NURSING PRACTICE
COMMITTEE MEETING

AGENDA

Embassy Suites San Francisco Airport-Waterfront
150 Anza Blvd.
Burlingame, CA  94010
(650) 342-4600

January 8, 2014

Wednesday, January 8, 2014  1:00 pm – 2:00 pm

10.0 Review and Vote on Approval of Minutes:
   1.  October 1, 2013

10.1 Information and Discussion:
   Nurse Practitioner Laws and Regulations – Title 16 of the California Code of Regulations, Article 8, Sections 1480 - 1484; Nursing Education Consultant APRN (Advanced Practice Registered Nurse) Workgroup suggested updating and revising of current regulations.
   1.  Attachment - Agenda Item 10.1 from October 1, 2013 Nursing Practice Committee Meeting

10.2 Approve/not approve advisory statement for Registered Nursing: Nurse Practitioner and Certified Nurse Midwife
   1.  Nurse Practitioner and Certified Nurse Midwife Advisory
      a. Supervision of Medical Assistants

10.3 Nurse Practitioners with Multiple Specialties
   1.  Breeze tracking system ability to track multiple specialties

10.4 Public comment for items not on the agenda

NOTICE: All times are approximate. Meetings may be canceled without notice. For verification of meeting, call (916) 574-7600 or access the Board’s Web site www.rn.ca.gov under “Meetings.”

The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting the Administration Unit at (916) 574-7600 or email webmasterbrn@dca.ca.gov or send a written request to the Board of Registered Nursing Office at 1747 North Market Suite 150, Sacramento, CA 95834. (Hearing impaired: California Relay Service: TDD phone (800) 326-2297). Providing your request at least five (5) business days before the meeting will help to ensure the availability of the requested accommodation.

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.
Tuesday, October 1, 2013
Meeting was called to order at 2:30 pm
Members Present: Trande Phillips, Michael Jackson, and Cynthia Klein
Introductions of Board Members and Katie introduced the Staff APRN Workgroup (Katie, Miyo, Julie and Carol)

10.0 Review and vote to accept minutes:
Accept the Minutes of August 7, 2013 as presented.

MSC: Klein/Jackson voted to accept meeting minutes of August 7, 2013.

10.1 Information Only: APRN BRN Staff Workgroup Update
Katie Daugherty, NEC, presented a summary background and current issues, following the agenda items summary topics throughout the presentation. She discussed the history of 2008 Consensus Model: 48 organizations came together and endorsed; studies have proven APRNs have provided safe and cost effective care over time; Affordable Care Act – greater access to primary care; IOM Recommendations – removing barriers, expanding role of nursing, increased education, removal of practice barriers

Explained that the workgroup is in the early stages of gathering information and first priority is CNPs since they are largest group of APRNs. Currently in California there are over 18,700 active CNPs (72% of all APRNs). California already recognizes the four APRN roles and total approximately 3,400 CNSs, 2200 CRNAs, and 1243 CNMs.
Katie Daugherty, NEC, highlighted workgroup activities, especially the crosswalk document to compare CA current rules and regulations with the national consensus model to see if there are areas that need updating/changing; adding questions to the Annual School Survey to determine where APRN educational programs are in the process. She reviewed the workgroups preliminary beliefs/assumptions. She mentioned the attachment and that it contains good background and information related to the National Consensus Model and that is focuses on uniformity of Titles, Roles, Licensure and Certification, graduate degree/post graduate certificate, national certification by certifying bodies accepted by the BRN. She mentioned the six areas of population foci.

Katie Daugherty, NEC, also mentioned that the consensus model focuses on independent practice and prescriptive authority, which CNPs do not have authority in California.

Miyo Minato, SNEC, added that the workgroups goal is to review the regulations related to education and licensing requirements and make possible changes to comply with the national consensus model. We will be reviewing licensing requirements, accreditation of schools, APRN national certification, standardizing educational requirements to meet consensus model. We are beginning with CNPs and will move to others over time.

Public Comments:
California Action Coalition Co-Lead Recommendation #1 Provided comments – see written testimony she provided.

California Association of Nurse Anesthetists, Inc. - Supports the national consensus model and the BRN and said there have been many studies and information that supports the work of APRNs and there is information/studies available on their website. (I will download these to the G drive)

California Nurse Midwives Association – Supports the national consensus model and offers the BRN their resources and support.

California Nurses Association – Would like to see what regulatory changes might need to be changed and why. BRN seems to be leaning toward national consensus model and CNA does not support model as they have concerns about uniformity emphasis for nurses to move across state lines, which is similar to compacts and CNA opposes. CNA would like to see an analysis of what is wrong with current regulations and what is and is not working, and why is the BRN choosing the national consensus model as the model for California.

American Nurses Association of California – They support the national consensus model in concept and will support the BRN and staff and offer assistance with this process.

Trande Phillips, Chair, asked for clarification on why the national consensus model was chosen and Katie responded with the following:
- Language most similar to California
- Approved by 48 organizations
- Janette Wackerly, SNEC, has been working on this more extensively and could discuss more later
Louise Bailey, E.O., commented that the consensus model does not have to be accepted as a whole but we can pick and choose and select what is applicable for California and Katie said we are looking at language in our statutes and regulations for conformity and congruency.

10.2 Public Comments for Items not on the Agenda
No comments

Adjourned at 3:05 pm

Submitted by: Janette Wackerly, MBA, BSN, RN, SNEC (Supervising Nursing Education Consultant) NP Liaison
Accepted by: Trande Phillips, RN, Chair, Direct Practice Member
AGENDA ITEM: 10.1
DATE: January 8, 2014

ACTION REQUESTED: Information for Review and Discussion: California Code of Regulations; Article 8 Standards for Nurse Practitioners

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

BACKGROUND: The BRN staff APRN workgroup has continued review of BRN regulations, Article 8 Nurse Practitioners Laws and Regulations, the NCSBN Model Act, and language implemented in other states. Attached from the APRN workgroup is a comparative document which includes the current regulations and draft suggested language for review and discussion.

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
### 1480. Definitions

(a) "Nurse practitioner" means a registered nurse who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program conforms to board standards as specified in Section 1484.

(b) "Primary health care" is that which occurs when a consumer makes contact with a health care provider who assumes responsibility and accountability for the continuity of health care regardless of the presence or absence of disease.

(c) "Clinically competent" means that one possesses and exercises the degree of learning, skill, care and experience ordinarily possessed and exercised by a member of the appropriate discipline in clinical practice.

(d) "Holding oneself out" means to use the title of nurse-practitioner.

**Authority cited:** Section 2715, Business and Professions Code. Reference: Section 2834, Business and Professions Code.

**History:**
1. New Article 8 (Sections 1480-1485) filed 7-13-79; effective thirtieth day thereafter (Register 79, No. 28).
2. Amendment filed 12-7-85; effective thirtieth day thereafter (Register 85, No. 49).

### 1481. Categories of Nurse Practitioners

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

**Authority cited:** Section 2715, Business and Professions Code. Reference: Sections 2834 and 2836, Business and Professions Code.

**History:**
1. Amendment filed 12-4-85; effective thirtieth day thereafter (Register 85, No. 49).

**Draft Revisions for Discussion**

**BRN Nursing Practice Committee 1/8/14**

1480. Definitions

Definitions are still under review by BRN staff.
| Current California Code of Regulations  
| Article 8 – Standards for Nurse Practitioners |
| Draft Revisions for Discussion  
| BRN Nursing Practice Committee 1/8/14 |

**c.** In addition to the RN scope of practice and within the APRN role and population focus, CNP practice shall include:

1. Standardized procedures for CNP practitioners
2. Conducting an advanced assessment
3. Ordering and interpreting diagnostic procedures
4. Establishing primary and differential diagnoses
5. Furnishing/prescribing therapeutic measures as set forth in Business & Professions Code Section 2836.1.
6. Physician delegated supervisory functions for medical assistants performing tasks and supportive services pursuant to approved written standardized procedure. *(Per SB 352, Chapter 286, effective January 1, 2014)*
7. Consulting/collaborating with other disciplines and providing referrals to health care agencies, health care providers and community resources
8. Wearing identification which clearly identifies the nurse as a CNP when providing direct patient care, unless wearing identification creates a safety or health risk for either the nurse or the patient and
9. Other acts that require education and training consistent with professional standards and commensurate with the CNP’s education, certification, demonstrated competencies and experience

**d.** CNPs are certified interdependent practitioners within standards established or recognized by the BRN. Each CNP is accountable to patients, the nursing profession and the BRN for:

1. Complying with the requirements of this Act and the quality of advanced nursing care rendered
2. Recognizing limits of knowledge and experience
3. Planning for the management of situations beyond the CNP’s expertise and
4. Consulting with or referring patients to other health care providers as appropriate
### Current California Code of Regulations
#### Article 8 – Standards for Nurse Practitioners

**1482. Requirements for Holding Out As a Nurse Practitioner**

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

(a) Active licensure as a registered nurse in California; and
(b) One of the following:
   (1) Successful completion of a program of study which conforms to board standards; or
   (2) Certification by a national or state organization whose standards are equivalent to those set forth in Section 1484; or
   (3) A nurse who has not completed a nurse practitioner program of study which meets board standards as specified in Section 1484, shall be able to provide:
      (A) Documentation of remediation of areas of deficiency in course content and/or clinical experience, and
      (B) Verification by a nurse practitioner and by a physician who meet the requirements for faculty members specified in Section 1484(c), of clinical competence in the delivery of primary health care.

