NURSING PRACTICE COMMITTEE MEETING

AGENDA

The Mission Inn Hotel
3649 Mission Inn Avenue
Spanish Art Gallery
Riverside, CA 92501
(800) 678-8946

March 6, 2014

Tuesday, March 6, 2014  2:00 pm – 3:00 pm

10.0 Review and Vote on whether to approve previous meeting’s minutes:
   ➢ January 8, 2014

10.1 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:
   1. Section 1480 - Definitions
   2. Section 1481 – Categories of Nurse Practitioners
   3. Section 1482 – Requirements for Nurse Practitioners
   4. Section 1483 – Evaluation of Credentials
   5. Section 1483.1 – Approved APRN-NP Program Accreditation Required and Board Notification Process
   6. Section 1483.2 – Application for APRN-NP Program Approval
   7. Section 1483.3 - Changes to an Approved Program
   8. Section 1484 - APRN-NP Education

10.2 Approve/not approve advisory statements for RNs and APRNs
   2. Abortion

10.3 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.
BOARD OF REGISTERED NURSING
NURSING PRACTICE COMMITTEE MINUTES

October 1, 2013

2:30 pm to 3:05 pm

Ontario Airport Hotel and Convention Center
700 North Haven Avenue
Ontario, CA 91764

MEMBERS PRESENT:
Trande Phillips, RN, Chair
Cynthia Klein, RN, Direct Practice Member
Michael Jackson, BSN, RN, CEN, MICN

STAFF PRESENT:
Katie Daugherty, MN, RN, Nursing Education Consultant
Julie Campbell-Warnock, MA Research Program Specialist
Not in Attendance - Janette Wackerly, MBA, BSN, RN, SNEC,
Staff Liaison

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 #1Provided 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.

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
MEMBERS PRESENT:  Trande Phillips, RN, Chair  
Cynthia Klein, RN, Direct Practice Member  
Michael Jackson, BSN, RN, CEN, MICN

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

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

Members Present: Trande Phillips, Michael Jackson, and Cynthia Klein (arrived late)

Introductions of Board Members.

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

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

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

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

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

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

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

1483: Straightforward in language

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

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

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

Public Comments:

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

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

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

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

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

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

1483- Evaluation of Credentials
No public comments

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

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

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

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

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

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

Adjourned at 3:10 pm

Submitted by: Janette Wackerly, MBA, BSN, RN, SNEC (Supervising Nursing Education Consultant) NP Liaison
Accepted by: Trande Phillips, RN, Chair, Direct Practice Member
AGENDA ITEM: 10.1
DATE: March 6, 2014

ACTION REQUESTED: Information and Discussion: Nurse Practitioner Laws and Regulations – Title 16 of the California Code of Regulations, Article 8, Sections 1480-1484

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

BACKGROUND: The BRN staff APRN workgroup has continued review of 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.

The attached documents for discussion include some new sections (1480, 1483.1, 1483.2 and 1483.3) since the previous meeting, and revised sections (1481, 1482, 1483, and 1484) based on public comment and further workgroup review.

A cited document identifying sources is attached.

Attached is correspondence received by the BRN since the last Nursing Practice Committee Meeting.

a. Judy Martin-Holland, PhD., RN, CNS, FNP, FAAN
   Letter of 1-31-2014

The following materials were presented at the February 6, 2014 Board meeting, and are subsequent to the January 8, 2014 Practice Committee meeting.

1. California Action Coalition Letter of 10-1-2013
2. California Association of Certified Nurse Specialists Letter of 1-6-2014
3. American Association of Retired Persons Letter of 1-7-2014
4. Samuel Merritt University Letter 1-8-2014
5. California Action Coalition Letter of 1-16-2014
At the January 8, 2014 Nursing Practice Committee meeting, the California Nursing Association requested that materials have their sources noted. This is completed by footnotes in the document corresponding to the cited documents page, and is included in the attachments. The packet of materials for that meeting will be made available on the BRN website at least 10 days prior to the actual meeting date.

**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
Current California Code of Regulations
Article 8 – Standards for Nurse Practitioners

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.


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).

Draft Revisions for Discussion
BRN Nursing Practice Committee 3/6/14

1480. Definitions
(a) “Academic year” means two semesters, each semester is 15-18 weeks, or three quarters, each quarter is 10-12 weeks.
(b) “Acute care” means focus of care is on restorative care characterized by rapidly changing clinical conditions and provides care for patients with unstable chronic, complex acute and critical conditions.
(c) “Advanced assessment” means the process of collecting information regarding a client's health care status including, but not limited to, illness; health risks of the individuals, families and groups; resources; strengths and weaknesses, coping behaviors; and the environment. The skills involved in the assessment process may include, but are not limited to: obtaining the health histories, conducting physical examinations, ordering, interpreting a broad range of diagnostic procedures (e.g., laboratory studies, EKGs, and x-rays). Advanced assessment includes the processes resulting in differential diagnoses.
(d) “Advanced pathophysiology” – work in progress
(e) “Advanced pharmacology” – work in progress
(f) “Advanced practice registered nursing (APRN) core” means the essential broad-based curriculum courses for all APRN students in the areas of advanced health assessment, advanced physiology/pathophysiology, and advanced pharmacology. This content must be presented in three separate comprehensive graduate-level courses.
(g) “California based nurse practitioner program” means an academic program that is physically located in California, approved by the California BRN, and accredited by a nursing accrediting body that is recognized by the United States Secretary of Education and/or the Council for Higher Education Accreditation (CHEA), or its successor organization, as acceptable by the Board that offers a graduate degree or higher, or a post-graduate level certificate.
(h) “Certified nurse practitioner” means a registered nurse who possesses additional preparation and skills in physical diagnosis,
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<td>psycho-social assessment, and management of health-illness needs in primary and acute care, and who has been prepared in a program that conforms to board standards as specified in Section 1484.[1],[6]</td>
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<td>(i) “Clinical practice experience” means the supervised provision of direct patient care in a clinical setting that complements course work and ensures acquisition of advanced practice nursing skills.[4]</td>
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<td>(j) “Clinical preceptor” means health care provider qualified by education and clinical competence to provide direct supervision of the clinical experience of a Nurse Practitioner student.[4]</td>
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<td>(k) “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.[1]</td>
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<td>(l) “Collaboration” means working with another health care provider to jointly provide client care.[4]</td>
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<td>(m) “Consultation” means discussion with another health care provider for the purpose of obtaining information or advice in order to provide client care.[4]</td>
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<td>(n) “Counseling” means a mutual exchange of information through which advice recommendations, instruction, or education is provided to the client.[4]</td>
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<td>(o) “Direct supervision” means the clinical preceptor or faculty member physically present at the practice site who retains the responsibility for patient care while overseeing the student and if necessary, redirecting, or intervening in the delivery of patient care if necessary.[4],[6]</td>
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<td>(p) “Furnishing number” – work in progress</td>
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<td>(q) “Graduate core” means the foundational core courses deemed essential for all students who pursue a graduate degree in nursing regardless of specialty or functional focus.[6],[7]</td>
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<td>(r) “Graduate nurse practitioner program” means a nurse practitioner program for preparing advanced practice registered nurses at the graduate level, including the graduate core, advanced practice...</td>
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| Current California Code of Regulations  
Article 8 – Standards for Nurse Practitioners | Draft Revisions for Discussion  
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<td>registered nursing core, and nurse practitioner role and population-focused courses. Specialty courses with a narrow focus of practice may be an added emphasis of educational preparation in addition to the NP role and population focus (e.g., oncology, palliative care).</td>
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<td>(s) “Lead nurse practitioner faculty” means a Nurse Practitioner who is responsible for the administrative functions for each NP population focus program in a multiple track nurse practitioner program. Lead NP faculty are nationally certified in the specific program’s population focus. Administrative functions include curricular design, and oversight of curriculum implementation and evaluation.</td>
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<td>(t) “Multiple track nurse practitioner program” means a graduate educational program whose curriculum offers more than one NP population focused track or primary and acute care NP tracks in the same population focused area of practice.</td>
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<td>(u) “National certification” means current certification, if such certification is available, as a Nurse Practitioner in a role and population focus through testing accredited by the National Commission on Certifying Agencies or the American Boards of Nursing Specialties or other certifying bodies, as approved by the Board. An individual’s educational preparation (population focus) must be congruent with the certification examination.</td>
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<td>(v) “Nurse practitioner program administrator” refers to a qualified Advanced Practice Registered Nurse who is responsible and accountable for the nursing education program, including those functions aligned with program and curricular design and resource acquisition and allocation. These duties may be fulfilled by the program director.</td>
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<td>(w) “Nurse practitioner program director/coordinator” refers to a qualified California Certified Nurse Practitioner who is responsible for the implementation of the program and the achievement of the program objectives, including ensuring that there are adequate qualified faculty assigned to coordinate and administer each Nurse Practitioner program track offered.</td>
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### Current California Code of Regulations

**Article 8 – Standards for Nurse Practitioners**

#### Draft Revisions for Discussion

**BRN Nursing Practice Committee 3/6/14**

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<td>(x) “Nurse practitioner program faculty” refers to a California Certified Nurse Practitioner faculty member who has responsibility for developing and implementing the curriculum, policies, and practices associated with student advising and evaluation, mentoring and collaborating with clinical preceptors and other health care professionals. [4], [6]</td>
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<td>(y) “Out of state based nurse practitioner program” – <em>work in progress</em></td>
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<td>(z) “Population focus/foci” means the concurrent didactic and clinical practice courses consistent with nationally recognized competencies for a population focus. The six population foci are primary or acute care adult-gerontology, primary or acute care pediatrics, family/across the lifespan, neonatal, women’s health/gender specific, and psychiatric-mental health. [6], [7]</td>
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<td>(aa) “Primary care” means focus of care is on comprehensive, continuous care characterized by a long term relationship between the patient and primary care CNP, regardless of the presence or absence of disease, and provides care for most health needs and coordinates additional health care services beyond the CNP’s area of expertise. [1], [7]</td>
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<td>(bb) “Referral” means directing the client to other resources for the purpose of assessment, diagnosis and/or intervention. [4], [6]</td>
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<td>(cc) “Standardized procedures” – <em>work in progress</em></td>
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### 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. 1).

### 1481. Categories of Nurse Practitioners [3], [4], [13]

(a) Advanced Practice Registered Nurse (APRN) is the title given to an individual licensed to practice advanced practice registered nursing within, but not limited to, one of the following roles: certified nurse practitioner (CNP), certified registered nurse anesthetist (CRNA), certified nurse-midwife (CNM) or clinical nurse specialist (CNS), and who functions in a population focus.

(b) Categories of nurse practitioners shall include, but are not limited to:

1. Family/individual across the lifespan
2. Primary or acute care adult-gerontology
### Current California Code of Regulations
#### Article 8 – Standards for Nurse Practitioners

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49).

(3) Neonatal
(4) Primary or acute care pediatrics
(5) Women’s health/gender-related
(6) Psychiatric/mental health

(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 practice
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. Providing physician delegated supervision 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 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
### 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).

#### 1483. Evaluation of Credentials

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.

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.

**Authority:** Section 2835.5, Business and Professions Code.

### Draft Revisions for Discussion

**BRN Nursing Practice Committee 3/6/14**

#### 1482. Requirements for Nurse Practitioner Certification

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

(b) Meet the following educational requirements:

1. Master’s Degree in Nursing or a higher degree in Nursing or a post-graduate certificate from a CCNE (Commission on Collegiate Nursing Education) or ACEN (Accreditation Commission for Education in Nursing) accredited graduate nursing program or other accreditation as approved by the Board. Graduate nursing degrees obtained outside of the U.S. which meet educational requirements of an accredited U.S. graduate nursing degree as approved by the Board.

