NURSING PRACTICE
COMMITTEE MEETING

Hilton Garden Inn San Francisco/Oakland Bay Bridge
Dock of the Bay Room
1800 Powell Street
Emeryville, CA 94608

AGENDA

October 9, 2014

Thursday, October 9, 2014 – 2:00 pm – 3:30 pm

10.0 Call to Order
   10.0.1 Review and Vote on whether to approve previous meeting’s minutes:
       ➢ August 7, 2014

10.1 Information and Discussion: Review Nurse Practitioner National Certification

10.2 Review and Vote Whether to Approve:
    Update to Frequently Asked Questions Regarding Nurse Practitioner Practice

10.3 Information and Discussion: California Association of Nurse Midwifery:
    a) Standardized Procedures related to ACNM Core Competencies for Basic Nurse-Midwifery Practice
    b) Out of Hospital CNM Practice and physician supervision
    c) Location of suturing and protection of public

10.4 Information: DEA Publishes Final Rule Rescheduling Hydrocodone Combination Products from Schedule III to Schedule II Controlled Substances

10.5 Information: Community Paramedicine- Office of Statewide Planning and Development Pilot Project 173

10.6 Public Comment for Items Not on the Agenda

10.7 Adjournment

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

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

Thursday, August 7, 2014
Meeting called to order at 2:30 PM by Trande Phillips
Members Introductions: Trande Phillips Chair, Michael Jackson, Elizabeth Woods, and Cynthia Klein

10.0  Review and Vote on whether to approve previous meeting minutes: May 7, 2014

MSC: Jackson/Klein move to approve meeting minutes of August 7, 2014

10.1  Information Only: Nurse Practitioner National Certifications
National Certification Organizations that meet the Board of Registered Nursing certification requirements for Nurse Practitioner Equivalency are: American Academy of Nurse Practitioners, American Nurses Credentialing Center, Pediatric Nursing Certification Board, National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialty, and the American Association of Critical-Care Nurses.

Susan Phillips, MSN, FNP-BC Associate Professor UC Irvine assisted BRN staff to develop the attached form displaying national certification organizations, degree required, certification fees, certification renewal fees, renewal requirements, accreditation and affiliations and testing service. Staff gathered data from all the listed national certification organizations and their websites.
Committee requested return of the attached national certification document for further explanation at the next Practice Committee meeting in October 2014. American Nurses Association- American Nurses Credentialing Center (ANCC) committee requested information regarding renewal requirements for role and population regarding the different options as described. Question regarding American Association of Critical-Care Nurses (AACN) nursing concentration on adult-gerontology acute care nurse practitioner.

10.2 **Review and Vote on Whether to Approve:**
Business and Professions Code 2725.4 Abortion by aspiration technique effective January 1, 2014 was the result of HWPP-171 nurse practitioners (NPs), certified nurse-midwives (CNMs), and physician assistants (PAs) can now provide comprehensive first trimester aspiration abortion care in California.

As part of HWPP-171, ANSIRH (Advancing New Standard in Reproductive Health) researchers evaluated a standardized, competency-based curriculum and training plan for education of primary care clinicians in early abortion care. The curriculum and training plan consists of didactic education, problem-based case review, and “hands on” clinical experience, along with knowledge testing and periodic clinical assessment, with the goal to train primary care clinicians to competence in all aspects of early aspiration care.


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

MSC Michael Jackson/Cynthia Klein voted to approve.

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

The Frequently Asked Questions Regarding Nurse Practitioner Practice are updated to include current laws and regulation changes that have occurred since the last update 12/2004. Added BPC Nursing Practice Act Section 2725.2 Dispensing of self-administered hormonal contraceptives; and 2725.4 Abortion by aspiration technique. Added to BPC nurse practitioner Section 2835.7 Authorized standardized procedure for ordering durable medical equipment, certifying disability in consultation with the physician pursuant to Unemployment Insurance Code, and plan of treatment or plan of care for home health in consultation with the physician. Other changes related to nurse practitioner practice.

MSC Jackson/Philips motion withdrawn
Committee members requested return of the Update to Frequently Asked Questions Regarding Nurse Practitioner Practice for further review at the October 2014 Practice Committee meeting.

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

Nursing Education Consultant APRN (Advanced Practice Registered Nurse) Workgroup has continued to review Article 8, Nurse Practitioner laws and regulations, NCSBN Model Act, and language implemented by other states. The Article 8 Standards for Nurse Practitioner are the existing regulations and proposed draft language changes. On May 7, 2014 NEC-APRN work group added a section called work in progress- Requirements for Clinical Practice Experience for Nurse Practitioner Students Enrolled in Out of State Based APRN-NP program. SNEC identified that BRN learns about out-of-state schools when graduate NP nursing student are applying for NP certification in California. There is interest to have out-of-state-NP educational programs identified to the BRN.

Sections of Article 8 Standards for Nurse Practitioner work in progress:

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

Grandfathering will be in accord with Section 2835.5 Submission of credentials Clause for NP will be added.

Feedback on the Sections of Article 8, Standards for Nurse Practitioner work in progress can be submitted in writing to the board’s office to the attention of Janette Wackerly, RN, SNEC.

The nursing education consultants will continue their work on updating the Article 8 Standards for Nurse Practitioner into 2015. The NEC group plan is to have organizations provide comment on all revisions when made available.

Open Forum:
Robert Frank CNM is requesting formation of the Nurse-Midwifery Committee to address today’s issues for CNMs and their practice.
Trisha Hunter ANA/C: The Licensed Midwives at the Medical Board through legislation have removed the requirement for physician supervision. CNMs are asking for a pathway for the CNMs to be Licensed Midwives. The Licensed Midwives through Medical Board are looking at regulations that will allow CNM to be Licensed Midwives.

Meeting adjourned at 3:30 p.m.

Submitted by:      Accepted by:

Janette Wackerly, MBA, BSN, RN, SNEC  Trande Phillips, RN, Chair, Direct Practice Member
Supervising Nursing Education Consultant
NP Liaison
AGENDA ITEM: 10.1
DATE: October 9, 2014

ACTION REQUESTED: Information: Nurse Practitioner National Certification

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

BACKGROUND:

National Certification Organizations that meet the certification requirement for Nurse Practitioner Equivalency by the Board of Registered Nursing

1. American Academy of Nurse Practitioners
2. American Nurses Credentialing Center
3. Pediatric Nursing Certification Board
4. National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialty
5. American Association of Critical-Care Nurses (AACN)

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

Committee requested return of the national certification document, specifically wanting detail from American Nurses Association-American Nurses Credentialing Center (AACN) renewal requirements

http://www.nursecredentialing.org/CertificationHandbook.aspx and American Association of Critical-Care Nurses (AACN) nursing concentration on Adult-Gerontology Acute Care Nurse Practitioner

RESOURCES:

American Academy of Nurse Practitioners National Certification Program(AANPCP)
https://www.aanpcert.org/ptistore/control/index
http://www.aanpcert.org/ptistore/control/recert/qualifications
American Nurses Credentialing Center (ANCC) http://www.nursecredentialing.org/Certificationhttp://www.nursecredentialing.org/AcuteCareNP-Eligibility.aspxhttp://www.nursecredentialing.org/RenewalRequirements.aspx
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
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<tr>
<th>Provider</th>
<th>Degree</th>
<th>Certification</th>
<th>Certification Renewal</th>
<th>Renewal Requirements</th>
<th>Accreditation &amp; Affiliation</th>
<th>Testing Service</th>
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<tbody>
<tr>
<td>American Academy of Nurse Practitioners Certification Program (AANPCP) <a href="https://www.aanpcert.org/ptistore/control/index">https://www.aanpcert.org/ptistore/control/index</a></td>
<td>Offered to graduates of a nationally-accredited graduate, post-graduate, and doctoral level adult, adult-gerontology, and family nurse practitioner programs in the U.S.A. and Canada <a href="http://www.aanpcert.org/ptistore/resource/documents/2013%20CandidateRenewalHandbook%20Rev%2011%2025%202013%20forNCCA(FINAL).pdf">http://www.aanpcert.org/ptistore/resource/documents/2013%20CandidateRenewalHandbook%20Rev%2011%2025%202013%20forNCCA(FINAL).pdf</a></td>
<td>Active RN license AANP member $240 non-AANP member $315</td>
<td>Every 5 years Recertification by Examination AANP Member $240, Non-Member $315</td>
<td>Active RN license Option 1: 1000 clinical hours as NP 75 CE applicable to population focus within 5 years</td>
<td>Accredited by the National Commission for Certifying Agencies (NCCA) &amp; the Accreditation Board for Specialty Nursing Certification (ABSNC). AANPCP is an independent, separately incorporated, nonprofit organization. The Certification Program is affiliated with the national professional membership organization, the American Association of Nurse Practitioners (AANP). Membership with AANP is not a requirement for certification with AANPCP.</td>
<td>Professional Examination Service (ProService). AANPCP’s National Certification Examinations are developed in cooperation with Professional Examination Service (ProExam, formerly known as PES), a not-for-profit testing company founded in 1941. Examinations are developed in conformity with standards established by the Institute of Credentialing Excellence (ICE), American Psychological Association, American Educational Research Association, National Council on Measurement in Education, and the U.S. Equal Employment Opportunity Commission</td>
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<td><strong>Pediatric Nursing Certification Board (PNCB)</strong></td>
<td><a href="http://www.pncb.org/pitistore/control/index">http://www.pncb.org/pitistore/control/index</a></td>
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<td><strong>Offered to graduates of a nationally-accredited master's or doctoral level pediatric primary care nurse practitioner or pediatric acute care nurse practitioner program.</strong></td>
<td><strong>Every 7 years $85 per module 2 PNCB Pediatric Updates Modules</strong></td>
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<td><strong>If purchased individually, the total cost is $170. If two modules are purchased at the same time, the cost is $160. There is no cost to apply previously purchased modules to your Recert application.</strong></td>
<td><strong>Active RN license each year complete 15 contact hours or equivalent activities accepted by PNCB.</strong></td>
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<td><strong>Accredited by The National Commission for Certifying Agencies (NCCA). PNCB certification programs are recognized by the National Council of State Boards of Nursing (NCSBN) and individual state boards of nursing. The PNCB is also a member of the American Board of Nursing Specialties (ABNS). PNCB is an independent, non-profit organization and is not affiliated with a professional association and no membership is required.</strong></td>
<td><strong>Childcare nurse practitioner (CPN), Certified Pediatric Nurse Practitioner (CPNP), and Certified Pediatric Medical Home Support Nurse Practitioner (PMHS).</strong></td>
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<tr>
<th><strong>National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialty (NCC)</strong></th>
<th><a href="http://www.ncwccwebsite.org/default.aspx">http://www.ncwccwebsite.org/default.aspx</a></th>
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<td><strong>Offered to graduates of a nationally-accredited masters, post-masters, or DNP level women's health care nurse practitioner or neonatal nurse practitioner program.</strong></td>
<td><strong>Active RN license Exam fee $325 Examination must be taken within 8 years of graduation date.</strong></td>
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<td><strong>Active RN license Exam fee $100 + $70 if 15 CEU completed $60 if 30 CEU completed $50 if 45 CEU completed using the NCC online modules Alternatives to Professional Development Certification Maintenance Program $175 <a href="https://www.ncwccwebsite.org/resources/docs/2014-maintenance-core.pdf">https://www.ncwccwebsite.org/resources/docs/2014-maintenance-core.pdf</a></strong></td>
<td><strong>Active RN license Professional Development Certification Maintenance Program Assessment to identify strengths &amp; knowledge gaps to build educational plan + CEU.</strong></td>
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<td><strong>Due March 31, 2014: Use credit earned from the day you take your Stage 2 Assessment to 3/31/14 Due June 30, 2014: Use credit earned from the day you take your Stage 2 Assessment to 6/30/14 Due September 30, 2014: Use credit earned from the day you take your Stage 2 Assessment to 9/30/14 Due December 31, 2014: Use credit earned from the day you take your Stage 2 Assessment to 12/31/14</strong></td>
<td><strong>NCC uses the services of testing vendor, Applied Measurement Professional, Inc (AMP) to assist in administration, scoring and analysis of the NCC's WHNP and NNP exams.</strong></td>
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<td><strong>Accredited by the National Commission for Certifying Agencies (NCCA), the accreditation body of the National Organization for Competency Assurance (NOCA). NCC is a not for profit organization that provides a national credentialing program for nurses, physicians and other licensed health care personnel. NCC is an independent, not for profit national certification organization and is not affiliated with a professional association and no membership is required.</strong></td>
<td><strong><a href="http://www.ncwccwebsite.org/Certification/HowdoIapply.aspx#how-computer-testing-works">http://www.ncwccwebsite.org/Certification/HowdoIapply.aspx#how-computer-testing-works</a></strong></td>
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<td>Offered to graduates of a nationally-accredited master’s degree or higher level adult-gerontology acute care nurse practitioner program. <a href="http://www.aacn.org/wd/certifications/content/documentsandhandbooks.pdf?menu=certification&amp;lastmenu=">http://www.aacn.org/wd/certifications/content/documentsandhandbooks.pdf?menu=certification&amp;lastmenu=</a></td>
<td>Active RN license AACN Members $245 Nonmembers $350 every 5 years Synergy Continuing Education Recognition Point (CERPs) AACN Members $120 Nonmembers $200 CCRN Renewal by Exam AACN Members $170 Nonmembers $275 <a href="http://www.aacn.org/WD/Certifications/Content/ccrnrenewal.pcms?menu=Certification">http://www.aacn.org/WD/Certifications/Content/ccrnrenewal.pcms?menu=Certification</a></td>
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MISSION

AACN Certification Corporation contributes to consumer health and safety through comprehensive credentialing of nurses to ensure their practice is consistent with established standards of excellence in caring for acutely and critically ill patients and their families.

VISION

As the undisputed leader in credentialing nurses, the AACN Certification Corporation has demonstrated that certification contributes to achieving optimal outcomes that are consistent with the goals and values of acutely and critically ill patients and their families.

VALUES

As the Corporation works to advance its mission and vision and fulfill its purpose and inherent obligation to ensure the health and well being of patients experiencing acute and critical illness, the Corporation is guided by a set of deeply rooted values.

- Providing leadership to bring all stakeholders together to create and foster cultures of excellence and innovation.
- Acting with integrity and upholding ethical values and principles in all relationships and in the provision of sound, fair and defensible credentialing programs.
- Committing to excellence in credentialing programs by striving to exceed industry standards and expectations.
- Promoting leading edge, research-based credentialing programs that reach diverse certificants.
- Demonstrating stewardship through fair and responsible management of resources and cost-effective business processes.