**Authority cited:** Section 2715, Business and Professions Code. Reference: Sections 2835 and 2836, Business and Professions Code.

**History:**
1. Amendment filed 12-4-85; effective thirtieth day thereafter (Register 85, No. 49).

### Draft Revisions for Discussion
#### BRN Nursing Practice Committee 1/8/14

**1482 Requirements for Nurse Practitioner Certification**

(a) Hold active, unencumbered registered nurse license in California;

(b) Meet the following educational requirements:
   (A) Master’s Degree in Nursing or a higher degree in Nursing from a CCNE (Commission on Collegiate Nursing Education) or ACEN (Accreditation Commission for Education in Nursing) accredited graduate nursing program or a credentials evaluation from a Board approved credentials service for graduate nursing degrees obtained outside of the U.S. which demonstrates educational equivalency to an accredited U.S. graduate nursing degree.
   (B) Satisfactory completion of board approved APRN-NP program accredited by a nursing accrediting body that is recognized by the U.S. Secretary of Education and/or the Council for Higher Education Accreditation (CHEA), or its successor organization, as acceptable by the board.
   (c) Hold a current national certification as APRN-CNP in the CNP role and population focus congruent with the educational preparation from a national organization recognized by the board.
### Current California Code of Regulations

**Article 8 – Standards for Nurse Practitioners**

<table>
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<tr>
<th><strong>1483. Evaluation of Credentials</strong></th>
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<tr>
<td>An application for evaluation of a registered nurse’s qualifications to hold out as a nurse practitioner shall be filed with the board on a form prescribed by the board and shall be accompanied by the fee prescribed in Section 1417 and such evidence, statements or documents as therein required by the board to conform with Sections 1482 and 1484.</td>
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<td>The board shall notify the applicant in writing that the application is complete and accepted for filing or that the application is deficient and what specific information is required within 30 days from the receipt of an application. A decision on the evaluation of credentials shall be reached within 60 days from the filing of a completed application. The median, minimum, and maximum times for processing an application, from the receipt of the initial application to the final decision, shall be 42 days, 14 days, and one year, respectively, taking into account Section 1410.4(e) which provides for abandonment of incomplete applications after one year.</td>
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**Authority cited:** Section 2715 and 2718, Business and Professions Code. Reference: Sections 2815 and 2835.5, Business and Professions Code. 

**History:**
1. Repealer and new section filed 8-21-86; effective thirtieth day (Register 86, No. 34).

### Draft Revisions for Discussion

**BRN Nursing Practice Committee 1/8/14**

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<td>An application for evaluation of a registered nurse’s qualifications as a Certified Nurse Practitioner (CNP) shall be filed with the board on a form prescribed by the board and shall be accompanied by the fee prescribed in Section 1417 and such evidence, statements or documents as therein required by the board to conform with Sections 1482 and 1484.</td>
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<td>CNP application includes submission of the following information:</td>
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<td>(a) Name of the graduate APRN-NP Program or post-graduate NP Program and the date of graduation or completion.</td>
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<td>(b) Documentation that verifies the date of graduation; credential conferred; record of courses and minimum of 500 hours of supervised clinical hours completed under direct supervision as described in Section 1484.</td>
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<td>The board shall notify the applicant in writing that the application is complete and accepted for filing or that the application is deficient and what specific information is required within 30 days from the receipt of an application. A decision on the evaluation of credentials shall be reached within 60 days from the filing of a completed application. The median, minimum, and maximum times for processing an application, from the receipt of the initial application to the final decision, shall be 42 days, 14 days, and one year, respectively, taking into account Section 1410.4(e) which provides for abandonment of incomplete applications after one year.</td>
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**History:**
1. Repealer and new section filed 8-21-86; effective thirtieth day (Register 86, No. 34).
### Current California Code of Regulations

**Article 8 – Standards for Nurse Practitioners**

1484. Standards of Education

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

(a) Purpose, Philosophy and Objectives

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

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

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

(b) Administration

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

(A) An institution of higher education that offers a baccalaureate or higher degree in nursing, medicine, or public health.

(B) A general acute care hospital licensed pursuant to Chapter 2 (Section 1250) of Division 2 of the Health and Safety Code, which has an organized outpatient department.

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

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

(4) Provide the graduate with official evidence indicating that he/she has demonstrated clinical competence in delivering primary health care and has achieved all other objectives of the program.

(5) Maintain systematic, retrievable records of the program including philosophy, objectives, administration, faculty, curriculum, students and graduates. In case of program discontinuance, the board shall be notified of the method provided for record retrieval.

(6) Provide for program evaluation by faculty and students during and following the program and make results available for public review.

### Draft Revisions for Discussion

**BRN Nursing Practice Committee 1/8/14**

1484. APRN-NP Education

The program of study preparing a certified nurse practitioner (CNP) shall meet the following standards of education:

(a) Administration and Organization of the NP Program:

(1) Program mission, philosophy, goals, and program outcomes are consistent with the purpose for preparation of the graduate APRN-NP providing primary care and/or acute care services to one of the following population foci:

a. Family/individual across the lifespan

b. Adult-gerontology (primary care or acute care)

c. Neonatal

d. Pediatrics (primary care or acute care)

e. Women’s health/gender-related or

f. Psychiatric/mental health

(2) Learning outcomes for the NP Program are measurable and reflect assessment and evaluation of the theoretical knowledge and clinical competencies of the graduate.

(3) The policies and procedures by which the NP program is administered shall reflect the philosophy and learning outcomes of the program, and be available to all students.

(4) The NP program shall have a written total program evaluation plan for program improvement, including attrition and retention of students, and performance of NP graduates on the national certification exam and meeting community needs.

(a) The program shall have sufficient resources to achieve the program objectives.

(b) In the event of program closure, the program shall notify the method provided for retrieval of records.
(c) **Faculty.** There shall be an adequate number of qualified faculty to develop and implement the program and to achieve the stated objectives.

1. Each faculty person shall demonstrate current competence in the area in which he/she teaches.

2. The director or co-director of the program shall:
   
   A. be a registered nurse;
   
   B. hold a Master's or higher degree in nursing or a related health field from an accredited college or university;
   
   C. have had one academic year's experience, within the last five (5) years, as an instructor in a school of professional nursing, or in a program preparing nurse practitioners.

3. Faculty in the theoretical portion of the program must include instructors who hold a Master's or higher degree in the area in which he or she teaches.

4. A clinical instructor shall hold active licensure to practice his/her respective profession and demonstrate current clinical competence.

5. A clinical instructor shall participate in teaching, supervising and evaluating students, and shall be appropriately matched with the content and skills being taught to the students.

(b) **Faculty:**

1. There shall be a qualified NP program administrator and an adequate number of qualified faculty to develop and implement the program and to achieve the program objectives.

2. The NP Program administrator shall have sufficient time dedicated for the administration of the program.

3. The program shall appoint a program administrator for the NP program whose qualifications shall include:
   
   a. an active, unencumbered CA registered nurse license;
   
   b. certified as a CNP in CA;
   
   c. a Master’s degree in nursing or higher degree in nursing;
   
   d. two years of clinical experience as an APRN-NP within the last five (5) years, as an instructor in a school of professional nursing, or in a program;
   
   e. current national APRN-NP certification.

4. The NP Program administrator shall ensure that there is a qualified faculty assigned to coordinate and administer each NP track when there is more than one NP options offered for the population foci.