2. Satisfactory completion of an 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, if such certification is available, as APRN-CNP in the CNP role and population focus congruent with the educational preparation from a national organization recognized by the board.

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

#### 1483. Evaluation of Credentials

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.

CNP application includes submission of the following information:
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| 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. |

**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).

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| (a) Name of the graduate APRN-NP Program or post-graduate NP Program and the date of graduation or completion. |
| (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. |

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.

**Authority:** Sections 2715, 2718, 2815, and 2835.5, Business and Professions Code.

### 1421. Application for Approval

(a) An institution of higher education or affiliated institution applying for approval of a new prelicensure registered nursing program (program applicant) shall be in the state and shall comply with the requirements specified in the board's document entitled, "Instructions for Institutions Seeking Approval of a New Prelicensure Registered Nursing Program", (EDP-I-01Rev 03/10), ("Instructions"), which is hereby incorporated by reference, including:

1. Notify the board in writing of its intent to offer a new program that complies with board requirements;
2. Submit a feasibility study in accordance with the requirements specified in the "Instructions";
3. Appoint a director who meets the requirements of section 1425(a). Such appointment shall be made upon board acceptance of the feasibility study for the proposed program.
4. After acceptance of the feasibility study by the board, and no later than six (6) months prior to the proposed date for enrollment of students, submit a self-study to the board in accordance with the requirements specified in the

### 1483.1. Approved APRN-NP Program Accreditation Required and Board Notification Process

(a) Programs that are located in the state of California and prepare nurse practitioners for state certification must be approved by the Board and shall submit to the Board:

1. A copy of their most recent program self-evaluation reports;
2. Current accreditation and survey reports from all nursing accrediting agencies; and
3. Interim reports submitted to the national nursing accreditation agency.

These documents must be submitted to the Board upon receipt to or release from the accrediting agency.

(b) Programs which prepare nurse practitioners for state certification under development or pre-accreditation review shall submit the
"Instructions" demonstrating how the program will meet the requirements of sections 1424 through 1432 of this article and sections 2786.6(a) and (b) of the code.

(5) Have a representative at public meetings of the board and board committee pursuant to the "Instructions" when the feasibility study and self-study are considered.

(b) The board shall consider the feasibility study and accept, reject, or defer action on the study to permit the program applicant time to provide additional information to be considered, based upon the following criteria:

(1) Evidence of initial and sustainable budgetary provisions for the proposed program;
(2) Institution of higher education's authority to grant an associate of arts, baccalaureate, or higher degree;
(3) For an affiliated institution, an agreement with an institution of higher education in the same general location authorized to grant an associate of arts, baccalaureate, or higher degree to students successfully completing the nursing program;
(4) Evidence of availability of clinical placements for students of the proposed program;
(5) Plans for administrative and faculty recruitment to staff the proposed program.

(c) The board's designee shall review the self-study, conduct a site visit of the proposed program, and submit a written report to the board that contains findings as to whether the application and supporting documentation for the proposed program comply with the requirements set forth in (a)(4).

(d) The board shall consider the application along with the written report and may thereafter grant or deny approval, or defer action on the application. The board's decision is based on the applicant's demonstration that it meets the requirements of sections 1424 through 1432 and sections 2786.6(a) and (b) of the code.

Authority cited: Sections 2715, 2785, 2785.5, 2786, 2786.6, Business and Professions Code.

History:
1. Amendment of section heading and section filed 9-21-2010; operative 10-21-2010 (Register 2010, No. 39).

1422. Certificate of Approval
(a) A certificate of approval shall be issued to each nursing program when it is initially approved by the board.

(b) The board shall revoke a nursing program's approval, and the program shall return the certificate of approval to the board under the following conditions:

1483.2 Application for APRN-NP Program Approval
Any university or college wishing to establish a Nurse Practitioner education program must make application to the Board on forms supplied by the Board no later than one year before proposed following for review by the Board:

(1) Copies of the curricula within 30 days of sending the information to the accrediting agency;
(2) Copies of self-evaluation reports and any interim reports provided to all national nursing accreditation agencies, at the time of notification from the accrediting agency that the program has not been fully accredited;
(3) Verification of accreditation from all accrediting agencies within 30 days of receipt by the program;
(4) Annual reports which enable the monitoring of continued compliance with Board requirements.

(c) Grounds for denial of graduate nurse practitioner applicants for initial certification include failure of the Nurse Practitioner program to:

(1) Maintain accreditation status through a US Department of Education recognized national nursing accrediting body;
(2) Submit curricula, self-evaluation reports, interim reports or notice of accreditation reports as required by the Board;

(d) Students who graduate from a program which was accredited at the time of their completion shall be considered to have graduated from an accredited program regardless of the current program status for the purpose of licensure.

Authority: Sections 2715, 2785, 2785.5, 2786, 2786.6, Business and Professions Code.
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| (1) The institution of higher education cannot grant degrees; or  
(2) The board determines that the nursing program is in non-compliance with  
the requirements set forth in this article or sections 2786 through 2788 of the  
code.  
**Authority cited:** Section 2715, Business and Professions Code. Reference:  
Sections 2786-2788, Business and Professions Code.  
**History:**  
1. Amendment of section heading and section filed 9-21-2010; operative 10-21-  
2010 (Register 2010, No. 39). |
| enrollment of students.  
A material misrepresentation of fact by a program applicant or an  
approved nursing program in any information required to be submitted  
to the board is grounds for denial of approval or revocation of the  
program's approval.  
(a) The following information must be included with the initial  
application along with supporting documentation:  
(1) Required fee per Section 2786.5;  
(2) Purpose for establishing the nursing education program;  
(3) Community needs and studies made as the basis for establishing a  
nursing education program;  
(4) Type of program including clear identification of proposed licensure  
role and population foci for graduates;  
(5) Accreditation status, relationship of educational program to parent  
institution;  
(6) Financial provision for the educational program;  
(7) Potential student enrollment;  
(8) Provision for qualified faculty;  
(9) Proposed clinical facilities and other physical facilities;  
(10) Proposed time schedule for initiating the program.  
(b) Board representatives will conduct in person visits to nursing  
programs for the following purposes:  
(1) Review of application for initial program approval;  
(2) Initial and continuing full approval of an educational program;  
(3) Receipt by the Board of cause for review including but not limited  
to:  
(A) Significant curricular change which includes addition of a new  
state certification recognized population focus or role;  
(B) Evidence that graduates fail to meet national certification  
criteria;  
(C) Violation of Board standards.  
(c) If approval is denied or withdrawn, the applicant may request a  
hearing before the Board. |

| 1423. Approval Requirements  
(a) In order for a program to be approved by the board or to retain its approval,  
it shall comply with all requirements set forth in this article and in sections 2786  
through 2788 of the code.  
(b) A material misrepresentation of fact by a program applicant or an approved  
nursing program in any information required to be submitted to the board is  
grounds for denial of approval or revocation of the program's approval.  
**Authority cited:** Section 2715, Business and Professions Code. Reference:  
Sections 2786-2788, Business and Professions Code.  
**History:**  
1. Amendment of section heading and section filed 9-21-2010; operative 10-21-  
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**1432. Changes to an Approved Program**

(a) Each nursing program holding a certificate of approval shall:

(1) File its legal name and current mailing address with the board at its principal office and shall notify the board at said office of any change of name or mailing address within thirty (30) days prior to such change. It shall give both the old and the new name or address.

(2) Notify the board within ten (10) days of any:

(A) Change in fiscal condition that will or may potentially adversely affect applicants or students enrolled in the nursing program.

(B) Substantive change in the organizational structure, administrative responsibility, or accountability in the nursing program, the institution of higher education in which the nursing program is located or with which it is affiliated that will affect the nursing program.

(b) An approved nursing program shall not make a substantive change without prior board authorization. These changes include:

(1) Change in location.

(2) Change in ownership.

(3) Addition of a new campus or location.

(4) Significant change in the agreement between an approved nursing program that is not an institution of higher education and the institution of higher education with which it is affiliated.

**Authority cited:** Sections 2715, 2786 and 2788, Business and Professions Code.

**Reference:** Sections 2715, 2786 and 2788, Business and Professions Code.

**History:**

1. Renumbering of former section 1430 to new section 1432, including amendment of section heading, section and Note, filed 9-21-2010; operative 10-21-2010 (Register 2010, No. 39).

**1483.3 Changes to an Approved APRN-NP Program**

(a) Each nursing program holding a certificate of approval shall:

(1) File its legal name and current mailing address with the board at its principal office and shall notify the board at said office of any change of name or mailing address within thirty (30) days prior to such change. It shall give both the old and the new name or address.

(2) Notify the board within ten (10) days of any:

(A) Change in fiscal condition that will or may potentially adversely affect applicants or students enrolled in the nursing program.

(B) Substantive change in the organizational structure, administrative responsibility, or accountability in the nursing program, the institution of higher education in which the nursing program is located or with which it is affiliated that will affect the nursing program.

(b) An approved nursing program shall not make a substantive change without prior board authorization. These changes include:

(1) Change in location.

(2) Change in ownership.

(3) Addition of a new campus or location.

(4) Significant change in the agreement between an approved nursing program that is not an institution of higher education and the institution of higher education with which it is affiliated.
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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.

1484. APRN-NP Education  
The program of study preparing a certified nurse practitioner (CNP) shall be approved by the Board and 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) Primary or acute care adult-gerontology  
(C) Neonatal  
(D) Primary or acute care pediatrics  
(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.  
(5) The program shall have sufficient resources to achieve the program objectives.  
(6) 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.

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- (7) NP Programs may have a program administrator who is responsible and accountable for the nursing education program or could be fulfilled by the program director. Qualifications for a program administrator shall include:
  - (A) an active, unencumbered CA registered nurse license;
  - (B) certified as an APRN in CA;
  - (C) A Master’s degree in nursing or higher degree in nursing.
- (8) The program shall appoint a qualified NP program director and adequate number of qualified faculty to develop and implement the program and to achieve the program objectives.
- (9) The NP Program director 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.
- (10) The NP Program director shall have sufficient time dedicated for the administration of the program.
- (11) The program director for the NP program 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; and
  - (E) current national APRN-NP certification.

**Authority:** 2715, 2835, 2835.5, 2836, Business and Professions Code

### (b) Faculty

1. 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>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.</td>
<td>(E) current knowledge, competence, and current national APRN-NP certification in the role and population foci consistent with the teaching responsibilities. (2) Interdisciplinary faculty who teach non-clinical NP nursing courses shall have advanced graduate degree appropriate to the content taught, such as pharmacology. (3) Each faculty member shall assume responsibility and accountability for instruction, evaluation of students, and planning and implementing curriculum content. Faculty responsibilities shall include: (A) making arrangements with agency personnel in advance of the clinical experience which provides and verifies student supervision, preceptor orientation, and faculty defined objectives; (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; (C) Providing direct supervision by a qualified faculty or experienced licensed clinical supervisor as required for patient safety and student skill attainment. (4) 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. (5) Clinical faculty employed solely to supervise NP clinical experience for students shall meet faculty qualifications listed in Section 1484(b)(1). (6) 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: (A) an active, unencumbered CA registered nurse license and CA certified as an NP or CNM; (B) current national certification;</td>
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| (C) Qualified to practice unencumbered as a CNP or non-NP healthcare provider who meets all of the above requirements in their discipline and practices in the population foci; |
| (D) Functions as a supervisor and teacher and evaluates the student’s performance in the clinical setting. |
| (7) CNP 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 for each role or population focus 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. |

**Authority:** 2715, 2835, 2835.5, 2836, Business and Professions Code.

(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 subject to fee per Section 2786.5.
2. The CNP program may be full-time or part-time and shall be a minimum of one academic year in length.
(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
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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
instruction and supervision for the student.

