NURSING PRACTICE
COMMITTEE MEETING

Hilton Orange County / Costa Mesa
Pac 1 Meeting Room
3050 Bristol Street
Costa Mesa, CA 92626

AGENDA

August 7, 2014

Thursday, August 7, 2014 – 2:00 pm – 3:30 pm

10.0 Call to Order

10.0.1 Review and Vote on whether to approve previous meeting’s minutes:
   ➤ May 7, 2014

10.1 Information Only: Nurse Practitioner National Certifications

10.2 Review and Vote on Whether to Approve:
   Curriculum, Training Plan, and Core Competencies for NPs and CNMs to perform abortion by aspiration technique: Section 2725.4 to Business and Professions Code, Nursing Practice Act. (HWPP-171)

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

10.4 Information Only: Nurse Practitioner Laws and Regulations-Title 16 of the California Code of Regulation, Article 8, 1480-1484

Nursing Education Consultant APRN (Advanced Practice Registered Nurse) Workgroup suggested updating and revision of:

1. Section 1480 — Definitions
2. Section 1481 — Categories of Nurse Practitioners
3. Section 1482 — Requirements for Nurse Practitioner
4. Section 1483 — Evaluation of Credentials
5. Section 1483.1 — Approved APRN-NP Program Accreditation Required and Board Notification Process
6. Section 1483.2 — Application for APRN-NP Program Approval
7. Section 1483.3 — Changes to an Approved Program
8. Section 1484 — APRN-NP Education
9. Section ??? — Clinical Practice Experience for Nurse Practitioner Student Enrolled in Out-of-State Based APRN-NP Programs
Draft of Grandfathering Clause for NP will be added.

10.5 Public Comment for Items Not on the Agenda

10.6 Adjournment

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Board members who are not members of this committee may attend meetings as observers only, and may not participate or vote. Action may be taken on any item listed on this agenda, including information only items. Items may be taken out of order for convenience, to accommodate speakers, or maintain a quorum. The public will be provided an opportunity to comment on each agenda item at the time it is discussed; however, the committee may limit the time allowed to each speaker.
BOARD OF REGISTERED NURSING
NURSING PRACTICE COMMITTEE MINUTES

May 7, 2014

2:00 pm to 3:30 pm

Hilton Sacramento Arden West
2200 Harvard Street
Sacramento, CA 95815
(916) 922-4700

MEMBERS PRESENT
Trande Phillips, RN Chair
Michael Jackson, MSN, BSN, RN, CEN, MICN
Cynthia Klein, RN
Elizabeth A. Woods, RN, FNP, RN

STAFF PRESENT:
Janette Wackerly, MBA, BSN, RN, SNEC, Staff Liaison

Wednesday May 7, 2014
Meeting called to order at 2:00 PM by Trande Phillips
Members Introductions: Trande Phillips Chair, Michael Jackson, Elizabeth Woods, and Cynthia Klein

10.1 Review and Vote on whether to approve previous meeting minutes:
January 8, 2014 and March 6, 2014
MSC: Jackson/Phillips move to approve meeting minutes of January 8, 2014 and March 6, 2014

Public Comment: Susanne J. Phillips MSN, RN, FNP-BC introduced California Action Coalition Recommendation #1 to remove all barriers to full practice authority for California nurses. The Coalition is in support of the BRN work to update the 30-40 year-old nurse practitioner regulations. Phillips stated that she has seen first-hand the importance of updated regulatory guidance in training our registered nurses (RN) and advanced practice registered nurses (APRN). Phillips statements are attached to these meeting minutes.

10.2 Nurse Practitioner: Education and Practice.

BRN-NEC presented talking points: documents attached for the minutes.

Report of the National Task Force on Quality Nurse Practitioner Education-2012
The National Association of Nurse Practitioner Faculties (NONPF)
And
Nurse Practitioner Practice information provided by the American Nurses Association and American Association of Nurse Practitioners.

**Resources:**
- American Academy of Nurse Practitioners (www.aanp.org)
- American Association of Colleges of Nursing (www.aacn.nche.edu)
- American College of Nurse Practitioners (www.acnpweb.org)
- American Nurses Association (www.Nursing World .org)
- Center for Medicare and Medicaid (CMS.gov)

Committee members asked for some additional detailed information on NP national certification, certification requirements for active NP practice, and certification fees. Staff will research and bring back the information to the committee.

### 10.3 Information and Discussion: Nurse Practitioner Laws & Regulations-Title 16 of the California Code of Regulation, Article 8. Section 1480-1484

The BRN staff APRN workgroup has continued to review Article 8 Nurse Practitioner Laws and Regulations, the NCSBN Model Act and language implemented in other states. Attached from APRN-NP work group is the current working document which includes the existing regulations. The working document is in black ink, type and underlining and cross out have been incorporated to reflect changes.

Added by the BRN staff APRN work group is a Work in Progress Requirements for Clinical Practice Experience for Nurse Practitioner Students Enrolled in an Out-of-State Based APRN-NP programs.

Liaison briefly described Section 1481 Categories of Nurse Practitioner; 1482 Requirements for Nurse Practitioner Certification; 1483 Evaluation of Credentials: Work in progress 1483.1 Approved APRN-NP Program Accreditation Required and Board Notification Process; 1483.2 Application for APRN-NP Program Approval; 1483.3 Changes to an Approved APRN-NP Program. Section 1484 APRN-NP Education includes Administration and Organization of the APRN-NP Program, Faculty and Curriculum, Clinical Agency, and Student Participation.

Liaison described Work in Progress (possibly 1485) Requirements for Clinical Experience for Nurse Practitioner Students Enrolled in Out-of-State Based APRN-NP Programs.

Staff responded that there are many out-of-state online APRN-NP program educating NP nursing students in California. BRN advance practice licensing becomes aware of the online APRN-NP programs when an applicant seeks NP certification from the BRN. SNEC staff has contacted several online out-of-state APRN-NP programs for details regarding NP student practice in California. NEC staff are recommending a method for online out-of-state APRN-NP programs to obtain a prior BRN authorization for nursing students to participate in a NP clinical practice experience in California. Most online out-of-state programs report to the SNEC that programs have the NP nursing student refer to BRN website for information on the legal aspects of NP practice in California.
Executive Officer will refer to legal counsel the question of whether BRN has authority to require out-of-state nurse practitioner program to obtain board approval (authorization) which includes NP nursing students doing their clinical practicum in California.

BRN APRN-NP work group will develop grandfathering language base on BPC 2835.5 Submission of credentials; Issuance of certificate; Persons already found qualified. BPC 2835.5 (a), (b), (c), (d), (1), (2), (3).

10.4 Public Comments:

California Nurses Association (CNA) presented their points to the proposed Nurse Practitioner laws and regulations – Title 16 of the California Code of Regulations, Article 8 Section 1480-1484 and provided staff with a written copy dated May 7, 2014, attached.

CNA mentioned seeing additional amendments to proposed regulations, thought about taking a break/stepping back and going back to look at rational, more clarification, how comments are being addressed.

SNEC stated at this time not addressing comments, the NEC-APRN group still working on language and not in the regulatory process. NEC-APRN work group will consider all feedback at the time of placing proposed regulations. CCR Article 8 Section 1480-1484 with any additions on the calendar for the regulatory process.