5. Faculty who teach within the NP program shall be educationally and clinically qualified in the same population foci as the theory and clinical areas taught. Qualification for the NP faculty shall include:
   
   a. an active, unencumbered CA registered nurse license;
   
   b. certified as a CNP in CA;
   
   c. a Master’s degree in nursing or higher degree in nursing;
   
   d. at least two years of clinical experience as an APRN-NP;
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<td>(e) current knowledge, competence, and current national APRN-NP certification in the role and population foci consistent with the teaching responsibilities.</td>
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<td>(6) Interdisciplinary faculty who teach non-clinical NP nursing courses shall have advanced graduate degree appropriate to the content taught, such as pharmacology.</td>
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<td>(7) Each faculty member shall assume responsibility and accountability for instruction, evaluation of students, and planning and implementing curriculum content. Faculty responsibilities shall include:</td>
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<td>(a) making arrangements with agency personnel in advance of the clinical experience which provides and verifies student supervision, preceptor orientation, and faculty defined objectives;</td>
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<td>(b) monitoring student assignments, making periodic site visits to the agency, evaluating students’ performance on a regular basis with input from the student and preceptor, and availability for direct supervision during students’ scheduled clinical time;</td>
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<td>(c) Providing direct supervision by a qualified faculty or experienced licensed clinical supervisor as required for patient safety and student skill attainment.</td>
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<td>(8) Each faculty member shall participate in an orientation program, including, but not limited to, the program’s curriculum, policies and procedures, strategies for teaching, and student supervision and evaluation.</td>
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<td>(9) Clinical faculty employed solely to supervise NP clinical experience for students shall meet faculty qualifications listed in Section 1484(b)(3).</td>
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<td>(10) Clinical preceptors may be used to enhance faculty-directed clinical learning experiences. Clinical preceptors shall demonstrate competencies in the assigned population foci and qualifications shall include:</td>
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**Article 8 – Standards for Nurse Practitioners**

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| (a) an active, unencumbered CA registered nurse license; |
| (b) certified as a CNP in CA; |
| (c) current national certification as APRN-NP; |
| (d) Privilege to practice unencumbered as a CNP or non-NP who meets all of the above requirements in their discipline and practices in a comparable population foci; |
| (e) Functions as a supervisor and teacher and evaluates the student’s performance in the clinical setting. |

**(11) NP Preceptorship experience**

| (a) Student-preceptor ratio shall be appropriate to accomplishment of learning objectives, to provide for patient safety, and to the complexity of the clinical situation. |
| (b) Functions and responsibilities for the preceptor shall be clearly documented in a written agreement between the agency, the preceptor, and the clinical program. |
| (c) Initial experiences in the clinical practicum and a majority of the clinical experiences shall be under the supervision of clinical preceptors who are CNPs. |
| (d) A minimum of 500 hours of clinical experience shall be under direct supervision by the preceptor or faculty. |
| (e) Faculty member conducts periodic on-site meetings/conferences with the preceptor and the student; and, faculty member completes the final evaluation of the student with input from the preceptor; |
| (f) Preceptor record that includes preceptor name, license, certification, student name, and dates of preceptorship shall be maintained. |
(d) Curriculum

(1) The program shall include all theoretical and clinical instruction necessary to enable the graduate to provide primary health care for persons for whom he/she will provide care.

(2) The program shall provide evaluation of previous education and/or experience in primary health care for the purpose of granting credit for meeting program requirements.

(3) Training for practice in an area of specialization shall be broad enough, not only to detect and control presenting symptoms, but to minimize the potential for disease progression.

(4) Curriculum, course content, and plans for clinical experience shall be developed through collaboration of the total faculty.

(5) Curriculum, course content, methods of instruction and clinical experience shall be consistent with the philosophy and objectives of the program.

(6) Outlines and descriptions of all learning experiences shall be available, in writing, prior to enrollment of students in the program.

(7) The program may be full-time or part-time and shall be comprised of not less than thirty (30) semester units, (forty-five (45) quarter units), which shall include theory and supervised clinical practice.

(8) The course of instruction shall be calculated according to the following formula:

(A) One (1) hour of instruction in theory each week throughout a semester or quarter equals one (1) unit.

(B) Three (3) hours of clinical practice each week throughout a semester or quarter equals one (1) unit.

(C) One (1) semester equals 16-18 weeks and one (1) quarter equals 10-12 weeks.

(9) Supervised clinical practice shall consist of two phases:

(A) Concurrent with theory, there shall be provided for the student, demonstration of and supervised practice of correlated skills in the clinical setting with patients.

(B) Following acquisition of basic theoretical knowledge prescribed by the curriculum the student shall receive supervised experience and instruction in an appropriate clinical setting.

(C) At least 12 semester units or 18 quarter units of the program shall be in clinical practice.

(10) The duration of clinical experience and the setting shall be such that the student will receive intensive experience in performing the diagnostic and treatment procedures essential to the practice for which the student is being prepared.

(11) The program shall have the responsibility for arranging for clinical

(c) Curriculum:

(1) The curriculum of an APRN-CNP program shall be that set forth in this section and shall be approved by the board. Any revised curriculum shall be approved by the board prior to its implementation.

(1) The CNP program may be full-time or part-time and shall be a minimum of one academic year in length.

(2) The curriculum content shall contain theory and clinical experience in the select NP role and population focus, preparing the graduate to meet all competencies consistent with APRN-CNP practice including physical assessment, pharmacology, pathophysiology, differential diagnosis and clinical management;

(3) Post-graduate NP programs which prepare an individual for dual role or population focus certification must meet all competencies designated for the NP role including supervised clinical hours of no less than 500 hours for each role or population focus. (Oregon)

(4) Each CNP curriculum for a population focus shall have a minimum of 500 supervised clinical hours directly related to the role and population focus, including pharmacotherapeutic management of patients.

(5) There shall be provisions for the recognition of prior learning and advanced placements in the curriculum for individuals who hold a master’s in nursing and are seeking preparation in a different role and population focus. Post-masters nursing students shall complete the requirements of the master’s APRN-NP program through a formal graduate level certificate in the desired role and population focus. Post-master students must meet the same APRN-CNP outcome competencies as the master level students.

(6) The course of instruction shall be calculated according to the following formula:
### Current California Code of Regulations
**Article 8 – Standards for Nurse Practitioners**

Instruction and supervision for the student.

12. The curriculum shall include, but is not limited to:

- Normal growth and development
- Pathophysiology
- Interviewing and communication skills
- Eliciting, recording and maintaining a developmental health history
- Comprehensive physical examination
- Psycho-social assessment
- Interpretation of laboratory findings
- Evaluation of assessment data to define health and developmental problems
- Pharmacology
- Nutrition
- Disease management
- Principles of health maintenance
- Assessment of community resources
- Initiating and providing emergency treatments
- Nurse practitioner role development
- Legal implications of advanced practice
- Health care delivery systems

13. The course of instruction of a program conducted in a non-academic setting shall be equivalent to that conducted in an academic setting.

**Authority cited:** Section 2715, Business and Professions Code. Reference: Section 2836, Business and Professions Code.

### Draft Revisions for Discussion
**BRN Nursing Practice Committee 1/8/14**

- One (1) hour of instruction in theory each week throughout a semester or quarter equals one (1) unit.
- Three (3) hours of clinical practice each week throughout a semester or quarter equals one (1) unit.
- One (1) semester equals 15-18 weeks and one (1) quarter equals 10-12 weeks.

7. The curriculum shall be congruent with national standards for graduate level and advanced practice nursing education and is consistent with the NP core competencies and the population focused competencies in the area of educational preparation (NONPF, 2013) and includes, but is not limited to:

- Three separate graduate level courses (the APRN-core, including the 3 P’s) in:
  1. Advanced physiology and pathophysiology, including general principles that apply across the lifespan
  2. Advanced health assessment, which includes assessment of all human systems, advanced assessment techniques, concepts and approaches and
  3. Advanced pharmacology, which includes pharmacodynamics, pharmacokinetics and pharmacotherapeutics of all broad categories of agents;
- Diagnosis and management of diseases across practice settings including diseases representative of all systems;
- Preparation that provides a basic understanding of the principles for decision making in the identified role;
- Preparation in the core competencies for the identified APRN-CNP role; and
- Role preparation in one of the six population foci of practice, including legal, ethical and professional responsibilities of the APRN-CNP.
Current California Code of Regulations  
Article 8 – Standards for Nurse Practitioners

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<td>(8) The curriculum shall include content related to CA NPA, BPC, Div. 2, Chapter 6, Article 8, Nurse Practitioner and CCR Title 16, Div. 14, Article 8, Standards for Nurse Practitioners, including but not limited to:</td>
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<tr>
<td>(a) BPC section 2835.7 Authorized standardized procedures;</td>
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<td>(b) BPC section 2836.1 Furnishing or ordering of drugs or devices.</td>
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<tr>
<td>(9) Curriculum, course content, methods of instruction and clinical experience shall be consistent with the philosophy and objectives of the program.</td>
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<td>(10) Course materials, including descriptions of all learning experiences and evaluation methods are published in written or electronic format and shall be available to students prior to the start of the course.</td>
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<tr>
<td>(11) Supervised clinical practice shall consist of two phases:</td>
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<tr>
<td>(a) Concurrent with theory, there shall be provided for the student, demonstration of and supervised practice of correlated skills.</td>
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<tr>
<td>(b) Following acquisition of basic theoretical knowledge prescribed by the curriculum the student shall receive a minimum of 500 hours of supervised experience and instruction in an appropriate clinical setting in direct patient care.</td>
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<tr>
<td>(12) The curriculum shall have appropriate course sequencing and requirements for matriculation into the program, including completion of all pre-licensure nursing curriculum requirements before advancement into nurse practitioner clinical coursework.</td>
</tr>
<tr>
<td>(13) Each student enrolled in an APRN program shall have an unencumbered CA RN license to participate in the clinical experience.</td>
</tr>
</tbody>
</table>
| Current California Code of Regulations  
| Article 8 – Standards for Nurse Practitioners | Draft Revisions for Discussion  
|  
| BRN Nursing Practice Committee 1/8/14 |  

(d) Clinical Agency:
(1) The program shall have the responsibility for arranging for clinical instruction and supervision for the student.
(2) The NP program shall maintain a written agreement with each agency where the students have clinical experiences with a preceptor, and such agreements shall include the following:
   (a) Assurance of the availability and appropriateness of the learning environment in relation to the program’s written objectives;
   (b) Provisions for orientation of faculty and students;
   (c) Specification of the responsibilities and authority of the preceptor as related to the program and to the educational experience of the students;
   (d) Provisions for continuing communication between the facility and the program; and
   (e) Description of the responsibilities of faculty assigned to the course.

