank you for the opportunity to provide comments regarding AB 1306, introduced by Assembly Member Autumn Burke.

As you recall, following comments brought by the California Nurse-Midwives Association to the committee at the October 2014 meeting regarding concerns about current wording in the Business and Professions Code Sections 2746.2, 2746.5, 2746.51, 2746.52, committee members encouraged CNMA members in attendance to address the concerns through the legislative process. The current statute requires physician supervision "to attend cases of normal childbirth and to provide prenatal, intrapartum, and post-partum care, including family-planning care, for the mother and immediate care for the newborn." The supervision requirement has resulted in barriers to the full practice authority of certified nurse midwives (CNMs) throughout the state, and the difficulty in obtaining a supervising physician has particularly resulted in barriers to provision of care to women seeking out-of-hospital care.

AB 1306 seeks to bring the Nurse Practice Act language regarding CNM practice in concert with the current practice standards established by the American College of Nurse Midwives and its accreditation and certification bodies, as well as the recognition of full practice authority for APRNs (advanced practice registered nurses) published in numerous policy and position papers promulgated by a variety of professional nursing organizations. The following points provide a summary of the priority concepts required to ensure the ability of CNMs to provide nurse-midwifery care to the full extent of their education, continued training and certification.

- **Removal of physician supervision.** Physician supervision, while required by current statute, is not defined and therefore is open to multiple interpretations of the requirement, depending on circumstances. The statute clearly states that " 'supervision' shall not be construed to require the physical presence of the supervising physician," yet nurse-midwives often face arbitrary requirements to demonstrate a supervisory relationship with a physician. This results in limiting the ability of CNMs to provide care in a variety of geographic areas and health care facilities, as well as limiting their ability to provide full scope of services in underserved communities. Physician supervision also places a burden on our physician colleagues. Most facilities require physician co-signatures for admission and discharge, even though the physician may not have been present during care and may not have had a personal encounter with the patient. This results

in physicians providing record-keeping documentation when they could be providing direct care to patients requiring physician care.

- **Authorization of provision of care in all settings, “including but not limited to the home.”** Current language inhibits the safe provision of care in out-of-hospital settings by restricting certain procedures in the home. AB 1306 proposes the authorization to perform and repair episiotomies and to repair 1<sup>st</sup> and 2<sup>nd</sup> degree lacerations in the home setting. The bill also deletes the need for a written standardized procedure to perform these procedures.
- **Establishment of “current advanced national certification by a certifying body that meets standards established and approved by the board” as a requirement for practice in the state.** This requirement will provide consistency with the growing body of evidence that demonstrates the association of professional certification with patient safety.
- **Establishment of a Nurse-Midwifery Advisory Council to “make recommendations to the board on all matters related to nurse-midwifery practice, education and other matters specified by the board.”** Current language has been interpreted the establishment of a Council to be optional as determined by the board. Periodic meetings of an advisory council has the potential to decrease the need for costly disciplinary proceedings by clarifying CNM practice and improving communication with licentiates regarding regulatory expectations.
- **Removal of the requirement that “drugs and devices are furnished or ordered in accordance with standardized procedures and protocols.”** This requirement establishes barriers to CNMs in a variety of settings, but particularly in out-of-hospital settings. Proposed new wording would remove the standardized procedure requirement and authorize the CNM to directly procure supplies and devices and to order, obtain and administer drugs and diagnostic tests, and to order diagnostic testing and receive reports necessary for practice.

CNMA and CABCA (California Birth Center Association) have developed these priorities by enlisting the wisdom and insight of numerous leaders in women’s health care in the state. We believe that passage of this bill will contribute to increasing access to care that has been shown to 1) reduce morbidity and mortality related to the use of unnecessary interventions; 2) decrease health care costs by supporting normal physiologic birth to low risk pregnant women; 3) increase access to high quality care (particularly in underserved communities and populations), and 4) increase patient satisfaction.

I appreciate the time to present these priorities to this committee and welcome any questions you may have.