(12) The curriculum shall include, but is not limited to:
(A) Normal growth and development
(B) Pathophysiology
(C) Interviewing and communication skills
(D) Eliciting, recording and maintaining a developmental health history
(E) Comprehensive physical examination
(F) Psycho-social assessment
(G) Interpretation of laboratory findings
(H) Evaluation of assessment data to define health and developmental
problems
(I) Pharmacology
(J) Nutrition
(K) Disease management
(L) Principles of health maintenance
(M) Assessment of community resources
(N) Initiating and providing emergency treatments
(O) Nurse practitioner role development
(P) Legal implications of advanced practice
(Q) 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.

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includes, but is not limited to:
(A) The APRN core consisting of three separate graduate level
courses 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 pharmacokinetics and
pharmacotherapeutics of all broad categories of agents;
(B) Diagnosis and management of diseases across practice settings
including diseases representative of all systems;
(C) Preparation that provides a basic understanding of the principles
for decision making in the identified role;
(D) Preparation in the core competencies for the identified APRN-
CNP role; and
(E) Role preparation in one of the six population foci of practice,
including legal, ethical and professional responsibilities of the APRN-
CNP

(9) 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:
(A) BPC section 2835.7 Authorized standardized procedures;
(B) BPC section 2836.1 Furnishing or ordering of drugs or devices.
(10) Curriculum, course content, methods of instruction and clinical
experience shall be consistent with the philosophy and objectives of
the program.

(11) 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.
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| (12) 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.  
(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 each role or population focus in an appropriate clinical setting in direct patient care.  
(C) Each student enrolled in an NP program shall have an active unencumbered CA RN license.  
**Authority:** 2715, 2835, 2835.5, 2836, Business and Professions Code.  
(d) **Clinical Agency:** [1], [2], [6]  
(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:** [1], [2]  
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;
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| (2) Learning experiences; and  
(3) Curriculum, instruction and evaluation of the various aspects of the program, including clinical facilities.  
**Authority:** 2715, 2835, 2835.5, 2836, Business and Professions Code. | **Clinical Practicum in California for Nurse Practitioner Students Enrolled in Non-California Based Graduate Program**[4], [6]  
(a) A nurse practitioner student enrolled in a Non-California Based Graduate Program may not participate in a clinical practicum in California without prior authorization by the board.  
(b) The non-California based graduate program must provide the following requirements for prior board authorization:  
(1) A completed registration form;  
(2) Verification of a current, unencumbered registered nurse license in California for the nurse practitioner student;  
(3) Verification of enrollment of the nurse practitioner student in a Master's Degree in Nursing or a higher degree in Nursing program from a CCNE (Commission on Collegiate Nursing Education) or ACEN (Accreditation Commission for Education in Nursing) accredited graduate nursing program. (And make whatever changes decided in 1482 here)  
(4) Verification of enrollment of the nurse practitioner student in a Master’s Degree in Nursing or a higher program accredited by a nursing accrediting body that is recognized by the secretary of Education and/or the Council of Higher Education Accreditation (CHEA) or its successor organization as acceptable by the Board. (And make whatever changes decided in 1482 here)  
(5) Verification of a written signed agreement between the Non-California Based Graduate Program responsible for the student and the California licensed preceptor, per CCR 1484(b)(8); verify correct section to reference?  
(6) Identification of the faculty advisor accountable for general supervision from the Non-California Based Graduate Program; and |
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<td>(8) The preceptorship experience meets requirements per CCR 1484(b)(9). verify correct section to reference?</td>
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<td>(c) The non-California based graduate program must have California licensed preceptors that are responsible for validating that the student has registered and received Board authorization prior to participating in a clinical practicum in California. (Not sure how we would track this)</td>
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<td>(d) A nurse practitioner student shall practice under the direct supervision of an approved California licensed nurse practitioner, medical physician, or doctor of osteopathy who agrees to serve as preceptor, and general supervision of a faculty member as approved in the clinical practicum registration.</td>
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<td>(e) California faculty will be approved by the Board based on congruence of clinical scope and expertise to the student’s clinical placement and meets the qualifications per CCR1484 (b)(4). (This is something we do not do currently for NP programs, but for out-of-CA NP schools, we might consider it?)</td>
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<td>(f) The student’s assigned preceptor may not simultaneously serve as their designated faculty of record. The faculty of record must provide on-site evaluation of both the student and the preceptor.*</td>
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<td>*For clinical/preceptor etc. could we just say must meet same requirements per CCR 1484(b)(9)-(11)? Note: d above is different than what we have in 1484(b)(10) for CA based programs.</td>
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<td>(g) 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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Draft APRN Regulations

Cited Documents

2-21-2014

1. Current California Nursing Practice Act, APRN Regulations
2. Current California Nursing Practice Act, Pre-Licensure Regulations
4. Oregon State Board of Nursing Administrative Rules; Division 50 – Nurse Practitioners
6. BRN-APRN Workgroup developed language
7. National Organization of Nurse Practitioner Faculties (NONPF)
8. American Association of Colleges of Nursing (AACN)
9. The Commission on Collegiate Nursing Education (CCNE)
10. Accreditation Commission for Education in Nursing (ACEN)
11. American Nurses Credentialing Center (ANCC)
12. Council for Higher Education Accreditation (CHEA)
13. Recommendations from the public reviewing the documents
To: California Board of Registered Nursing, Nursing Practice Committee
From: Susanne J. Phillips, MSN, FNP-BC, California Action Coalition Co-Lead Recommendation #1
Date: October 1, 2013
Subject: Committee Testimony Supporting APRN Consensus Model Regulations

Good afternoon Chair Phillips, Committee members Klein, Jackson, and Dong, and BRN staff

My name is Susanne Phillips and I am an advanced practice registered nurse, certified as a family nurse practitioner. I am currently working with University of California; Irvine as an Associate Clinical Professor where I have both academic and clinical responsibilities. I am here on behalf of the California Action Coalition, serving as the Co-Lead of workgroup #1, Scope of Practice with my colleague, Garret Chan, a certified acute care nurse practitioner and clinical nurse specialist, who serves as an Associate Adjunct Professor at the University of California, San Francisco as well as Stanford University Medical Center. My previous background includes serving as the Director of Health Policy and Practice for the California Association for Nurse Practitioners for 10 years as well as serving as a member of this Board, holding positions of member of the Education & Licensing Committee, member and Chair of the Nursing Practice Committee, Vice President of the Board, as well as President of the Board.

The California Action Coalition is part of the national Future of Nursing Campaign for Action, established by the Robert Wood Johnson Foundation to Implement the Institute of Medicine’s recommendations for the future of nursing throughout the United States. Over the past two years, our Workgroup has been involved in researching and documenting statutes and regulations pertaining to nursing scope of practice in California, in addition to being heavily involved in legislative efforts to remove practice barriers for nurses. Our workgroup is comprised of over 100 registered nurses, both standard and advanced practice, working in diverse settings from academia to business, to the bedside. As experts in scope and standards of nursing care, we would like to be of service to the Board and assist and support the members in issues related to RN and APRN practice and regulation, including consideration of the consensus model.

I have been in regular communication with Janette Wackerly as she has shepherded this process along with the BRN staff workgroup and we are available to answer any questions they may have, as many of us have been through academic accreditation review and are very familiar with the Consensus Model recommendations and more specifically, the education regulations. As your staff has reported, their main task for fiscal year 2013-14 is to focus primarily on identifying needed changes in existing Certified Nurse Practitioner rules and regulations. As a member of the American Academy of Nurse Practitioners as well as a member of the National Organization of Nurse Practitioner Faculties Curriculum Committee, I am acutely aware of how these model rules are being adopted nationwide. As you are aware, all four national APRN organizations have endorsed the Consensus Model as well as the faculty associations for those respective APRN roles, and we are eager to move forward here in California to address the gaps and outdated regulations that we are practicing under.

We acknowledge and support the Board’s decision to incrementally address this process and look forward to working with your staff as we systematically address all four APRN groups. Our workgroup is committed to providing thoughtful, evidence-based recommendations, input and feedback on current
the mechanism for BRN state-approval of educational programs, comprehensive graduate educational standards consistent with national standards, national program accreditation, preparation for national certification examination, and the development of competency-based graduate outcomes. I have provided you with this written testimony as well as some references from national experts on the adoption of the National Council of State Boards of Nursing's Consensus Model for APRN Regulation. I understand that you have been provided with the NCSBN's documents.

Thank you for your attention and I am happy to answer any questions you may have.

Respectfully Submitted,

Susanne J. Phillips, MSN, RN, FNP-BC
Co-Lead, Workgroup #1: Scope of Practice
California Action Coalition
sjphilli@ucl.edu

Garrett Chan, Ph.D, RN, ACNP-BC, CNS, FAAN
Co-Lead, Workgroup #1: Scope of Practice
California Action Coalition
Garrett.Chan@me.com

"As long as regulatory requirements differ from state to state, each state border represents an obstacle to portability—potentially preventing access to professionals and access to care. The Consensus Model for APRN Regulation has the potential to harness this power by outlining regulatory requirements in licensure, accreditation, certification, and education that should be adopted by every state."


January 6, 2014

State of California
Board of Registered Nursing

RE: Advanced Practice Registered Nurse (APRN) Regulations

Dear BRN Nursing Practice Committee Members:

This letter is being written on behalf of the members of California Association of Clinical Nurse Specialists (CACNS). CACNS is the professional organization for Clinical Nurse Specialists.

Our organization would like to convey our support for the BRN regulatory revisions to align with the National Council of State Boards of Nursing Consensus Model regulatory language. We would also like to offer the BRN our resources and support.

In the proposed revisions, we would recommend changes to the following sections:

1. Page 3, section 1482(b)(A): should reflect the language in section 1483 on Page 4 and include the post-graduate (Post-Master’s, Post-Doctoral) certificate program graduates be recognized as nurse practitioners if their credentials reflect appropriate preparation. Page 4, section 1483 (a) allows for the BRN to evaluate credentials from a post-graduate NP program to see if the applicant is eligible for licensure as an NP.

   Recommendation: Page 3, section 1482(b)(A) Change it to read "Master’s Degree in Nursing, a post-graduate certificate, or a higher degree in Nursing from a CCNE...”.

2. Page 7, section 1484 (b)(10): This regulation speaks to clinical preceptors and who clinical preceptors can be. The proposed regulations restrict the clinical preceptors to be nationally certified nurse practitioners. With the need to reduce silos of education and conduct more interdisciplinary education a clinical preceptor should be approved by faculty and hold an active license or privilege to practice that is not encumbered as an APRN or physician and practices in a comparable practice focus.

   Recommendation: Consider utilizing the wording similar yet broader than the NCSBN Consensus Model such as "Clinical preceptors will be approved by faculty and meet the following requirements: a) hold an active license or privilege to practice that is not encumbered as an APRN, physician, or other allied health provider and practices in a comparable practice focus and b) function as a supervisor and teacher and evaluate the individual’s performance in the clinical setting."