(e) Student Participation:
Students shall be provided the opportunity to participate with the faculty in the identification of policies and procedures related to students including but not limited to:
(1) Philosophy and objectives;
(2) Learning experiences; and
(3) Curriculum, instruction and evaluation of the various aspects of the program, including clinical facilities.

Clinical Practicum in California for Nurse Practitioner Students Enrolled in Non-California Based Graduate Program

This section still under review by BRN staff.
Recent legislation (Senate Bill 352; Chapter 286) enacted September 9, 2013, deletes the requirement that services performed by a medical assistant be in a specified clinic when under the specific authorization of a physician assistant, nurse practitioner, or certified nurse-midwife. Written instructions by the licensed physician and surgeon or podiatrist may provide that the supervisory function for the medical assistant for tasks or supportive services be delegated in a standardized procedure to the nurse practitioner or certified nurse-midwife. Medical Assistant tasks may be performed when the supervising physician and surgeon is not onsite, if the nurse practitioner or certified nurse-midwife is functioning pursuant to standardized procedures, as defined by Section 2725 of the Business and Professions Code. The nurse practitioner, certified nurse-midwife, or physician assistant is prohibited from authorizing a medical assistant to perform any clinical laboratory test or examination for which the medical assistant is not authorized, as specified, a violation of which would constitute unprofessional conduct.

The legislation amends Section 2069 of the Business and Professions Code and uses the following definitions which are summarized here:
“Medical assistant” means a person at least 18 years of age who may be unlicensed and performs basic administrative, clerical, and technical support services under the supervision for a licensed physician and surgeon, a licensed podiatrist, physician assistant, nurse practitioner, or certified nurse-midwife, and has had at least the minimum amount of hours of appropriate training established by the Medical Board of California. The medical assistant shall be issued a certificate indicating satisfactory completion of the required training and copies must be retained by the employer.

“Specific authorization” means a specific written or a standing order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the certified nurse-midwife authorizing the procedures to be performed on a patient, the duration of which shall be consistent with accepted medical practice. The specific written or standard order shall be placed in the patient’s medical record.

“Supervision” means the supervision of procedures authorized by a licensed physician and surgeon, a licensed podiatrist, a physician assistant, nurse practitioner, or certified nurse-midwife, within the scope of their respective practices, who shall be physically present in the treatment facility during the performance of those procedures.

“Technical supportive services” means simple routine medical tasks and procedures that may be safely performed by a medical assistant who has limited training and who functions under the supervision of a licensed physician and surgeon or a licensed podiatrist, or a physician assistant, a nurse practitioner, or a certified nurse-midwife.

For additional information and specific legislative language regarding this new legislation please see the following website:
http://www.leginfo.ca.gov/cgi-bin/postquery?bill_number=sb_352&sess=CUR&house=B&author=pavley_<pavley>
NURSE PRACTITIONERS and NURSE MIDWIVES

Legislation enacted during 2012-2013 Session

New Legislation for Medical Assistants Impacting Nurse Practitioners and Certified Nurse-Midwives

Recent legislation (Senate Bill 352; Chapter 286) enacted September 9, 2013, deletes the requirement that services performed by a medical assistant be in a specified clinic when under the specific authorization of a physician assistant, nurse practitioner, or certified nurse-midwife. Written instructions by the licensed physician and surgeon or podiatrist may provide that the supervisory function for the medical assistant for tasks or supportive services be delegated in a standardized procedure to the nurse practitioner or certified nurse-midwife. Medical Assistant tasks may be performed when the supervising physician and surgeon is not onsite, if the nurse practitioner or certified nurse-midwife is functioning pursuant to standardized procedures, as defined by Section 2725 of the Business and Professions Code. The nurse practitioner, certified nurse-midwife, or physician assistant is prohibited from authorizing a medical assistant to perform any clinical laboratory test or examination for which the medical assistant is not authorized, as specified, a violation of which would constitute unprofessional conduct.

The legislation amends Section 2069 of the Business and Professions Code and uses the following definitions which are summarized here:

“Medical assistant” means a person at least 18 years of age who may be unlicensed and performs basic administrative, clerical, and technical support services under the supervision for a licensed physician and surgeon, a licensed podiatrist, physician assistant, nurse practitioner, or certified nurse-midwife, and has had at least the minimum amount of hours of appropriate training established by the Medical Board of California. The medical assistant shall be issued a certificate indicating satisfactory completion of the required training and copies must be retained by the employer.

“Specific authorization” means a specific written or a standing order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the certified nurse-midwife authorizing the procedures to be performed on a patient, the duration of which shall be consistent with accepted medical practice. The specific written or standard order shall be placed in the patient’s medical record.

“Supervision” means the supervision of procedures authorized by a licensed physician and surgeon, a licensed podiatrist, a physician assistant, nurse practitioner, or certified nurse-midwife.
nurse-midwife, within the scope of their respective practices, who shall be physically present in the treatment facility during the performance of those procedures.

“Technical supportive services” means simple routine medical tasks and procedures that may be safely performed by a medical assistant who has limited training and who functions under the supervision of a licensed physician and surgeon or a licensed podiatrist, or a physician assistant, a nurse practitioner, or a certified nurse-midwife.

For additional information and specific legislative language regarding this new legislation please see the following website:
http://www.leginfo.ca.gov/cgi-bin/postquery?bill_number=sb_352&sess=CUR&house=B&author=pavley

SECTION 1.
Section 2069 of the Business and Professions Code is amended to read:

An act to amend Section 2069 of the Business and Professions Code, relating to healing arts.
[Approved by Governor September 9, 2013. Filed with Secretary of State September 9, 2013.]

2069.
(a) (1) Notwithstanding any other law, a medical assistant may administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical supportive services upon the specific authorization and supervision of a licensed physician and surgeon or a licensed podiatrist. A medical assistant may also perform all these tasks and services upon the specific authorization of a physician assistant, a nurse practitioner, or a certified nurse-midwife.
(2) The supervising physician and surgeon may, at his or her discretion, in consultation with the nurse practitioner, certified nurse-midwife, or physician assistant, provide written instructions to be followed by a medical assistant in the performance of tasks or supportive services. These written instructions may provide that the supervisory function for the medical assistant for these tasks or supportive services may be delegated to the nurse practitioner, certified nurse-midwife, or physician assistant within the standardized procedures or protocol, and that tasks may be performed when the supervising physician and surgeon is not onsite, if either of the following apply:
(A) The nurse practitioner or certified nurse-midwife is functioning pursuant to standardized procedures, as defined by Section 2725, or protocol. The standardized procedures or protocol, including instructions for specific authorizations, shall be developed and approved by the supervising physician and surgeon and the nurse practitioner or certified nurse-midwife.
(B) The physician assistant is functioning pursuant to regulated services defined in Section 3502, including instructions for specific authorizations, and is approved to do so by the supervising physician and surgeon.
(b) As used in this section and Sections 2070 and 2071, the following definitions apply:
(1) “Medical assistant” means a person who may be unlicensed, who performs basic administrative, clerical, and technical supportive services in compliance with this section and Section 2070 for a licensed physician and surgeon or a licensed podiatrist, or group thereof, for a medical or podiatry corporation, for a physician assistant, a nurse
practitioner, or a certified nurse-midwife as provided in subdivision (a), or for a health care service plan, who is at least 18 years of age, and who has had at least the minimum amount of hours of appropriate training pursuant to standards established by the board. The medical assistant shall be issued a certificate by the training institution or instructor indicating satisfactory completion of the required training. A copy of the certificate shall be retained as a record by each employer of the medical assistant.

(2) “Specific authorization” means a specific written order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the certified nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed on a patient, which shall be placed in the patient’s medical record, or a standing order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the certified nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed, the duration of which shall be consistent with accepted medical practice. A notation of the standing order shall be placed on the patient’s medical record.

(3) “Supervision” means the supervision of procedures authorized by this section by the following practitioners, within the scope of their respective practices, who shall be physically present in the treatment facility during the performance of those procedures:

(A) A licensed physician and surgeon.
(B) A licensed podiatrist.
(C) A physician assistant, nurse practitioner, or certified nurse-midwife as provided in subdivision (a).