Sincerely,

Linda V. Walsh CNM, MPH, Ph.D., FACNM  
President, California Nurse Midwives Association

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

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**AGENDA ITEM:** 10.4

**DATE:** April 2, 2015

**ACTION REQUESTED:** Discussion and possible vote on whether to recommend regulatory language for aspiration abortion techniques implementing section 2725.4 of the Business and Professions Code

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

**BACKGROUND:** In order to perform an abortion by aspiration techniques pursuant to Section 2725.4, a person with a license or certificate to practice as a nurse practitioner or a certified nurse-midwife shall complete training recognized by the Board of Registered Nursing. The proposed regulatory action will set forth parameters in order to comply with BCP Section 2725.4.

**RESOURCES:**

**NEXT STEPS:** Board

**FISCAL IMPACT, IF ANY:** None

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



**BOARD OF REGISTERED NURSING**  
PO Box 944210, Sacramento, CA 94244-2100  
P (916) 322-3350 F (916) 574-8637 | [www.rn.ca.gov](http://www.rn.ca.gov)  
**Louise R. Bailey, MEd, RN, Executive Officer**

#### **2725.4. Abortion by aspiration techniques; Requirements**

Notwithstanding any other provision of this chapter, the following shall apply:

(a) In order to perform an abortion by aspiration techniques pursuant to Section 2253, a person with a license or certificate to practice as a nurse practitioner or a certified nurse-midwife shall complete training recognized by the Board of Registered Nursing. Beginning January 1, 2014, and until January 1, 2016, the competency-based training protocols established by Health Workforce Pilot Project (HWPP) No. 171 through the Office of Statewide Health Planning and Development shall be used.

(b) In order to perform an abortion by aspiration techniques pursuant to Section 2253, a person with a license or certificate to practice as a nurse practitioner or a certified nurse-midwife shall adhere to standardized procedures developed in compliance with subdivision (c) of Section 2725 that specify all of the following:

- (1) The extent of supervision by a physician and surgeon with relevant training and expertise.
- (2) Procedures for transferring patients to the care of the physician and surgeon or a hospital.
- (3) Procedures for obtaining assistance and consultation from a physician and surgeon.
- (4) Procedures for providing emergency care until physician assistance and consultation are available.
- (5) The method of periodic review of the provisions of the standardized procedures.

(c) A nurse practitioner or certified nurse-midwife who has completed training and achieved clinical competency through HWPP No. 171 shall be authorized to perform abortions by aspiration techniques pursuant to Section 2253, in adherence to standardized procedures described in subdivision (b).

(d) It is unprofessional conduct for any nurse practitioner or certified nurse-midwife to perform an abortion by aspiration techniques pursuant to Section 2253 without prior completion of training and validation of clinical competency.

(Added Stats 2013 ch 662 § 2 (AB 154), effective January 1, 2014.)

#### **2725.5. "Advanced practice registered nurse" defined**

"Advanced practice registered nurse" means those licensed registered nurses who have met the requirements of Article 2.5 (commencing with Section 2746), Article 7 (commencing with Section 2825), Article 8 (commencing with Section 2834), or Article 9 (commencing with Section 2838).

(Added Stats 2003 ch 640 § 6 (SB 358).)

#### **2726. Unauthorized practices**

Except as otherwise provided herein, this chapter confers no authority to practice medicine or surgery.

(Added Stats 1939 ch 807 § 2. Amended Stats 1974 ch 355 § 2.)

#### **2727. Practices not prohibited**

This chapter does not prohibit:

- (a) Gratuitous nursing of the sick by friends or members of the family.
- (b) Incidental care of the sick by domestic servants or by persons primarily employed as housekeepers as long as they do not practice nursing within the meaning of this chapter.



**BOARD OF REGISTERED NURSING**  
PO Box 944210, Sacramento, CA 94244-2100  
P (916) 322-3350 F (916) 574-8637 | [www.rn.ca.gov](http://www.rn.ca.gov)  
**Louise R. Bailey, MEd, RN, Executive Officer**

(c) Domestic administration of family remedies by any person.

(d) Nursing services in case of an emergency. "Emergency," as used in this subdivision includes an epidemic or public disaster.

(e) The performance by any person of such duties as required in the physical care of a patient and/or carrying out medical orders prescribed by a licensed physician; provided, such person shall not in any way assume to practice as a professional, registered, graduate or trained nurse.

(Added Stats 1939 ch 807 § 2. Amended Stats 1943 ch 573 § 1.)