Respectfully,

Patti Radovich, PhD, RN, CNS
Legislative Liaison
California Association of Clinical Nurse Specialists
January 7, 2014

California Board of Registered Nursing
Ms. Trande Phillips, RN, Chairperson
Nursing Practice Committee

Dear Chairperson Phillips:

On behalf AARP’s more than 3 million members and consumers of health care in this great state, we applaud the important step taken under your leadership to allow the California Board of Registered Nursing to conduct an evaluation of what the NCSBN Consensus Model regulatory language says, and compare it to current California regulations. We anticipate this gap analysis will illuminate what changes can be made through the regulatory process, and which changes will require going through the legislative process. AARP strongly believes this work is critical to the millions of Californians who depend on safe, high-quality, and affordable health care.

Advance Practice Registered Nurses (APRNs) play a critical and expanding role in meeting the healthcare needs of consumers in California and across the country. AARP supports the Consensus Model, which has been endorsed by 48 professional nursing groups, because it seeks to address both the inconsistency of the definitions of APRN roles, and the lack of uniformity across states. We urgently need consistency and uniformity across all APRN roles to effectively align the education, accreditation, certification, and licensure of APRNS, so that access to quality, cost-effective care can be improved for all Californians.

AARP stands firm in our commitment to championing access to affordable, quality health care for all generations, providing the tools needed to save for retirement, and serving as a trusted information source on issues critical to Americans age 50 and older. A comparative analysis like this one, performed by the California BRN, can help us to identify where to focus our resources as well as where we can work together with you and others in making the regulatory changes needed to help address California’s lack of primary and specialty care providers.

The gap analysis between current regulations and the NCSBN Consensus Model is particularly timely as California has now fully implemented the Affordable Care Act, and an estimated 4.7 million previously uninsured Californians will be seeking primary care services amidst a shortage of primary care physicians. A study by the Council on Graduate Medical Education
found that California has far fewer practicing primary care physicians than are needed to provide adequate care for the population. In 2008, only 16 of our state’s 58 counties met the recommended 60 to 80 primary care physicians per 100,000 residents. APRNs can be instrumental in easing this shortage. Decades of evidence demonstrate that APRNs have been providing high quality health care with positive outcomes equal to the care provided by their physician counterparts. In fact in a recent member survey voters ages 40-70 years old conducted by AARP, 88 percent support allowing Nurse Practitioners to approve home visits and prescribe medication and medical equipment as a solution to help seniors remain in their homes.

A recent report from the National Governors Association entitled "The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care," recommends that states consider easing their scope-of-practice restrictions on nurse practitioners, emphasizing their role in the growing demand for primary care. Additionally, the Institute of Medicine’s evidence-based report, "The Future of Nursing: Leading Change, Advancing Health," recommends that states remove scope-of-practice barriers and allow APRNs to practice at the full extent of their training and education. Consistent with these reports, the Center to Champion Nursing in America and AARP support the efforts of the California BRN in analyzing the APRN Consensus Model for its utility in removing barriers and improving access to quality healthcare.

We are grateful to the California Action Coalition and APRNs in California for requesting this CA BRN evaluation of the NCSBN Consensus Model and its comparison to existing California regulatory language. AARP and CCNA look forward to tomorrow’s presentation of results and a clearer understanding of the potential impact of regulatory, rather than statutory, change in California.

Sincerely,

Blanca Castro-Paszinski
Advocacy Manager
Comments to California Board of Registered Nursing Practice Committee
In Support for APRN Consensus Language Application to CA APRN Regulations
January 8, 2014
Karen Anne Wolf PhD, ANP, APRN-BC, FNAP
Professor & Faculty Development Coordinator
Samuel Merritt University
School of Nursing

Samuel Merritt University School of Nursing supports revision of the California Board of Advanced Practice Nurse Regulations within the framework of the APRN Consensus Report. Because the intent of the APRN Consensus report is directed at assuring the quality of advance nurses, this act is in the public interest. The Consensus report reflects a collaborative effort on the part of more than 500 organizations, including the National Council of State Boards of Nursing (NCSBN) to guide alignment of four advanced practice roles of advanced practice nurse (certified registered nurse anesthetist, certified nurse midwife, clinical nurse specialist and certified nurse practitioner). The APRN Consensus Report suggests that there be an alignment of licensure at the state level with the accreditation standards of advance practice programs, credentialing of advance practice nurses, and the educational curricula for advanced practice nurses. The Consensus Report establishes a defined population focus (family health, adult-gerontology, child health, and women’s health care) at both the level of primary care and acute care. This new alignment will assure that advanced practice nurses are will be well grounded in the care of population and area of practice, and restrict advanced practice nurses from practicing out-side of their educational practice by their own initiative or employers mandate. For example, a pediatric nurse practitioner prepared for primary care, would not be allowed to practice in the care of frail elders in an acute care setting. The consensus model has been adopted by the major educational accreditation bodies at the national level (CCNE and NONPF) and is foundational to advanced practice educational programs as well as the certification examination. As a result of the adoption of the APRN Consensus report language, APRNs will be better positioned to meet requirements for participation in Medicare reimbursement programs. The California regulations governing the practice of advanced practice nurses in California in their current state, may impede efforts of advanced practice nurses to be recognized in accordance with the Patient Protection and Affordable Health Act for reimbursement by Medicare and Medicaid.

All major California Nursing organizations have agreed that access to quality health care is needed. The adoption of the language of the consensus report is intended to assure that that candidates for licensure demonstrate that their education has provided them with sufficient depth and breadth to reflect the intended license to practice in Advanced Nursing roles The revision of the CA APRN regulations, particularly nurse practitioner regulations, is an important first step in helping to expand much needed access to advanced practice nurses under the such programs as Covered CA, and expanding ACOs, Medical or Health Care Homes.
January 16, 2014

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

Dear Ms. Wackerly,

On behalf of the California Action Coalition (CA AC), a coalition of nursing and consumer groups in the State of California, we thank you for reviewing and modernizing Title 16 regulations regarding nurse practitioners. This is important work that will help protect the public and ensure that Californians have access to high-quality and safe patient care. We are responding to the Board of Registered Nursing call for public comment on sections 1480-1484.

Please feel free to contact us if you have any questions.

Respectfully,

Garrett Chan, PhD, NP, CNS, RN, FAEN, FPCN, FNAP, FAAN
Susanne Phillips, MS, NP, RN
Co-Leads, Recommendation #1 Work Group
California Action Coalition

1480- Definitions

The CA AC will respond to public comment when this section is being presented to the Nursing Practice Committee.

1481- Categories of NPs

The California Action Coalition supports the proposed new language.

1482- Requirements NP Certification

The CA AC asks that the wording, “post-graduate certificate,” be included in 1482 (b)(A). In addition, in Section 1482 (b), we ask that all NP programs in the State be approved by the BRN.

1483- Evaluation of Credentials

The CA AC agrees with the proposed draft language.
1484- APRN-NP Education

The CA AC recommends the following:

Section 1484(b)(3)(c) – NP program administrators should have a minimum of a master’s degree in nursing, health-related science, business, or education (need to expand beyond a Master’s in nursing).

Section 1484(b)(5)(c)- NP program faculty should have a minimum of a master’s degree in nursing, health-related science, business, or education.

Section 1485(b)(10)(a-e)- strike these and replace with “APRN, physician, or other licensed health professional and hold an unencumbered license” or some similar phrase to allow for other disciplines to serve as clinical preceptors.
January 28, 2014

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

Dear Ms. Wackerly,

Please include this addendum to our letter dated January 16, 2014. Below, please find additional notes under section 1481 which are underlined.

On behalf of the California Action Coalition (CA AC), a coalition of nursing and consumer groups in the State of California, we thank you for reviewing and modernizing Title 16 regulations regarding nurse practitioners. This is important work that will help protect the public and ensure that Californians have access to high-quality and safe patient care. We are responding to the Board of Registered Nursing call for public comment on sections 1480-1484.

Please feel free to contact us if you have any questions.

Respectfully,

Garrett Chan, PhD, NP, CNS, RN, FAEN, FPCN, FNAP, FAAN
Susanne Phillips, MSN, FNP-BC, RN
Co-Leads, Recommendation #1 Work Group
California Action Coalition

1480- Definitions

The CA AC will respond to public comment when this section is being presented to the Nursing Practice Committee.

1481- Categories of NPs

The California Action Coalition supports the proposed new language. For consistency with the Model, we are requesting the following inclusion:

(b)(2) Please include “primary or acute care”
(b)(4) Please include “primary or acute care”

(d) Please remove the term “interdependent,” as this is not currently defined.

1482- Requirements NP Certification
The CA AC asks that the wording, “post-graduate certificate,” be included in 1482 (b)(A). In addition, in Section 1482 (b), we ask that all NP programs in the State be approved by the BRN.

1483- Evaluation of Credentials

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Section 1484(b)(5)(c) - NP program faculty should have a minimum of a master’s degree in nursing, health-related science, business, or education.

Section 1485(b)(10)(a-e) - strike these and replace with “APRN, physician, or other licensed health professional and hold an unencumbered license” or some similar phrase to allow for other disciplines to serve as clinical preceptors.
Janette Wackerly, MBA, BSN, RN  
Supervising Nursing Education Consultant  
Board of Registered Nursing  
P.O. Box 944210  
Sacramento, CA 94244-2100  
Via Email: Janette.Wackerly@dca.ca.gov

Dear Ms. Wackerly:

I am writing to provide comments on the APRN Workgroup draft suggested language for revision of current BRN regulations, Article 8 Nurse Practitioners Laws and Regulations, to implement the NCSBN Model Act in California.

1. Section 1481. Categories of Nurse Practitioners. The proposed language limits the preparation and practice of clinical nurse specialists CNSs to the same population foci as NPs and to a specific list of areas or populations. While this list may be all inclusive of current nurse practitioner (NP), certified nurse-midwife (CNM) and certified registered nurse anesthetist (CRNA) practice, such population specific foci are overly restrictive to the clinical nurse specialist (CNS) role and practice. While under this paragraph, I agree with the designation and definition of Advanced Practice Registered Nurse (APRN) which includes CNSs for our state, I disagree with the limitation on the future CNS practice. The practice of the CNS differs in that the goal is not primary care. In many areas of CNS specialty practice, the physiological changes and responses to disease and/or conditions within that specialty may or may not differ amongst the population foci listed. If, for example, my clinical specialty is in the area of pulmonary and I have the educational, scientific, and clinical expertise to support my practice in caring for individuals with asthma who are 16 years old as well as the older adult population, is my category Family/Individual across the lifespan or is it women’s health? Is asthma different in women versus men or adult-gerontology populations versus women?

While CNSs should be included in the definition of APRNs, the CNS should not be restricted to have education, scientific, and clinical expertise in the areas noted in the population foci listed.

2. I understand there were comments made during the January 8 meeting in disagreement with language presented in section 1482 Requirements for Nurse Practitioner Certification. I agree with the language as presented in this section without change. However, I strongly urge us to create a mechanism in our state to recognize new and innovative practice foci and settings, without requiring national certification before a new practice role or setting for APRNs can be allowed. In other words, new areas of practice, new population foci, new areas of specialty for APRNs in a dynamic and changing healthcare system, given the current language, could not be implemented or recognized in our state until or unless a national certification agency creates a certification exam.
While I do not have new language to add to this section outlining a proposed process for an exception, I believe we can and should identify both in California and push for nationally a defined mechanism which allows for expansion of practice of APRNs roles into new and innovative arenas to meet societal needs, in ways we cannot imagine now. Under the current language, Acute Care NPs would not be able to have been created 20 years ago. We must allow for our graduate-prepared APRNs to be creative in forging new areas of foci or specialty to meet the needs of Californians and our nation, as our health care delivery system undergoes dramatic change. Their ability to do so should not be dependent upon a national certification exam to be in place first.