(4) “Technical supportive services” means simple routine medical tasks and procedures that may be safely performed by a medical assistant who has limited training and who functions under the supervision of a licensed physician and surgeon or a licensed podiatrist, or a physician assistant, a nurse practitioner, or a certified nurse-midwife as provided in subdivision (a).

(c) Nothing in this section shall be construed as authorizing any of the following:

(1) The licensure of medical assistants.
(2) The administration of local anesthetic agents by a medical assistant.
(3) The board to adopt any regulations that violate the prohibitions on diagnosis or treatment in Section 2052.
(4) A medical assistant to perform any clinical laboratory test or examination for which he or she is not authorized by Chapter 3 (commencing with Section 1200).
(5) A nurse practitioner, certified nurse-midwife, or physician assistant to be a laboratory director of a clinical laboratory, as those terms are defined in paragraph (8) of subdivision (a) of Section 1206 and subdivision (a) of Section 1209.
(d) A nurse practitioner, certified nurse-midwife, or physician assistant shall not authorize a medical assistant to perform any clinical laboratory test or examination for which the medical assistant is not authorized by Chapter 3 (commencing with Section 1200). A violation of this subdivision constitutes unprofessional conduct.
(e) Notwithstanding any other law, a medical assistant shall not be employed for inpatient care in a licensed general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code.
AGENDA ITEM: 10.3  
DATE: January 8, 2014

ACTION REQUESTED: Review and Vote to Approve - Recognition of Nurse Practitioners with Multiple Specialties

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

BACKGROUND: The Board of Registered Nursing is receiving inquiries from certified Nurse Practitioners (NPs) who have returned to school and completed an academic program, usually a post-master’s program, in an additional specialized area. These NPs are requesting recognition in all of their specialties. The prior Applicant Tracking System would not accommodate more than one specialty; however, the current BreEZe System will accommodate multiple specialties.

Previously, the Board has asked only for evidence of national certification as a NP in the additional specialty. This document was added to the existing NP application; however, it could not be added to the CAS (Teale) system. The only way a prospective employer would know a NP was able to practice in a particular specialty was to contact the Board. Staff would pull the NP application to ensure documentation of the additional specialty had been provided.

To provide consistency, we are recommending the Board require any NP wanting an additional specialty added to their existing certification be required to submit the following documentation:

A written request from the Nurse Practitioner  
Evidence of certification from a national organization/association (a list of accepted organizations/associations is available on the Board’s website)  
An official transcript from the school reflecting completed course work and if applicable, the degree and degree conferral date.

When verifying a NP certification on the Board’s website, the specialties would be listed under “Qualification:”
<table>
<thead>
<tr>
<th>License Number:</th>
<th>Current Date:</th>
</tr>
</thead>
</table>

| Name: | Nurse Practitioner |
| License Type: | Nurse Practitioner |
| License Status: | FAMILY NURSE PRACTITIONER |
| Qualification: | FAMILY NURSE PRACTITIONER |

| Expiration Date: | Original Issuance Date: |

**NEXT STEPS:**

Present to Board

**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
ADDENDUM

For reference attached are the following materials from the October 1, 2013 Committee Meeting:

AIS 10.1 Information: Advanced Practice Registered Nurse (APRN) BRN Staff Workgroup Update

Campaign for APRN Consensus
AGENDA ITEM: 10.1  
DATE:  October 1, 2013

ACTION REQUESTED:  
Information: Advanced Practice Registered Nurse (APRN)  
BRN Staff Workgroup Update

REQUESTED BY:  
Katie Daugherty, MN, RN  
Julie Campbell-Warnock, MA  
Nursing Education Consultant  
Research Program Specialist

BACKGROUND:

At the April 10, 2013 Board meeting, the Board approved a request from the Nursing Practice Committee to appoint an advanced practice registered nurse (APRN) advisory committee. Suggested goals of the advisory committee were to review and recommend to the Board:

- Respond to the changing health care environment by addressing changes in rules and regulations.
- Respond to APRN regulations and need for updating for practice and education.
- Discuss scope of practice and educational issues.

Louise Bailey, Executive Officer, announced at the August 7, 2013, Nursing Practice Committee meeting that due to BRN budgetary constraints it is not possible to fund an APRN Advisory Committee. In order to move forward in providing the Nursing Practice Committee and Board the requested information, an internal Board staff workgroup has been established. Workgroup membership includes:

- Janette Wackerly, MBA, BSN, RN–SNEC-North and Nursing Practice Committee Staff Liaison
- Miyo Minato, MN, RN–SNEC-South and Nursing Education Committee Staff Liaison
- Katie Daugherty, MN, RN – NEC-North
- Carol McKay, MN, RN – NEC-South
- Julie Campbell-Warnock, MA – Research Program Specialist and BRN Representative to the APRN Workgroup for the California Action Coalition

The workgroup’s main task for Fiscal Year 2013-2014 is to focus primarily on identifying needed changes in existing Certified Nurse Practitioner rules and regulations here in California. In addition, the workgroup will be reviewing current information pertinent to all four nationally recognized APRN roles: Certified Registered Nurse Anesthetists (CRNAs), Certified Nurse-Midwives (CNMs), Clinical Nurse Specialists (CNSs) and Certified Nurse Practitioners (CNPs).

In FY 2013-2014 workgroup activities will encompass the following:

- Information gathering and review of pertinent national and state level materials; written analyses/conclusions.
• Written workgroup reports to the Nursing Practice Committee where the public will be provided ongoing opportunities to provide input and feedback.
• Formulation of recommendations for California APRNs, specifically CNPs based on workgroup analyses/recommendations and the comments/input and feedback from the Nursing Practice Committee, the full Board, the public and key stakeholders.

**Highlights of Workgroup Activities**
The BRN staff workgroup is in the initial phases of its work. The following activities are in progress:

• Review of pertinent national and state level APRN information.
• Monitor legislation relating to APRN, most specifically CNP practice.
• Collaborate with other BRN staff monitoring legislation and regulatory development.
• Add a set of questions to the 2012-2013 Annual School Survey to determine: (1) Status of implementing CNP curriculum according to the four roles and the six population focus/foci described in the Consensus Model for APRN Regulation; (2) Program requirements for graduates in relation to taking the national certification exam in the designated role and population focus; (3) Data on which national exams are required; and (4) If the program officially tracks student success on the national certification exams.
• Develop an up-to-date database of California approved APRN educational programs, beginning with CNP programs.
• Compile an up-to-date list of key stakeholders and interested parties so the Board may keep them abreast of workgroup activities and solicit input/feedback on an ongoing basis.
• Identify methods for tracking workgroup activities, progress and reporting timelines.
• Assess and identify anticipated fiscal impact associated with any APRN regulatory changes.
• Develop a written “crosswalk” document comparing existing California CNP rules and regulations and National Council of State Boards of Nursing (NCSBN) 2012 APRN Model Act and Rules language based on the Consensus Model.
• Use the crosswalk to determine needed California CNP practice and education regulatory changes as a starting point.
• Consult with BRN legal counsel as needed.

Some preliminary workgroup beliefs/assumptions guiding workgroup activities at this juncture of review are:

• California has already adopted the title Advanced Practice Registered Nurse (APRN) in B&P Code Section 2725.5, however, further integration throughout the APRN regulations/rules may be needed.
• New CNPs are to be prepared with acute care and/or primary care competencies for adult-gerontology and pediatric populations and may be certified in one or more subtypes and foci based on transcript proof of multiple areas of educational preparation.
• California plans to enhance clarity in regulations and rules so it is clear that California APRNs practice under both their California RN license and their California APRN certification(s).
- All California newly certified APRNs are to be licensed RNs with required graduate degree preparation in at least one APRN role and population focus.
- All California newly certified APRNs must complete an accredited graduate level education program (graduate degree or post-master’s/doctorate certificate) and pass the required national certification examination for certification in California.
- APRN educational preparation and APRN role and population focus certification is to build on California RN licensure competencies.
- All APRNs are to be educationally prepared to provide a variety of services across the health wellness-illness continuum in at least one APRN role and at least one of six specific population focus/foci:
  - Family/Individual Across the Life Span
  - Adult-Gerontology (subtype acute and or primary)
  - Neonatal
  - Pediatrics (subtype acute and or primary)
  - Women’s Health/Gender Related
  - Psychiatric/Mental Health (across the life span)
- New California APRNs may complete graduate level education and be certified in one or more roles and population foci. Transcript evidence of role/population foci in each area will be required.
- California certification as an APRN in one role and at least one population foci will be required for all new APRNs while currently certified APRNs will be “grandfathered”.
- CA APRNs will only provide services for the role and population in which they are certified.
- APRN specialization beyond a California APRN role and population certification will not be assessed or regulated by the California BRN. Such specialty competency examination (for example in oncology etc.) will be assessed by professional nursing associations/organizations.
- Any such specialization designation beyond BRN approved APRN certification/population foci will not expand the APRNs scope of practice beyond the role and population foci in which the individual is California APRN certified.
- Regulatory language to accommodate APRNs seeking California APRN certification by endorsement will need to be revised to be congruent with any proposed regulatory changes/revisions.