ETHICS

AACN and AACN Certification Corporation consider the American Nurses Association (ANA) Code of Ethics for Nurses foundational for nursing practice, providing a framework for making ethical decisions and fulfilling responsibilities to the public, colleagues and the profession. AACN Certification Corporation’s mission of public protection supports a standard of excellence that certified nurses have a responsibility to read, understand and act in a manner congruent with the ANA Code of Ethics for Nurses.

The following AACN Certification Corporation programs have been accredited by the National Commission for Certifying Agencies (NCCA), the accreditation arm of the Institute for Credentialing Excellence (ICE):

- Adult CCRN® and CCRN-ETM
- Pediatric and Neonatal CCRN®
- Adult, Pediatric and Neonatal CCNS®
- Adult ACNPC®
- Adult CMC®
- Adult CSC®

Our advanced practice certification programs, CCNS and ACNPC, have also been recognized by the National Council of State Boards of Nursing (NCSBN).
As healthcare becomes increasingly complex and challenging, certification has emerged as a mark of excellence showing patients, employers and the public that a nurse is qualified and competent, and has met the rigorous requirements to achieve specialty and/or subspecialty certification.

AACN Certification Corporation programs were created to protect healthcare consumers by validating the knowledge of nurses who care for the acutely and critically ill. We are pleased to provide you with this handbook with information about how to apply for and take the ACNPC-AG certification exam.

Today, more than 85,000 practicing nurses hold one or more of these certifications from AACN Certification Corporation:

**Specialty Certifications**

- **CCRN®** is for nurses providing direct bedside care to acutely and/or critically ill adult, pediatric or neonatal patients.
- **CCRN-E™** is for nurses working in a tele-ICU monitoring acutely and/or critically ill adult patients from a remote location.
- **CCRN-K™** is for nurses whose non-bedside practice influences patients, nurses and/or organizations to have a positive impact on acutely and/or critically ill adult, pediatric or neonatal patients.
- **PCCN®** is for progressive care nurses providing direct bedside care to acutely ill adult patients.
- **CNML** is for nurse managers and leaders; offered in partnership with AONE (American Organization of Nurse Executives) Credentialing Center.

**Subspecialty Certifications**

- **CMC®** is for certified nurses providing direct bedside care to acutely and/or critically ill adult cardiac patients.
- **CSC®** is for certified nurses providing direct bedside care to acutely and/or critically ill adult patients during the first 48 hours after cardiac surgery.

**Advanced Practice Consensus Model-Based Certifications**

- **ACNPC-AG®** is for the adult-gerontology acute care nurse practitioner educated at the graduate level.

  The ACCNS credentials are for clinical nurse specialists educated at the graduate level to provide care across the continuum from wellness through acute care:

  - **ACCNS-AG®** is for the adult-gerontology clinical nurse specialist.
  - **ACCNS-P®** is for the pediatric clinical nurse specialist.
  - **ACCNS-N®** is for the neonatal clinical nurse specialist.

**Advanced Practice Certifications**

- **ACNPC®** is for the acute care nurse practitioner educated at the graduate level to provide care to adult patients.
- **CCNS®** is for the acute/critical care clinical care specialist educated at the graduate level to provide care to adult, pediatric or neonatal patients.

We continually seek to provide quality certification programs that meet the changing needs of nurses and patients. Please visit www.certcorp.org > Documents and Handbooks, or call (800) 899-2226 for more information about the above certifications.

Thank you for your commitment to patients and their families and to becoming certified.
Please direct inquiries to:

AACN Certification Corporation, 101 Columbia, Aliso Viejo, CA 92656-4109
(800) 899-2226 • Fax (949) 362-2020 • APRNcert@aacn.org

Please include your AACN customer number with all correspondence to AACN Certification Corporation.
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The following information can be found in the Certification Exam Policy Handbook online at www.certcorp.org:
Documents and Handbooks:
  • AACN Certification Programs
  • Name and Address Changes
  • Confidentiality of Exam Application Status
  • Testing Site Information
  • Exam Scheduling and Cancellation
  • On the Day of Your Exam
  • Duplicate Score Reports
  • Recognition of Certification
  • Use of Credentials
  • Denial of Certification
  • Revocation of Certification
  • Review and Appeal of Certification Eligibility
The adult-gerontology acute care nurse practitioner (ACNP) is a registered nurse educated at the graduate level to provide advanced nursing care across the continuum of healthcare services to meet the specialized physiologic and psychologic needs of adult-gerontology patients with complex acute and/or chronic health conditions. This care is continuous and comprehensive. The population in acute care practice includes acutely ill patients experiencing episodic illness, exacerbation of chronic illness or terminal illness.

The practice of the adult-gerontology ACNP is not defined by setting but rather is determined by the acuity of patient needs. The ACNP practices in any setting in which patient care requirements include complex monitoring and therapies, high-intensity nursing intervention or continuous nursing vigilance within the range of high-acuity care. While ACNPs may traditionally practice in acute care and hospital-based settings, including subacute care, emergency care and intensive care, the continuum of acute care services spans the geographic settings of home, ambulatory care, urgent care and rehabilitative care.

ACNPC-AG® Registered Service Mark

ACNPC-AG is a registered service mark and denotes certification as an adult-gerontology acute care nurse practitioner as granted by AACN Certification Corporation. Adult-gerontology ACNPs who have not achieved ACNPC-AG certification or whose ACNPC-AG certification has lapsed are not authorized to use the ACNPC-AG credential.

Purpose Statement

To ensure public protection, new graduate acute care nurse practitioners are required to pass a psychometrically sound exam that measures the advanced practice competencies needed to perform safely and effectively as a newly licensed, entry-level acute care nurse practitioner.

State boards of nursing may use the results of AACN Certification Corporation APRN exams as a factor in making APRN licensure determinations.

Exam Structure and Content

The ACNPC-AG exam is three-and-a-half (3 ½) hours and consists of 175 multiple-choice items. Of the 175 items, 150 are scored. The remaining 25 items are used to gather statistical data on item performance for future exams.

- Seventy-three percent (73%) of the items test clinical judgment related to nursing care of the adult-gerontology patient population (young adults, older adults and frail elderly).
- The remaining items test non-clinical judgment knowledge required for adult-gerontology ACNP practice.

The ACNPC-AG exam is based on a study of practice, also known as a job analysis, that is conducted at least every five years, which validates the knowledge, skills and abilities required for safe and effective advanced practice as an entry-level adult-gerontology ACNP.

The test plan, which provides an outline of exam content, is developed by an expert ACNP panel based on the results of the study of practice. The organizing framework for all AACN Certification Corporation exams is the AACN Synergy Model for Patient Care. Please refer to pages 11-12 for more about the Synergy Model.

Following are the major content dimensions of the adult-gerontology ACNP (ACNPC-AG) exam, which are part of the test plan:

- **Patient Care Problems** validated by the job analysis as those regularly encountered by the entry-level ACNP.
  
  Refer to pages 13-14 for the list of patient care problems.
Skills and Procedures validated by the job analysis as those pertinent to the entry-level ACNP. In addition to classifying exam items according to the specified patient care problems and related validated competencies, items may require an understanding of skills and procedures pertinent to adult-gerontology ACNP practice.

Refer to page 15 for the list of skills and procedures.


Refer to pages 16-19 for a complete listing of the ACNPC-AG Validated Competencies.

Integrated Concepts

To meet criteria for regulatory sufficiency, APRN certification exams must test national practice standards and core competencies for the role and patient population(s) being certified. The ACNPC-AG exam incorporates the following standards and competencies:

• AACN Synergy Model for Patient Care. American Association of Critical-Care Nurses.


Score Reporting

For purposes of evaluating educational programs, exam pass/fail status and a breakdown of exam scores by content area will be reported to the candidate’s program director.

The board of nursing in the state(s) in which you have applied for or intend to apply for licensure will also be notified of your pass/fail status.
ACNPC-AG EXAM ELIGIBILITY

Licensure
Current unencumbered licensure as an RN or APRN in the United States is required.

- An unencumbered license is not currently being subjected to formal discipline by any state board of nursing and has no provisions or conditions that limit the nurse’s practice in any way.

Candidates and ACNPC-AG-certified nurses must notify AACN Certification Corporation within 30 days if any restriction is placed on their RN or APRN license.

Education
Completion of a graduate-level advanced practice education program that meets the following requirements:

1. The program is through a college or university that offers a CCNE or ACEN accredited master’s degree or higher in nursing with a concentration as an adult-gerontology ACNP. The program must include in-depth competencies to care for the entire adult population (young adults, older adults and frail elderly).

2. The program has demonstrated compliance with the National Task Force Criteria for Evaluation of Nurse Practitioner Programs (NTFC).

3. Both direct and indirect clinical supervision must be congruent with current AACN and nursing accreditation guidelines.

4. The curriculum includes but is not limited to:
   a. Biological, behavioral, medical and nursing sciences relevant to practice as an adult-gerontology ACNP, including advanced pathophysiology, pharmacology and physical assessment
   b. Legal, ethical and professional responsibilities of the ACNP
   c. Supervised clinical practice relevant to the specialty of acute care

5. The curriculum meets the following criteria:
   a. The curriculum is consistent with competencies of adult-gerontology ACNP practice.
   b. The instructional track/major has a minimum of 500 supervised clinical hours overall.
   c. All clinical hours are focused on the direct care of acutely ill adult-gerontology patients and completed within the U.S.
   d. The supervised clinical experience is directly related to the knowledge and all role components of the adult-gerontology ACNP.

Didactic coursework with content specific to care of acutely ill adult-gerontology patients is required.

- The program director of your education program must complete an Educational Eligibility Form (see page 23).
- You must submit originals of all graduate-level educational transcripts showing degree(s) conferred. A secure, electronic transcript may be provided by your school directly to APRNcert@aacn.org.
- If you are making up clinical or didactic coursework to meet ACNPC-AG exam eligibility, courses must be completed in a post-graduate certificate or DNP program.

Questions regarding eligibility should be emailed to APRNcert@aacn.org. Applicants determined to be ineligible for the ACNPC-AG exam will have their application fee refunded.

AACN Certification Corporation may adopt additional eligibility requirements at its sole discretion. Any such requirements will be designed to establish, for purposes of ACNPC-AG certification, the adequacy of a candidate’s knowledge in the care of acutely ill adult-gerontology patients.

Please check with the board of nursing in the state(s) in which you (intend to) practice to confirm that AACN Certification Corporation is recognized as an authorized certification body for advanced practice licensure or designation.
**ACNPC-AG APPLICATION FEES**

<table>
<thead>
<tr>
<th>Service</th>
<th>AACN Members</th>
<th>Nonmembers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACNPC-AG Computer-Based Exam</strong></td>
<td>$245</td>
<td>$350</td>
</tr>
<tr>
<td><strong>ACNPC-AG Retest</strong></td>
<td>$200</td>
<td>$305</td>
</tr>
<tr>
<td><strong>ACNPC-AG Renewal by Exam</strong></td>
<td>$200</td>
<td>$305</td>
</tr>
</tbody>
</table>

Payable in U.S. funds. A $15 fee will be charged for a returned check.

If you are determined to be ineligible for ACNPC-AG certification your application fee will be refunded.
Please ensure that AACN has your current contact information on record. Updates may be made online at www.aacn.org/myaccount or emailed to info@aacn.org. For name changes, please call AACN Customer Care at (800) 899-2226.

1. Receive email notification of receipt of application
   - AACN will send you an email confirming that your application has been received and forwarded to a Certification Specialist for evaluation.
     - Evaluation can take 1 to 4 weeks - depending on whether we need to contact your school to request additional information to determine your eligibility.

2. Receive application approval email
   - AACN will send an email notification of your approval to test.

3. Receive scheduling information email
   - AACN’s testing service (AMP) will send an email and mail a postcard to eligible candidates within 5 to 10 days after application approval that will include:
     - A toll-free number and online instructions to schedule your testing appointment
     - The 90-day period during which you must schedule and take the exam
     - Your exam identification number, which is your unique AACN customer number preceded by the letter “C” (e.g., C00123456)
     - If you do not receive an email or postcard from AMP within 10 days of application approval, please contact AACN Customer Care at (800) 899-2226.

4. Schedule the exam
   - Upon receipt of AMP’s email or postcard:
     - Confirm that you are scheduled for the correct certification exam
     - Promptly schedule your exam appointment for a date and time that falls within your 90-day testing window
   - Testing is offered twice daily, Monday through Friday, at 9 a.m. and 1:30 p.m. Saturday appointments are available at some testing centers.
   - To locate one of the more than 175 AMP testing centers within the U.S., visit www.goAMP.com.

5. Sit for the exam
   - Upon completion of computer-based exams, results with a score breakdown will be presented on-site.
   - Results of paper and pencil exams will be mailed to candidates 2 to 4 weeks following paper testing.
   - Successful candidates will receive their wall certificate within 2 to 4 weeks of passing the exam.
ACNPC-AG CERTIFICATION RENEWAL

Renewal Period

ACNPC-AG certification is granted for a period of 5 years. Your certification period begins the first day of the month in which the ACNPC-AG exam is passed and ends 5 years later, e.g., October 1, 2014 through September 30, 2019.

The purpose of certification renewal is to enhance continued competence. Renewal notifications will be mailed and emailed to you starting 4 months before your scheduled ACNPC-AG renewal date.

You are responsible for renewing your certification even if you do not receive a renewal notice.

Eligibility

To maintain a current ACNPC-AG certification, renewal must be completed prior to your certification expiration date.

To reobtain certification you would need to meet the current ACNPC-AG initial exam eligibility requirements (based on educational preparation) and pass the ACNPC-AG exam.

Eligible candidates for ACNPC-AG renewal must hold a current, unencumbered U.S. RN or APRN license. An unencumbered license has not been subjected to formal discipline by any state board of nursing during the 5-year certification period and has no provisions or conditions that limit the nurse’s practice in any way.

ACNPC-AG-certified nurses must notify AACN Certification Corporation within 30 days if any restriction is placed on their RN or APRN license.

Renewal Options

At renewal time you may seek certification renewal by one of 3 options:

- Option 1 - 1,000 Practice Hours and 150 CE Points
- Option 2 - 1,000 Practice Hours and Exam
- Option 3 - 150 CE Points and Exam

For those renewing by CE Points, 25 pharmacology CEs are required.

Nurse practitioners should contact AACN Certification Corporation regarding eligible practice hours in Canada.