School nurses: Concern regarding school nurses being asked to teach school unlicensed personnel to administer controlled substances to school children. Committee chair asked school nurses speaking to add their information for the agenda. Chair asked school nurses for details regarding what is occurring including medications being administered, concerns the school nurses would like the Practice Committee to consider for recommendations, examples of problems school nurses are facing.

Meeting adjourned at 3:30 p.m.

Submitted by: Janette Wackerly, MBA, BSN, RN, SNEC Supervising Nursing Education Consultant NP Liaison

Accepted by: Trande Phillips, RN, Chair, Direct Practice Member
June 26, 2014

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

Dear Ms. Wackerly,

Below you will find our testimony presented May 7, 2014 during the Nursing Practice Committee Meeting in Sacramento, CA. The CAC would like to thank the members of the Board and the Board Staff for their interest in amending outdated regulations pertaining to NP education.

Good afternoon Chair Phillips, members of the Nursing Practice Committee. My name is Susanne Phillips and I am an Associate Clinical Professor and a family nurse practitioner at UC Irvine.

I am here today on behalf of the California Action Coalition, as the Co-Lead for Recommendation #1, to remove all barriers to full practice authority for California’s nurses. The California Action Coalition supports the BRN’s work to update the 30-40-year-old nurse practitioner education regulations. As a nurse practitioner and nurse educator in the UC System approaching 20 years, as well as a former member & President of this Board, I have seen first-hand the importance of updated regulatory guidance in training our registered nurses (RNs) and advanced practice registered nurses (APRNs). In an effort to support the movement toward full practice authority for all nurses in the State of California, it is imperative that our education regulations mandate uniform comprehensive, high quality training.

We have done good work over the years by moving NP education to academic institutions. All NP education is now completed at the Master’s degree or higher level as a result of legislation signed in 2004, mandating that NPs enter into practice with a minimum of a Master’s degree in nursing. At the last meeting, there was a question pertaining to national certification and why it was not included in that legislation in 2004. I personally worked on AB 2226 and national certification was removed due to political opposition, not opposition by the author, sponsor, or the legislative body at large.

As you know, nurse practitioners began working in rural ambulatory practices, primarily in pediatrics and women’s health in the late 1960’s. Even as late as the mid-80’s, when the NP education regulations were last updated, NP practice has evolved immensely. Although the vast majority of NPs still practice in primary care ambulatory settings in California, such as community-based settings and private practice, college health, correctional facilities, occupational health, hospice & palliative care, home health, and hospital-based clinics, the acuity of care provided in those settings has changed dramatically, leaving our current NP educational regulations lacking in depth and breadth. Additionally, educational programs developed a new line of NP education in response to health systems demand, the acute care NP tracks, which train nurse practitioners to provide high quality advanced practice nursing care in acute care settings, such as neonatal, pediatric, & adult ICUs; step-down units, and medical-surgical floors; specializing in interventional radiology, orthopedic, neuro, and cardiovascular surgery,
interventional cardiology, rehabilitation, oncology, emergency and trauma, and a host of other acute care specialties. These nurse practitioners are serving on hospitalist and intensivist teams, providing 24-hour provider coverage at these facilities.

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

California licenses over 18,000 active nurse practitioners; the largest numbers of NPs in the country are actively practicing in our state and the vast majorities are working in small private and community-based practices. In fact, the largest individual employers of NPs in the state, Kaiser and the UC system, employ less than 20%. Those systems provide an infrastructure of support for nurse practitioners as their practice evolves; however, most NPs in our state do not practice in those settings; they are working in small practices, side-by-side with physician partners, and we have a social and ethical responsibility to ensure they are universally prepared to deliver high quality care. The CAC understands that there are sensitive issues surrounding compact language. We are not in a position to take a stand on that issue and our support of this process has to do with ensuring California’s education standards meet or exceed national standards. Current language is far below the national benchmark.

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

Respectfully submitted

Susanne J. Phillips, MSN, RN, FNP-BC
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Information only: Nurse Practitioner: Education and Practice
June 12, 2014
Nursing Practice Committee Agenda Item

Graduate and Postgraduate Education

- Broad-based graduate education;
- Comprehensive core graduate-level courses in advanced physiology/pathophysiology, health assessment, and pharmacology including clinical and didactic experiences;
- Program preparation for the graduate with core competencies for specific CNP role and for one of six populations: family, adult/gerontology (primary & acute), neonatal, pediatric (primary & acute), women's health, and psychiatric-mental health; and
- Educational programs nationally accredited.

National Organization of Nurse Practitioner Faculties (NONPF)

- Scientific Foundation Competencies;
- Leadership Competencies;
- Quality Competencies;
- Practice Inquiry Competencies;
- Technology and Information Literacy Competencies;
- Policy Competencies;
- Health Delivery Systems Competencies;
- Ethics Competencies; and
- Independent Practice Competencies
Information Only: Nurse Practitioner: Education and Practice
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Nursing Practice Committee Agenda Item 10.2

Nurse Practitioner Core Competences April 11, 2011 and Amended 2012 (NONPF)
The Nurse Practitioner Core Competencies integrate and build upon existing Master's and DNP core
competencies and are guidelines for educational programs preparing NPs to implement the full scope
of practice as a licensed independent practitioner. The competencies are essential behaviors of all
NPs. These competencies are demonstrated upon graduation regardless of the population focus of the
program and are necessary for NPs to meet the complex challenges of translating rapidly expanding
knowledge into practice and function in a changing health care environment

Nurse Practitioner graduates have knowledge, skills, and ability that are essential to independent
clinical practice. The NP Core Competencies are acquired through mentored patient care experiences
with emphasis on independent and interprofessional practice; analytic skills for evaluating and
providing evidence-based, patient centered care across settings; and knowledge of the health care
delivery system.

Scientific Foundation Competencies
1. Critical analyzes data and evidence for improving advanced nursing practice;
2. Integrated knowledge from the humanities and sciences within the context of
nursing science;
3. Translate research and other forms of knowledge to improve practice processes
and outcomes; and
4. Develop new practice approaches based on the integration of research, theory and
practice knowledge.

Leadership Competencies
1. Assumes complex and advanced leadership roles to initiate and guide change;
2. Provides leadership to foster collaboration with multiple stakeholders (e.g. patients,
community, integrated health care team, and policy makers) to improve health care
Nurse Practitioner Core Competencies;
3. Demonstrates leadership that uses critical and reflective thinking;
4. Advocates to improve access, quality and cost effective health care;
5. Advances practice through the development and implementation of innovation incorporating principle of change;
6. Communicates practice knowledge effectively both orally and in writing; and
7. Participates in professional organizations and activities that influence advanced practice nursing and/or health outcomes of a population focus.

Quality Competencies
1. Uses best available evidence to continuously improve quality of clinical practice;
2. Evaluates the relationships among access, cost, quality, and safety and their influence on health care;
3. Evaluates how organizational structure, care processes, financing, marketing and policy decisions impact the quality of health care;
4. Applies skills in peer review to promote a culture of excellence; and
5. Anticipates variation in practice and is proactive in implementing interventions to ensure quality.

Practice Inquiry Competencies
1. Provides leadership in the translation of new knowledge into practice;
2. Generates knowledge from clinical practice to improve practice and patient outcomes;
3. Applies clinical investigative skills to improve health outcomes;
4. Leads practice inquiry, individually or in partnerships with others;
5. Disseminates evidence from inquiry to diverse audiences using multiple modalities; and
6. Analyzes clinical guidelines for individual application into practice.