**Consensus Model for APRN Regulation**
The Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education (LACE) were published July 7, 2008; LACE refers to the following:

- **Licensure** refers to the requirement for APRN licensure/or certification; California uses the term Certification for all four APRN roles.
- **Accreditation** refers to the requirement that the APRN’s education program will have national nursing accreditation by a recognized accrediting body such as Commission on Collegiate Nursing Education (CCNE) or Accreditation Commission for Education in Nursing (ACEN).
- **Certification** in the Consensus Model context this means the Board of Nursing will require all new APRNs to successfully pass a national certification examination in their designated APRN role(s) and population focus/foci; each Board of Nursing will
determine the specific national certification bodies that are acceptable in their respective jurisdiction.

- **Education** means the APRN graduate level education program is a Board approved graduate degree APRN program and a program that meets National APRN educational standards developed by organizations such as the National Organization of Nurse Practitioner Faculties (NONPF) and other such entities specifying current education standards for APRN programs.

The APRN Consensus Model defines APRN practice, identifies APRN titles to be used, and describes roles and population foci for APRN education and practice. The Model is explained in detail in the NCSBN attachment *Model for Uniform National Advanced Practice Registered Nurse (APRN) Regulation: A Handbook for Legislators*.

In addition to this attachment, NCSBN has developed a variety of tools to assist Boards of Nursing in implementing the APRN Consensus Model and enacting appropriate rules and regulations for implementation as appropriate to each state board. This information can be found on the NCSBN website at [https://www.ncsbn.org/4213.htm](https://www.ncsbn.org/4213.htm).

While California already has some of the Consensus Model categories/standards and regulatory language incorporated in existing rules and regulations, full implementation and suggested regulatory changes may not be currently applicable to California. The major task of the APRN workgroup for Fiscal Year 2013-2014 and moving forward is to review current California rules and regulations and make recommendations for changes where appropriate. The workgroup is working to determine the best way to incorporate the model regulations in California given the fact the Consensus Model advocates for independent practice and prescriptive authority across all Board of Nursing jurisdictions and these are not in place at this time in California.

The next APRN workgroup report will be presented at the January 2014 Nursing Practice Committee.

**NEXT STEPS:**

Place on Board agenda.

**FISCAL IMPACT, IF ANY:**

**PERSON(S) TO CONTACT:**

Janette Wackerly, MBA, BSN, RN
Supervising Nursing Education Consultant
Phone: 916-574-7686
Email: janette.wackerly@dca.ca.gov
Model for Uniform National Advanced Practice Registered Nurse (APRN) Regulation:
A Handbook for Legislators
Introduction

This legislative resource was developed in response to requests for information about advanced practice registered nurse (APRN) regulatory issues. It outlines the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education, which formulates national standards for uniform regulation of APRNs.

Model APRN regulation is aimed at public protection by ensuring uniformity across all jurisdictions. Uniformity of national standards and regulation not only allows for the mobility of nurses, it also serves the public by increasing access to care. Currently, each jurisdiction devises its own standards in regard to APRNs. This has resulted in a huge diversity of rules and regulations between jurisdictions. The lack of uniformity between jurisdictions leads to confusion on the part of the public, profession and related fields, given that even APRN titles differ from one jurisdiction to the next. The need for standardization also affects the livelihood of practicing APRNs and their ability to relocate to areas experiencing health care shortages. An APRN may have extensive experience in one jurisdiction, but is limited in mobility because moving to another jurisdiction would mean being subject to different qualifications or standards of practice.

The recommendations offered in this booklet present an APRN regulatory model that is a collaborative effort among APRN educators, accreditors, certifiers and licensure bodies. The recommendations reflect a collaboration among regulatory bodies to achieve a sound model and continued communication, with the goal of increasing the clarity and uniformity of APRN regulation. This document defines APRN practice, describes the APRN regulatory model, identifies the titles to be used, defines specialties, describes the roles and population foci, and presents strategies for implementation.

The model for APRN regulation is the product of substantial work conducted by the Advanced Practice Nursing Consensus Work Group and the National Council of State Boards of Nursing (NCSBN®), which came together to form the APRN Joint Dialogue Group, representing 144 organizations. Together, this group designed a framework whereby jurisdictions can implement and oversee the uniform licensure, accreditation, certification and education of APRNs.

We hope you use the information provided to guide your decisions with regard to APRN practice, licensure, education and certification.
Advanced Practice Registered Nurses (APRNs)

APRNs include certified registered nurse anesthetists (CRNAs), certified nurse-midwives (CNMs), clinical nurse specialists (CNSs) and certified nurse practitioners (CNPs). There are currently over 250,000 APRNs in the U.S. (U.S. Department of Health and Human Services Health Resources and Services Administration, 2010). Over the past several decades, the number of APRNs has increased and their capabilities have expanded, becoming a highly valued and an integral part of the health care system. APRNs provide care in a wide array of practice settings, including hospitals, physician offices, home care, nursing homes, schools and various types of clinics. Because of the importance of APRNs in caring for the current and future health needs of patients, the education, accreditation, certification and licensure of APRNs needs to be effectively aligned in order to continue to ensure patient safety while at the same time, expanding patient access to care.

APRN Definition
An APRN is a nurse with a graduate degree who has been licensed in an advanced role that builds on the competencies of registered nurses (RNs). Licensure as an APRN is contingent upon completion of an accredited graduate-level education program and passage of a national certification examination. An APRN must have extensive clinical experience, and have acquired advanced clinical knowledge and skills preparing him/her to provide direct care to patients. An APRN accepts responsibility and accountability for health promotion and/or maintenance, as well as the assessment, diagnosis and management of patient problems, which includes the administration and prescription of pharmacologic and nonpharmacologic interventions.

APRNs are licensed independent practitioners who are expected to practice within standards established or recognized by a licensing body. Each APRN is accountable to patients, the nursing profession and the licensing board to comply with the requirements of the jurisdiction’s nursing law and to assure that quality advanced nursing care is rendered; to recognize limits of knowledge and experience; to plan for the management of situations beyond the APRN’s expertise; and to consult with or refer patients to other health care providers, as appropriate.

APRN Roles
All APRNs are educationally prepared to provide a variety of services across the health wellness-illness continuum to at least one of six population foci: family/individual across the lifespan, adult-gerontology, pediatrics, neonatal, women’s health/gender-related or psych/mental health; however, the emphasis and implementation within each APRN role varies. The services or care provided by APRNs is not defined or limited by setting, but rather by patient care needs. Although all APRNs are educationally prepared to provide care to patients across the health wellness-illness continuum, the emphasis and implementation within each APRN role varies. Licensure and scope of practice are based on graduate education in one of the four roles and in one of the defined population foci.

Certified Registered Nurse Anesthetist (CRNA)
A CRNA is prepared to provide the full spectrum of patients’ anesthesia care and anesthesia-related care to individuals across the lifespan, whose health status may range from healthy through all recognized levels of acuity, including persons with immediate, severe, or life-threatening illnesses or injury. This care is provided in diverse settings, including hospital surgical suites; obstetrical delivery rooms; critical access hospitals; acute care; pain management centers; ambulatory surgical centers; and the offices of dentists, podiatrists, ophthalmologists and plastic surgeons.

Certified Nurse-Midwife (CNM)
A CNM provides a full range of primary health care services to women throughout the lifespan, including gynecologic care, family planning services, preconception care, prenatal and postpartum care, child birth, and care of a newborn. The practice includes treating the male partner of their female clients for sexually transmitted disease and reproductive health. This care is provided in diverse settings, which may include home, hospital, birth center and a variety of ambulatory care settings, including private offices, and community and public health clinics.

Clinical Nurse Specialist (CNS)
A CNS is a unique APRN role that integrates care across the continuum and through three spheres of influence: patient, nurse and system. The three spheres are overlapping and interrelated, but each sphere possesses a distinctive focus. The primary goal of a CNS is continuous improvement of patient outcomes and nursing care. Key elements of CNS practice are to create environments through mentoring and system changes that empower nurses to develop caring, evidence-based practices to alleviate patient distress; and facilitate ethical decision making. A CNS is responsible and accountable for diagnosis and treatment of health/illness states, disease management, health promotion, and prevention of illness and risk behaviors among individuals, families, groups and communities.
Certified Nurse Practitioner (CNP)

For a CNP, care along the wellness-illness continuum is a dynamic process in which direct primary and acute care is provided across settings. CNPs are members of the health delivery system, practicing autonomously in areas as diverse as family practice, pediatrics, internal medicine, geriatrics and women’s health care. CNPs are prepared to diagnose and treat patients with undifferentiated symptoms, as well as those with established diagnoses. Both primary and acute care CNPs provide initial, ongoing, and comprehensive care, including taking comprehensive histories, providing physical examinations, and other health assessment and screening activities, and diagnosing, treating, and managing patients with acute and chronic illnesses and diseases. This includes ordering, performing, supervising, and interpreting laboratory and imaging studies; prescribing medication and durable medical equipment; and making appropriate referrals for patients and families. Clinical CNP care includes health promotion, disease prevention, health education and counseling, as well as the diagnosis and management of acute and chronic diseases. CNPs are prepared to practice as primary care CNPs and/or acute care CNPs, which have separate national consensus-based competencies and separate certification processes.