For complete information, refer to the ACNPC-AG Renewal Handbook online at www.certcorp.org > Documents and Handbooks
The ACNPC-AG certification program is based on the AACN Synergy Model for Patient Care. The basic tenet of the Synergy Model is that optimal patient outcomes can be produced through the synergistic interaction between the needs of the patient and the competencies of the nurse. AACN Certification Corporation is committed to ensuring that certified nursing practice is based on the needs of patients. Integration of the AACN Synergy Model for Patient Care into AACN Certification Corporation’s certification programs puts emphasis on the patient and says to the world that patients come first.

The Synergy Model creates a comprehensive look at the patient. It puts the patient in the center of nursing practice. The model identifies nursing’s unique contributions to patient care and uses language to describe the professional nurse’s role. It provides nursing with a venue that clearly states what we do for patients and allows us to start linking ourselves to, and defining ourselves within, the context of the patient and patient outcomes.

NOTE:
AACN certification exams do not test for knowledge of the Synergy Model or its terminology; this is the theoretical model within which the tests have been designed.

**Patient Characteristics**

The Synergy Model encourages nurses to view patients in a holistic manner rather than the “body systems” medical model. Each patient and family is unique, with a varying capacity for health and vulnerability to illness. Each patient, regardless of the clinical setting, brings a set of unique characteristics to the care situation. Depending on where they are on the healthcare continuum, patients may display varying levels of the following characteristics:

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resiliency</td>
<td>Capacity to return to a restorative level of functioning using compensatory/coping mechanisms; the ability to bounce back quickly after an insult.</td>
</tr>
<tr>
<td>Vulnerability</td>
<td>Susceptibility to actual or potential stressors that may adversely affect patient outcomes.</td>
</tr>
<tr>
<td>Stability</td>
<td>Ability to maintain a steady-state equilibrium.</td>
</tr>
<tr>
<td>Complexity</td>
<td>Intricate entanglement of two or more systems (e.g., body, family, therapies).</td>
</tr>
<tr>
<td>Resource Availability</td>
<td>Extent of resources (e.g., technical, fiscal, personal, psychological and social) the patient/family/community bring to the situation.</td>
</tr>
<tr>
<td>Participation in Care</td>
<td>Extent to which patient/family engages in aspects of care.</td>
</tr>
<tr>
<td>Participation in Decision Making</td>
<td>Extent to which patient/family engages in decision making.</td>
</tr>
<tr>
<td>Predictability</td>
<td>A characteristic that allows one to expect a certain course of events or course of illness.</td>
</tr>
</tbody>
</table>

**FOR EXAMPLE:**

A healthy, uninsured, 40-year-old woman undergoing a pre-employment physical could be described as an individual who is (a) stable (b) not complex (c) very predictable (d) resilient (e) not vulnerable (f) able to participate in decision making and care, but (g) has inadequate resource availability.

On the other hand: a critically ill, insured infant with multisystem organ failure can be described as an individual who is (a) unstable (b) highly complex (c) unpredictable (d) highly resilient (e) vulnerable (f) unable to become involved in decision making and care, but (g) has adequate resource availability.

continued
### Nurse Characteristics

Nursing care reflects an integration of knowledge, skills, abilities and experience necessary to meet the needs of patients and families. Thus, nurse characteristics are derived from patient needs and include:

<table>
<thead>
<tr>
<th>Nurse Characteristics</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Judgment</strong></td>
<td>Clinical reasoning, which includes clinical decision making, critical thinking and a global grasp of the situation, coupled with APRN skills acquired through a process of integrating formal and informal experiential knowledge and evidence-based guidelines. Includes differential diagnosis.</td>
</tr>
<tr>
<td><strong>Advocacy/Moral Agency</strong></td>
<td>APRN activities that create a compassionate, supportive and therapeutic environment for patients and staff, with the aim of promoting comfort and healing and preventing unnecessary suffering. Includes but is not limited to vigilance, engagement and responsiveness of caregivers, including family and healthcare personnel. Content in this category includes pain management, infection control, risk assessment and the nurse practitioner/patient relationship.</td>
</tr>
<tr>
<td><strong>Caring Practices</strong></td>
<td>APRN activities that create a compassionate, supportive and therapeutic environment for patients and staff, with the aim of promoting comfort and healing and preventing unnecessary suffering. Includes but is not limited to vigilance, engagement and responsiveness of caregivers, including family and healthcare personnel. Content in this category includes pain management, infection control, risk assessment and the nurse practitioner/patient relationship.</td>
</tr>
<tr>
<td><strong>Collaboration</strong></td>
<td>Working with others (e.g., patients, families, healthcare providers) in a way that promotes/encourages each person's contributions toward achieving optimal/realistic patient/family goals. Includes initiating referrals, providing consultation and the coordination of inter- and intradisciplinary teams to develop or revise plans of care focused on patient and/or family concerns.</td>
</tr>
<tr>
<td><strong>Systems Thinking</strong></td>
<td>Body of knowledge and tools that allow the APRN to manage whatever environmental and system resources exist for the patient/family and staff, within or across healthcare and non-healthcare systems. Includes analysis and promotion of cost-effective resource utilization that results in optimal patient outcomes.</td>
</tr>
<tr>
<td><strong>Response to Diversity</strong></td>
<td>The sensitivity to recognize, appreciate and incorporate differences into the provision of care. Differences may include, but are not limited to, cultural differences, spiritual beliefs, gender, race, ethnicity, lifestyle, socioeconomic status, age and values.</td>
</tr>
<tr>
<td><strong>Facilitation of Learning</strong></td>
<td>The ability to facilitate learning for patients/families, nursing staff, other members of the healthcare team and community. Includes both formal and informal facilitation of learning.</td>
</tr>
<tr>
<td><strong>Clinical Inquiry</strong></td>
<td>The ongoing process of questioning and evaluating practice and providing informed practice. Creating practice changes through research utilization and experiential learning.</td>
</tr>
</tbody>
</table>

Nurses become competent within each continuum at a level that best meets the fluctuating needs of their population of patients. More compromised patients have more severe or complex needs, requiring nurses to have advanced knowledge and skills in an associated continuum.

**FOR EXAMPLE:**

If the gestalt of a patient were stable but unpredictable, minimally resilient and vulnerable, primary competencies of the nurse would be centered on clinical judgment and caring practices (which includes vigilance). If the gestalt of a patient were vulnerable, unable to participate in decision making and care, and inadequate resource availability, the primary competencies of the nurse would focus on advocacy and moral agency, collaboration and systems thinking.

Although all eight competencies are essential for contemporary nursing practice, each assumes more or less importance depending on a patient’s characteristics. *Synergy results when a patient’s needs and characteristics are matched with the nurse’s competencies.*

The certification program is also based on the three spheres of influence in which NPs operate: Patient, Nurses/Nursing Practice and Organizations/Systems. A sphere of influence identifies the focus of practice activities and target outcomes associated with the area. The certification exam is based on the activities performed by NPs in connection with the eight nurse characteristics in the context of the three spheres of influence.

Based on the most recent AACN Certification Corporation job analysis completed in 2011, the test plans for AACN certification exams reflect the Synergy Model as well as findings related to nursing care of the patient population studied, e.g., ACNP practice in the care of adult-gerontology patients.

For more information about the AACN Synergy Model for Patient Care, visit www.certcorp.org.
TEST PLAN
ADULT-GERONTOLOGY ACUTE CARE NURSE PRACTITIONER

I. CLINICAL JUDGMENT (73%)

A. Cardiovascular (21%)
   1. Acute coronary syndromes
   2. Acute inflammatory disease (e.g., myocarditis, endocarditis, pericarditis)
   3. Cardiac surgery
   4. Cardiac tamponade
   5. Cardiac trauma (blunt and penetrating)
   6. Cardiogenic shock
   7. Cardiomyopathies (e.g., hypertrophic, dilated, restrictive, idiopathic)
   8. Decompensated heart failure
   9. Dyslipidemia
  10. Dysrhythmias
  11. Heart failure
  12. Hypertension
  13. Hypertensive crisis
  14. Peripheral vascular insufficiency (e.g., acute arterial occlusion, carotid artery stenosis, endarterectomy, peripheral stents and femoral popliteal bypass)
  15. Pulmonary edema
  16. Ruptured or dissecting aneurysm
  17. Structural heart defects and diseases (e.g., acquired and congenital)

B. Pulmonary (12%)
   1. Acute pulmonary embolus
   2. Acute respiratory distress syndrome (ARDS, to include acute lung injury or ALI)
   3. Acute respiratory failure
   4. Air-leak syndromes (e.g., pneumothorax, pulmonary interstitial emphysema [PIE], pneumopericardium, pneumomediastinum)
   5. Aspirations
   6. Asthma and reactive airway disease
   7. Chronic lung disease
   8. Exacerbation of chronic lung disease
   9. Obstructive sleep apnea
  10. Pulmonary hypertension
  11. Pulmonary infections
  12. Thoracic surgery (e.g., lung contusion, fractured ribs, hemothorax, lung reduction surgery, pneumonectomy, lobectomy, tracheal surgery)
  13. Thoracic and pulmonary trauma and injuries
  14. Upper airway obstruction

C. Endocrine (3%)
   1. Adrenal disorders
   2. Diabetes insipidus
   3. Diabetes mellitus
   4. Diabetic ketoacidosis/hyperglycemic hyperosmolar nonketotic coma (HHNK)
   5. Hyperglycemia
   6. Hypoglycemia
   7. Syndrome of inappropriate secretion of antidiuretic hormone (SIADH)
   8. Thyroid disorders

D. Musculoskeletal (3%)
   1. Functional issues (e.g., immobility, debility, falls, gait disorders)
   2. Infections
   3. Osteoarthritis
   4. Fractures

E. Hematology/Immunology/Oncology (4%)
   1. AIDS/HIV
   2. Anemia
   3. Autoimmune diseases
   4. Blood group incompatibilities
   5. Coagulopathies (e.g., thrombocytopenia)
   6. Leukemias and tumors

F. Neurology (7%)
   1. Encephalopathy
   2. Head and brain trauma and injury
   3. Hydrocephalus
   4. Increased intracranial pressure

continued
TEST PLAN
ADULT-GERONTOLOGY ACUTE CARE NURSE PRACTITIONER

F. Neurology (cont’d)
5. Intracranial and intraventricular hemorrhage
6. Neurologic infectious diseases
7. Neuromuscular disorders
8. Seizure disorders
9. Space-occupying lesions
10. Spinal cord injury
11. Stroke
12. Vascular malformation

G. Gastrointestinal (5%)
1. Abdominal trauma
2. Acute GI hemorrhage
3. Bowel infarction/obstruction/perforation
4. Gallbladder disease
5. Gastroesophageal reflux
6. Gastrointestinal infectious diseases
7. GI motility disorders
8. GI surgeries
9. Hepatic failure and coma
10. Hepatitis
11. Malnutrition
12. Nausea and vomiting
13. Pancreatitis

H. Renal/Genitourinary (4%)
1. Acute renal failure
2. Chronic renal failure
3. Electrolyte imbalances
4. Fluid volume imbalances
5. Infections (e.g., UTI, PID, STDs)
6. Prostate problems

I. Integumentary (2%)
1. Infectious skin disorders
2. Pressure ulcers
3. Wounds (surgical and non-surgical)

J. Multisystem (9%)
1. Compartment syndrome
2. Distributive shock (e.g., anaphylaxis, neurogenic)
3. Hypovolemic shock
4. Hypoxic ischemic encephalopathy
5. Infectious diseases (e.g., congenital, viral, bacterial, hospital-acquired)
6. Multisystem trauma
7. Pain diagnosis and treatment
8. Sensory impairment (e.g., hearing loss)
9. Systemic inflammatory response syndrome (SIRS)/sepsis/septic shock/multiple organ dysfunction syndrome (MODS)
10. Toxic exposure
11. Toxic ingestions and inhalations

K. Psychosocial/Behavioral/Cognitive Health (3%)
1. Age-related developmental issues
2. Anxiety disorders (e.g., PTSD, OCD, fears, phobias)
3. Delirium
4. Dementia
5. Medical nonadherence
6. Mood disorders (e.g., depression)
7. Risk-taking behaviors (e.g., tobacco, unprotected sex)
8. Substance abuse
9. Suicidal behavior

II. PROFESSIONAL CARING AND ETHICAL PRACTICE
A. Advocacy/Moral Agency (3%)
B. Caring Practices (6%)
C. Collaboration (5%)
D. Systems Thinking (3%)
E. Response to Diversity (2%)
F. Clinical Inquiry (4%)
G. Facilitation of Learning (3%)

The sum of these percentages is not 100 due to rounding.
Order of content does not necessarily reflect importance.
TEST PLAN
ADULT-GERONTOLOGY ACUTE CARE NURSE PRACTITIONER
SKILLS AND PROCEDURES

In addition to classifying exam items according to the specified patient care problems and identifying related underlying competencies on the following pages, items may require an understanding of skills and procedures pertinent to the adult-gerontology acute care nurse practitioner. If applicable to assessment of knowledge of the patient care problem, the following skills and procedures may be incorporated within items.