**Proposed amendments to BRN Draft Regulations:**

***1463.5 Abortion by aspiration techniques***

*For the purposes of Section 2725.4 of the Code, after January 1, 2016, certified nurse-midwives may use these aspiration techniques during the first trimester of pregnancy if they have the requisite training in performing these procedures acquired in any of the following:*

- (1) A Board-approved nurse-midwifery program or in a post-graduate course offered by an accredited nurse-midwifery program;*
- (2) A course offered by a Board-approved continuing education provider that reflects evidence-based ~~national~~ curriculum and training guidelines or a course approved for Category I continuing medical education;*
- (3) A course offered by a state or national health care professional or accreditation organization.*

*NOTE: Authority cited: Section 2715, Business and Professions Code. Reference: Section 2725.4,*

***1485.5 Abortion by aspiration techniques***

*For the purposes of Section 2725.4 of the Code, after January 1, 2016, certified nurse practitioners may use these aspiration techniques during the first trimester of pregnancy if they have the requisite training in performing these procedures acquired in any of the following:*

- (1) A Board-approved nurse practitioner program or in a post-graduate course offered by an accredited nurse practitioner program;*
- (2) A course offered by a Board-approved continuing education provider that reflects evidence-based ~~national~~ curriculum and training guidelines or a course approved for Category I continuing medical education;*
- (3) A course offered by a state or national health care professional or accreditation organization.*

*NOTE: Authority cited: Section 2715, Business and Professions Code. Reference: Section 2725.4,*

## BOARD OF REGISTERED NURSING

### Specific Language of Proposed Changes

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

#### **1463.5 Abortion by aspiration techniques**

For the purposes of Section 2725.4 of the Code, after January 1, 2016, certified nurse-midwives may use these aspiration techniques during the first trimester of pregnancy if they have the requisite training in performing these procedures acquired in any of the following:

- (1) A Board-approved nurse-midwifery program or in a post-graduate course offered by an accredited nurse-midwifery program;
- (2) A course offered by a Board-approved continuing education provider that reflects evidence-based national training guidelines or a course approved for Category I continuing medical education;
- (3) A course offered by a state or national health care professional or accreditation organization.

NOTE: Authority cited: Section 2715, Business and Professions Code. Reference: Section 2725.4, Business and Professions Code.

#### **1485.5 Abortion by aspiration techniques**

For the purposes of Section 2725.4 of the Code, after January 1, 2016, certified nurse practitioners may use these aspiration techniques during the first trimester of pregnancy if they have the requisite training in performing these procedures acquired in any of the following:

- (1) A Board-approved nurse practitioner program or in a post-graduate course offered by an accredited nurse practitioner program;
- (2) A course offered by a Board-approved continuing education provider that reflects evidence-based national training guidelines or a course approved for Category I continuing medical education;
- (3) A course offered by a state or national health care professional or accreditation organization.

NOTE: Authority cited: Section 2715, Business and Professions Code. Reference: Section 2725.4, Business and Professions Code.



CALIFORNIA ASSOCIATION  
FOR NURSE PRACTITIONERS

1415 L Street, Suite 1000  
Sacramento, CA 95814  
916 441-1361 o | 916 443-2004 F

canpweb.org

March 2, 2015

California Board of Registered Nursing  
PO Box 944210  
Sacramento, CA 94244-2100  
P (916) 322-3350 F (916) 574-8637  
[www.rn.ca.gov](http://www.rn.ca.gov)

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: Clarifying regulatory language for aspiration abortion techniques implementing section 2725.4 of the Business and Professions Code**

Dear California Board of Registered Nursing:

On behalf of the California Association for Nurse Practitioners (CANP) we respect the Board of Nursing's request for clarifying regulations as necessary related to abortion training (AB154) 2725.4(a). AB 154 became law on January 2014 which allows California NPs, CNMs and PAs to provide first trimester abortions by uterine aspiration procedures. We recommend the following amendments to clarify the options:

- In option 1463.5 (1) and 1485.5(1), a CNM or NP Program could offer abortion care procedures training (knowledge achievement/skill in ultrasound for gestational age, pregnancy options counseling, medication abortion, MVA/EVA procedures, complication treatment) to matriculated students or as part of a post-grad course (with BRN-approval or CME approval).
- In option 1463.5 (2) and 1485.5(2), a course could be offered by a BRN-approved CE provider that reflects evidence-based curriculum and training guidelines or a course approved for Category I CME.
  - A credentialed CE provider who meets the BRN CE provider requirements could offer such a course.
  - A course offered by a Board-approved CE provider that reflects evidence-based curriculum and training guidelines or a course approved for Category I CME.
- In option 1463.5 (3) and 1485.5(3), courses offered by a state health care professional or accreditation organization could include CANP, CNMA, CFHC (state) or ARHP, AANP, ACNM, NPWH, PPFA (national).