Quality of APRN Care

The recent report published by the Institute of Medicine (IOM) stated “a number of barriers prevent nurses from being able to respond effectively to rapidly changing health care settings and an evolving health care system.” The report continues to state that “The United States has the opportunity to transform the health care system, and nurses can and should play a fundamental role in this transformation.” And that “Nurses should practice to the full extent of their education and training” (IOM, 2010).

The ability of APRNs to provide safe, cost-effective, high quality care that is comparable to care provided by physicians is well documented in many studies conducted over the past 30 years. The landmark study published in the Journal of the American Medical Association (JAMA) in 2000 provided definitive results demonstrating the quality of care provided by CNPs. In this study, the researchers evaluated the health status of patients receiving care from physicians or CNPs; however, the CNPs practiced independently without a mandatory relationship with a physician. The patients were assigned to a provider for primary care following an urgent care or emergency room visit. Researchers found the status of the CNP patients and the physician patients were comparable at the initial, six and 12 month visits. In a follow-up study two years later by some of the same researchers, the outcome was the same. The researchers determined that CNP care was comparable to that of a physician in all areas, including health status, satisfaction and use of specialists (Lenz, Mundinger, Kane, Hopkins, & Lin, 2004).

In a review of studies comparing nurses and doctors in providing primary care services, the authors concluded, “[t] he findings suggest that appropriately trained nurses can produce as high quality care as primary care doctors and achieve good health outcomes for patients. Indeed nurses providing first care for patients needing urgent attention tend to provide more health advice and achieve higher levels of patient satisfaction compared with doctors” (Laurant, Reeves, Hermens, Braspenninck, Grol, & Sibbald, 2009).

Beyond patient satisfaction, a 2009 study related to CNPs showed that the safety ratio of CNPs was significantly higher when compared to the safety ratios of medical doctors (MDs) and doctors of osteopathic medicine (DOs). The National Practitioner Data Bank ratio of malpractice and adverse actions for NPs was 1:173 compared to 1:4 for MDs and DOs (Pearson, 2009).

Studies showed that CNPs had more complete records, gave more advice to patients, and had longer consultations with patients (Horrocks, Anderson, & Salisbury, 2002). The difference in APRN approach to care is attributed to nursing education, which focuses on prevention, wellness and health maintenance (Gordon, 2010). This approach “results in better patient management with fewer visits to emergency rooms and hospitals” (Gordon, 2010). Overall, “nurse practitioners seemed to provide a quality of care that is at least as good, and in some ways better, than doctors” (Horrocks, Anderson, & Salisbury, 2002).

A study published in the American Journal of Public Health (1997) compared differences in obstetric care provided by obstetricians, family physicians and CNMs to low-risk patients. Researchers concluded that patients of the CNMs had lower cesarean rates than the other providers (8.8 percent for CNMs compared to 13.6 percent for obstetricians and 15.1 percent for family physicians). Overall, CNMs used 12.2 percent fewer expensive hospital resources than the other providers (Rosenblatt, Dobie, et al., 1997).

In 2006 findings of a study were published comparing perinatal outcomes in care provided by a physician or a CNM in a large inner city obstetric care setting. There were 375 patients studied and the researchers found no differences in neonatal (first six weeks after birth) outcomes and fewer interventions were used by the CNM group (Cragin & Kennedy, 2006).

A study published in 2003 compared surgical patients’ safety with anesthesia services provided by a CRNA or an
anesthesiologist (Pine, Holt, & Lou, 2003). Over 400,000 cases were studied in 22 states. Researchers found no statistically significant difference between mortality rates of patients treated by CRNAs independently versus those in which the CRNA collaborated with the anesthesiologist. In addition, the findings indicated that hospitals where CRNAs were the sole providers of anesthesia services (without anesthesiologists on staff) had results similar to those in hospitals in which anesthesiologists provided or directed anesthesia services (Pine, Holt, & Lou, 2003).

In 2001, the Center for Medicare & Medicaid Services allowed states to opt-out of the requirement for physician oversight of CRNA’s provision of anesthesia care to patients. A new study of data from opt-out and non-opt-out states was published in Health Affairs in 2010. The researchers compared outcomes of care provided by CRNAs and anesthesiologists, each practicing independently and as a team. The Medicare A/B data were collected over seven years and the results indicated that in opt-out states, the CRNA solo group mortality rates were lower than that of the solo anesthesiologist group, both before and after the implementation of the opt-out. In addition, researchers found comparable surgical complication rates among the three provider groups leading them to conclude that removal of the supervision requirement for CRNAs does not increase surgical risks to patients (Dulisse & Cromwell, 2010).

Outcomes of care by CNSs on prenatal, maternal and infant health and cost through one year after delivery were published in the American Journal of Managed Care in 2001. The complex group of patients studied was women with a high risk of delivering low-birth weight babies. The patients received home care provided by CNSs or traditional care in the office setting. The group receiving care from CNSs experienced a lower infant mortality rate, fewer preterm babies, more twin pregnancies carried to term, fewer prenatal hospitalizations and fewer infant rehospitalizations with a cost savings of more than 750 hospital days and more than 2.8 million dollars. (Brooten, Youngblut, Brown, et al., 2001).

A 1994 study reviewed the effects of a discharge planning protocol implemented by CNSs as compared to the standard hospital discharge protocols. The researchers found from initial discharge to six weeks after discharge, patients who were in the medical intervention group had fewer readmissions to the hospital, fewer total days if rehospitalized, lower readmission charges and lower charges for health care services following discharge from the hospital. The researchers concluded the interventions by CNSs improved patient outcomes after hospitalization and decreased costs (Naylor, Brooten, Jones, et al., 1994).

It stands to reason that one way to improve access to patient-centered care would be to allow nurses to make more decisions at the point of care. Yet in many cases, outdated regulations, biases and policies prevent nurses, particularly APRNs, from practicing to the full extent of their education, skills and competencies (Hansen-Turton, et al., 2008; Ritter & Hansen-Turton, 2008; Safriet, 2010).
Need for Uniform APRN Regulation

With the passage of the Affordable Care Act, the need for experienced nurses is more important than ever. Expansion of coverage will simultaneously create a demand for qualified care providers. APRNs are in a position to competently fill the gaps in access to care that will result when an estimated 32 million Americans become newly insured (Croft, 2010).

Currently, there is no uniform model of regulation of APRNs across the jurisdictions. Each jurisdiction independently determines the APRN legal scope of practice, the roles that are recognized, the level of prescriptive authority, the degree of collaboration, the criteria for entry into advanced practice and the certification examinations accepted for entry-level competence assessment. This has created a significant barrier for APRNs to easily move from jurisdiction to jurisdiction and also directly affects patients through decreased access to care.

Model APRN National Standards

The goal of the Consensus Model for APRN Regulation is to create consensus among the jurisdictions in their efforts to establish a common understanding in the APRN regulatory community that will continue to promote quality APRN education and practice; design a vision for APRN regulation, including education, accreditation, certification and licensure; set standards that protect the public; improve mobility and improve access to safe, quality APRN care.

The following section outlines the major components of the regulatory model developed by the Joint Dialogue Group. It identifies the title to be used, licensure requirements, and accreditation and education standards. Also included is a diagram that illustrates the structure and relation of the model entities.

* The population focus adult-gerontology encompasses the young adult to the older adult, including the elderly. APRNs educated and certified in the adult-gerontology population are educated and certified across both areas of practice and will be titled Adult-Gerontology CNP or CNS. In addition, all APRNs in any of the four roles providing care to the adult population, e.g., family or gender specific, must be prepared to meet the growing needs of the older adult population. Therefore, the education program should include didactic and clinical education experiences necessary to prepare APRNs with these enhanced skills and knowledge.

** The population focus, psychiatric/mental health, encompasses education and practice across the lifespan.

+ The CNS is educated and assessed through national certification processes across the continuum from wellness through acute care.

++ The CNP is prepared with the acute care CNP competencies and/or the primary care CNP competencies. At this point in time the acute care and primary care CNP delineation applies only to the pediatric and adult-gerontology CNP population foci. Scope of practice of the primary care or acute care CNP is not setting specific, but is based on patient care needs. Programs may prepare individuals across both the primary care and acute care CNP competencies. If programs prepare graduates across both sets of roles, the graduate must be prepared with the consensus-based competencies for both roles and must successfully obtain certification in both the acute and primary care CNP roles. CNP certification in the acute care or primary care roles must match the educational preparation for CNPs in these roles.
New National Standards for APRN Regulation

Title
The title “advanced practice registered nurse (APRN)” is the licensing title to be used for this subset of nurses who are prepared with advanced, graduate-level nursing knowledge to provide direct patient care in one of the four APRN roles. At a minimum, an individual must legally represent themselves, including in a legal signature, as an APRN and by the role. Only those who are licensed to practice as an APRN may use the APRN title or any of the APRN role titles. An APRN may also indicate the population and specialty title in which they are professionally recognized, in addition to the legal title of APRN and role.