**Cardiovascular**

- Interpret ECG rhythms
- Interpret 12-lead ECGs
- Determine lead selection for ECGs
- Interpret hemodynamic values
- Interpret noninvasive hemodynamic values
- Manage transcutaneous (external) pacemakers
- Insert temporary transvenous pacemakers
- Manage temporary transvenous pacemakers
- Manage permanent transvenous pacemakers
- Manage epicardial pacemakers
- Manage implantable cardioverter defibrillators (ICDs)
- Remove intra-aortic balloon catheter
- Manage cardiac assist devices (e.g., RVAD, BVAD, LVAD, ECMO)
- Direct cardiopulmonary resuscitation
- Insert arterial pressure catheters
- Insert central venous pressure catheters
- Insert pulmonary artery pressure catheters
- Adjust pulmonary artery pressure catheters
- Interpret echocardiograms
- Perform elective cardioversion
- Disconnect pacer wire
- *Interpret stress tests
- *Perform pericardiocentesis

**Pulmonary**

- Order nasal/facial CPAP/BiPAP
- Initiate mechanical ventilation
- Manage mechanical ventilation
- Wean mechanical ventilation
- Perform thoracentesis
- Insert chest tube
- Disconnect chest tube
- Interpret pulmonary function tests
- Perform intubation

**Endocrine**

- Perform rapid ACTH stimulation test

**Neurology**

- Perform lumbar puncture
- *Remove epidural ICP monitoring device
- *Remove subdural ICP monitoring device
- *Remove intraventricular ICP monitoring device
- *Remove cerebral oxygenation monitoring device
- *Monitor SiO₂ results

**Gastrointestinal**

- *Perform paracentesis

**Renal/Genitourinary**

- Initiate renal replacement therapies
- *Perform pelvic exams

**Integumentary**

- Suture wounds
- Provide wound care
- Incise and drain abscesses

**Multisystem**

- Interpret diagnostic imaging
- Provide nonpharmacologic interventions for pain
- Prescribe pharmaceutical interventions
- Prescribe durable medical equipment

Skills and procedures noted with an asterisk (*) may not be widely performed but are a significant part of practice for those who perform them. As such, if these skills or procedures are incorporated in an item, knowledge about the skill or procedure would be limited to its purpose and would not require in-depth knowledge of the performance of the skill or procedure.
Clinical Judgment

- Provide health promotion services
- Provide disease prevention services
- Provide health protection interventions
- Provide anticipatory guidance
- Provide counseling
- Promote a mutually respectful environment that enables nursing and other healthcare personnel to make optimal individual contributions and systems to function most effectively
- Incorporate community needs, strengths and resources into practice
- Apply principles of epidemiology and demography in clinical practice
- Demonstrate critical thinking and diagnostic reasoning skills in clinical decision making
- Obtain a health history from the patient supplemented by health information from collateral sources, including electronic health records and databases, as needed, e.g., with cognitively impaired, sensory impaired or non-self-disclosing patients, observing ethical and legal standards of care
- Perform and accurately document a pertinent, comprehensive and focused physical examination, demonstrating knowledge about developmental, age-related and gender-specific variations
- Differentiate among normal, variations of normal and abnormal findings, including those associated with development and aging in acute, critical and complex illness
- Employ age-appropriate screening and diagnostic strategies
- Assess the impact of an acute, critical and/or chronic illness or injury and the patient’s health promotion needs, social support, and physical and mental health status
- Assess the impact of an acute, critical and/or chronic illness or injury in relation to activity level, mobility and immobility, cognition, decision making capacity, pain, skin integrity, nutrition, sleep and rest patterns, sexuality, immunization status, neglect/abuse, substance use/abuse, quality of life, family/social/educational relationships, genetic risks, health risk behaviors, safety and advanced care planning preferences
- Conduct a pharmacologic assessment addressing polypharmacy, drug interactions and other adverse events, over-the-counter, complementary alternatives, and the ability to obtain, purchase, self-administer and store medications safely and correctly
- Assess the effect of complex acute, critical and chronic illness, disability and/or injury on the individual’s functional status, independence, physical and mental status, social roles and relationships, sexual function and well-being, and economic or financial status
- Assess the complex acutely, critically and/or chronically ill patient for urgent and emergent conditions, using both physiologically and technologically derived data to evaluate for physiologic instability and potential life-threatening conditions
- Analyze data to determine health status
- Perform invasive diagnostic tests
- Develop differential diagnosis
- Recognize the presence of comorbidities, their impact on presenting health problems, potential for rapid physiologic deterioration or life-threatening instability and the risk for iatrogenesis
- Diagnose complex acute, critical and chronic physical illnesses, including disease exacerbation and/or progression, multisystem health problems, associated complications and iatrogenic conditions
- Recognize common mental health and substance use or addictive disorder/disease, such as anxiety, depression and alcohol and drug use, in the presence of complex acute, critical and chronic illness and make appropriate referrals
- Confirm the clinical diagnosis

continued
TEST PLAN
ADULT-GERONTOLOGY ACUTE CARE NURSE PRACTITIONER
VALIDATED COMPETENCIES

Clinical Judgment (cont’d)

- Prioritize differential diagnoses based on the interpretation of available data and the complexity and severity of the patient’s condition
- Collect data in an ongoing process in recognition of the dynamic nature of acute, critical and complex chronic illness
- Formulate an evidence-based plan of care integrating knowledge of the rapidly changing pathophysiology of acute or critical illness
- Individualize the plan of care to reflect the dynamic nature of the patient’s condition, developmental and life transitions, and patient’s and family’s needs
- Implement interventions to support and stabilize the patient with a rapidly deteriorating physiologic condition, including the application of basic and advanced life support and other invasive interventions or procedures to regain physiologic stability
- Perform therapeutic and diagnostic interventions appropriate to acute and critical health problems, such as suturing, wound debridement, line and tube insertion, and lumbar puncture
- Manage interventions that utilize technological devices to monitor and sustain physiological function through ordering, performing, interpreting or supervising
- Manage diagnostic strategies and therapies to monitor and sustain physiological function and ensure patient safety including, but not limited to, ECG interpretation, radiograph interpretation, respiratory support, hemodynamic monitoring and nutritional support
- Prescribe medications within legal authorization while acknowledging and monitoring for adverse drug outcomes and polypharmacy, especially in high-risk and vulnerable populations such as women of childbearing age, adults with comorbidities and older adults
- Assess interactive and synergistic effects of pharmacologic and nonpharmacologic interventions
- Determine the need for transition to a different level or type of care based on an assessment of an individual’s acuity, stability, resources and need for assistance
- Counsel the patient on the use of complementary/alternative therapies
- Prescribe therapeutic devices
- Evaluate outcomes of care
- Communicate effectively using professional terminology, format and technology
- Provide for continuity of care
- Demonstrate evidence-based approaches to care
- Communicate personal strengths and professional limits
- Coordinate inter- and intra-disciplinary teams to develop or revise plans of care focused on patient and/or family needs and concerns
- Manage the health/illness status over time
- Perform invasive procedures

Advocacy/Moral Agency

- Deliver safe care
- Empower patients and families to act as own advocate across the continuum of healthcare including in complex, acute healthcare environments
- Facilitate patient and family decision making regarding complex acute, critical and chronic illness treatment decisions, end-of-life care, right to refuse treatment, and organ donation in a manner that ensures informed decisions
- Advocate for the individual’s and family’s rights regarding healthcare decision making such as emancipation, guardianship, durable power of attorney, healthcare proxy, advance directives and informed consent, within ethical and legal standards
- Act ethically
- Evaluate implications of health policy
- Participate in policy-making activities
- Demonstrate leadership to achieve optimal care outcomes for the acutely ill adult-gerontology population in practice, policy and other venues
- Maintain confidentiality and privacy

continued
Caring Practices

- Attend to the patient’s responses to changes in health status and care
- Foster a trusting relationship with the individual, family and other caregivers that facilitates discussion of sensitive issues, such as suicide prevention, self-injury, sexually related issues, substance use/abuse, risk-taking behavior, driving safety, independence, finances, violence, abuse and mistreatment, prognosis, care transitions, changes in levels of care and palliation
- Provide comfort and emotional support
- Apply principles for behavioral change
- Preserve the patient’s control over decision making
- Negotiate a mutually acceptable plan of care
- Respect the patient’s inherent worth and dignity
- Use self-reflection to further a therapeutic relationship
- Maintain professional boundaries
- Monitor, treat and implement prevention strategies in geriatric syndromes such as falls, loss of functional abilities, dehydration, delirium, depression, dementia, malnutrition, incontinence and constipation
- Promote safety and risk reduction through the use of interventions such as devices to promote mobility and prevent falls, cognitive and sensory enhancements, reduced urinary catheter use and restraint-free care
- Order and implement palliative and end-of-life care in collaboration with the patient, family and members of the multidisciplinary healthcare team
- Manage pain and sedation for patients with complex chronic, acute and critical illness
  - Monitor and evaluate the patient’s pain and sedation response
  - Change the plan of care according to patient reaction and treatment goals
  - Prescribe nonpharmacologic interventions*

*Pharmacologic interventions fall under Clinical Judgment

- Provide culturally appropriate and effective communication that supports therapeutic relationships with individuals, families and caregivers facing acute onset or exacerbations of complex chronic physical and/or psychosocial conditions
- Design and implement interventions to prevent or reduce risk factors that contribute to
  - decline in physical or mental function
  - impaired quality of life
  - social isolation
  - excess disability

Collaboration

- Participate as a member of healthcare teams
- Collaborate with other healthcare providers
- Consult with and make appropriate referrals to other healthcare providers
- Function in a variety of roles
- Advocate for the advanced practice role of the nurse
- Promote the adult-gerontology acute care nurse practitioner and other advanced practice nursing roles
- Work collaboratively with a variety of health professionals to promote stabilization and restoration of health in complex acute, critical and chronic illness
- Recognize the limits of one’s education, clinical expertise and scope of practice, collaborate with colleagues and recognize when to refer patients appropriately

Systems Thinking

- Incorporate access, cost, efficacy and quality when making care decisions
- Demonstrate current knowledge of healthcare system financing as it affects delivery of care
- Analyze organizational structure, functions and resources to affect delivery of care

continued
Systems Thinking (cont’d)

- Prescribe and perform diagnostic, pharmacologic, non-pharmacologic and therapeutic interventions consistent with the adult-gerontology acute care nurse practitioner’s education, practice and state regulatory requirements as authorized within the scope of practice

- Apply business strategies

- Analyze data generated through quality improvement and safety (QSEN) initiatives to identify opportunities to enhance care and the care delivery system

- Participate in all aspects of community health programs

- Advocate for policies that positively affect healthcare

- Negotiate legislative change to influence healthcare delivery systems

- Coordinate comprehensive care in and across care settings for patients who have acute and chronic care needs

- Analyze challenges to optimal care created by the competing priorities of patients, payers, providers and suppliers

- Negotiate system barriers to care and to providing care coordination

- Participate in the design, development and evaluation of current and evolving healthcare services to optimize care and outcomes for the adult-gerontology population

Clinical Inquiry

- Monitor quality of care

- Assume accountability for practice

- Engage in continuous quality improvement and patient safety initiatives

- Accept personal responsibility for professional development

- Incorporate current technology

- Advance the profession through mentoring, writing, publishing and presenting

- Participate in the design, implementation and evaluation of evidence-based, age-appropriate professional standards and guidelines for care

- Contribute to knowledge development for improved care of the adult-gerontology acute care population

Facilitation of Learning

- Assess the patient’s educational needs

- Create an effective learning environment

- Design a personalized plan for learning

- Provide health education

- Coach the patient for behavioral changes

- Evaluate the outcomes of patient education

- Educate individuals, families, caregivers and groups regarding strategies to manage the interaction among normal development, aging, and mental and physical disorders

- Adapt teaching-learning approaches based on physiological and psychological changes, age, developmental stage, readiness to learn, health literacy, the environment and resources

Response to Diversity

- Prevent personal biases from interfering with the delivery of quality care

- Provide culturally sensitive care

- Assist patients of diverse cultures to access quality care

- Assist patients and families to meet their spiritual needs

- Address cultural, spiritual and ethnic influences that potentially create conflict among individuals, families, staff and caregivers

- Incorporate patient’s spiritual beliefs into care

- Incorporate cultural preferences, values, health beliefs and behaviors into the management plan

- Develop strategies to reduce the impact of biases including ageism and sexism on healthcare policies and systems
1. Following cardiac surgery, a patient in sinus rhythm suddenly converts to the following rhythm. The patient is asymptomatic. Treatment should include
A. sedation and cardioversion.
B. diltiazem (Cardizem) infusion.
C. emergency defibrillation.
D. digoxin (Lanoxin).
*(Clinical Judgment – Cardiovascular)*

2. Following a 10-foot fall, a young adult presents on a backboard with a c-collar on. The patient had an initial loss of consciousness at the scene and was lucid on arrival, but LOC is rapidly deteriorating. The right pupil is round and reactive, but the left is dilated and unresponsive to light. The ACNP should first suspect
A. a basilar skull fracture.
B. a subdural hematoma.
C. an epidural hematoma.
D. a cerebellar herniation.
*(Clinical Judgment – Neurology)*

3. A patient is readmitted due to a suspected pulmonary embolus. Home medications include metformin (Glucophage). Which of the following available diagnostic methods would be indicated?
A. V/Q scan
B. spiral CT
C. pulmonary angiogram
D. venous doppler study
*(Clinical Judgment – Pulmonary)*

4. The ACNP should recognize that a toxic exposure to
A. methanol is best treated with a sodium bicarbonate infusion.
B. salicylates is best treated with n-acetylcysteine (Mucomyst).
C. benzodiazepines is best treated with hemodialysis.
D. carbon monoxide is best treated with hyperbaric oxygen.
*(Clinical Judgment – Multisystem)*

5. When assessing the weaning ability of a 75-year-old COPD patient who is being mechanically ventilated, it is important for the ACNP to consider that elderly patients
A. have a greater respiratory reserve than younger patients.
B. have equivalent PaO₂/FiO₂ ratios compared to younger patients.
C. tend to breathe faster and shallower than younger patients.
D. tend to have a lower A-a gradient compared to younger patients.
*(Clinical Judgment – Pulmonary)*

6. While discharging a patient following knee replacement surgery, the patient experiences a new onset episode of chest pain lasting 10 minutes. The cardiac biomarkers and 12-lead ECG are unremarkable. The patient is currently pain free and anxious to go home. The ACNP should
A. discharge the patient and have them follow up with their primary care provider.
B. hold discharge and repeat cardiac biomarkers in 8 hours.
C. discharge the patient and schedule an appointment for a cardiology follow-up.
D. hold discharge and schedule an emergent cardiac catheterization.
*(Clinical Judgment – Cardiovascular)*

7. Concerns are raised about a unit’s increasing utilization of blood products. The ACNP is asked to participate on a newly formed inter-professional team. Upon agreeing to participate, the ACNP should first
A. verify that the meeting schedule would align with the ACNP’s schedule.
B. ensure that the ACNP’s suggestions will be adopted.
C. find out who else will be participating.
D. identify the goals assigned to the team.
*(Collaboration)*

Answers:
1. B
2. C
3. A
4. D
5. C
6. B
7. D


Many references are available through AACN; visit www.aacn.org/bookstore.

More current versions may be available.