Power in Practice



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1415 L Street, Suite 1000  
Sacramento, CA 95814  
916 441-1361 o | 916 443-2004 F  
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We also request the Board of Nursing's consideration of the following additional options:

- CA BRN would recognize coursework completed in CNM or NP programs outside California. Whereas other education programs outside of California may apply to be a BRN-approved CE provider.
- CA BRN to delineate a timeline for the regulatory process and to identify the level of support required to be in place by January 2016.

We appreciate the Board and Nurse Practice Committee's time and consideration of this issue.

Thank you for your continued work on this important area of our collective APRN practice. Please feel free to contact CANP with any further questions.

Respectfully,

A handwritten signature in black ink that reads 'Donna Emanuele'. The signature is written in a cursive, flowing style.

Donna Emanuele, DNP, RN, FNP-BC, CNS, FAANP  
CANP President  
1415 L Street, Suite 1000  
Sacramento, CA 95814  
ph: 916 441-1361  
Website: [canpweb.org](http://canpweb.org)

Ms. Louise R. Bailey, MEd, BSN, RN  
Executive Officer  
California Board of Registered Nursing  
PO Box 944210  
Sacramento, CA 94244



March 5, 2015  
RE: Proposed Regulations 1463.5 and 1485.5

Dear Ms. Bailey:

Thank you for the opportunity to comment on proposed regulations being voted on by the BRN Practice Committee today. Proposed regulations 1463.5 and 1485.5 address the statutory requirement that certified nurse practitioners and nurse-midwives performing aspiration abortion must complete training recognized by the Board of Nursing.

As you know, CNMA is the California affiliate of the American College of Nurse-Midwives. We are a professional organization whose purpose it is to facilitate the integration of certified nurse-midwives into the health care system of California, promote specific legislation and/or regulations supportive of maternal-child/women's health and nurse-midwifery practice. In line with this purpose, CNMA would like to bring to your attention our comments on the proposed regulations.

There are two language edits that we would request as below:

*1463.5 Abortion by aspiration techniques*

*For the purposes of Section 2725.4 of the Code, after January 1, 2016, certified nurse-midwives may use these aspiration techniques during the first trimester of pregnancy if they have the requisite training in performing these procedures acquired in any of the following:*

- (1) A Board-approved nurse-midwifery program or in a post-graduate course offered by an accredited nurse-midwifery program;*
- (2) A course offered by a Board-approved continuing education provider that reflects evidence-based ~~national~~ curriculum and training guidelines or a course approved for Category I continuing medical education;*
- (3) A course offered by a state or national health care professional or accreditation organization.*

*NOTE: Authority cited: Section 2715, Business and Professions Code. Reference: Section 2725.4,*

*1485.5 Abortion by aspiration techniques*

*For the purposes of Section 2725.4 of the Code, after January 1, 2016, certified nurse practitioners may use these aspiration techniques during the first trimester of pregnancy if they have the requisite training in performing these procedures acquired in any of the following:*

- (1) A Board-approved nurse practitioner program or in a post-graduate course offered by an accredited nurse practitioner program;
- (2) A course offered by a Board-approved continuing education provider that reflects evidence-based national curriculum and training guidelines or a course approved for Category I continuing medical education;
- (3) A course offered by a state or national health care professional or accreditation organization.

NOTE: Authority cited: Section 2715, Business and Professions Code. Reference: Section 2725.4,

Justification:

1. ANSIRH training, the current curriculum and training guidelines, are evidence-based guidelines and are not national. BRN endorsement of national guidelines is clear in (3), when referring to health professional or accreditation organizations.
2. "Curriculum and training guidelines" more accurately represents the important combination of didactic education, problem-based case reviews, and "hands-on" clinical experience, along with knowledge testing and periodic clinical assessment, to ensure competencies are satisfied.