3. Section 1484. APRN-NP Education.
   a. Under “b” Faculty – I propose NP programs be allowed to have a NP Program Administrator and a NP Program Director, at their discretion. A program can have both but should be required to have, at minimum, a NP Program Director. The director would meet all of the requirements listed in (b) Faculty (3), and hold responsibility for instituting (b) Faculty (1) through (11). I strongly urge for the Master’s Degree to be in the discipline of nursing and/or a degree accredited by CCNE or ACEN, no matter what the specific degree is titled. It is important to keep the nursing profession identity strong in NP and APRN leadership roles at the graduate level.
   b. The Program Administrator, should a program choose to have one, does not have to be a NP, but must meet the same requirements as in the current article (c) Faculty (A) RN... (B) MS or higher in nursing, or a related field, (C) have had one year’s experience, within the last five years, as an instructor in a school of professional nursing, or a program preparing nurse practitioners. This allows for programs on larger college or university campuses to have a graduate program administrator – who may oversee many nurse graduate programs, including but not restricted to a NP program. However, this also allows the NP program to have an appropriately credentialed director.

Thank you for the opportunity to comment on the proposed language. I am happy to discuss the comments and suggestions I have made here, should there be questions or clarification needed.

I appreciate the work of the Nursing Practice Committee, the BRN, and you Janette, to move the profession of nursing forward for the benefit of all Californians!

Warm Regards,

Judy Martin-Holland, PhD, RN, CNS, FNP, FAAN
judybapma@gmail.com; cell: 510-599-2709
February 18, 2014

Janette Wackerly, RN, MBA
Nursing Education Consultant
California Board of Registered Nursing
P.O. Box 944210
Sacramento, CA 94244-2100

RE: Draft Revisions to California Code of Regulations,
Article 8, Sections 1480-1484 - OPPOSE

Dear Ms. Wackerly:

Thank you for the opportunity to provide comments on the draft revisions to California Code of Regulations (CCR) Article 8, Sections 1480-1484, Standards for Nurse Practitioners as proposed by the Board of Registered Nursing’s (BRN) staff workgroup. The California Nurses Association (CNA) represents 86,000 Registered Nurses (RNs), many of whom are Advanced Practice Registered Nurses (APRNs) and RNs seeking to become APRNs. As such, we have a vested interest in both current and future APRN regulations, and appreciate your consideration of our comments.

While the BRN intends to review and revise all APRN regulations, the draft language released by the BRN staff workgroup focuses on Nurse Practitioner (NP) regulations. At this juncture, we must oppose the draft revisions for numerous reasons, including but not limited to, the following:

1. Use of the “Consensus Model for APRN Regulation”

The Consensus Model for APRN Regulation, a document prepared by the National Council of State Boards of Nursing (NCSBN,Inc) in conjunction with other professional organizations, serves as the foundation for the changes to current regulations governing NPs proposed by the BRN’s staff workgroup. As you are aware, based on previous public testimony our organization has provided to the Nursing Practice Committee and the full Board, CNA does not endorse or support the NCSBN’s Consensus Model, and thus maintains strong concerns with any efforts to conform California statute or regulation to it.

We oppose the Consensus Model, in part, due to its stated goals of allowing for “mutual recognition [of NPs] through compact.” As you are well aware, CNA strongly opposes compact licensure. Based on previous public discussion regarding compact licensure, it appears that several, if not most, of the members of the BRN also carry strong concerns regarding compact licensure. The APRN Consensus Model clearly covets the principles of compact licensure, explicitly calling for uniformity of all standards across jurisdictions.
in order to allow for the mobility of nurses. In our perspective, to embrace the APRN Consensus Model in California will put our state on track toward compact licensure, which is something we strongly oppose.

2. **Requirements for national certification**

We strongly oppose requirements for national certification as a prerequisite for certification, another cornerstone of the APRN Consensus Model for a number of reasons. First, we question whether the BRN has the authority to require national certification without an enabling statute. Business and Professions Code (B&P) § 2835.5 sets requirements for NP certification, and does not appear to grant the BRN the latitude necessary to require national certification via regulations.

Second, B&P § 2836(a) states that any requirement for completion of an academically affiliated program must also provide equivalent standards for RNs who have not completed such a program.

California Code of Regulations (CCR) § 1482(b) provides for the equivalent standards required by the B&P code:

> "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."

In this case, the “equivalent standard” includes national or state certification or documentation of remediation of areas of deficiency and verification by an NP and a physician of clinical competence. The draft regulations do not provide for the “equivalent standard” required by law.

We assert that the proposed regulations requiring national certification conflict with this statute, and question the BRN’s authority to disregard this requirement.

Third, we do not agree that requiring national certification offers any additional protection or advantage for RNs or the public, and will dramatically increase the cost of obtaining NP certification. There is no credible scientific evidence to show that such
"certified" practitioners are safer or are more competent than those without national certification. Additionally, obtaining and maintaining national certification will more than triple (and for some, more than quintuple) the cost of initial certification and continuing practice, without a demonstrated rationale for requiring certification. Increasing cost in such drastic amounts may well discourage poor and minority applicants from pursuing advanced practice. Therefore, we urge the Board to refrain from ceding power and authority to regulate nursing practice to a private enterprise.

Fourth, we are concerned about delegation of authority by the BRN to national certification organizations. The Consensus Model was developed by a workgroup of which have a vested interest in requiring national certification— the certification corporations themselves. The proposed language mandates “current national certification as APRN-CNP in the CNP role.” Because the BRN is charged with determining qualifications for practice, and NPs are already, by definition, authorized to use the initials APRN, we object to language that codifies privatization of a State responsibility and mandates this function be divested to “a national organization recognized by the board,” and/or use of a private “credentials service.” Further, because at least two of the major national certification organizations, the American Nurses Credentialing Center (ANCC) and National Credentialing Corporation (NCC) require a Master’s degree from an approved NP program to be eligible to take the national certification exam, the proposed language providing alternate pathways to licensure for RNs with master's degrees not from an NP program is rendered null and void. This clearly exceeds the boards statutory authority. In effect, by requiring national certification to obtain California APRN certification, the national certification corporations can then dictate to the California BRN what certification requirements will be.

3. Implications of draft revisions on currently certified NPs are unclear.
The draft regulations make no allowances for NPs currently practicing in California; that is, if implemented, practicing NPs would have to meet new requirements to maintain their certification. When B&P § 2835.5 was amended in 2004 by AB 2226 to add subsection (d) requiring applicants for initial qualification or certification as a nurse practitioner on or after January 1, 2008 to possess a master’s or other graduate degree in nursing, or a master’s degree in a clinical field related to nursing, the Legislature protected the status of existing NPs, without requiring those who were already qualified or certified to obtain an advanced degree in order to continue holding themselves out as nurse practitioners. The proposed amendments to 8 CCR § 1482 conflict with B&P Code § 2835.5 and would require “grandfathered” individuals currently practicing as certified nurse practitioners to meet the new criteria of obtaining a master’s degree in nursing. Additionally, the proposed amendments would require all nurse practitioners in California to hold a current national certification as a nurse practitioner, something the Legislature considered and specifically rejected when it passed AB 2226. As introduced, AB 2226 would have required applicants for certification as nurse practitioners on or after January 1, 2008 to, among other things, “[p]resent documentation of initial certification that he or she has been granted a nurse practitioner credential by a national certification organization recognized by the board.” Thus, the proposed amendments
would impose through administrative fiat a requirement that the Legislature specifically declined to incorporate in the Nursing Practice Act.

The proposed amendments to 16 CCR § 1482 further defy the Legislature by requiring a “Master’s Degree in Nursing or a higher degree in Nursing....” In terms of advanced degrees, B&P § 2835.5(d) specifically allows qualification to those possessing “a master’s degree in nursing, a masters degree in a clinical field related to nursing, or a graduate degree in nursing.” (Italic added for emphasis.) Notably, as introduced, AB 2226 would have required “a master’s degree in nursing or graduate degree in nursing.” By amending the bill to permit more flexibility (i.e., allowing a master’s in a clinical field related to nursing, as well as a master’s degree in nursing), the Legislature specifically rejected the requirement that the proposed regulatory amendment now seeks to impose.

(As noted above, the statute’s requirement for any advanced degree applies only to those seeking initial certification on or after January 1, 2008.) Again, the Board must not presume authority to impose by regulation terms and conditions on certification that the Legislature specifically declined to write into law.

4. **Lack of clarity among a number of draft provisions**
A number of proposed provisions in the draft revisions do not provide the clarity needed for the public to understand how the draft language, if adopted, could be implemented and enforced. Furthermore, as you are aware, we previously requested that the BRN provide the public with a clear, written rationale for an overhaul of the NP regulations. We are dismayed that our request was rejected by the BRN, as having the rationale and reasoning behind the language may help explain the changes. Nonetheless, we seek further clarification on a number of provisions, and assert that as it stands now, the draft revisions may not meet standards for clarity cited in the Administrative Procedures Act.

Enclosed is a copy of our comments on the “Draft revisions for Discussion, BRN Nursing Practice Committee 1/8/14” for your review and consideration. Our comments provide additional detail on the issues outlined above, and raise a number of other issues, concerns, and questions regarding the draft revisions.

As many thousands of Californians are gaining broader access to our health system through the Patient Protection and Affordable Care Act, APRNs will be key providers of primary and specialty care, in both outpatient and inpatient settings. For this reason, it is vitally important that the Board act deliberately and methodically in order to protect the public interest.

Thank you for your time and consideration. If you have any questions regarding our comments, please feel free to contact Marti Smith or Kelly Green in our Government Relations Office at 916-446-5019.

Sincerely,

Bonnie Castillo, RN
Director of Government Relations

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Cc: Trande Phillips, RN, Chair, Nursing Practice Committee
Louise Bailey, RN, Executive Director, BRN
CALIFORNIA NURSES ASSOCIATION COMMENTS ON ARTICLE 8, SECTIONS 1480-1484 – STANDARDS FOR NURSE PRACTITIONERS

§ 1480. Definitions
The APRN Workgroup has not proposed changes to this section at this time.

§ 1481. Categories of Nurse Practitioners

Subsection (a)

This subsection changes the title recognition from Nurse Practitioner (NP) to Advanced Practice Registered Nurse, conforming the title to the definition found in B&P Article 2 § 2725.5. This change creates an umbrella title which applies to all Nurse Practitioners, Nurse Midwives, Certified Registered Nurse Anesthetists, and Clinical Nurse Specialists. Additionally, the titles Nurse Practitioner will change to Certified Nurse Practitioner and Nurse Midwife will change to Certified Nurse Midwife.

Since the section is headed “Categories of Nurse Practitioners,” it does not make sense to us to include this language which concerns all APRNs in the section reserved for NPs. We recommend this subsection § 1481 pertain solely to NPs as it does today.

This subsection also clearly defines authority to practice as an APRN as licensure, rather than certification. Is it the Board's intention to create a new category of licensure? If so, what is the rationale for this and what purpose will this serve? Does the BRN have authority to require licensure, given B&P § 2835.5, which calls for “issuance of (a) certificate”?

Subsection (b)

In existing §1481, categories of sub-specialization include, but are not limited to, “adult nurse practitioner, pediatric nurse practitioner, obstetrical-gynecological nurse practitioner, and family nurse practitioner.” The proposed changes to this subsection fundamentally change how nurse practitioners are certified in that they will have to provide proof of didactic and clinical preceptorship for one or more of six population foci: family/individual across the lifespan, adult-gerontology, neonatal, pediatrics, women’s health/gender-related, and psychiatric/mental health. While we are aware that these specialties have existed in California for years, we are unaware of any problems arising out of the current regulations. Therefore, without further information, we cannot comment on this language at this time.