Technology and Information Literacy Competencies
1. Integrates appropriate technologies for knowledge management to improve patient health;
2. Translates technical and scientific health information appropriate for various needs;
   2a) Assesses the patient’s and caregiver’s educational needs to provide effective, personalized health care;
   2b) Coaches the patient and caregiver for positive behavioral change;
3. Demonstrates information literacy skills in complex decision making;
4. Contributes to the design of clinical information systems that promote safe, quality and cost effective care; and
5. Uses technology systems that captures data on variable for the evaluation of nursing care.

Policy Competencies
1. Demonstrates an understanding of the interdependence of policy and practice;
2. Advocates for ethical policies and promotes access, equality, quality, and cost;
3. Analyzes ethical, legal, and social factors influencing policy development;
4. Contributes to the development of health policy;
5. Analyzes the implications of health policy across disciplines; and
6. Evaluates the impact of globalization on health policy development.

Health Delivery Systems Competencies
1. Applies knowledge of organizational practices and complex systems to improve health care delivery;
2. Effective health care changes using board based skills including negotiating, consensus-building, and partnering;
3. Minimize risk to patients and providers at the individual and system level;
4. Facilitates the development of health care systems that address the needs of culturally diverse populations, providers, and other stakeholders;
5. Evaluates the impact of health care delivery on patients, providers, others stakeholders, and the environment;
6. Analyzes organizational structure, functions, and resources to improve the delivery of care; and
7. Collaborates in planning for transition across the care continuum of care.

Ethics Competencies
1. Integrates ethical principles in decision making;
2. Evaluates the ethical consequences of decisions; and
3. Applies ethically sound solutions to complex issues related to individuals, populations and systems of care.

Independent Practice Competencies
1. Functions as a licensed independent practitioner;
2. Demonstrates the highest level of accountability for professional practice;
3. Practices independently managing previously diagnosed and undiagnosed patients;
   3a). Provides the full spectrum of health care services to include health promotion, disease prevention, health protection, anticipatory guidance, counseling, disease management, palliative and end of life care;
   3b). Uses advanced health assessment skill to differentiate between normal, variations of normal, and abnormal findings;
   3c). Employs screening and diagnostic strategies in the development of diagnoses;
   3d). Prescribes medications within scope of practice;
   3e). Manages the health\illness status of patients and families over time;
4. Provides patient-centered care recognizing cultural diversity and the patient or designee as a full partner in decision-making;
   4a). Works to establish a relationship with the patient characterized by mutual respect, empathy, and collaboration;
   4b). Creates a climate of patient centered care to include confidentiality, privacy, comfort, emotional support, mutual trust, and respect;
   4c). Incorporates the patient's cultural and spiritual preferences, values, and beliefs into health care; and
   4d). Preserves the patients control over decision making by negotiating a mutually acceptable plan of care.

California Board of Registered Nursing
Nursing Practice Committee Meeting
June 12, 2014

Understanding Advanced Practice Registered Nursing:
The Role of the Nurse Practitioner and Consumer Safety

• Advanced Practice Nurses- Who are they?
  o educated, trained and skilled to provide primary, preventive and chronic care
  o possess additional preparation and skills in physical diagnosis, psychosocial
    assessment, and management of health-illness needs in primary health care, and
    who has been prepared in a program that conforms to the California Board of
    Registered Nursing Section 1480

• Practice settings- Where do they practice?
  o Patient-Centered medical homes
  o Accountable Care Organizations
  o Hospitals
  o Long-term care facilities
  o Telehealth/Telemedicine

• Reimbursement for services- What are the requirements?
  o Must be a graduate of master's, post master's or Doctorate in Nursing Practice
    program
  o Must be certified by a nationally recognized certifying body
  o Must be recognized by their state as nurse practitioners.
  o Must have a NPI number
Understanding Advanced Practice Registered Nursing: 
The Role of the Nurse Practitioner and Consumer Safety

Nurses should practice to the full extent of their education and training (IOM, 2010). Advanced practice nurses are crucial in providing and advocating for competent, safe, coordinated, quality and compassionate care.

Advanced Practice Registered Nurses (APRN) are educated, trained and skilled to provide primary, preventive and chronic care (ANA, 2011). California Board of Registered Nursing defines APRN as those licensed registered nurses who meet the requirements of Article 2.5 Nurse-Midwives, Article 7 Nurse Anesthetists, Article 8 Nurse Practitioners and Article 9. Clinical Nurse Specialists. NP are registered nurses who possesses additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in primary health care, and who has been prepared in a program that conforms to the California Board of Registered Nursing standards of education Section 1480. Nurse Practitioner Core Competencies include scientific foundations, leadership, quality, practice inquiry, technology and information literacy, policy, health delivery systems, ethics and independent practice (NONPF, 2012). Population focused competencies for NP include Family/Across the Lifespan, Neonatal, Acute Care Pediatric, Primary Care Pediatric, Psychiatric-Mental Health, & Women’s Health/Gender-Related (NONPF, 2013).

Primary care is provided by NP to meet the health and safety needs of consumers. Care provided by NP includes initial evaluation of new-onset of symptoms, chronic disease management, and preventative care interventions (Health Policy Brief, 2012). The quality of care and patient outcomes by nurse practitioners and physicians were similar (Health Policy Brief, 2012). Comparison studies looking at outcome measures between NP and physicians showed that patient satisfaction, patient follow-up, provisions of screening, assessment, and counseling were better with the NP (Health Policy Brief, 2012).

Nurse practitioners provide primary care to individuals, families, groups and communities (ANA, 2011). Primary care is provided in different settings such as nurse-managed clinics, long term care facilities, acute care facilities and schools (ANA, 2011). Other areas where NP may work include Patient-Centered medical homes and Accountable Care Organizations (ACO). Accountable Care Organizations is a system where coordinated, unduplicated, and safe care is provided to Medicare recipients. NP provide comprehensive, coordinated health promoting and maintenance care. (Health Policy Brief, 2012).

Advanced Practice Registered Nurses must have their own billing number in order to bill Medicare for ordering or performing services such as physical therapy and occupational therapy, diagnostic tests, durable medical equipment, sigmoidoscopies and colonoscopies and telemedicine according to the Balanced Budget Act of 1997 (AANP, 2013).
State medical boards adopt policy guidelines for safe practice of telemedicine (2014) to ensure patient protection in this dynamic health care environment. According to the Telemedicine and Telehealth Association, Nurse practitioners provide telemedicine or telehealth services. Medicare provides reimbursement to NP for the telehealth services. For NP to receive Medicare reimbursement for telehealth services, they require a NPI number.

APRNs are crucial to the goals of healthcare reform (American Academy of Nursing, 2010) The Centers for Medicare and Medicaid (CMS) and the Affordable Care Act (ACA) aim is to reduce avoidable hospital readmissions within 30-days of discharge for patient diagnosed with Acute Myocardial Infarction (AMI), heart failure (HF) and pneumonia (PN). There are plans to expand applicable conditions in 2015. The goal is to improve outcomes and transition of care from hospital to non-hospital settings including long-term care facilities. Robert Wood Johnson Foundation (2013) The Revolving Door: A Report on U.S. Hospital Readmissions states that the Affordable Care Act directs CMS to develop the Community-based Care Transitions Program (CCTP) and to test models for improving care transitions for high-risk Medicare patients.