CNMA is interested in how the following can be addressed:

1. There are other states in which a CNM or NP may be taught how to perform MVA. Which provision allows for the BRN to accept content achieved as part of an educational program that is not in California?
2. What are the requirements in order to be a BRN CE provider? Can small rural clinics provide this curriculum, if not affiliated with a large institution? Could the training be done by either physician or NP or CNM?
3. What is the regulatory timeline and how can we ensure that there will not be a gap between when regulations are in place and January 1, 2016?

CNMA is in gratitude to you for your service to the Board of Registered Nursing and our profession.

Sincerely,



Kim Q. Dau, CNM MS  
Chair, Health Policy Committee  
California Nurse-Midwives Association

cc:  
Linda Walsh, President, California Nurse-Midwives Association  
Members of the CNMA Board of Directors  
Members of the CNMA Health Policy Committee

## Core Competencies for Early Abortion Care by Primary Care Clinicians: First-Trimester Aspiration Abortion

Primary, secondary and tertiary prevention of unintended pregnancy<sup>1</sup> is an essential element of sexual and reproductive health care, a specialty of primary medical care and public health services. Early abortion care is considered one component of secondary prevention of unintended pregnancy.

This document describes the entry-level specialty competencies for primary care clinicians providing early abortion care, regardless of setting. These specialty competencies are the essential knowledge, behaviors, and skills that primary care clinicians should be able to demonstrate upon application for practice in abortion care and secondary prevention of unintended pregnancy. They are intended to supplement the health-professional core competencies for primary-care clinicians (e.g. CNM, DO, MD, NP, PA) as well as population-focused competencies (e.g. women's health care, family practice).

### I. Competence Level Descriptors: Measurement of achievement and progression

Competence is a baseline level for safe independent practice, with further (post-training) exposure and experience leading to proficiency and subsequent expertise. Attainment and assessment of any competency should progress through all three of the following stages.<sup>2</sup>

#### **Level 1 (observation or indirect methods)**

- Demonstrate thorough understanding of the principles of the competency/clinical skill/situation, including the indication for the procedure and common complications
- Observe the procedure on a number of occasions before direct supervision of clinical skill
- Use other methodologies (e.g. drills, simulation, e-learning, case-based discussion assessments) if direct experience is not possible

#### **Level 2 (direct supervision across different clinical situations)**

- Perform the clinical skill/manage case under supervision
- The number of times the competency/clinical skill/situation needs to be supervised depends on the complexity of the case and individual aptitude
- No limit to the number of times the procedure can be supervised; both trainee and trainer must be certain that the procedure can be safely performed in a number of different clinical situations and levels of complexity
- Be able to manage any unexpected complication and know when to summon senior help

**Level 3 (independent practice)**

- Ability and confidence to perform the clinical skill/situation competently when senior staff is not immediately available
- Willingness to move on to experiential learning with further case exposure
- Keep a record of the numbers of cases/procedures subsequently managed (including any complications and their resolution)

**II. Specific competencies to be attained*****Pre-requisite to training: Unintended Pregnancy Care Competencies***

- Perform comprehensive pregnancy options counseling and care coordination (for adoption, prenatal care, abortion)
- Effectively communicate with patients and accompanying persons, respecting diversity of beliefs
- Effectively counsel the psychosocially complex patient (e.g. ambivalence, mental health conditions, religious belief conflicts)
- Perform pregnancy test, including appropriate type (urine v. serum), interpret results and deliver results neutrally
  - If positive, calculate estimated gestational age and discuss pregnancy options in an unbiased, non-directional manner
- If patient indicates desire to continue: Initiate antenatal/adoption care pathways/clinical guidelines
- If patient indicates desire to terminate: Initiate abortion care pathways/clinical guidelines
- Assess and manage identified clinical and non-clinical risks
- Perform STI risk assessment and manage positive responses appropriately by performing relevant screening, providing risk reduction counseling and referrals as necessary
- Provide contraceptive education and counseling and provide selected method, or refer, as appropriate
- Provide supportive counseling and education (written, verbal, electronic) to promote closure of encounter, including follow-up and coordination of care or referral

***Pre-Procedure Assessment Competencies***

- Perform pre-abortion clinical history including complete medical, reproductive and sexual and social history and risk assessment
  - Manage positive responses appropriately by providing necessary screenings, counseling and referrals and partner notification if positive STI screening results
- Perform appropriate clinical examination including assessment of gestation
  - Arrange/perform laboratory and ultrasound investigations, and specific investigations as prompted by history and examination