More importantly, we are concerned about the potential impact of the proposed subsection (b) on NPs currently certified by the BRN. What, then, would the implications be for currently practicing NPs? Given that the language is silent on this matter, we assume that NPs currently certified by the BRN will have to comply with the new requirements set forth in the proposed language. We would appreciate clarification on this.
Subsection (c)(8)

Wearing appropriate identification badges is important, but it is not part of NP practice.

Subsection (c)(9)

"Other acts that require education and training" is vague and not measurable as written.

Subsection (d)

This subsection attempts to establish accountability criteria but contains terms and language that is unclear. Specifically, what is a "certified interdependent practitioner?" Please clarify what this title intends to convey. Further, what are the "standards established or recognized by the BRN" referenced in this subsection? Language requiring adherence to "standardized procedures developed through collaboration among administrators and health professionals, including physicians and surgeons and nurses" (B&P § 2835.7).

Subsection (d)(1)

We are unclear as to the meaning of "Complying with...the quality of advanced nursing care rendered." We would suggest language requiring "adherence to recognized standards of practice" be substituted.

Subsection (d)(2)

We are concerned that "Recognizing the limits of knowledge and experience" is unclear. What is the bar for measuring this? How would it be enforced?

Subsection (d)(3)

This language is duplicative. Subsection (d)(4) addresses referrals. Is there a distinct meaning for this language besides referring patients to more appropriate providers when the situation is beyond the NPs expertise?

§ 1482 Requirements for Nurse Practitioner Certification

Subsection (b)(A)

This subsection will require all NP programs to be accredited, which may impact the availability of opportunities for RNs to advance their practice. Existing § 1482 allows for a masters-prepared (or higher) RN to be trained in a formal NP program, to obtain state or national certification, or to provide "documentation of remediation... in course content and/or clinical experience" and "verification by a nurse practitioner and a physician who meet the requirements for (NP program) faculty members." The proposed regulation would no longer allow this latter option and thus reduces flexibility in advancing to NP practice. RNs with graduate degrees
would then have to attend a formal NP program rather than (potentially) meeting the requirements for certification through these other means.

B&P § 2835.5 sets the requirements for NP certification. The BRN lacks authority to promulgate regulations that conflict with the statute.

Subsection (b)(B)

This language would require all NP programs to be accredited, virtually eliminating certification by national exam, by hospital-based training, and by verification of skills as regulations currently allow, because while established colleges and universities will be accredited, it is unlikely that hospital-based programs or individual physician or NPs who wish to provide verification of a candidate's competence will undergo this time-consuming and expensive process.

Subsection (b)(C)

Government Code § 11349(b) and (d) require that an agency must have statutory authority to adopt, amend, or repeal a regulation and that such regulations must be consistent with existing statutes.

We question whether the Board maintains the authority to promulgate new additional requirements via regulations for NP certification as the Business and Professions Code (B&P), § 2835.5 (d) specifies that an applicant for initial qualification or certification as a nurse practitioner meet the following requirements:

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

By requiring national certification as a condition of BRN certification as an NP, it appears that the BRN is proposing language that supersedes the requirements of Business and Professions Code § 2835.5, and thus may violate Government Code § 11349(d) which requires regulations be consistent with existing statute. We request clarification on the authority upon which the BRN proposes to require national certification without an enabling statute.

We oppose efforts to compel RNs and APRNs to obtain and maintain national certification as there is no evidence that national certification improves patient outcomes. Additionally, these examinations are quite costly and there is little to no oversight of their content or validity.

According to NCSBN’s Uniform Advanced Practice Registered Nurse Licensure/Authority to Practice Requirements, “A Board using professional certification as a qualification for licensure/authority to practice should establish criteria for accepting the certification and retains control of the licensure/authority to practice.” In essence, then, the certification exam becomes the equivalent of the state board exam. Unfortunately, the BRN does not have control over the contents of the exam, exam security, or validity to current clinical practice; therefore, we must recommend the Workgroup eliminate this language. There is no requirement that organizations
that provide national certification, such as American Nurses Credentialing Center (ANCC) or National Certification Corporation (NCC) notify the BRN when test content changes, no requirement they share the changes made in test content, no way for the BRN to oversee test security, no way for the BRN to check the test’s validity to current practice standards. The Board, then, would cede its statutory authority to set requirements for certification in that the test may or may not reflect validated current practice and may or may not change over time – which would be completely out of the control of the Board.

Additionally, both the ANCC and NCC eligibility requirements currently conflict with the proposed regulations. The ANCC and the NCC require a graduate degree conferred by a credentialed NP program to sit for the exam. However, both current and proposed regulations allow other routes to NP certification for RNs with existing graduate degrees in nursing or a clinical field. While established NP programs will be prepared to undertake the accreditation process, it is very unlikely that a hospital-based program (see § 1484 (b)(1)(B)) or certification by verification of competency (as in § 1482 (b)(3)) would undergo such a rigorous and costly process.

Essentially, the Board would cede its statutory authority to regulate certification since the proposed proprietary certification exam would become a requirement for authority to practice as an NP (as opposed to current regulations, in which certification is not mandatory and is just one pathway to Board certification), in essence allowing national certification corporations to dictate APRN certification requirements to California. This presents a serious legal concern. The legal authority associated with accreditation is fundamentally linked to the legal authority to pursue enforcement. A non-governmental credentialing body cannot protect healthcare consumers by disciplining nurses for failing to practice in conformity with California’s Nursing Practice Act. Adding non-governmental accreditors to the system as a mandatory component of certification without the Board having control over the content of the required certification exams they write and administer would create uncertainty with interpretation of legal standards and requirements of advance practice nursing. It is the government’s duty to ensure that licensed professionals are practicing safely, within their scope and in the best interest of public health. Breaking the fundamental link between accreditation and enforcement would have the effect of the Board losing in-house expertise, jeopardizing not only the right of advance practice nurses to fair pathways to certification, but also the core function of the Board in protecting the interests of healthcare consumers by ensuring that a sufficient number of well qualified advance practice nurses are available to provide competent, cost effective care.

We object strongly to the language that NPs would be required to pay additional money to a private enterprise, such as the ANCC or NCC in order to acquire national certification, which under the proposed language is necessary for certification. Clearly the existing requirement for regulating APRN practice, as set forth in § 1484, is the current standard to be met; as long as the licensee has completed a nurse practitioner program of study which meets board standards.

Further, B&P § 2836 states, “If the board sets standards for use of nurse practitioner titles which include completion of an academically affiliated program, it shall provide equivalent standards for registered nurses who have not completed such a program.” Under current CCR § 1482, RNs who have not completed an NP program which conforms to BRN standards, can seek
certification in one of two ways: she can obtain state or national certification that meets BRN standards found in § 1484, or she can provide proof of remediation of areas of course or clinical deficiency as well as verification of clinical competence provided by an NP and a physician who meet the BRN’s requirements for faculty members found in § 1484(c).

Since the national certification exams require completion of an academically affiliated program, the Board cannot require national certification in order to obtain Board certification, because this conflicts with existing statute.

What is the APRN Workgroup’s rationale for this requirement beyond conformity with the Consensus Model? Can the Board provide citations supporting its authority to require certification?

§ 1483 Evaluation of Credentials

Subsection (b)

This subsection reduces the number of required supervised clinical hours. Current regulations require 12 semester units (per existing and proposed regulation, a semester is 14-16 weeks) of supervised clinical (per existing and proposed regulation, one unit of supervised clinical is a minimum of 3 hours per week). This is 576 hours of supervised clinical preceptorship. However, the proposed regulations require only 500 hours. Why is 500 hours sufficient clinical time when the Board currently requires 576 hours?

§ 1484 APRN-NP Education

Subsection (a)(2)

Under the proposed regulations, NP programs would no longer be required to have admission requirements and policies for withdrawal, dismissal and readmission clearly stated and available to the student in written form, thus reducing protections afforded to RNs seeking advanced practice roles. The board should not weaken the existing regulation that protects nursing students. We urge the Board to retain the existing regulation.

Subsection (a)(3)

This proposed subsection would remove the requirement that students be notified of the academic status of the program. Again, this reduces protections to RNs seeking advanced practice roles. We urge the Board to retain the existing regulations.

Subsection (a)(4)

This subsection removes the requirements that NP programs provide graduates with official evidence indicating demonstrated clinical competence and program completion as well as the requirement to “maintain systematic, retrievable records of the program including philosophy,
objectives, administration, faculty, curriculum, students and graduates.” We do not understand why the Board would weaken these protections.

Additionally, the term “sufficient resources to achieve the program objectives” is unclear. What does this mean? How will it be measured and evaluated?

With regards to this entire section - 1484 - we will reiterate our request for the source of this language. What purpose does this new language serve?

Subsection (b)(2)

We are unclear as to what “sufficient time” means. Does this mean, for example, that the administrator cannot teach a didactic or clinical course? We recommend the Board provide more specificity.

Subsection (b)(2)(c)

The requirement that the administrator have a master’s degree or higher in nursing eliminates existing language that provides for the administrator to have a master’s degree or higher in “a related health field” and removes the requirement that the degree come from an accredited college or university. Is it the intention of the Board to remove administrators with non health related graduate degrees from their positions? If so, have there been problems with this in the past? We would like further clarification on this.

Subsection (b)(3)(d)

The proposed language would require experience as an instructor, but there is no requirement that the administrator ever have practiced in an APRN role. Is it intended that clinical practice as an APRN is not necessary in order to qualify as a program administrator? Without more information on the source of this language and the rationale behind it, we are unable to determine if it is beneficial or if it places the public at risk to the public.

Subsection (b)(10)(b, c, d)

These provisions contradict one another. Subsection (b)(10)(b and c) require current NP certification and certification, while (b)(10)(d) provides for a “CNP or non-NP” to function as a clinical preceptor.

Subsection (b)(10)(e)

Subsection (b)(10) lists the qualifications to be a clinical preceptor. Subsection (b)(10)(e) is a duty of preceptors, not a qualification. We recommend this be either removed or placed among faculty duties in regulation.
Subsection (b)(11)(a)

It is unclear what "appropriate to accomplishment of learning objectives" and "complexity of the clinical situation" means. How will this be defined, evaluated, and enforced? It clearly lacks clarity.

Subsection (b)(11)(c)

This subsection also conflicts with (b)(10)(b and c) when it states "a majority of the clinical experiences shall be under the supervision of clinical preceptors who are CNPs." This appears to mean that non-NPs can precept. Again, we suggest elimination of the conflicts in the language.

Subsection (b)(11)(d)

As previously noted, the Board is proposing to decrease the number of supervised clinical hours required for certification. Without a rationale, and from a public protection standpoint, this seems counterintuitive and we recommend retaining the current requirement.

Subsection (b)(11)(e)

The term "periodic" is vague and lacks the specificity necessary for monitoring and enforcement. We recommend quantifying this expectation.

Subsection (c)(11)

The proposed regulations actually shorten the required minimum length of NP programs. Current regulations (§ 1484(d)(7)), require thirty semester units. The proposed regulations require "one academic year," which is vague as to whether or not that includes summer session. With thirty units at a full time course load of twelve units per spring/fall semester, a student would normally take two 12 unit fall or spring semesters and an additional six units during a summer session, or one calendar year, rather than one academic year. Without knowing the rationale for this change, we recommend retaining the original regulatory language.

Subsection (c)(5)

The intent of the proposed language lacks clarity. While the intent of this language appears to allow for alternate pathways to NP certification, the national certification requirements would not be met with "a formal graduate level certificate" unless the student is already an NP and is just adding another population focus to her practice.