Licensure
APRNs will be regulated via an APRN license. APRNs will be licensed as independent practitioners for practice at the level of one of the four APRN roles within at least one of the six identified population foci.

Boards of nursing have the responsibility to:
1. License APRNs (except in states where state boards of nurse-midwifery regulate nurse-midwives);
2. Ensure APRNs have completed the congruent education requirements and national certification examination;
3. Allow for mutual recognition of APRN licenses through the APRN Compact;
4. Have at least one APRN representative position on the board of nursing and utilize an APRN advisory committee that includes representatives of all four APRN roles; and
5. Institute a grandfathering clause that will exempt those APRNs already practicing in the state from new eligibility requirements.

Certification
Individuals who have the appropriate education will sit for a certification examination to assess national competencies of the APRN core, role and at least one population focus area of practice for regulatory purposes.

Certification programs have the responsibility to:
1. Follow established certification testing and psychometrically sound, legally defensible standards for APRN examinations for licensure;
2. Assess the APRN core and role competencies across at least one population focus of practice;
3. Assess specialty competencies, if appropriate, separately from the APRN core, role and population-focused competencies;
4. Be nationally accredited by the American Board of Nursing Specialties (ABNS) or the National Commission for Certifying Agencies (NCCA);
5. Enforce congruence between education and certification examination;
6. Provide a mechanism to ensure ongoing competence and maintenance of certification; and
7. Participate in a mutually agreeable mechanism to ensure communication with boards of nursing and schools of nursing.

Accreditation
All developing APRN education programs or tracks must be preapproved, have preaccreditation, or be accredited prior to admitting students. APRN education programs must be housed within graduate programs that are nationally accredited and their graduates must be eligible for national certification used for state licensure. Accreditation must be completed by a nursing accrediting organization that is recognized by the U.S. Department of Education (USDE) and/or the Council for Higher Education Accreditation (CHEA).

Accreditors have the responsibility to:
1. Evaluate and assess APRN education programs in light of the APRN core, role core and population core competencies;
2. Assess developing APRN education programs and tracks using established accreditation standards and granting preapproval, preaccreditation or accreditation prior to student enrollment;
3. Include an APRN on the visiting team when an APRN program/track is being reviewed; and
4. Monitor APRN educational programs throughout the accreditation period.

Education
APRN education consists of an extensive broad-based education, which includes appropriate clinical experiences, as well as coursework in graduate-level courses in advanced physiology/pathophysiology, advanced health assessment and advanced pharmacology, including pharmacodynamics, pharmacokinetics and pharmacotherapeutics.
APRN education programs/tracks leading to APRN licensure, including graduate degree granting and postgraduate certificate programs, have the responsibility to:

1. Follow established educational standards and ensure attainment of the APRN core, role core and population core competencies;
2. Be accredited by a nursing accrediting organization that is recognized by the USDE and/or CHEA;
3. Be preapproved, preaccredited or accredited prior to the acceptance of students, including all developing APRN education programs and tracks;
4. Ensure that graduates of the program are eligible for national certification and state licensure; and
5. Ensure that official documentation (e.g., transcripts) specifies the role and population focus of the graduate.

For entry into APRN practice and for regulatory purposes, APRN education must:

1. Be formal, comprehensive education with a graduate degree or postgraduate certificate;
2. Prepare the graduate to practice in one of the four identified APRN roles across at least one of the six population foci;
3. Provide a basic understanding of the principles for decision making in the identified role; and
4. Prepare the graduate to assume responsibility and accountability for health promotion and/or maintenance, as well as the assessment, diagnosis and management of patient problems, which includes the administration and prescription of pharmacologic and non-pharmacologic interventions.

**Emergence of New APRN Roles and Population-foci**

As nursing practice evolves and health care needs of the population change, new APRN roles or population-foci may evolve over time. An APRN role would encompass a unique or significantly differentiated set of competencies from any of the other APRN roles. For licensure, there must be clear guidance for national recognition of a new APRN role or population-focus.

**APRN Specialization**

Preparation in a specialty area of practice is optional, but if included, must build on the APRN role/population-focused competencies. APRNs cannot be licensed solely within a specialty area. Specialty practice represents a much more focused area of preparation and practice than does the APRN role/population focus level. Specialization does not expand an APRN’s scope of practice. A specialty evolves out of an APRN role/population focus and indicates that an APRN has additional knowledge and expertise in a more discrete area of specialty practice. Competence at the specialty level will not be assessed or regulated by boards of nursing, but rather by the professional organizations. Competency in the specialty areas could be acquired either by educational preparation or experience and assessed in a variety of ways through professional credentialing mechanisms. Professional certification in the specialty area of practice is strongly recommended.
Conclusion

Establishing uniform APRN regulations across all states is an ongoing collaborative process that is fluid and dynamic. As health care evolves and new standards and needs emerge, the Consensus Model for APRN Regulation will advance accordingly to allow APRNs to care for patients in a safe environment to the full potential of their nursing knowledge and skill.

A target date for full uniformity across all states is the year 2015. Because this model was developed through a consensus process with participation of APRN certifiers, accreditors, public regulators, educators and employers, it is expected that the recommendations will inform decisions made by each of these entities as they fully implement the Consensus Model for APRN Regulation.
Organizations Represented at the Joint Dialogue Group Meetings

American Academy of Nurse Practitioners Certification Program
American Association of Colleges of Nursing
American Association of Nurse Anesthetists
American College of Nurse-Midwives
American Nurses Association
American Organization of Nurse Executives
Compact Administrators
National Association of Clinical Nurse Specialists
National League for Nursing Accrediting Commission
National Organization of Nurse Practitioner Faculties
National Council of State Boards of Nursing
NCSBN APRN Advisory Committee Representatives (5)

Organizations Participating in APRN Consensus Process

Academy of Medical-Surgical Nurses
American College of Nurse-midwives Division of Accreditation
American Academy of Nurse Practitioners
American Academy of Nurse Practitioners Certification Program
American Association of Colleges of Nursing
American Association of Critical Care Nurses Certification
American Association of Neuroscience Nurses
American Association of Nurse Anesthetists
American Association of Occupational Health Nurses
American Board for Occupational Health Nurses
American Board of Nursing Specialties
American College of Nurse-Midwives
American College of Nurse-Midwives Division of Accreditation
American College of Nurse Practitioners
American Holistic Nurses Association
American Nephrology Nurses Association
American Nurses Association
American Nurses Credentialing Center
American Organization of Nurse Executives
American Psychiatric Nurses Association
American Society of PeriAnesthesia Nurses
American Society for Pain Management Nursing
Association of Community Health Nursing Educators
Association of Faculties of Pediatric Nurse Practitioners
Association of Nurses in AIDS Care
Association of PeriOperative Registered Nurses
Association of Rehabilitation Nurses
Association of State and Territorial Directors of Nursing
Association of Women’s Health, Obstetric and Neonatal Nurses
Board of Certification for Emergency Nursing
Council on Accreditation of Nurse Anesthesia Educational Programs
Commission on Collegiate Nursing Education
Commission on Graduates of Foreign Nursing Schools
District of Columbia Board of Nursing
Department of Health
Dermatology Nurses Association
Division of Nursing, DHHS, HRSA
Emergency Nurses Association
George Washington University
Health Resources and Services Administration
Infusion Nurses Society
International Nurses Society on Addictions
International Society of Psychiatric-Mental Health Nurses
Kentucky Board of Nursing
National Association of Clinical Nurse Specialists
National Association of Neonatal Nurses
National Association of Nurse Practitioners in Women’s Health, Council on Accreditation
National Association of Pediatric Nurse Practitioners
National Association of School of Nurses
National Association of Orthopedic Nurses
National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties
National Conference of Gerontological Nurse Practitioners
National Council of State Boards of Nursing
National League for Nursing
National League for Nursing Accrediting Commission
National Organization of Nurse Practitioner Faculties
Nephrology Nursing Certification Commission
North American Nursing Diagnosis Association International
Nurses Organization of Veterans Affairs
Oncology Nursing Certification Corporation
Oncology Nursing Society
Pediatric Nursing Certification Board
Pennsylvania State Board of Nursing
Public Health Nursing Section of the American Public Health Association.
Rehabilitation Nursing Certification Board
Society for Vascular Nursing
Texas Nurses Association
Texas State Board of Nursing
Utah State Board of Nursing
Women’s Health, Obstetric & Neonatal Nurses
Wound, Ostomy, & Continence Nurses Society
Wound, Ostomy, & Continence Nursing Certification
References