- Conduct assessment to determine/confirm gestational age (ultrasound for pregnancy elements, bimanual exam for uterine size)
- Manage unexpected findings from routine assessment as per clinical guidelines (e.g. miscarriage, ectopic gestation, molar pregnancy)
- Communicate effectively with patients and accompanying persons they wish to have present
  - Explain clearly and without bias—treatment regimens, potential side effects of drugs and complications of procedures
  - Demonstrate consistent respect for diversity of beliefs and values
  - Counsel the psychosocially complex patient (e.g. ambivalence, mental health conditions, family conflicts) and engage other health professionals as needed (e.g. therapist, social worker) to ensure effective communication and management plan
- Arrange abortion procedure or refer to another agency, including cervical priming and follow-up as necessary
  - Arrange interpreter/signer if required
- Prescribe drugs required for chosen procedure including cervical priming/local antibiotic prophylaxis policy/contraception as per clinical guidelines
- Formulate, implement and, if necessary, modify management plans in consultation with patient
- Complete documentation including consent
  - Seek informed consent after assessment of cognitive competency
  - Document episode accurately
- Provide contraceptive and sexual health advice and supplies

### **First-Trimester Aspiration Abortion Procedure Competencies**

*Up to 14 weeks, with manual vacuum aspiration (MVA) and/or electric vacuum aspiration (EVA)*

- Verify absence of changes in health
- Confirm consent for procedure and post-abortion contraceptive plan choice since pre-procedure assessment
- Confirm all medications prescribed and administered/taken including cervical priming, antibiotics and contraception
- Check equipment and supplies for procedure including for analgesia, sedation
- Manage pain appropriately using local anesthesia and analgesia
- Manage pain using moderate/conscious sedation – optional depending on institutional guidelines
- Complete abortion procedure by MVA and/or EVA
  - Position patient
  - Use ‘no-touch’ clean technique throughout procedure

- Perform:
  - Bimanual examination (empty bladder)
  - Speculum examination
  - Stabilization of cervix
  - Application of local anesthetic to cervix
  - Cervical dilation
  - Aspiration of uterine contents
  - Use of ultrasound during the aspiration procedure
  - Gross identification of products of conception and disposal of same with due regard to respect and dignity
- Manage if inadequate products of conception (i.e. incomplete or failed abortion, rule out ectopic or molar pregnancy)
- Manage immediate complications including: dilation difficulties, poor aspiration of uterine contents, blockage of cannula, excessive bleeding/hemorrhage, uterine atony, incomplete abortion, continuing pregnancy, vasovagal reaction, allergic reaction, uterine false passage/perforation, cervical laceration, air embolism, acute hematometra
- Provide immediate post-abortion contraception (including IUD insertion, implants, DMPA)

### Post-Procedure Assessment and Follow-up Competencies

- Perform immediate post-procedure clinical assessment and routine follow-up.
  - Conduct investigations with ultrasound and/or laboratory assessments to confirm resolution of pregnancy (e.g. beta HCG, hemoglobin) as necessary
- Confirm procedure complete by gross or additional examination of uterine contents (i.e. products of conception examination) by identifying pregnancy elements consistently and accurately
- Assess physical and psychological wellbeing of patient; review counseling and support needs
- Review needs for social support and assistance following procedure with special attention to patients with particular vulnerability (e.g. minors; those with psychiatric conditions/mood disorders, limited social support, or high risk for intimate partner violence, repeat unintended pregnancy or STI)
- Contact patient after discharge to assess problems and/or to determine return to primary prevention methods of unintended pregnancy or reproductive life plan
- Manage delayed complications including bleeding, infection, retained products of conception, ongoing pregnancy, and emotional distress
- Complete documentation

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<sup>1</sup> Taylor D, James EA. (2011). An Evidence-Based Guideline for Unintended Pregnancy Prevention. *Journal of Obstetric, Gynecologic & Neonatal Nursing* 40(6):782-793.

<sup>2</sup> Informed by HWPP-171 project evaluation, the TEACH Program Training Plan (page 6, Early Abortion Training Workbook, <http://www.ansirh.org/training/workbook.php>), and UK Faculty of Sexual & Reproductive Health Competency-based Curriculum (2012, [www.fsrh.org](http://www.fsrh.org)).