Post-discharge transitional care management services are provided by APRNs to facilitate transition from inpatient hospitalization settings to community-based setting without a gap to address medical and/or psychological problems that require moderate or high complexity medical decision making. Under the 2013 Medicare Physician Fee Schedule Rule, the CMS reimburses APRN (Nurse Practitioners, Clinical nurse Specialists and Certified Midwives) for TCM services. To bill for TCM services furnished by a Nurse Practitioner, the nurse needs to meet the required qualifications set forth by the Department of Health and Human Services, Centers for Medicare and Medicaid, to receive their National Provider Identifier (NPI) number.

Nurses need to meet the following requirements to obtain a Medicare National Provider Identifier (NPI) number:

**Required Qualifications**

- A NP must be a registered professional nurse authorized by the State in which services are furnished to practice as a NP in accordance with State law and meet one of the following:
  - Obtained Medicare billing privileges as a NP for the first time on or after January 1, 2003, and:
    - Is certified as a NP by a recognized national certifying body that has established standards for NPs; and
    - Has a Master's degree in nursing or a Doctor of Nursing Practice (DNP) doctoral degree;
  - Obtained Medicare billing privileges as a NP for the first time before January 1, 2003, and meets the certification requirements described above; or
  - Obtained Medicare billing privileges as a NP for the first time before January 1, 2001.
References


Centers for Medicare & Medicaid Services http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html


What they do: NPs provide primary and specialized care health care to individuals, families, and groups, and communities in a wide range of settings from nurse managed clinics, nursing homes, and hospitals to health maintenance organizations, workplaces, schools, or their own practices. Most have a specialty—for example adult, family, pediatric, gerontological care, as well as other areas such as women’s health and psychiatric/mental health. NPs take health histories; conduct physical exams; diagnose and treat common acute illnesses and injuries; give immunizations; manage high blood pressure, diabetes, and other chronic conditions; order and interpret x-rays and other laboratory tests; counsel patients on disease prevention and health lifestyles; and refer patient to other health providers as needed. (ANA 2011) http://nursingworld.org/FunctionalMenuCategories/MediaResources/MediaBackgrounders/APRN-New-Age-in-Health-Care.pdf

Let me know: if January 2011 federal laws required Medicaid to recognize only some advanced practice—specifically pediatric and family nurse practitioners and certified nurse midwives— as eligible for reimbursement under the fee-for-service program. Did the Medicaid Advanced Practice Nurses and Physician Assistants Access Act (S.56) recognize all nurse practitioners and certified nurse-midwives as primary care managers and allow direct reimbursement to all nurse practitioners and clinical nurse specialist. In addition, the measure would require Medicaid to include NPs, CNSs, CNMs and CRNAs on all of the program’s managed care. Nurse practitioners authorized to apply to a Medi-Cal provider number and bill Medi-Cal independent of a physician (AB 1591, Chan, Chapter 719, Statutes of 2006)-2011 through administrative advocacy, CANP works with Department of Health Care Services to issues provider number to NP, allowing all NPs to bill Medi-Cal directly rather than a physician’s medical number.

Medicare Update: American Association of Nurse Practitioners (AANP):
*Effective with the passage of the Balanced Budget Act of 1997, all NPs, CNSs, and Pas must have their own billing number in order to bill Medicare, even if they are employed and ever if their employer has always billed for their services using the employer’s billing number. Initially, payment for NPs, CNSs and Pas was based on a PIN number provided by CMS. Now it is based on a NPI numbers, which can be obtained by nurse practitioner for identification and billing.
*Billing Directions: NPs are expected to submit claims to Part B carrier under their own NPI number.
*Duplicate Payments: No separate payment may be made to the nurse practitioner when a facility or other provider payment or charges is made for the same professional services. This includes SNIFs, NFs, comprehensive outpatient rehabilitation facilities (CORF), ASCs community mental health centers (CMHF), rural health centers (CRHC) or federally qualified health centers (FQHC).

*Qualification for NPs Seeking Reimbursement for Services to Medicare Patients: In order to obtain a Medicare NPI number for the first time, nurse practitioner must be a graduate of a master’s, postmasters, or DNP programs, nationally certified, and recognized in their state as a nurse practitioner.

*Ordering Physical Therapy and Occupational Therapy: Under provisions of the statute, nurse practitioners are authorized to order physical therapy and occupational for Medicare patients under their care.

Ordering and Performing Diagnostic tests: Nurse practitioner are authorized to order diagnostic tests for patients under their care. They may also be reimbursed for performing diagnostic tests and interpreting tests they are authorized to perform. Physician supervision is not required.

Ordering and Performing Sigmoidoscopies and Colonoscopies: Nurse Practitioner are authorized to order and perform screening colonoscopies and screening sigmoidoscopies on Medicare patients.

*Durable Medical Equipment: A face to face encounter must be conducted and documented prior to ordering durable medical equipment (DME).

*Telemedicine Services: Nurse Practitioners are authorized as both primary care providers and consultants in the utilization of telemedicine for the management of Medicare Patients in federally designated Health Manpower Shortage Areas.

*Medicare Managed Care: Under the statute and regulation for Medicare Managed Care, nurse practitioners may serve as PCPs on Medicare Managed Care Panels. They may also appeal claims in behalf of the patient. Non-discrimination language in the legislation prevents carriers from excluding nurse practitioners from providing panels and allows them to represent patients in for rejected claims.

*“Incident to”: At present time, the rules for “incident to" services are unchanged and continue to be limited to services provided strictly as a follow up to the provider plan of care." Incident to" billing is limited the office setting and the NP must be on the office site to bill.

*Shared Visits in Hospitals: Nurse Practitioner who have their own billing number and provide shared visits with a Physicians in hospitals may bill for services as 100% as the physician has also seen the patient the same day in a "face to face" encounter. Billing will take place under the physician billing number.

*Attending in Home Health and Hospice Care: Nurse Practitioners are authorized to receive reimbursement for serving as "attending physicians" in hospice and home health care. While this does not allow nurse practitioners to order/authorize hospice or home health care, nurse practitioners are allowed to re-certify patient eligible for hospice care/ home health care services a face to face encounter with an eligible provide must occur with 90 days of the start of service. A nurse practitioner may conduct an encounter, but a physician must still document its occurrence.

*Face to Face Requirement to Order Home Health: In order for patients to obtain home health care services a face to face encounter with an eligible provide must occur with 90 days of the start of service. A nurse practitioner may conduct an encounter, but a physician must still document its occurrence.

*Hospital Admitting Examinations: The physician counter signature requirement for hospital admitting physical examinations conducted by the nurse practitioner has been eliminated.
*Supervising Procedures in Outpatient Settings: Nurse practitioners may directly supervise all hospital outpatient therapeutic services in both hospitals and satellite sites that they may perform themselves. (This does not include pulmonary, cardiovascular and intensive cardiovascular rehabilitation services). Direct supervision in this case means the nurse practitioner must be present on the same campus and immediately available to furnish assistance and direction throughout the performance of the procedure. 
MEMBERS PRESENT: Trande Phillips, RN, Chair
Cynthia Klein, RN, Direct Practice Member
Michael Jackson, BSN, RN, CEN, MICN

STAFF PRESENT: Janette Wackerly, MBA, BSN, RN, SNEC,
Staff Liaison

Wednesday, January 8, 2014 at 1:48 p.m.