**PUBLISHER CONTACTS:**

AACN – (800) 899-2226
American Heart Association – (800) 242-8721
ASHSP, Special Publishing – (301) 657-3000
Elsevier (including Mosby, W. B. Saunders and Hanley & Belfus) – (800) 545-2522
F. A. Davis – (800) 323-3555
Jones & Bartlett – (800) 832-0034
Lippincott Williams & Wilkins – (800) 638-3030
McGraw-Hill – (877) 833-5524
Springer Publishing – (877) 687-7476
Wiley-Blackwell Publishing – (800) 216-2522
## AACN PRODUCTS FOR ACNPC-AG EXAM PREPARATION

<table>
<thead>
<tr>
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<th>Item #</th>
</tr>
</thead>
<tbody>
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<td>* <strong>Online</strong> Adult-Gerontology Acute Care NP Certification Review Course: Individual Purchase. For additional information go to <a href="http://www.aacn.org/ondemand">www.aacn.org/ondemand</a>.</td>
<td>ACNPCOD</td>
</tr>
<tr>
<td>* Practice ACNPC-AG Exam Questions. (2013). AACN Certification Corporation. 50 questions.</td>
<td>200705</td>
</tr>
<tr>
<td>Advanced Practice Nursing of Adults in Acute Care. (2012). Whetstone-Foster, J. &amp; Prevost, S. 752 pages.</td>
<td>128100</td>
</tr>
<tr>
<td>Critical Care Nursing of Older Adults. (2010). Foreman, M., Fulmer, T. &amp; Milisen, K. 448 pages.</td>
<td>304012</td>
</tr>
</tbody>
</table>

*Included at no charge with purchase of ACNPC-AG exam.

For more details and to place an order, visit www.aacn.org/marketplace, or call AACN Customer Care at (800) 899-2226, weekdays between 7:30 a.m. and 4:30 p.m. Pacific Time.
# EDUCATIONAL ELIGIBILITY FORM

**ACNPC-AG Certification for Adult-Gerontology Acute Care Nurse Practitioners**

*To be completed by Program Director and returned to AACN Certification Corporation.*

## CANDIDATE NAME

<table>
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<tr>
<th>Last</th>
<th>First</th>
<th>MI</th>
<th>Maiden</th>
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</thead>
</table>

## CANDIDATE EMAIL ADDRESS

---

## ADULT-GERONTOLOGY ACUTE CARE NURSE PRACTITIONER PROGRAM INFORMATION

### SCHOOL NAME

---

### SCHOOL ADDRESS

---

### PROGRAM TYPE

- [ ] Adult-Gerontology Acute Care NP
- [ ] Other (specify)

### DEGREE AWARDED

- [ ] Master’s
- [ ] DNP
- [ ] Post-Graduate Certificate

### PROGRAM START DATE (MM/DD/YY)

### GRADUATION DATE (MM/DD/YY)

### PROGRAM DESCRIPTION

- *for time period applicant was in program*

<table>
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<tr>
<th>DIDACTIC</th>
<th>Course Number(s)</th>
<th>☑ If Transfer Credit</th>
<th>Course Type*</th>
<th>Number of Credit Hours</th>
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<tr>
<td>Advanced Pathophysiology</td>
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<tr>
<td>Advanced Pharmacology</td>
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<tr>
<td>Advanced Physical Assessment</td>
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<tr>
<td>Health Promotion/Maintenance</td>
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<tr>
<td>Adult-Gerontology Acute Care</td>
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<th>Course Type*</th>
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<th>Number of Clinical Hours</th>
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<tr>
<td>Acutely Ill Adult-Gerontology Patient Care</td>
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</tbody>
</table>

If adult clinical hours and gerontology clinical hours are completed in separate courses, list “A” (adult) or “G” (gerontology) next to the Course Number.

---

*Course Type:*

- [ ] D: Didactic
- [ ] C: Clinical
- [ ] D/C: Didactic/Clinical

Clinical hour total below should not include hours from the 3Ps.

---

Total number of supervised clinical clock hours directly related to the knowledge and all roles of the adult-gerontology acute care nurse practitioner: _______

---

My signature on this form attests to the fact that at the time of graduation the above-named applicant met the program requirements noted above. I understand that AACN Certification Corporation may contact me, if needed, for clarification.

---

**Program Director Signature**

<table>
<thead>
<tr>
<th>Phone</th>
<th>Date</th>
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**Printed Name**

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<tr>
<th>Email</th>
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This completed form with an original signature may be submitted to AACN Certification Corporation via mail to:

**AACN Certification Corporation, 101 Columbia, Aliso Viejo, CA 92656.**

Alternatively, the form may be scanned/emailed directly from the school to APRNcert@aacn.org.
ACNPC-AG EXAM APPLICATION

1. REGISTRATION INFORMATION

PLEASE PRINT CLEARLY. PROCESSING WILL BE DELAYED IF INCOMPLETE OR NOT LEGIBLE. LEGAL NAME AS IT APPEARS ON YOUR GOVERNMENT-ISSUED ID CARD IS REQUIRED FOR EXAM.

AACN CUSTOMER: RN/APRN LICENSE:

<table>
<thead>
<tr>
<th>Number</th>
<th>Exp. Date</th>
<th>Number</th>
<th>State</th>
<th>Exp. Date</th>
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LEGAL NAME:

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<th>Last</th>
<th>First</th>
<th>MI</th>
<th>Maiden</th>
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HOME ADDRESS:

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<thead>
<tr>
<th>City</th>
<th>State</th>
<th>ZIP</th>
</tr>
</thead>
</table>

EMAIL: HOME PHONE:

EMPLOYER NAME: BUSINESS PHONE:

EMPLOYER ADDRESS:

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>ZIP</th>
</tr>
</thead>
</table>

2. AACN MEMBERSHIP

I would also like to join/renew/extend my AACN membership at this time and select member pricing for my exam fees:

(check one box only)

☐ 1-year AACN membership...............................................................$78
☐ 2-year AACN membership............................................................$148
☐ 3-year AACN membership............................................................$200

AACN membership includes nonrefundable $12 and $15 one-year subscriptions to Critical Care Nurse® and the American Journal of Critical Care®, respectively. AACN dues are not deductible as charitable contributions for tax purposes, but may be deducted as a business expense in keeping with Internal Revenue Service regulations.

Member exam fee ($245) + 1-year Membership ($78) = Savings of $27 over Nonmember fee

3. EXAM FEES

ACNPC-AG Exam | Initial Exam Fee | Retest Fee
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<tr>
<td>AACN Member</td>
<td>Nonmember</td>
<td>AACN Member</td>
</tr>
<tr>
<td>Check one box only</td>
<td>□ $245</td>
<td>□ $350</td>
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☐ Check this box if you’ve attached a request and supporting documentation for special testing accommodations.

4. PAYMENT INFORMATION

– application must be accompanied by payment

☐ Check or money order attached – payable to AACN Certification Corporation. U.S. funds only.

Bill my credit card ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover Card

Credit Card #: Exp. Date (mm/yy)

Name on Card ___________________________ Signature ___________________________

Amount Billed $ ______ Signature ___________________________

☐ Please do not include my name on lists sold to other organizations.

Please complete pages 2 and 3 of application.
5. DEMOGRAPHIC INFORMATION
Check one box in each category. Information used for statistical purposes and may be used in eligibility determination.

Primary Area Employed
- Acute Hemodialysis Unit (21)
- Burn Unit (13)
- Cardiac Rehabilitation (26)
- Cardiac Surgery/OR (36)
- Cardiovascular/Surgical ICU (09)
- Catheterization Lab (22)
- Combined Adult/Ped. ICU (23)
- Combined ICU/CCU (01)
- Coronary Care Unit (03)
- Crit. Care Transport/Flight (17)
- Direct Observation Unit (39)
- Emergency Dept. (12)
- General Med./Surg. Floor (18)
- Home Care (25)
- Intensive Care Unit (02)
- Interventional Cardiology (31)
- Long-Term Care (27)
- Medical Cardiology (34)
- Medical ICU (04)
- Medical Surgical ICU (35)
- Neonatal ICU (06)
- Neuro./Neurosurgical ICU (10)
- Oncology Unit (19)
- Operating Room (15)
- Outpatient Clinic (29)
- Pediatric ICU (05)
- Private Practice (32)
- Progressive Care Unit (16)
- Recovery Room/PACU (14)
- Respiratory ICU (08)
- Stepdown Unit (30)
- Subacute Care (28)
- Surgical ICU (07)
- Tele-ICU (37)

Primary Position Held
- Academic Faculty (07)
- Acute Care Nurse Practitioner (09)
- Administrator/V.P. (43)
- Bedside/Staff Nurse (01)
- Charge Nurse (45)
- Clinic Nurse (40)
- Clinical Coordinator (44)
- Clinical Director (04)
- Clinical Nurse Specialist (08)
- Elected Official (12)
- Home Healthcare Nurse (41)
- In-service/Staff Devel. Instructor (06)
- Legal Nurse Consultant (47)
- Manager (03)
- Nurse Anesthetist (02)
- Nurse Educator (46)
- Nurse Midwife (13)
- Nurse Practitioner (05)
- Physician (16)
- Physician Assistant (17)
- Researcher (18)
- Respiratory Therapist (19)
- Social Worker (20)
- Unit Coordinator (22)
- Other - specify below
- (99)

Highest Nursing Degree
- Associate's Degree
- Bachelor's Degree
- Diploma
- Doctorate
- Master's Degree
- Other - specify below
- (99)

Primary Type of Facility in Which Employed
- College/University (08)
- Community Hospital (Nonprofit) (01)
- Community Hospital (Profit) (02)
- County Hospital (07)
- Federal Hospital (05)
- HMO/Managed Care (12)
- Home Health (13)
- Military/Government Hospital (04)
- Non-Academic Teaching Hosp. (14)
- Private Industry (11)
- Registry (10)
- Self-Employed (09)
- State Hospital (06)
- Travel Nurse (15)

6. COMPLETE ADDITIONAL FORMS
- Complete the ACNPC-AG Honor Statement (3rd page of application) on page 27.
- Have the Educational Eligibility Form on page 23 completed and signed by the program director of your school. The school may email the completed form directly to AACN.

7. SUBMIT APPLICATION AND DOCUMENTATION
Attach the following to this application:
- Completed Educational Eligibility Form with original signature of program director
- Original transcript(s) of all graduate-level coursework showing degree(s) conferred. A secure, electronic transcript may be provided by your school directly to APRNcert@aacn.org.

Submit with payment to:
AACN Certification Corporation, 101 Columbia, Aliso Viejo, CA 92656-4109.

Retest applications may be faxed to (949) 362-2020.

NOTE: Allow 1 to 4 weeks* from the date received by AACN Certification Corporation for application processing.

*If school must be contacted to verify eligibility or application is incomplete, processing may be delayed.

Questions? Please visit www.certcorp.org, email APRNcert@aacn.org or call us at (800) 899-2226.
ACNPC-AG EXAM HONOR STATEMENT

PROCESSING WILL BE DELAYED IF INCOMPLETE OR NOT LEGIBLE.

PLEASE PRINT CLEARLY.

NAME: ________________________________

Last                        First                        MI

AACN CUSTOMER #: ________________________________

I hereby apply for ACNPC-AG certification. I have read and understand the exam policies and eligibility requirements as documented in the ACNPC-AG Exam Handbook and the Certification Exam Policy Handbook.

I acknowledge that certification depends upon successful completion of the specified requirements. I authorize AACN Certification Corporation to contact my graduate nursing program to verify my educational eligibility for the ACNPC-AG certification exam.

LICENSURE: I possess a current unencumbered U.S. RN or APRN license. My ____________________________ (state) nursing license ____________________________ (number) is due to expire ____________________________ (date). An unencumbered license is not currently being subjected to formal discipline by any state board of nursing and has no provisions or conditions that limit my practice in any way. I understand that I must notify AACN Certification Corporation within 30 days if any restriction is placed on my RN or APRN license in the future.

AUDIT: I understand that my certification application is subject to audit, and failure to respond to or pass an audit will result in revocation of certification.

ETHICS: I understand the importance of ethical standards and agree to act in a manner congruent with the ANA Code of Ethics for Nurses.

NON-DISCLOSURE OF EXAM CONTENT: Submission of this application indicates my agreement to keep the contents of the exam confidential and not disclose or discuss specific exam content with anyone except AACN Certification Corporation. Per AACN Certification Corporation policy, sharing of exam content is cause for revocation of certification.

SCORE REPORTING: I authorize AACN Certification Corporation to release my ACNPC-AG exam pass/fail status to the ____________________________ state board(s) of nursing, to which I have applied or intend to apply for advanced practice licensure. I understand that my ACNPC-AG exam pass/fail status and a breakdown of my exam scores by content area will be reported to the program director of my school.

To the best of my knowledge, the information contained in this application and all supporting documentation is accurate and submitted in good faith. My signature below indicates I have read this honor statement and meet the requirements as outlined.

Applicant’s Signature: ________________________________ Date: ________________________________

Please allow 1 to 4 weeks from the date received by AACN Certification Corporation for processing of your application.
CERTIFICATION
GENERAL TESTING AND RENEWAL HANDBOOK

EFFECTIVE DATE: OCTOBER 22, 2013
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ABOUT THIS HANDBOOK

This handbook provides important information about the ANCC policies, processes, and procedures for those interested in taking an ANCC certification examination and an overview of information on renewing certification.

More detailed ANCC testing and renewal information, including information related to specific exams—such as test content outline, references, and sample practice questions—can be obtained at ANCC’s Web site at www.nursecredentialing.org or by calling 1.800.284.2378.

ABOUT ANCC EXAMS

Most ANCC certifications are accredited by the Accreditation Board for Specialty Nursing Certification (ABSNC, formerly the American Board of Nursing Specialties) or the National Commission for Certifying Agencies (NCCA).

The U.S. Department of Veterans Affairs, Centers for Medicare & Medicaid (CMS), and health insurance companies recognize ANCC certifications. ANCC APRN certifications are accepted by the National Council of State Boards of Nursing (NCSBN) and state boards of nursing.

ANCC certification examinations are in a multiple-choice format, and some examinations include test item types such as drop and drag, hot spot, and multiple responses. Examinations are offered at domestic and international test centers. They are designed to objectively assess entry-level competency in advanced practice registered nursing (APRN) and validate nursing practice specialties.

All ANCC programs are administered without discrimination on the basis of age, color, creed, disability, gender, health status, lifestyle, nationality, race, religion, or sexual orientation.

WHAT IS CERTIFICATION?

Certification is the process by which a nongovernmental agency or an association grants recognition to an individual who has met certain predetermined qualifications. Certification can be used for entry into practice, validation of competence, recognition of excellence, and/or for regulation. It can be mandatory or voluntary. Certification validates an individual’s knowledge and skills in a defined role and clinical area of practice, based on predetermined standards.

HOW ARE EXAMS DEVELOPED?

The ANCC certification examinations are developed consistent with the technical guidelines recommended by the American Educational Research Association, the American Psychological Association, and the National Council on Measurement in Education (AERA, APA, NCME; 1999). Additionally, the ANCC certification examinations meet accreditation standards of the Accreditation Board for Specialty Nursing Certification (ABSNC) and the National Commission for Certifying Agencies (NCCA).