Subsection(c)(7)

Proposed language in this subsection would supersede existing § 1484(d)(12) and would lose the specificity therein. It is then unclear whether schools would continue to be required to cover the following subjects in their curriculum: normal growth and development, interviewing and communication skills, recording health assessments, interpretation of laboratory values, evaluation of assessment findings to define health and developmental problems, nutrition, assessment of community resources, initiating and providing emergency treatments, and health care delivery systems. We are
concerned that the proposed language regarding curriculum content is less specific than current regulations.

Subsection (c)(7)(d)

The reference to "core competencies" is not defined, unless the intent is to reference the existing scope language in CCR § 1481(c). If this is the case, the reference should be explicit. If the core competencies are not in the statute, the Board will need to define the term core competencies.

Subsection (c)(11)(b)

This is another reference to the decreased requirement for supervised clinical hours. See discussion regarding § 1483(b).

Subsection (d)(2)(d)

The phrase "continuing communication" is vague and requires further definition. In person? Electronically? How often?
AGENDA ITEM: 10.2
DATE: March 6, 2014

ACTION REQUESTED: Review and vote to approve/not approve

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

BACKGROUND: AB154 was a bill to amend Business and Professions Code Section 2725.4 – Abortion by aspiration techniques; requirements. Amends Section 123468 of the Health and Safety Code.

Update to California Nursing Practice Act to include the amendment to Business and Professions Code Section 2725.4 being made available on the Board’s website.

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
§2725.4 Abortion by aspiration techniques; Requirements

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

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

(b) In order to perform an abortion by aspiration techniques pursuant to Section 2253, a person with a license or certificate to practice as a nurse practitioner or a certified nurse-midwife shall adhere to standardized procedures developed in compliance with subdivision (c) of Section 2725 that specify all of the following:
1. The extent of supervision by a physician and surgeon with relevant training and expertise.
2. Procedures for transferring patients to the care of the physician and surgeon or a hospital
3. Procedures for obtaining assistance and consultation from a physician and surgeon.
4. Procedures for providing emergency care until physician assistance and consultation are available.
5. The method of periodic review of the provisions of the standardized procedures

(c) A nurse practitioner or certified nurse-midwife who has completed training and achieved clinical competency through HWPP No. 171 shall be authorized to perform abortions by aspiration techniques pursuant to Section 2253 without prior completion of training and validation of clinical competency.

California Health and Safety Code §123468

The performance of an abortion is unauthorized if either of the following is true:

(a) The person performing the abortion is not a health care provider authorized to perform an abortion pursuant to Section 2253 of the Business and Professions Code.

(b) The abortion is performed on a viable fetus, and both of the following are established:
   (1) In the good faith medical judgment of the physician, the fetus was viable.
   (2) In the good faith medical judgment of the physician, continuation of the pregnancy posed no risk to life or health of the pregnant woman.

AB 154 (Atkins)
Signed into Law Oct 9, 2013 by Gov. Jerry Brown
Effective date: January 1, 2014
Credentialed School Registered Nurse Nurse Practitioner with a Furnishing Number

An act to amend Section 120365 of the Health and Safety Code, relating to communicable disease.

CHAPTER 821 FILED WITH SECRETARY OF STATE SEPTEMBER 30, 2012

Effective date January 1, 2014.

AB 2109, Pan. Communicable Disease: immunization exemption.

Existing law prohibits the governing authority of a school or other institution from unconditionally admitting any person as a pupil of any private or public elementary or secondary school, child care center, day nursery, nursery school, family day care home, or development center, unless prior to his or her first admission to that institution he or she has been fully immunized against various diseases, as specified.

Existing law exempts a person from the above-described immunization requirement if the parent or guardian or other specified persons file with the governing authority a letter or affidavit stating that the immunization is contrary to his or her beliefs.

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

SECTION 1. Section 120365 of the Health and Safety Code is amended to read:

120365. (a) Immunization of a person shall not be required for admission to a school or other institution listed in Section 120335 if the parent or guardian or adult who has assumed responsibility for his or her care and custody in the case of a minor, or the person seeking admission if an emancipated minor, files with the governing authority a letter or affidavit that documents which immunizations required by Section 120355 have been given, and which immunizations have not been given on the basis that they are contrary to his or her beliefs.

(b) On and after January 1, 2014, a form prescribed by the State Department of Public Health shall accompany the letter or affidavit filed pursuant to subdivision (a). The form shall include both of the following:

(1) A signed attestation from the health care practitioner that indicates that the health care practitioner provided the parent or guardian of the person who is subject to the immunization requirements of this chapter, the adult who has assumed responsibility for the care and custody of the person, or the person if an emancipated minor, with information regarding the benefits and risks of the immunization and the health risks of the communicable
diseases listed in Section 120335 to the person and to the community. This attestation shall be signed not more than six months prior to the date when the person first becomes subject to the immunization requirement for which exemption is being sought.

(2) A written statement signed by the parent or guardian of the person who is subject to the immunization requirements of this chapter, the adult who has assumed responsibility for the care and custody of the person, or the person if an emancipated minor, that indicates that the signer has received the information provided by the health care practitioner pursuant to paragraph (1). This statement shall be signed not more than six months prior to the date when the person first becomes subject to the immunization requirements as a condition of admittance to a school or institution pursuant to Section 120335.

(c) The following shall be accepted in lieu of the original form:

(1) A photocopy of the signed form.

(2) A letter signed by a health care practitioner that includes all information and attestations included on the form.

(d) Issuance and revision of the form shall be exempt from the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(e) When there is good cause to believe that the person has been exposed to one of the communicable diseases listed in subdivision (a) of Section 120325, that person may be temporarily excluded from the school or institution until the local health officer is satisfied that the person is no longer at risk of developing the disease.

(f) For purposes of this section, "health care practitioner" means any of the following:

(1) A physician and surgeon, licensed pursuant to Section 2050 of the Business and Professions Code.

(2) A nurse practitioner who is authorized to furnish drugs pursuant to Section 2836.1 of the Business and Professions Code.

(3) A physician assistant who is authorized to administer or provide medication pursuant to Section 3502.1 of the Business and Professions Code.

(4) An osteopathic physician and surgeon, as defined in the Osteopathic Initiative Act.

(5) A naturopathic doctor who is authorized to furnish or order drugs under a physician and surgeon's supervision pursuant to Section 3640.5 of the Business and Professions Code.

(6) A credentialed school nurse, as described in Section 49426 of the Education Code.

SEC. 2. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.
Section 2725. Legislative intent: Practice of Nursing Defined

2725. (a) In amending this section at the 1973-74 session, the Legislature recognizes that nursing is a dynamic field, the practice of which is continually evolving to include more sophisticated patient care activities. It is the intent of the Legislature in amending this section at the 1973-74 session to provide clear legal authority for functions and procedures that have common acceptance and usage. It is the legislative intent also to recognize the existence of overlapping functions between physicians and registered nurses and to permit additional sharing of functions within organized health care systems that provide for collaboration between physicians and registered nurses. These organized health care systems include, but are not limited to, health facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, clinics, home health agencies, physicians' offices, and public or community health services.

(b) The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all of the following:

(1) Direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures.

(2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code.

(3) The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries.

(4) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (A) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.

(c) "Standardized procedures," as used in this section, means either of the following:

(1) Policies and protocols developed by a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code through collaboration among administrators and health professionals including physicians and nurses.
(2) Policies and protocols developed through collaboration among administrators and health professionals, including physicians and nurses, by an organized health care system which is not a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

   The policies and protocols shall be subject to any guidelines for standardized procedures that the Division of Licensing of the Medical Board of California and the Board of Registered Nursing may jointly promulgate. If promulgated, the guidelines shall be administered by the Board of Registered Nursing.

   (d) Nothing in this section shall be construed to require approval of standardized procedures by the Division of Licensing of the Medical Board of California, or by the Board of Registered Nursing.

   (e) No state agency other than the board may define or interpret the practice of nursing for those licensed pursuant to the provisions of this chapter, or develop standardized procedures or protocols pursuant to this chapter, unless so authorized by this chapter, or specifically required under state or federal statute. "State agency" includes every state office, officer, department, division, bureau, board, authority, and commission.

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

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

   (c) Nothing in this section shall be construed to limit any other authority granted to a certified nurse-midwife pursuant to Article 2.5 (commencing with Section 2746), to a nurse practitioner pursuant to Article 8 (commencing with Section 2834), or to a physician assistant pursuant to Chapter 7.7 (commencing with Section 3500).

   (d) Nothing in this section shall be construed to affect the sites or types of health care facilities at which drugs or devices are authorized to be dispensed pursuant to Chapter 9 (commencing with Section 4000).

2725.2. (a) Notwithstanding any other provision of law, a registered nurse may dispense self-administered hormonal contraceptives approved by the federal Food and Drug Administration (FDA) and may administer injections of hormonal contraceptives approved by the FDA in strict adherence to standardized procedures developed in compliance with subdivision (c) of Section 2725.
(b) The standardized procedure described in subdivision (a) shall include all of the following:

1. Which nurse, based on successful completion of training and competency assessment, may dispense or administer the hormonal contraceptives.
2. Minimum training requirements regarding educating patients on medical standards for ongoing women's preventive health, contraception options education and counseling, properly eliciting, documenting, and assessing patient and family health history, and utilization of the United States Medical Eligibility Criteria for Contraceptive Use.
3. Demonstration of competency in providing the appropriate prior examination comprised of checking blood pressure, weight, and patient and family health history, including medications taken by the patient.
4. Which hormonal contraceptives may be dispensed or administered under specified circumstances, utilizing the most recent version of the United States Medical Eligibility Criteria for Contraceptive Use.
5. Criteria and procedure for identification, documentation, and referral of patients with contraindications for hormonal contraceptives and patients in need of a follow-up visit to a physician and surgeon, nurse practitioner, certified nurse-midwife, or physician assistant.
6. The extent of physician and surgeon supervision required.
7. The method of periodic review of the nurse's competence.
8. The method of periodic review of the standardized procedure, including, but not limited to, the required frequency of review and the person conducting that review.
9. Adherence to subdivision (a) of Section 2242 in a manner developed through collaboration with health care providers, including physicians and surgeons, certified nurse-midwives, nurse practitioners, physician assistants, and registered nurses. The appropriate prior examination shall be consistent with the evidence-based practice guidelines adopted by the federal Centers for Disease Control and Prevention in conjunction with the United States Medical Eligibility Criteria for Contraceptive Use.
10. If a patient has been seen exclusively by a registered nurse for three consecutive years, the patient shall be evaluated by a physician and surgeon, nurse practitioner, certified nurse-midwife, or physician assistant prior to continuing the dispensation or administration of hormonal contraceptives.

(c) Nothing in this section shall be construed to affect the sites or types of health care facilities at which drugs or devices are authorized to be dispensed pursuant to Chapter 9 (commencing with Section 4000).

2725.3. (a) A health facility licensed pursuant to subdivision (a), (b), or (f), of Section 1250 of the Health and Safety Code shall not assign unlicensed personnel to perform nursing functions in lieu of a registered nurse and may not allow unlicensed personnel to perform functions under the direct clinical supervision of a registered nurse that require a substantial amount of scientific knowledge and technical skills, including, but not limited to, any of the following:

1. Administration of medication.
2. Venipuncture or intravenous therapy.
3. Parenteral or tube feedings.
4. Invasive procedures including inserting nasogastric tubes, inserting catheters, or tracheal suctioning.
5. Assessment of patient condition.
(6) Educating patients and their families concerning the patient's health care problems, including post-discharge care.
(7) Moderate complexity laboratory tests.
(b) This section shall not preclude any person from performing any act or function that he or she is authorized to perform pursuant to Division 2 (commencing with Section 500) or pursuant to existing statute or regulation as of July 1, 1999.