Members Present: Trande Phillips, Michael Jackson, and Cynthia Klein (arrived late)
Introductions of Board Members.

Agenda items are presented in order here but were reordered at the meeting to 10.3, 10.1, 10.0, 10.2 and 10.4.

10.0 Review and Approve Minutes from 8/7/13
Approved with non-substantive changes.

MSC: Klein/Jackson voted to approve the minutes of 8/7/2013

10.1 Information and Discussion: NP Laws & Regulations
Committee Liaison explained that the BRN is presenting current Article 8 Standards for Nurse Practitioner with suggested changes in regulations for information and providing an opportunity to gather input from a variety of sources. The BRN NECs have been involved in NP program approval for many years. The original regulations were developed in 1985 and 1986 largely based on education in NP certificate programs. On or after 1/1/2008 an applicant for nurse practitioner certification must have completed a Master’s degree in nursing, master’s degree in a clinical field of nursing, or a graduate degree in nursing.
The BRN NEC staff workgroup has focused primarily on needed changes in existing NP regulation language. National Model Act and Rules provides language and National Organization of Nurse Practitioner Faculties (NONPF) has moved to “population foci” to describe the areas of preparation for nurse practitioners.

The attached document in this packet is a comparison of current regulations Section 1481 through 1484 describing some of the BRN workgroup ideas for additions/changes. The liaison reviewed the additions/changes to the following sections:

1481: Population Foci categories are included and in addition to RN Scope of Practice, Standardized Procedures was added; information related to recent bill regarding medical assistant wearing ID, ordering laboratory work; accountability for the NPs.

1482: Some entries need to be added/edited in this section

1483: Straightforward in language

1484: Curriculums have been developed by NONPF/American Association of Colleges of Nursing nationally. Clinical Master’s education program includes advanced assessment, advanced pathophysiology, and advanced pharmacology, which are often referred to as the 3P’s. The BRN workgroup is still working on language to include in Section 1484 Standards of Education.

Article 8 Standards for Nurse Practitioners, Section 1480-1485 became effective in 1985 when most of the NP educational programs were certificate education programs. Since January 1, 2008, the additional requirement for NP certification requires a Master’s degree in nursing, a master’s degree in a clinical field related to nursing, or a graduate degree. Currently CA BRN does not require national certification in a NP specialty and most other states require national certification in a specialty for state certification as a nurse practitioner.

The committee requested public comment and asked that we go section by section.

Public Comments:
1481 - Categories of Nurse Practitioners
Garrett Chan, Director of Advanced Practice at Stanford and Adjunct Professor at UCSF, representing the California Action Coalition: Thanked the staff workgroup for their work and supports the changes for this section.

Karen Wolf, Samuel Merritt supports this section and also provided some history of why the consensus model came about. There was increasing fragmentation among APRNs and there was a need for consistency to have better public protection. It was determined that each category of APRNs should have training in population. More consistency will support APRNs to get national reimbursement under Medicare and more access for APRNs to provide care. At present not all APRNs can get reimbursement which has prevented some from being hired or hamper their ability to practice.

Kelly Green, CNA: Their organization did not have time to do a complete review and requested a timeline for providing feedback. The BRN agreed that in the future we will post meeting materials at least 10 days before the scheduled meeting to allow time for review. For these sections, BRN said written comments should be sent to committee liaison by 1/22/14, close of business as the next staff workgroup meeting is on 1/24/14. Kelly also commented that they would like more information about why this and all other revisions are necessary. What current harm, hindrance, difficulties or access problem is created by current
regulations? What is the source of information to create the new regulation? Would like to know where
language comes from, would like to see it footnoted. Stakeholders need as much information/background
as possible to make this a transparent process and so they can provide feedback.

Garrett Chan at this point, read and submitted a copy of a letter of support from AARP articulating the
need for regulatory revision and to encourage the BRN in the process.

Kathy Ware, NP at UC Davis Medical Center and former Board member: Supports updates and changes
to 1481. MediCal does not recognize all NP categories so these changes should help with that.

1482- Requirements NP Certification
CA Action Coalition: Requested that “post-graduate certificate” be included in 1482 (b)(A). A CACNS
Letter of Support was read and submitted to the BRN.
CANA- requested that additional degrees beyond nursing be included in 1482(b)(A) such as nursing,
medicine, health service, or public health. In addition, all programs must be accredited by an appropriate
accrediting agency for the role (e.g., CCNE, ACEN, other).
BRN: All NPs would need to hold a Master’s degree, post-graduate, or higher degree; graduate from an
accredited program accepted by the Board.

1483- Evaluation of Credentials
No public comments

1484- APRN-NP Education
BRN: 1484(a)(2) - Learning outcome measures should be part of the NP educational program. Need to
add courses and minimum of 500 hours of supervised clinical experience which is currently only in the
application and this needs to be added to regulations.

CA Action Coalition: 1484(b)(3)(c) – NP program administrators should have a minimum of a master’s
degree in nursing, health-related science, business, or education (need to expand beyond a Master’s in
nursing).
CA Action Coalition/CACNS/CANA- 1484(b)(5)(c)- NP program faculty should have a minimum of a
master’s degree in nursing, health-related science, business, or education. 1485(b)(10)(a-e) - strike these
and replace with “APRN, physician, or other licensed health professional and hold an unencumbered
license” or some similar phrase to allow for other disciplines licensed in California to serve as clinical
preceptors. BRN will review pre-licensure regulations in this area to see if same language could apply
here.

10.2 Vote to approve/not approve advisory statement for RN: NP and CNM related to Supervision
of Medical Assistants

MSC: Klein/Jackson voted to approve NP and CNM Supervision of Medical Assistants advisory

Liaison summarized Senate Bill 352 Chapter 286 enacted September 9, 2013 that deletes the requirement
that services performed by a medical assistant is in specified clinic when under the specific authorization
by nurse practitioner, certified nurse-midwife, and physician assistant. There was a public comment from
Donna Emanuel representing the California Association of Nurse Practitioners that they support NPs
supervising Medical Assistants.
10.3 Nurse Practitioners with Multiple Specialties
Certified NPs have been requesting whether an additional specialty can be added to their original specialty for NP certification. An example of the request is family nurse practitioner having completed academic work and nation certification as a psychiatric mental health nurse practitioner who wishes the new designation be listed on the board licensing screen. BreEZe (the new BRN computer system) has the capacity to hold two NP specialty titles. The BRN would require additional documentation and payment to review and add these specialties based on request by the NP. Details of how to handle this will have to be determine by licensing and BRN.

10.4 Public Comments for Items not on the Agenda
Karen Wolf reported that she is aware of agencies where Medical Assistants are being directed by doctors to supervise/teach RNs.