Each examination is developed by ANCC in cooperation with a Content Expert Panel (CEP) composed of carefully selected experts in the field. CEPs analyze the professional skills and abilities from role delineation studies, which provide the evidence for the test content outline (also called the test blueprint).
Test questions or “items” are written by certified nurses in their discipline who have received training by ANCC staff in writing items. The items are then reviewed by the CEP with the ANCC staff and pilot-tested to ensure validity and psychometric quality before being used as scored items on the actual examinations. ANCC adheres to a variety of guidelines during the development of items to ensure that the items are appropriate for the specialty and certification level (e.g., APRN vs. generalist). This includes editing and coding items, referencing items to the approved test content outlines and reference books, and screening items for bias and stereotypes.

Items for the examinations are selected that reflect the test content outline and item distributions. The validity and reliability of the exams are monitored by ANCC staff. Certification examinations are updated approximately every three years.

**HOW ARE EXAMS SCORED?**

ANCC reports its examinees’ test score results as pass or fail. If an examinee fails, the score report includes diagnostic feedback for each of the major content areas covered on the examination.

ANCC examinations are criterion-referenced tests, which means that an examinee’s performance on the examination is not compared to that of other examinees in determining the examinee’s pass/fail status. In a criterion-referenced test, an examinee must achieve a score equal to or greater than the minimum passing score for the examination. The minimum passing score represents the absolute minimum standards that the examinee must achieve to demonstrate the ability to practice the profession safely and competently. With the guidance of a measurement expert (e.g., a psychometrician), a panel of subject matter experts in the nursing specialty sets the minimum passing score for each ANCC examination. In setting the minimum passing score, ANCC uses the Modified Angoff Method, which is well-recognized within the measurement field.

Each exam contains between 150 to 175 scored test items plus 25 pilot test items that do not count towards the final score. For specific information on the number of items each exam contains, please refer to the test content outline associated with that exam.

Scores on ANCC examinations are reported on a scale with a maximum possible score of 500. To pass the ANCC examination, an examinee must achieve a scale score of 350 or higher. Prior to conversion of an examinee’s score to this scale, the examinee’s raw score on the examination is determined, which is simply the number of test items that the examinee answered correctly (e.g., 105 out of 150). The raw score is then converted to a scale score, using a conversion formula.

For examinees who do not achieve a scale score of at least 350, the score report will show the scale score achieved, “fail” status, and diagnostic feedback for each of the content areas covered by the examination.

**The diagnostic feedback categories are:**

**LOW** The score you obtained for this content area is below an acceptable level. Substantial study of this content area is recommended prior to retaking the examination.

**MEDIUM** The score you obtained for this content area is marginally acceptable; however, further study of this content area is recommended.

**HIGH** The score you obtained for this content area is well above average; however, a review of this content area may be helpful to you prior to retaking the examination.

The diagnostic feedback is intended to identify content areas that contributed to a failing score. The purpose of the diagnostic feedback is to help failing candidates tailor their study for a future examination.

Please note, reporting the score in scale format does not affect the pass/fail status of a candidate. The pass/fail status is determined based on whether the candidate has correctly responded to the required number of items.
GENERAL REQUIREMENTS FOR INITIAL CERTIFICATION

You must meet all the eligibility requirements for the certification exam you are seeking to take. If you do not meet all the eligibility requirements when you apply, you will not be permitted to take a certification examination. The specific eligibility requirements for your certification are available at www.nursecredentialing.org/certification.aspx#specialty.

For exams that require academic transcripts for eligibility: transcripts must be original documents, in sealed envelopes directly from the university registrar’s office, and must include the degree-awarded date (degree-conferral date)*. Transcripts may be sent electronically directly from the university registrar’s office to aprnvalidation@ana.org.

*APRN certification candidates may be authorized to sit for the examination after all coursework is complete, prior to degree conferral. ANCC will retain the candidate’s exam result and will issue certification on the date the requested documents are received, all eligibility requirements are met, and a passing result is on file.

All practice requirements must have been met while holding an active registered nurse license in a U.S. state or territory or the professional, legally recognized equivalent in another country. Any hours of practice as a licensed practical nurse OR a licensed vocational nurse OR working outside of the nursing field do not qualify as part of the practice hour requirement. Practice hours may be either part of your employment or voluntary.

All fees must be paid at the time your application is submitted to ANCC. Applications received with insufficient funds delay the review of your application for eligibility and delay your ability to schedule and take a certification examination.

Applications received with missing documentation (including signatures) delay the review of your application for eligibility and delay your ability to schedule and take a certification examination.

SPECIAL TESTING ACCOMMODATIONS

The American Nurses Credentialing Center (ANCC) and its testing vendor make every effort to reasonably accommodate candidates with documented disabilities as defined by the Americans with Disabilities Act (ADA). If you have a disability as defined under the ADA, you must notify ANCC by submitting a report regarding your request from your physician or a qualified healthcare professional. The information must be on the physician’s or other qualified healthcare professional’s letterhead, typed, dated, and signed by the healthcare professional.

The report must document the following information in order to be considered:

▶ A specific diagnosis and date of your diagnosis
▶ Specific and current findings that support your diagnosis (relevant medical history, tests administered, date of the most current evaluation, within the last 3 years)
▶ A description of your substantial day-to-day functional limitations resulting from your stated disabilities
▶ Specific recommendations for your testing accommodation(s) including a detailed explanation of why the accommodation is needed. If the accommodation includes extra time, please indicate the amount of time requested.

Important Note: Additional information may be requested after a review of your information.
INTERNATIONAL TESTING

ANCC exams are available internationally. For test center locations, please visit www.prometric.com/ANCC.

▶ If you are licensed outside the US: Please have the RN license verified for equivalency by a credentials evaluation organization, such as WES or CGFNS prior to application.

▶ If you were educated outside the US and the exam requires a degree (NON-APRN only)*: Please have degrees verified for equivalency by a credentials evaluation organization, such as WES or CGFNS prior to application.

▶ If you are an APRN (Clinical Nurse Specialist and Nurse Practitioner) applicant: Candidates must meet all current eligibility requirements. This includes: hold a master’s, postgraduate, or doctoral degree from program accredited by the Commission on Collegiate Nursing Education (CCNE) or the National League for Nursing Accrediting Commission (NLNAC). ANCC does not accept individual course-by-course evaluations of programs.

*This applies to nurses licensed both inside and outside the US.

Contact the ANCC Customer Care Center at 1.800.284.2378 or 301.628.5000 or certification@ana.org for details or if you have additional questions.

TEST SITES

You can locate exam test sites, addresses, and phone numbers at www.prometric.com/ANCC.

PREPARING FOR THE CERTIFICATION EXAMINATION

Each certification exam has a test content outline, reference list, and sample questions available for free to prepare you for the examination.

Study Plan

Approximately 6 months before you plan to take your exam, develop a study plan. This could include self-study, finding a study buddy or group, taking a review course, taking an online narrated review course, reviewing current textbooks and articles, or other methods. The key is to have a study plan and follow through with it.

Test Content Outlines

You can find a complete test content outline on the ANCC Web site. The test content outline includes the number of questions for each domain of practice and identifies the areas that are included on the examination.

Sample Questions

To practice, you can answer sample questions that are similar to those on the actual examination but do not represent the full range of content or levels of difficulty. There is no time limit associated with reviewing the sample questions, and you can review them as many times as you wish, for free.

References

For additional reading, you might want to look over the list of authoritative texts. While the list is not all-inclusive, it may act as a guide to help you prepare.
RECORDS MANAGEMENT AND RETENTION

ANCC Record Retention Policy is to collect and maintain all records necessary to fulfill the legal requirements for record retention and disposition. This includes all information submitted in support of initial certification and certification renewal. The names of candidates for a test or names of individuals failing a test or individual test scores are not released.

Certificant and Candidate information and certification test results are maintained indefinitely in the ANCC Certification database, Personify. The records are password protected and accessible only to staff involved with the certification process. Information from hard copy applications or supporting documents is manually entered into Personify and the document imaged for storage on a password protected secure site. Supporting documents include but are not limited to transcripts, licenses, membership cards, or written communications.

ANCC maintains records of submitted hard copy documentation for a minimum of five years. In addition, ANCC maintains electronic records of all customer activity and online applications within its database system.

MAINTAINING YOUR CONTACT INFORMATION

Change of Address
If you have a change to any of your contact information, please call us at 1.800.284.2378 or update “Access My Account” on www.nursecredentialing.org to inform us of the change, so we can ensure you receive all correspondence.

Change of Legal Name
Requests for legal name change due to marriage, divorce, or a court-approved legal name change must be sent in writing with a copy of the marriage certificate, divorce decree, or court-approved legal name change document. For clinicians who have applied in the past under one name and are currently applying under a different name, please note that ANCC requires copies of legal name change documents before proceeding with the application review process.

Send a request for legal name change, by mail, with accompanying documentation to:

ANCC Certification
ATTN: Name Change
8515 Georgia Avenue, Suite 400
Silver Spring, MD 20910

If you are currently certified and have already been issued a wall certificate but wish to order a duplicate wall certificate with your new legal name, please send a completed Duplicate Wall Certificate Order Form: www.nursecredentialing.org/Certification/CertificationPolicies/WallOrderCertificationForm.aspx with payment, to:

ANCC Certification
ATTN: Duplicate Wall Certificate
8515 Georgia Avenue, Suite 400
Silver Spring, MD 20910
SCHEDULING A TEST DATE

All ANCC examinations are computer-based and offered through the Prometric™ testing system. The testing system is an international network of testing centers. Additional information about the location of test centers, including the address and telephone number of each center, is available at www.prometric.com/ANCC.

After you receive an Authorization to Test Notice, you will have 90 days to make an appointment with Prometric to take the test. You cannot schedule an appointment prior to receiving your Authorization to Test Notice or after the expiration date on your Authorization to Test Notice. Schedule as soon as possible for your preferred date and time. If you wait until near the end of the eligibility period, you may have to accept any appointment available.

You can schedule an appointment online at the Prometric Registration Web site at www.prometric.com/ANCC or by calling the Prometric Registration Center at 1.800.350.7076.

There is a processing fee, payable to Prometric, to reschedule or cancel an appointment if the change is made less than 30 days and up to noon eastern time the fifth business day before your appointment.

Extending the 90-Day Testing Window

In the event that you are unable to test during the 90-day testing window, you may, one time only, request a new 90-day testing window. This new testing window must begin less than 6 months from the last day of the initial testing window; requests should be received after the end of the initial 90-day testing period. If you do not test during your new testing period, you will need to reapply as a new applicant, meet any new eligibility requirements, and pay all applicable fees. To make this request, please complete the Testing Window Re-Assignment Request form at www.nursecredentialing.org/ReAssignmentRequestForm.aspx.

THE DAY OF THE EXAM

What to Bring

When you arrive at the test center, you must present one form of acceptable identification from the list below:

- Driver's license issued by the Department of Motor Vehicles in one of the 50 states in the United States, the District of Columbia, or one of the U.S. territories
- State identification issued by the Department of Motor Vehicles in one of the 50 states in the United States, the District of Columbia, or one of the U.S. territories
- Passport
- U.S. military identification

Your identification must be valid (unexpired) and contain both your signature and a recent (no more than 10 years old) photograph. All identification must be in English and signed in English. If you are currently serving in the U.S. military and are testing outside the United States, the District of Columbia, and the U.S territories, then you are required to provide valid U.S. military identification. If your valid military identification does not have both your signature and a recent photograph, you will need to provide additional identification that meets the aforementioned requirements. The only identification acceptable in test centers outside of the United States, the District of Columbia, and the U.S. territories is a valid passport for candidates who cannot provide valid U.S. military identification.

If you do not bring one form of acceptable identification (possibly two forms of acceptable identification, if testing outside of the United States) listed above, you can substitute an official ID that does not contain a signature plus a secondary ID that does contain a signature.
If you do not bring acceptable ID, you will not be admitted to the test and your eligibility window will end. You will be required to submit additional documentation and fees in order to schedule a new testing date. Please contact ANCC for details.

It is not necessary for you to bring the ANCC Authorization to Test Notice to the test center, and it will not be counted as an acceptable form of identification.

**Restrictions**

Do NOT bring any of these items to the testing center: books, paper, calculators, tissues, food, drink, water, notes, cell phone, PDA, or personal electronics of any kind.

Use of a cellular phone or other electronic or other devices is strictly prohibited and will result in dismissal from the examination and additional actions by ANCC.

No documents or notes of any kind may be removed from the examination room, and such removal may result in dismissal from the examination and additional actions by ANCC.

No questions concerning the test content may be asked during the examination, and asking questions may result in dismissal from the examination and additional actions by ANCC.

**Time of Arrival**

You must arrive at the test center at least 15 minutes before your scheduled appointment time. If your arrival is so late that your session would interfere with the test center schedule, you will be considered a “no show” and your testing window will automatically expire. You will be required to submit additional documentation and fees in order to schedule a new testing date. Please contact ANCC for details.

**Length of Time for Exam**

Total time for most exams is 4 hours, which includes time set aside for check-in, instructions, and a practice session on the computer. The actual time allotted for most tests is 3.5 hours. Please refer to the individual certification page at [www.nursecredentialing.org](http://www.nursecredentialing.org) for the total time allotted for your exam. Before starting the actual test, you may take a practice session that allows you to become familiar with the computer system.

After finishing the test, you will be asked to complete a brief survey before leaving the testing center. Completing this survey provides feedback to ANCC for quality improvement initiatives.

Any issues that occur at the test site that affect test performance must be reported before leaving the test center. These issues must be reported to the proctor before leaving the test center. Please also call the Prometric Customer Care hotline at 1.800.350.7076 and ANCC at 1.800.284.2378 to discuss concerns that affected your test experience.

**Rules for Taking ANCC Exams**

- Sufficient time has been provided for you to respond to all questions. You are advised not to spend an inordinate amount of time on individual questions until you have had an opportunity to respond to every question. Time is not intended to be a factor in the examination.

- There is no penalty for guessing; you are encouraged to respond to every examination question. Computer-based exams DO allow you to mark questions you are unsure about and go back to them later.
▶ All instructions given by the proctor must be followed in order to ensure proper processing of your examination results.

▶ All candidates will be checked-in at the test site prior to being admitted to the examination room. You are required to place all personal possessions in a designated area.

▶ All ANCC exams are “closed book.” Books, paper, calculators, PDAs, cell phones, or electronic or other devices or resources are not allowed. Test center administrators will issue scratch paper and pencils that must be turned in at the end of the test session. Failure to follow these instructions can result in your scores being revoked and may prohibit you from retesting or taking other ANCC certification examinations.