**2725.4 Abortion by aspiration techniques; Requirements**

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

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

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

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

(c) A nurse practitioner or certified nurse-midwife who has completed training and achieved clinical competency through HWPP No. 171 shall be authorized to perform abortions by aspiration techniques pursuant to Section 2253 without prior completion of training and validation of clinical competency.

2725.5. "Advanced practice registered nurse" means those licensed registered nurses who have met the requirements of Article 2.5 (commencing with Section 2746), Article 7 (commencing with Section 2825), Article 8 (commencing with Section 2834), or Article 9 (commencing with Section 2838).

2726. Except as otherwise provided herein, this chapter confers no authority to practice medicine or surgery.

2727. This chapter does not prohibit:

(a) Gratuitous nursing of the sick by friends or members of the family.

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

(c) Domestic administration of family remedies by any person.
(d) Nursing services in case of an emergency. "Emergency," as used in this subdivision includes an epidemic or public disaster.

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

2727.5. A person licensed under this chapter who in good faith renders emergency care at the scene of an emergency which occurs outside both the place and the course of that person's employment shall not be liable for any civil damages as the result of acts or omissions by that person in rendering the emergency care.

This section shall not grant immunity from civil damages when the person is grossly negligent.

2728. If adequate medical and nursing supervision by a professional nurse or nurses is provided, nursing service may be given by attendants, psychiatric technicians, or psychiatric technician interim permittees in institutions under the jurisdiction of the State Department of State Hospitals or the State Department of Developmental Services or subject to visitation by the State Department of Public Health or the Department of Corrections and Rehabilitation. Services so given by a psychiatric technician shall be limited to services which he or she is authorized to perform by his or her license as a psychiatric technician. Services so given by a psychiatric technician interim permittee shall be limited to skills included in his or her basic course of study and performed under the supervision of a licensed psychiatric technician or registered nurse.

The Director of State Hospitals, the Director of Developmental Services, and the State Public Health Officer shall determine what shall constitute adequate medical and nursing supervision in any institution under the jurisdiction of the State Department of State Hospitals or the State Department of Developmental Services or subject to visitation by the State Department of Public Health.

Notwithstanding any other provision of law, institutions under the jurisdiction of the State Department of State Hospitals or the State Department of Developmental Services may utilize graduates of accredited psychiatric technician training programs who are not licensed psychiatric technicians or psychiatric technician interim permittees to perform skills included in their basic course of study when supervised by a licensed psychiatric technician or registered nurse, for a period not to exceed nine months.

2728.5. Except for those provisions of law relating to directors of nursing services, nothing in this chapter or any other provision of law shall prevent the utilization of a licensed psychiatric technician or psychiatric technician interim permittee in performing services used in the care, treatment, and rehabilitation of mentally ill, emotionally disturbed, or developmentally disabled persons within the scope of practice for which he or she is licensed or authorized in facilities under the jurisdiction of the State Department of State Hospitals or the State Department of Developmental Services or licensed by the State Department of Public Health, that he or she is licensed to perform as a psychiatric technician, or authorized to perform as a psychiatric technician interim permittee including any nursing services under Section 2728, in facilities under the jurisdiction of the State Department of State Hospitals or the State Department of Developmental Services or subject to visitation by the State Department of Public Health.
2729. Nursing services may be rendered by a student when these services are incidental to the course of study of one of the following:
   (a) A student enrolled in a board-approved prelicensure program or school of nursing.
   (b) A nurse licensed in another state or country taking a board-approved continuing education course or a postlicensure course.

2730. If he does not represent or hold himself out as a professional nurse licensed to practice in this State and if he has an engagement, made in another State or country, requiring him to accompany and care for a patient temporarily residing in this State during the period of such engagement, a nurse legally qualified by another State or country may give nursing care to such patient in this State.

2731. This chapter does not prohibit nursing or the care of the sick, with or without compensation or personal profit, when done by the adherents of and in connection with the practice of the religious tenets of any well recognized church or denomination, so long as they do not otherwise engage in the practice of nursing.

2732. No person shall engage in the practice of nursing, as defined in Section 2725, without holding a license which is in an active status issued under this chapter except as otherwise provided in this act.
   Every licensee may be known as a registered nurse and may place the letter "R. N." after his name.

2732.05. (a) Every employer of a registered nurse, every employer of a registered nurse required to hold any board-issued certification, and every person acting as an agent for such a nurse in obtaining employment, shall ascertain that the nurse is currently authorized to practice as a registered nurse or as a registered nurse pursuant to a board-issued certification within the provisions of this chapter. As used in this section, "board-issued certification" includes, but is not limited to, certification as a nurse practitioner, nurse practitioner with a furnishing number, nurse anesthetist, nurse midwife, nurse midwife with a furnishing number, public health nurse, clinical nurse specialist, or board listed psychiatric mental health nurse.
   (b) Every employer of a temporary licensee or interim permittee and every person acting as an agent for a temporary licensee or interim permittee in obtaining employment shall ascertain that the person is currently authorized to practice as a temporary licensee or interim permittee.
   (c) As used in this section, the term "agent" includes, but is not limited to, a nurses’ registry and a traveling nurse agency.
   Examination by an employer or agent of evidence satisfactory to the board showing the nurse's, licensee's, or permittee's current authority to practice under this chapter, prior to employment, shall constitute a determination of authority to so practice.
   Nothing in this section shall apply to a patient, or other person acting for a specific patient, who engages the services of a registered nurse or temporary licensee to provide nursing care to a single patient.

2732.1. (a) An applicant for license by examination shall submit a written application in the form prescribed by the board.
Upon approval of the application, the board may issue an interim permit authorizing the applicant to practice nursing pending the results of the first licensing examination following completion of his or her nursing course or for a maximum period of six months, whichever occurs first.

If the applicant passes the examination, the interim permit shall remain in effect until a regular renewable license is issued by the board. If the applicant fails the examination, the interim permit shall terminate upon notice thereof by first-class mail.

(b) The board upon written application may issue a license without examination to any applicant who is licensed or registered as a nurse in a state, district or territory of the United States or Canada having, in the opinion of the board, requirements for licensing or registration equal to or higher than those in California at the time the application is filed with the Board of Registered Nursing, if he or she has passed an examination for the license or registration that is, in the board's opinion, comparable to the board's examination, and if he or she meets all the other requirements set forth in Section 2736.

(c) Each application shall be accompanied by the fee prescribed by this chapter for the filing of an application for a regular renewable license.

The interim permit shall terminate upon notice thereof by first-class mail, if it is issued by mistake or if the application for permanent licensure is denied.

2733. (a) Upon approval of an application filed pursuant to subdivision (b) of Section 2732.1, and upon the payment of the fee prescribed by subdivision (k) of Section 2815, the board may issue a temporary license to practice professional nursing, and a temporary certificate to practice as a certified nurse midwife, certified nurse practitioner, certified public health nurse, certified clinical nurse specialist, or certified nurse anesthetist for a period of six months from the date of issuance.

A temporary license or temporary certificate shall terminate upon notice thereof by certified mail, return receipt requested, if it is issued by mistake or if the application for permanent licensure is denied.

(b) Upon written application, the board may reissue a temporary license or temporary certificate to any person who has applied for a regular renewable license pursuant to subdivision (b) of Section 2732.1 and who, in the judgment of the board, has been excusably delayed in completing his or her application for or the minimum requirements for a regular renewable license, but the board may not reissue a temporary license or temporary certificate more than twice to any one person.

2734. Upon application in writing to the board and payment of the biennial renewal fee, a licensee may have his license placed in an inactive status for an indefinite period of time. A licensee whose license is in an inactive status may not practice nursing. However, such a licensee does not have to comply with the continuing education standards of Section 2811.5.

2736. (a) An applicant for licensure as a registered nurse shall comply with each of the following:

1) Have completed such general preliminary education requirements as shall be determined by the board.

2) Have successfully completed the courses of instruction prescribed by the board for licensure, in a program in this state accredited by the board for training registered nurses, or have
successfully completed courses of instruction in a school of nursing outside of this state which, in the opinion of the board at the time the application is filed with the Board of Registered Nursing, are equivalent to the minimum requirements of the board for licensure established for an accredited program in this state.

(3) Not be subject to denial of licensure under Section 480.

(b) An applicant who has received his or her training from a school of nursing in a country outside the United States and who has complied with the provisions of subdivision (a), or has completed training equivalent to that required by subdivision (a), shall qualify for licensure by successfully passing the examination prescribed by the board.

2736.1. (a) The course of instruction for an applicant who matriculates on or after September 1, 1985, shall include training in the detection and treatment of alcohol and chemical substance dependency.

(b) The course of instruction for an applicant who matriculates on or after January 1, 1995, shall include training in the detection and treatment of client abuse, including, but not limited to, spousal or partner abuse. The requirement for coursework in spousal or partner abuse detection and treatment shall be satisfied by, and the board shall accept in satisfaction of the requirement, a certification from the chief academic officer of the educational institution from which the applicant graduated that the required coursework is included within the institution's required curriculum for graduation.

2736.5. (a) Any person who has served on active duty in the medical corps of any of the Armed Forces of the United States and who has successfully completed the course of instruction required to qualify him or her for rating as a medical service technician—indirect duty, or other equivalent rating in his particular branch of the Armed Forces, and whose service in the Armed Forces has been under honorable conditions, may submit the record of such training to the board for evaluation.

(b) If such person meets the qualifications of paragraphs (1) and (3) of subdivision (a) of Section 2736, and if the board determines that his or her education would give reasonable assurance of competence to practice as a registered nurse in this state, he or she shall be granted a license upon passing the standard examination for such licensure.

(c) The board shall, by regulation, establish criteria for evaluating the education of applicants under this section.

(d) The board shall maintain records of the following categories of applicants under this section:

(1) Applicants who are rejected for examination, and the areas of such applicants' preparation which are the causes of rejection.

(2) Applicants who are qualified by their military education alone to take the examination, and the results of their examinations.

(3) Applicants who are qualified to take the examination by their military education plus supplementary education, and the results of their examinations.

(e) The board shall attempt to contact by mail or other means individuals meeting the requirements of subdivision (a) who have been or will be discharged or separated from the Armed Forces of the United States, in order to inform them of the application procedure provided by this section. The board may enter into an agreement with the federal government in order to secure the names and addresses of such individuals.
2736.6. The board shall determine by regulation the additional preparation in nursing, in a school approved by the board, which is required for a vocational nurse, licensed under Chapter 6.5 (commencing with Section 2840) of this division, to be eligible to take the examination for licensure under this chapter as a registered nurse. The board shall not require more than 30 units in nursing and related science subjects to satisfy such preparation.

2737. An applicant for a license authorizing him to practice nursing in this State under this chapter, upon the filing of his application shall pay the fee required by this chapter.

2738. The board shall hold not less than two examinations each year at such times and places as the board may determine.

2740. Examinations shall be written, but in the discretion of the board may be supplemented by an oral or practical examination in such subjects as the board determines. All examinations shall be conducted by such persons and in such manner and under such rules and regulations as the board may prescribe.

The board shall finally pass or reject all applicants. Its actions shall be final and conclusive and not subject to review by any court or other authority.

2741. An application for reexamination shall be accompanied by the fees prescribed by this chapter.

2742. The board shall issue a license to each applicant who passes the examination and meets all other licensing requirements. The form of the license shall be determined in accordance with Section 164.