Adjourned at 3:10 pm

Submitted by: Janette Wackerly, MBA, BSN, RN, SNEC (Supervising Nursing Education Consultant) NP Liaison

Accepted by: Trande Phillips, RN, Chair, Direct Practice Member
BOARD OF REGISTERED NURSING
NURSING PRACTICE COMMITTEE MINUTES

March 6, 2014

2:00 pm to 3:10 pm

The Mission Inn Hotel
3649 Mission Inn Avenue
Spanish Art Galley
Riverside, CA 92501
March 6, 2014

MEMBERS PRESENT: Trande Phillips, RN, Chair
Michael Jackson, BSN, RN, CEN, MICN

STAFF PRESENT: Janette Wackerly, MBA, BSN, RN, SNEC,
Staff Liaison; Katie Daugherty MN, RN; Miyo Minato MSN, RN NECs and
Julie Campbell-Warnock, MA Research Program Specialist

Tuesday March 6, 2014
Meeting called to order at 2:00 PM
Members Present: Trande Phillips, and Michael Jackson: Introductions of Committee Members present.

10.0 Review and Approve Minutes from January 8, 2014
The Practice Committee did not have a quorum to approve the minutes for January 8, 2014: these minute deferred to next Practice Committee for review and approval.

Louise Bailey Executive Officer introduced two new board members Elizabeth (Betty) Woods RN, FNP, MSN Advanced Practice Member and Imelda Ceja-Butkiewicz Public Member.

10.1 Information and Discussion: NP Laws & Regulations
The BRN NEC staff workgroup has focused primarily on needed changes with draft language for CCR 1480 and 1483.1; 1483.2; 1483.3. Staff requested public comment/input on changes and to provide any responses of interest to the parties.

Public Comments:
Garrett K Chan RN, PhD, CNS Director of Advanced Practice at Stanford Medical Center and Adjunct Professor at UCSF representing California Action Coalition: He began by asking that we go
section by section since there are many substantive changes and he has some specific comments for sections. Trande Phillips asked that Garrett Chan summarize and provide specific feedback to the BRN staff. Garrett did indicate a generic question as to why so many definitions and staff replied to provide clarity for APRN-NP terms used for the certified CNP.

Catherine Hughes, SEIU: Suggested that we use strikethrough and underline for edits.

Genevieve Clavreul, RN, PhD Supports that the Board is making it clear what scope of NP Practice is in California and she provided a copy of an article she authored.

Kelly Green and Marti Smith California Nurses Association (CNA) presented their points of opposition and provided staff a copy:

- Use of consensus model-CAN does not endorse or support the consensus model. They don’t like the mutual recognition of compact licensure for APRN to allow for movement of APRNs and nationalized standards is a basis for the consensus model.
- Question BRN authority to require national certification. AB 2226 from 2004 included national certification when it was presented and this was deleted at the time.
- Draft language conflicts with current regulation/legislation that states there must be an equivalency method.
- Proposed regulation require MSN, current legislation states a similar degree, not just a MSN.
- Grandfathering has not been addressed
- Lack of clarity, there are terms that are unclear
- Concern about the process. A written rationale has not been provided by the Board. An analysis is needed of what the staff is looking at, what are the deficiencies and what are the needed changes.

Letter submitted by CNM March 6, 2014 which will be attached.

Karen McCauley PhD, DNP, MSN/FNP, RN, Associate Professor, University of San Diego Urged the board and CNA to move ahead with the consensus model. The NP curriculums are population based so the need is to make sure regulations are the same. Currently NPs do not have testing like RN-NCLEX. Nurse Practitioners need national certification in a population as currently NPs only have educational standards at this time.

Miyo Minato NEC BRN staff added that population focus education is important so CNPs are educated for the population they are working with and that national certification sets competency standards for practice.

Trande Phillips Practice Committee Chair discussed a need to outline reasons why we need to make these changes or not and at the May Nursing Practice Committee meeting we should take a step back and see what the problems are identified and how we want to address them, what would be critical and what would not.

Donna Emanuele, RN, MN, CNS, DNP, FNP President Elect Californian Association Nurse Practitioners (CANP). CANP supports in their review to update and modernize Title 16 regulations regarding Nurse Practitioner (NP) practice in our state and seek congruence with the APRN Consensus
Model. CANP is the only recognized professional NP organization and the voice that represents more than 17,000 practicing nurse practitioner statewide on policy and practice issues in California. Letter submitted by CANP dated March 4, 2014 which will be attached.

Katie Daugherty NEC BRN staff explained the NP national certification process and clarified that to bill for Medicare and insurance an NP must be nationally certified and that this has been in place a number of years.

Michael Jackson Practice Committee Member concurs with Trande Phillips Chair of the Practice Committee that we go back to the drawing board and come up with a document that will work for all parties and meet the need to protect the citizens of California. Michael Jackson also requested that documents be in black and white and not use color print.

10.2 Approve/not Approve advisory statement for RN and APRNs
   1.0 Communicable disease: Immunization exemption Supervision of Medical Assistant
   2.0 Abortion
Item 1.0 and 2.0 will be forwarded to the Board meeting for approval. The committee did not have a quorum to approve the advisories.

10.3 Public Comments for Items not on the Agenda.
Kim Dau, CNM a representative from the California Nurse Midwifery Association discussed a bill that makes it legal for licensed midwives (licensed by California Medical Board) to no longer need medical supervision. Nurse-midwives continue to be required to have physician supervision. Seeking assistance on how association should advise their members. Out of hospital nurse midwives are feeling the most vulnerable. The Medical Board is approaching the CNM organization for a possible equivalency method.

Adjourned at 3:00 pm

Submitted by:

Janette Wackerly, MBA, BSN, RN, SNEC
Supervising Nursing Education Consultant
NP Liaison

Accepted by:

Trande Phillips, RN, Chair, Direct Practice Member
ACTION REQUESTED: Information: Nurse Practitioner National Certification

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

BACKGROUND: National Certification Organizations that meet the certification requirement for Nurse Practitioner Equivalency by the Board of Registered Nursing
1. American Academy of Nurse Practitioners
2. American Nurses Credentialing Center
3. Pediatric Nursing Certification Board
4. National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialty
5. American Association of Critical-Care Nurses (AACN)

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

RESOURCES:

American Academy of Nurse Practitioners National Certification Program (AANPCP)
https://www.aanpcert.org/ptistore/control/index
http://www.aanpcert.org/ptistore/control/recert/qualifications

American Nurses Credentialing Center (ANCC) http://www.nursecredentialing.org/Certification
http://www.nursecredentialing.org/AcuteCareNP-Eligibility.aspx
http://www.nursecredentialing.org/RenewalRequirements.aspx

Pediatric Nursing Certification Board (PNCB)
http://www.pncb.org/ptistore/control/exams/open/fees
http://www.pncb.org/ptistore/control/resource/content/certs/PC_CPNP_Recert_Guide.pdf
http://www.pncb.org/ptistore/control/about/about_exams

National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialty (NCC)
http://www.nccwebsite.org/Certification/HowdoIapply.aspx#how-computer-testing-works
American Association of Critical-Care Nurses (AACN)
http://www.aacn.org/wd/certifications/content/initial-acnpe-certification.pcms?menu=certification
http://www.aacn.org/WD/Certifications/Content/ccrnrenewal.pcms?menu=Certification
https://www.pncb.org/pnctstore/control/resource/content/certs/CPN_Recert_Guide.pdf
http://www.aacn.org/wd/certifications/content/certcorpinfo.pcms?menu=certification&lastmenu=
http://www.aacn.org/wd/certifications/docs/cert-policy-hndbk.pdf

NEXT STEPS: Place on Board agenda.