▶ No test materials, documents, or memoranda of any sort may be removed from the examination room or retained. You may not copy any test questions or make any notes regarding the content of the examination. If you attempt to do so, your results will be invalidated and you may be prohibited from retesting or taking any other ANCC certification.

▶ No food or drink, including water, may be taken into the testing room. You may leave the testing room to use the restroom or get a drink of water, but you will need to sign out according to the instructions that will be explained at the test site. Your testing time will not be increased to accommodate a break. If you have a medical condition and cannot comply with this rule, you must apply for special testing accommodations.

▶ Please verify that you have been given the correct examination that you are eligible to take. Check the title and examination code on the cover/screen of the examination to make sure they match with the information the testing agency sent you. If you fail to take the correct examination, your score will be invalid.

▶ You may not ask questions concerning content of the examination during the examination period.

▶ During the examination, you must not give help to or receive help from others. Proctors are required to report any incident in which there is evidence of irregular behavior. Any such reports could result in the invalidation of your test scores and/or other sanctions.

▶ Additional testing center regulations are published on the Prometric Web page at www.prometric.com/TestTakers/FAQs/Regulations.htm.

▶ Confidentiality: You will be required to sign a confidentiality agreement; by signing it you agree not to release any details regarding the exam questions, including giving written or verbal information about the test questions to colleagues, faculty, etc. Violation of that agreement can result in loss of certification and liability for civil penalties and damages.

**Complete Withdrawal from an Exam**
Requests for permanent withdrawal must be received by ANCC before the expiration of the assigned 90-day eligibility period. You must cancel any previously scheduled appointments with Prometric in order to not be charged the full test fee. An administrative fee and any special fees are nonrefundable. If you decide to apply for certification again, you must complete a new application, pay fees, and meet all eligibility requirements in effect at the time at which you reapply.

Send a written request for withdrawal to:

ANCC  
ATTN: Exam Withdrawal  
8515 Georgia Ave, Suite 400  
Silver Spring, MD 20910-3492
AFTER THE EXAM

Test Results
All computer-based exams offer on-site testing results. This means you will receive a copy of your test results before you leave the test center. If you do not receive a copy of your results at the center, please call ANCC at 1.800.284.2378.

To protect candidates’ privacy and ensure no misinterpretations occur, test results are not released by telephone, fax, or email for any reason.

Your certification start date is the date you successfully completed the exam.*

*Please note: if your application is pending evidence of graduation/degree conferral, ANCC will retain your exam result and will issue certification and provide services described below on the date the requested documents are received and all eligibility requirements are met.

Your certificate and ANCC pin are mailed to you approximately 8 weeks after you have successfully completed the exam. You will also receive an official letter from ANCC with your specific 5-year certification period.

Verification of Certification
Request your one free verification of certification at www.nursecredentialing.org/certification/verificertification.aspx.

Additional verifications of certification can also be ordered from this site. ANCC does not automatically send verification to your state board of nursing or employer. Please request the verifications you need.

Exam Scoring
Test results are pass or fail. If you fail, your score report will include diagnostic information for each content area of the test.

Retesting
If you do not pass the examination you may retest after 60 days from the date you last tested. You may not test more than three times in any 12-month period. All candidates who retest must submit a retest application and meet eligibility requirements in effect when the retest application is submitted. ANCC can require additional supporting documentation to determine eligibility.

You can obtain a copy of the Retest Application at www.nursecredentialing.org/Certification/CertificationPolicies/RetestApplication.aspx or call Customer Care at 1.800.284.2378 for a copy of the application. You are required to retake the entire examination.
RENEWING YOUR CERTIFICATION

As an ANCC board certified professional, you must meet specified requirements in order to maintain and renew your certification every 5 years. The purpose of certification renewal is to provide evidence that you have continued to expand your professional knowledge to demonstrate evidence of continual competence in your certification specialty. It also allows you to continue to use your ANCC credentials.

The current renewal requirements are available at www.nursecredentialing.org/RenewalRequirements.aspx.

Helpful Hints:

▶ Visit the ANCC Web site on a regular basis to download the most current renewal requirements. Certification renewal criteria can change to reflect changes in practice or regulatory requirements.

▶ Develop a plan to show evidence of continual competence requirements for certification renewal.

▶ Provide ANCC with any changes to your contact information including a preferred email address.

▶ Maintain an active registered nurse license.

Warning: There is no grace period and no backdating. Certification renewal applications received after the certification expiration date will have a renewal period beginning with the date of approval and will therefore incur a gap in the certification dates. When there is a gap in certification dates, ANCC cannot backdate a certification renewal to meet regulatory, reimbursement, or other requirements for practice. You will need to check with your state licensing board, your employer, and/or the agency that is reimbursing your services to determine if you can continue to practice and/or receive reimbursement for services while you are in the process of reactivating your certification. If your employer or state board of nursing (SBON) requires certification in order for you to practice and your certification lapses, then the employer or SBON may no longer allow you to practice. Please submit the complete application when you renew—submitting a partial or incomplete renewal package will only delay approval of your certification renewal, resulting in a longer gap in the certification dates. All missing information will need to be reviewed and evaluated before a final decision is made.

CERTIFICATION REACTIVATION

A lapsed or expired ANCC certification may be reactivated. There is no “grace period.” The procedure to reactivate your ANCC certification depends on the amount of time that has lapsed since the certification expiration date and exam availability.

If it has been 2 years or less since your certification expired, you can reactivate your ANCC certification using a combination of professional development plus a minimum of 1,000 practice hours for your certification specialty within the past 5 years from the date you submit your application. If you do not have the practice hours, you can reactivate by professional development and retaking the exam, unless the exam is retired. You will need to pay the certification renewal fee plus the additional reactivation fee. Applications received without the correct fees and supporting documentation are considered incomplete and will delay the reactivation process.

If it has been more than 2 years since your certification expired and the exam is still offered, you can reactivate your ANCC certification by a combination of professional development plus testing for your certification specialty. You will need to pay the certification renewal fee plus the additional reactivation fee. Applications received without the correct fees and supporting documentation are considered incomplete and will delay the reactivation process. If your certification exam has been retired, this option is not available.

Retired Exam Warning: If an exam is retired, the only way to renew or reactivate is using professional development and clinical practice hours. Retired exams do not have a testing option.
You will need to check with your state licensing board, your employer, and the agency that is reimbursing your services to determine if you can continue to practice and/or receive reimbursement for services while you are in the process of reactivating your certification.

If you have multiple certifications that have expired, you will need to meet all certification renewal requirements for each expired certification and submit an application with the renewal fee and reactivation fee for each certification you are choosing to reactivate.

**Backdating of Certification**
When there is a gap in certification dates, ANCC cannot backdate a certification renewal to meet any regulatory or other requirements for practice. Certification renewal applications received after the certification expiration date will have a certification renewal period beginning with the date of approval and incur a gap in the certification dates. Submitting an incomplete certification renewal application (e.g., missing pages of the application, insufficient professional development documentation, expired license, missing signatures) will delay the evaluation of your application. All missing information will need to be received and evaluated before a final decision is made.

**EXPEDITED PROCESSING OF CERTIFICATION APPLICATIONS**

**Processing Time**
To shorten this processing time to 5 business days, complete the Certificate Expedite Review Request Form [pdf] and include the processing fee.

**Expedite Review Policy**
All certification applications are subject to the same review and must meet all ANCC eligibility requirements. No eligibility criteria will be waived. Furthermore, if an application is incomplete or ANCC requires additional information to determine eligibility for certification, the review of the application may not be completed within 5 days and additional delay may result.

**Fax Your Expedite Request**
Please fax (do not mail) your Certificate Expedite Review Request Form [pdf] to 301.628.5233. Mailing this form with your certification application will delay processing. If you both fax and mail it, you will be double-charged.

**Certification Verification**
ANCC encourages you to complete and fax the Verification Request Form [pdf] with the Certification Expedite Review Request Form to ensure the fastest verification processing time after your exam.

**APPEAL**
Please refer to www.nursecredentialing.org/CertificationAppealProcedure.aspx for the policy on Appeal.
DENIAL, SUSPENSION, AND REVOCATION OF CERTIFICATION

Certification can be denied, suspended, or revoked for cause, including but not limited to the following:

- Failing to complete or provide evidence of completion of the requirements for initial certification, certification renewal, or reactivation of certification
- Failure to maintain the required professional licensure
- Determination that initial certification or certification renewal was improperly granted or that certification was improperly reactivated
- Falsification or misstatement of information on any certification-related document
- Providing false or misleading information
- Misrepresentation
- Cheating or assisting others to cheat
- Causing, creating, or participating in an examination irregularity
- Assisting others to wrongfully obtain initial certification or to renew or reactivate certification
- Failure to comply with the scope and standards of practice in an area in which ANCC certification is held
- Failure to comply with the American Nurses Association's Code of Ethics for Nurses with Interpretive Statements
- Conduct unbecoming of the nursing profession

Reporting Revocation

- To Licensing Authorities: Suspension and revocation of certification is reported to licensing authorities.
- To Others: ANCC may report suspension or revocation of certification to employers, legal authorities, third-party payers, and other third parties, including but not limited to, law enforcement officers or agencies.

Misrepresentation of the ANCC Credential

If an individual is identified or recognized as misrepresenting themselves as certified when in fact they are not, the Commission on Certification has an obligation to take appropriate steps to protect the credential.

HOW TO DISPLAY YOUR NEW CREDENTIALS

The mission of the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA), is to promote excellence in nursing and health care globally through credentialing programs. ANCC’s internationally renowned credentialing programs certify and recognize individual nurses in specialty practice areas. It recognizes healthcare organizations that promote nursing excellence and quality patient outcomes, while providing safe, positive work environments. In addition, ANCC accredits health care organizations that provide and approve continuing nursing education. It also offers educational materials to support nurses and organizations as they work toward their credentials.

ANCC’s Certification Program enables nurses to demonstrate their specialty expertise and validate their knowledge to employers and patients. Through targeted exams that incorporate the latest nursing practice standards, ANCC certification empowers nurses with pride and professional satisfaction.
AGENDA ITEM: 10.2
DATE: October 9, 2014

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

REQUESTED BY: Trande Phillips, RN
Practice Committee Chair

BACKGROUND:
Request to bring back for review and vote on Frequently Asked Questions Regarding Nurse Practitioner Practice which is updated to include current laws and regulation changes that have occurred since the last update in 2004. The updated version includes Nursing Practice Act, (NPA) Section 2725.2 Dispensing of self-administered hormonal contraceptives by approved standardized procedures and Section 2725.4, Abortion by aspiration techniques; Requirements. NPA Section 2835.7 Authorized Standardized Procedures for ordering durable medical equipment, certifying disability in consultation with the physician pursuant to Unemployment Insurance Code, and plan of treatment or plan of care for home health in consultation with the physician. Other related changes that relate to nurse practitioner practice.

The Practice Committee at its August 7, 2014 meeting requested return of the update to Frequently Asked Questions Regarding Nurse Practitioner Practice to the October 2014 meeting for further review and discussion.

NEXT STEPS: Place on Board agenda.

FISCAL IMPACT, IF ANY: None

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

Practice Questions

Can a Registered Nurse dispense self-administered hormonal contraceptives and contraceptive injections?

Yes, a Registered Nurse may dispense self-administered hormonal contraceptives and may administer injections of hormonal contraceptives approved by the Federal Food & Drug Administration (FDA) in strict adherence to standardized procedures. Standardized procedure shall include minimum training requirements outlined in Section 2725.2 including examination that is consistent with Centers for Disease Control & Prevention (CDC) and the United States Medical Eligibility Criteria for Contraceptive Use guidelines, educating patients on medical standards for women’s health, referral criteria for patients with contraindications for hormonal contraceptives and follow-up visits, physician and surgeon supervision requirements, periodic review of nurses competence including frequency and person conducting the review. A patient seen exclusively by an RN for three consecutive years, prior to continuing dispensing or administering of hormonal contraceptives, shall be evaluated by physician, nurse practitioner, certified nurse midwife, or physician assistant.

(AB 2348 effective January 1, 2013)

Can a nurse practitioner with Schedule III-V furnishing privileges obtain Schedule II furnishing privileges to meet the rescheduling Hydrocodone Combination Products (HCP) legislation?

Yes, Nurse practitioners with Schedule III-V furnishing privileges already will need to take a continuing education course for Controlled Substances (CS) II Nurse Practitioners will need to complete a BRN-Approved CS II Authority Continuing Education Course.

Please mail to: Board of Registered Nursing
Advanced Practice Unit
1747 North Market Blvd., Suite 150
Sacramento, CA. 95834

Can a nurse practitioner function in the emergency department?

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

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

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

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

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

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

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

Can a nurse practitioner dispense medications? If so, what laws should the nurse practitioner know about to perform this function?
Business and Professions (B&P) Code Section 2725.1 allows registered nurses to dispense (hand to a patient) medication, except controlled substances, upon the valid order of a physician in primary, community and free clinics.

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

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

NPR-I-25 02/99
REV. 02/2003, 02/2004, 12/2004
Practice Committee, August 7 and 9, 2014
The mileage between the nurse practitioner and the supervising physician is not specifically addressed in the NPA. However, the physician should be within a geographical distance, which enables her/him to effectively supervise the nurse practitioner in the performance of the standardized procedure functions.

**Does the nurse practitioner need a physician supervisor who is approved by the medical board?**
No. Nurse practitioner laws do not require that the physician supervisor be approved by the Medical Board.

**I am a pediatric nurse practitioner and the physician wants me to start treating adults. I feel comfortable treating adults, so can we develop standardized procedures to cover this new population, diagnosis/treatments and furnishing?**
You must first be clinically competent to provide care to this new patient population. Clinically competent is defined in California Code of Regulations (CCR) Section 1480(c) as “…to possess and exercise the degree of learning, skill, care and experience ordinarily possessed and exercised by a member of the appropriate discipline in clinical practice.”. In this instance, you would have to demonstrate knowledge and skills comparable to those of an adult nurse practitioner. Clinical competence in this new specialty can be achieved by successful completion of theory course(s) and a supervised clinical practicum at an advanced level for the new patient population.

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

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

**Can I adopt my nurse practitioner program’s standardized procedures as my own when I go out into practice?**
Yes, if the nurse practitioner program’s standardized procedures meet the requirements of the Standardized Procedure Guidelines (CCR 1474) and are approved by the organized health care system including nursing, administration, and medicine.