FISCAL IMPACT, IF ANY: None

PERSON(S) TO CONTACT: Janette Wackerly, MBA, BSN, RN
Supervising Nursing Education Consultant
Phone: 916-574-7686
Email: janette.wackerly@dca.ca.gov
<table>
<thead>
<tr>
<th>Certification Organization</th>
<th>Degree Required</th>
<th>Certification Fees</th>
<th>Certification Renewal Fees</th>
<th>Renewal Requirements</th>
<th>Accreditation &amp; Affiliation</th>
<th>Testing Service</th>
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<tr>
<td>American Nurses Credentialing Program (AANPCP)</td>
<td>Graduation of accredited graduate, post-graduate, or doctoral level ANP programs in the U.S. and Canada through 2014 and 500 clinical clock hours of family-supervised practice completion.</td>
<td>Active BN license AANP Member $340</td>
<td>Active RN license</td>
<td>Options 1: 1,000 clinical hours + NP 75 CE applicable to population focus within 3 years. Options 2: take the minimal certification examination</td>
<td>Accredited by the National Commission for Certifying Agencies (NCQA) &amp; the Accreditation Board for Specialty Nursing Certification (ABSNCC). AANPCP is an independent, not-for-profit organization. Certification Program is affiliated with the national professional membership organization, the American Association of Nurse Practitioners (AANP). Membership with AANP is not a requirement for certification with AANPCP.</td>
<td>Professional Examination Service (ProExam). AANPCP’s National Certification Examinations are developed in cooperation with Professional Examination Service (ProExam, formerly known as FEES), a not-for-profit testing company founded in 1961. Examinations are developed in conformity with standards established by the Institute of Certifying Excellence (ICE), American Psychological Association, American Educational Research Association, National Council on Measurement in Education, and the U.S. Equal Employment Opportunity Commission.</td>
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<td>American Nurses Association-American Nurses Credentialing Center (ANCC)</td>
<td>Master’s, postgraduate, or doctoral degree* from an acute care nurse practitioner program accredited by the Commission on Collegiate Nursing Education (CCNE) or the Accreditation Commission for Education in Nursing (ACEN) (formerly NLNAC) (National League for Nursing Accrediting Commission). A minimum of 300 family-supervised clinical hours must be included in the acute care nurse practitioner role and population.</td>
<td>Active RN license ANA Members $370</td>
<td>Active RN license</td>
<td></td>
<td>Accredited by the National Commission for Certifying Agencies (NCQA) &amp; the Accreditation Board for Specialty Nursing Certification (ABSNCC). American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA). Membership with ANA is not a requirement for certification with ANCC.</td>
<td>The ANCC certification examinations are developed consistent with the technical guidelines recommended by the American Educational Research Association, the American Psychological Association, and the National Council on Measurement in Education (AERA, APA, NCME: 1999). Additionally, the ANCC certification examinations meet accreditation standards of the Accreditation Board for Specialty Nursing Certification (ABSNCC) and the National Commission for Certifying Agencies (NCQA).</td>
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<td>Pediatric Nursing Certification Board (PNCB)</td>
<td>Graduates from an accredited college or university that offers a ACEN or CCNE accredited formal nursing master's or doctoral degree with a concentration in pediatric primary care or a nurse practitioner or formal dual primary/acute care program.</td>
<td>Active RN license $35</td>
<td>Every 7 years $85 per module 2 PNCB Pediatric Update Modules If purchased individually, the total cost is $170. If two modules are purchased at the same time, the cost is $160. There is no cost to apply previously purchased modules to your Renewal application. $150 = PNCB Pediatric Update module + 7.5 contact hours of other accepted activity. Pay $85 to order the module in advance of recertifying. Pay $45 to document the other 7.5 hours of activity on the Renewal application. There is no cost to apply previously purchased modules to your Renewal application.</td>
<td>Active NNP, Minimum of 200 hours worked within 12 months providing neonatal care; completion of recertification application; submission of 20 hours of continuing education; a letter submitted from your employer or supervisor stating that you meet the requirements for recertification.</td>
<td>Accredited by The National Certification Corporation for Neonatal, Perinatal, and Critical Care Nurses (NNCP).</td>
<td>PNCB utilizes the services of Prometric to assist in the administration, scoring, and analysis of the PNCB’s CPN, CPNP and PMHC exams. Prometric is an independent testing agency and the testing provider of testing services and solutions for corporate, academic, government, financial and professional services clients. Our national exams are unique in that they are the only certification exams collaboratively designed by CPNPs, CPNPs, and pediatrics.</td>
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<td>National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialty (NCC)</td>
<td>ACEN accredited IP program with Master's, post-master's, DNP with 60 clinical clock hours in Women's Health (OPHN) or Neonatal (PNP).</td>
<td>Active RN license Exam fee $325 Examination must be taken within 5 years of graduation date.</td>
<td>Every 3 years Maintenance: Maintenance fee is $100 + $70 if 15 CEU completed $80 if 10 CEU completed $50 if 4 CEU completed using the NCC online modules. Professional Development Certification Maintenance Program $175</td>
<td>Active RN license, two years (24 months) of experience comprised of at least 2000 hours of practice time as a U.S. or Canadian RN in one of the exam specialties. Professional Development Certification Maintenance Program: Assessment to identify strengths &amp; knowledge gaps to build educational plan + CEU Due March 31, 2014 Use credit earned from the day you take your Stage 2 Assessment to 6/30/14 Due June 30, 2014. Use credit earned from the day you take your Stage 2 Assessment to 6/30/14 Due September 30, 2014. Use credit earned from the day you take your Stage 2 Assessment to 6/30/14 Due December 31, 2014. Use credit earned from the day you take your Stage 2 Assessment to 12/31/14.</td>
<td>Accredited by the National Certification Corporation for Neonatal, Perinatal, and Critical Care Nurses (NNCP).</td>
<td>NCC uses the services of testing vendor, Applied Measurement Professionals, Inc (AMP) to assist in administration, scoring and analysis of the NCC's WBBP and NPB exams.</td>
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<td>American Association of Critical-Care Nurses (AACN)</td>
<td>Accredited college or university that offers a CCNE or ACEN accredited graduate degree in nursing with a concentration in an adult-gerontology acute care nurse practitioner</td>
<td>Active RN license AACN Members $245 Nonmembers $330</td>
<td>Every 5 years</td>
<td>Active RN license Option 1 - Practice Hours and CE Points minimum of 1,000 practice hours 100 CE Renewal Points, 75 of which must be in Category 1 - Acute Care Education Programs. Option 2 - Practice Hours and Exam minimum of 1,000 practice hours meeting the hour requirement + the certification exam. Option 3 - CE Points and Exams, complete 150 CE Renewal Points, 75 of which must be in Category 1 - Acute Care Education Programs + the certification exam 25 of the 75 CE Renewal Points required under Category 1 must be in pharmacology.</td>
<td>Accredited by the National Certification Corporation for Critical Care Nurses (NCC). AACN Certification Corporation is a separately incorporated organization from the American Association of Critical Care Nurses. The Certification Corporation is not a membership organization. It is a certifying organization dedicated to consumer protection through certifying and recertifying nurses. Membership in the American Association of Critical-Care Nurses is not an eligibility requirement for AACN Certification programs.</td>
<td>The certification programs are administered by AACN Certification Corporation. The certification exams are conducted in cooperation with Applied Measurement Professionals, Inc. (AMP) AACN Certification Corporation develops ACRNP and ACNP-AC specialty exams.</td>
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AGENDA ITEM: 10.2  
DATE: August 7, 2014

ACTION REQUESTED: Review and Vote on Whether to Approve inclusion of HWPP-171 Curriculum, Training Plan and Core Competencies for Abortion Care: web information. Reference Business and Professions Code Section 2725.3

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

BACKGROUND:
Business and Professions Code Section 2725.4 Abortion by aspiration techniques; effective January 1, 2014 was the result of HWPP #171 nurse practitioners (NPs), certified nurse-midwives (CNMs), and physician assistants (PAs) can now provide comprehensive first trimester aspiration abortion care in California.
As part of HWPP #171, ANSIRH (Advancing New Standards in Reproduction Health) researchers evaluated a standardized, competency-based curriculum and training plan for education of primary care clinicians in early abortion care. The curriculum and training plan consists of didactic education, problem-based case reviews, and “hands on” clinical experience, along with knowledge testing and periodic clinical assessment, with the goal to train primary care clinicians to competence in all aspects of early aspiration abortion care.
Go to ANSIRH website for their information: http://www.ansirh.org/research/pic/hwpp/hwpp-curriculum-and-competency-resources.php

Contact: Diana Taylor RNP, PhD, FAAN  
Office: (510) 986-8950

NEXT STEPS: Place on Board agenda.

FISCAL IMPACT, IF ANY: None

PERSON(S) TO CONTACT: Janette Wackerly MBA, BSN, RN  
Supervising Nursing Education Consultant  
(916) 574-7686
§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.

The HWPP-171 webpage has been updated to include the Curriculum, Training Plan and Core Competencies for Abortion Care generally (secondary prevention of unintended pregnancy) and first trimester aspiration abortion specifically. Here are the links to the web pages:

- Direct link to core competencies: http://www.ansirh.org/wp-content/uploads/2014/05/ANSIRH_CoreCompetencies.pdf

(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 technique pursuant to 2253 without prior completion of training and validation of clinical competency.

Added Stats 2013 ch 662 § 2 (AB 154), effective January 1, 2014.
California Health and Safety Code §123468

The performance of an abortion is unauthorized if either of the following is true:
(a) The person performing the abortion is not a health care provider authorized to perform an abortion pursuant to Section 2253 of the Business and Professions Code.
(b) The abortion is performed on a viable fetus, and both of the following are established:
   (1) In the good faith medical judgment of the physician, the fetus was viable.
   (2) In the good faith medical judgment of the physician, continuation of the pregnancy posed no risk to life or health of the pregnant woman.

AB 154 (Atkins)
Signed into Law Oct 9, 2013 by Gov. Jerry Brown
Effective date: January 1, 2014
AGENDA ITEM: 10.3
DATE: August 7, 2014

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

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

BACKGROUND:
The Frequently Asked Questions Regarding Nurse Practitioner Practice will be updated to include current law and regulation changes that have occurred since the last update 12/2004. This will include updates to the Nursing Practice Act including Section 2725 for example Section 2725.2 Dispensing of self-administered hormonal contraceptives; Infections; Standardized Procedures and Section 2725.4 Abortion by aspiration techniques; Requirements. NP 2835.7 Authorized Standardized Procedure for ordering durable medical equipment, certifying disability in consultation with the physician pursuant to Unemployment Insurance Code, and plan of treatment or plan of care for home health in consultation with the physician. Other related changes that relate to nurse practitioner practice.

NEXT STEPS: Place on Board agenda.

FISCAL IMPACT, IF ANY: None

PERSON(S) TO CONTACT: Janette Wackerly, MBA, BSN, RN
Supervising Nursing Education Consultant
916-574-7686
FREQUENTLY ASKED QUESTIONS REGARDING
NURSE PRACTITIONER PRACTICE

Practice Questions

Can a nurse practitioner function in the emergency department?
Yes. Nurse practitioners are permitted to perform consultation and treatment in an emergency department under certain conditions. Section 1317.1 of the Health and Safety Code, relating to emergency services was repealed and amended September 26, 2011, changing definition of emergency service and care to include appropriately licensed persons, nurse practitioners and physician assistants, under the supervision of a physician and surgeon, to include medical screening, examination, and evaluation by a physician, or to the extent permitted by applicable law, by other appropriate personnel (NP&PA) under the supervision of a physician and surgeon, to determine care, treatment, and surgery by physician necessary to relieve or eliminate the emergency medical condition or active labor, within the capability of the facility.  
(SB 233, ch 333. (Pavley), Statutes of 2011)

Can nurse practitioners authorize durable medical equipment, certify disability and approve, sign, or modify care for home health services within the standardized procedure?
Yes. (SB 819 ch 158 (Bass) Statutes 2009)

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

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

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

Can nurse practitioners certify disability for purpose of persons obtaining a disability placard or disability car license plate?
Yes, a nurse practitioner is authorized to certify disability for purposes of a disability placard or disability license plate. (AB 2120, ch 116 (Liu) Statutes of 2007)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Delegation of duties to nurse practitioner in long-term health care facilities
Section 14111 Welfare and Institutions Code describes delegation of duties to nurse practitioners in long term health care facility.
(a) As permitted by federal law or regulation, for health care services provided in a long-term health facility that are reimbursed by Medicare, a physician and surgeon may delegate any of the following to a nurse practitioner:
(1) Alternating visits required by federal law and regulation with a physician and surgeon.
(2) Any duties consistent with federal law and regulation within the scope of practice of nurse practitioner so long as all the following conditions are met:
(A) A physician and surgeon approves, in writing, the admission of the individual facility.
(B) The medical care of each resident is supervised by a physician and surgeon.
(C) A physician and surgeon performs the initial visit and alternate required visits.
(b) This section does not authorize benefits not otherwise authorized by federal law or regulation.
(c) All responsibilities delegated to a nurse practitioner pursuant to this section shall be performed under the supervision of the physician and surgeon and pursuant to standardized procedures among the physician and surgeon, nurse practitioner, and facility.
(d) No task that is required by federal law or regulated to be performed personally by a physician may be delegated to a nurse practitioner.
(e) Nothing in this section shall be construed as limiting the authority of a long-term health care facility to hire and employ nurse practitioners so long as that employment is consistent with federal law and within the scope of practice of a nurse practitioner.

Added Stats 1982 ch 1048 § 2(AB 2849). Amended States 1994 ch 646 § 1(AB 2879)
Tasks of nurse practitioner in long-term health care facility

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

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

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

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

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

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

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

(c) All responsibilities undertaken by a nurse practitioner pursuant to this section shall be performed in collaboration with the physician and surgeon and pursuant to a standardized procedure among the physician and surgeon, nurse practitioner, and facility.

(d) Except as provided in subdivisions (a) to (c), inclusive, any task that is required by federal law or regulation to be performed personally by a physician may be delegated to a nurse practitioner who is not an employee of the long-term health care facility.

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

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

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

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

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

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

No. The nurse practitioner cannot furnish drugs and devices for the chiropractor's patients. The furnishing law, BPC 2836.1, the drugs and devices are furnished or ordered by a nurse practitioner in accord with standardized procedures or protocols developed by the nurse practitioner and the supervising physician and surgeon,