**I am a geriatric nurse practitioner and work with a physician who has patients in a number of long term health care facilities. We have developed standardized procedures for the medical care I will be providing in these facilities. Do the standardized procedures have to be approved by each facility?**
Yes. Standardized procedures are agency specific and must be approved by nursing, administration and medicine in the agency in which they are used.

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

Delegation of duties to nurse practitioner in long-term health care facilities

Section 14111 Welfare and Institutions Code describes delegation of duties to nurse practitioners in long term health care facility.

(a) As permitted by federal law or regulation, for health care services provided in a long-term health facility that are reimbursed by Medicare, a physician and surgeon may delegate any of the following to a nurse practitioner:

1. Alternating visits required by federal law and regulation with a physician and surgeon.
2. Any duties consistent with federal law and regulation within the scope of practice of nurse practitioner so long as all the following conditions are met:
   (A) A physician and surgeon approves, in writing, the admission of the individual facility.
   (B) The medical care of each resident is supervised by a physician and surgeon.
   (C) A physician and surgeon performs the initial visit and alternate required visits.

(b) This section does not authorize benefits not otherwise authorized by federal law or regulation.

(c) All responsibilities delegated to a nurse practitioner pursuant to this section shall be performed under the supervision of the physician and surgeon and pursuant to standardized procedures among the physician and surgeon, nurse practitioner, and facility.

(d) No task that is required by federal law or regulated to be performed personally by a physician may be delegated to a nurse practitioner.

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

Added Stats 1992 ch 1048 § 2(AB 2849). Amended States 1994 ch 646 § 1(AB 2879)

**Tasks of nurse practitioner in long-term health care facility**

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

1. With respect to visits required by federal law or regulations, making alternating visits, or more frequent visits if the physician and surgeon is not available.
2. Any duty or task that is consistent with federal law or regulation within the scope of practice of nurse practitioners, so long as all of the following conditions are met:
   (A) A physician and surgeon approves, in writing, the admission of the individual to the facility.
   (B) The medical care of each resident is supervised by a physician and surgeon.
   (C) A physician and surgeon performs the initial visit and alternate required visits.

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

NPR-I-25 02/99
REV. 02/2003, 02/2004, 12/2004
Practice Committee, August 7 and 9, 2014
(c) All responsibilities undertaken by a nurse practitioner pursuant to this section shall be performed in collaboration with the physician and surgeon and pursuant to a standardized procedure among the physician and surgeon, nurse practitioner, and facility.

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

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

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

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

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

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

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

No. The nurse practitioner cannot furnish drugs and devices for the chiropractor’s patients. The furnishing law, BPC 2836.1, the drugs and devices are furnished or ordered by a nurse practitioner in accord with standardized procedures or protocols developed by the nurse practitioner and the supervising physician and surgeon, when the drugs or devices furnished or ordered are consistent with the practitioner educational preparation or for which clinical competency has been established and maintained.

**May I call myself a nurse practitioner once I have completed my nurse practitioner program?**

No. You cannot use the title nurse practitioner until you have been certified by the BRN as a nurse practitioner. Furthermore, registered nurses who use the title NP without BRN certification may subject their RN license to possible discipline.

**I am a nurse practitioner and I do not have a nurse practitioner furnishing number. Can I still “furnish” medications for patients using a standardized procedure?**

No. There is explicit statutory language, BPC 2836.1 related to furnishing of drugs and devices by nurse practitioners. The furnishing of drugs and devices by nurse practitioners is conditional on issuance of a furnishing number to the nurse.
practitioner by the BRN. The furnishing number must be included on all nurse practitioner prescriptions transmittal order forms.

**Nurse Practitioner and Medicare Information: Required Qualifications.**
A NP must be a registered professional nurse authorized by the State in which services are furnished by the NP in accordance with state law: Obtain Medicare billing privileges as a NP for the first time on or after January 1, 2003, and:
- Is certified as a NP by a recognized national certification body that has established standards for NPs; and has a Master’s degree in nursing or a Doctor of Nursing Practice (DNP) doctoral degree.
- Obtain Medicare billing privilege as a NP for the first time before January 1, 2003, and meets the certification requirements described above, or
- Obtained Medicare billing privileges as a NP for the first time before January 1, 2001

(Department of Health and Human Services, Centers for Medicare and Medicaid Services)

**Nurse Practitioner and Medi-Cal Billing: Required Qualifications.**
Section 14132.41 Welfare and Institutions Code (a) Services provided by a certified nurse practitioner shall be covered under this chapter to the extent authorized by federal law, and subject to utilization controls. The department shall permit a certified nurse practitioner to bill Medi-Cal independently for his or her services; the department shall make payments directly to the certified nurse practitioner. For purposes of this section, “certified” means a nationally board certified in a recognized specialty. (AB 1591 chapter 719 Chan medical: nurse practitioners)

**What are the provisions of the Therapeutic Abortion Act that nurse practitioners need to know?**
The Reproductive Privacy Act deletes the provisions of the Therapeutic Abortion Act, among other things including the name of the act. The changes are found in Business and Professions Code Section 2253 and allow registered nurses, certified nurse practitioners, and certified nurse midwives to assist in the performance of a surgical abortion and to assist in performance of a non-surgical abortion. (SB 1301 Kuehl, Chapter 385, effective September 5, 2002).

The nurse practitioner may perform or assist in performing functions necessary for non-surgical abortion by furnishing or ordering medications in accordance with approved standardized procedures. (SB 1301 Kuehl, Chapter 385 effective September 5, 2002)

**What does the nurse practitioner need to know about the January 1, 2014 legislation adding Section 2725.4 Abortion by aspiration techniques, requirements?**
Section 2725.4 states 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 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 Work-force Pilot Project (HWPP) No 171 through the Office of Statewide Health Planning and Development will be used. ( added Stats 2013 ch 662 § 2 (AB154), effective January 1, 2014)

**Can a nurse practitioner request and sign for complimentary samples of dangerous drugs and devices from a manufacture’s sales representative?**
Yes, the certified nurse practitioner and the certified nurse midwife may sign for the request and receipt of complimentary samples of dangerous drugs and devices identified in their standardized procedures or protocol that has been approved by the physician. (SB 1558, Figueroa Chapter 263 effective August 24, 2002).

Can the certified nurse practitioner and the certified nurse midwife supervise Medical Assistants?
Yes, the supervising physician and surgeon may, at his or her discretion, in consultation with the nurse practitioner, certified nurse-midwife, or physician assistant, provide written instruction to be followed by a medical assistant in performance of tasks or supportive services. These written instructions may provide that the supervisory function for the medical assistant for tasks or supportive services may be delegated to the nurse practitioner, certified nurse-midwife, physician assistant within the standardized procedures or protocol, and that task may be performed when the supervising physician and surgeon is not onsite. The nurse practitioner or certified nurse-midwife is functioning pursuant to standardized procedures, as defined in BPC Section 2725 or protocol. The standardized procedure, including instruction for specific authorization, shall be developed and approved by the supervising physician and surgeon and the nurse practitioner or certified nurse-midwife. (amended Section 2069 of BPC related to healing arts: SB 352 (Pavely) Chapter 286, approved by the Governor September 09, 2013)

Can the nurse practitioner cosign worker’s compensation claimant report?
Yes, Section 3209.10 of the Labor Code gives nurse practitioners the ability to cosign Doctor’s First Report of Occupational injury or illness for a worker’s compensation claim to receive time off from work for a period not to exceed three (3) calendar days if that authority is included in standardized procedure or protocols. The treating physician is required to sign the report and to make any determination of any temporary disability. (AB 1194 ch229 (Correa) effective 1, 2001 and AB 2919 (Ridley –Thomas) effective January 1, 2005 extends the operation of this provision indefinitely)

Furnishing Questions

What is a formulary?
A pharmacy formulary is generally regarded as a drug compendium reference utilized by facilities or health plans as a reference. The drug name, dosage, clinical indications, and complications/adverse reactions are generally included. It is most common for the health insurer to identify by means of a formulary those drugs and devices covered by the plan. Nurse practitioners using furnishing numbers can identify a formulary(ies) in their furnishing standardized procedure.

What is the physician supervision requirement for when obtaining a furnishing number from the BRN?
Business and Professions Code Section 2836.1 (g) (2) amendment authorizes a physician and surgeon to determine the extent of the supervision necessary pursuant to this section in furnishing or ordering of drugs and devices. ( SB 1524 ch 796 (Hernandez) effective January 1, 2013)
After January 1, 2013 Nurse Practitioners are no longer required to have six (6) months physician-supervised furnishing experience prior to receiving a furnishing number from the Board of Registered Nursing.

**What are the requirements for an NP to furnish or order Schedule II controlled substances?**
The NPs standardized procedure and protocols address the diagnosis of illness, injury or condition for which the Schedule II controlled substance is to be furnished. The standardized procedure or protocol for Schedule II contains patient-specific protocol approved by the treating physician. The NP with a current furnishing number, and DEA registration, completes as a part of his or her continuing education requirement, a course including Schedule II controlled substances based on the standards developed by the BRN.  (AB 1196 (Montañez) Chapter 748 1/2004)

**What is a “patient-specific protocol” for Schedule II an III, controlled substances?**
The patient-specific protocol required for nurse practitioners to furnish Schedule II and III controlled substances, as defined in Health and Safety Code 11055 and 11056, in a protocol, contained within the standardized procedure or protocols, that specifies which categories of patients may be furnished this class of drugs. The protocol may state other limitations, such as the amount of substance to be furnished, and/or criteria for consultation.  (AB 1196 (Montañez) Chapter 748 1/2004)

**In my furnishing procedure, do I need to list the drugs and devices that can be furnished or can I use categories of drugs?**
The nurse practitioner cannot use a category of drug to meet the furnishing requirements. The law BPC 2836.1 Furnishing or ordering of drugs and devices by a nurse practitioner requires the identification of the drugs and devices in standardized procedure or protocol (BCP Section 2836.1 (c) (1). The standardized procedures or protocol covering the furnishing of drugs or devices shall specify which nurse practitioners may furnish drugs or devices, which drugs or devices may be furnished, under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the nurse practitioner’s competence, including peer review, and review of the provisions of the standardized procedures. (NPA, Section 2836.1)  (Emphasis added.)

**How many nurse practitioners, with a furnishing number, may a physician supervise at one time within a medical practice?**
The furnishing law requires that the physician supervise no more than four nurse practitioners at a time. If the nurse practitioners are not furnishing, there are no limitations on the number of nurse practitioners the physician may supervise.  (BCP Code Section 2836.1 (e))

**I am certified as both a nurse practitioner and a nurse midwife. Do I need to have two furnishing numbers?**
The BRN does not require you to maintain two furnishing numbers. NPs and CNMs are required to have approved furnishing standardized procedures. However, the furnishing laws are different in their authorizations.
DEA Questions

The DEA application asks for “State License No.”. Which number, RN license number or NPF number, should the NP put on the application?

The DEA requires the RN license number and the NPF number.

The DEA application asks for a business address. Can the NP use a work address or personal address?

The DEA requires a business address that is the physician’s address or clinic’s address for the DEA Registration Number. The DEA Number is clinic site specific for dispensing, prescribing and administering purposes. If you leave your place of employment, you must submit written notification to the DEA Office with a copy of your DEA Number, the California RN license and the NP Furnishing Number certificate. If you go to another clinic, you must submit a written request for change of address to the DEA. If the physician or office clinic has two locations (business addresses), the primary clinical site should be referenced for the DEA Registration Number.

Does the NP need a furnishing number issued by the BRN to obtain a DEA number?

Yes, an nurse practitioner furnishing number is required to obtain a DEA number for Schedule II through V Controlled Substances. (AB 1196 Montañez Chapter 748 1/2004 added Schedule II controlled substances)

The provisions of SB 816 added “order” to Business and Professions Code, Section 2836.1. SB 816 did not change the requirement to furnish using standardized procedures for controlled substances, Schedule III, IV, and V.

Does having a DEA number eliminate the need for a furnishing number?

No, the DEA number only allows NPs to write and or “order” controlled substances, Schedule II, III, IV, and V. NPs are required to have a furnishing number to make drugs and devices available to their patients using a transmittal form (prescription pad) and are to be furnished pursuant to approved standardized procedures. DEA registration numbers are site specific and used by the DEA for tracking prescribing of controlled substances.

On the DEA application, it asks “Administer, Dispense, Prescribe”. Can an NP as a result SB 816 and now 1/2004 AB 1196 Montañez Chapter 748 prescribe?

Yes, the B&P Code refers to furnishing or ordering a Schedule II through V controlled substance for the purposes of obtaining DEA registration.

Are NPs now considered “prescribers”?

For the purpose of obtaining a DEA number for (ordering) Schedule II, III, IV, V the NP with a furnishing number is considered by the DEA to be a prescriber.

Can the NP with a furnishing number use the physician’s DEA number?

No, the NP with a furnishing number may not use the physician’s DEA number. The new law requires the nurse practitioner with the furnishing number to obtain his or her own DEA number to furnish controlled substances.
**What is required to be printed on the prescription pad/transmittal order/drug order for Schedule II through V?**

When furnishing a controlled substance, Schedule II, III, IV, or V, write the “order” and include your name, title, furnishing number, and DEA number.

**How long is a controlled substance prescription (Schedule II –V) valid?**

The controlled substance prescription is valid for 6 months from the date of issuance. (SB 151 Burton Chapter 406 1/2004)

**Do nurse practitioners have prescriptive authority and can nurse practitioners get DEA numbers?**

Furnishing is a delegated authority and is done in accordance with approved standardized procedures. Physician supervision is required and the physician must be available, at least by telephonic means, at the time the nurse practitioner examines the patient. (BCP 2836.1(d))

**History of laws related to Furnishing schedule III-V and schedule II controlled substances**

SB 816, Chapter 749, (Escutia), effective January 1, 2000, authorizes NPs with furnishing certificates to apply for a DEA number and furnish or order Schedule III-V controlled substances. The new law added “order” and “drug order” to Section 2836.1. The intent of this legislation is furnishing can now be known as an “order”, and can be considered the same as an “order” initiated by the physician.

AB 1196 Montañez Chapter 748 1/2004 expands NP furnishing to Schedule II controlled substances that requires a United States Drug Enforcement Registration in addition to the Schedule III through V. This law requires NPs to use the new controlled substance prescription forms for Schedule II controlled substances prescriptions. January 1, 2005, triplicate prescription forms are no longer valid and all written controlled substance prescriptions (oral or faxed for Schedule II through V are permitted) shall be on controlled substance prescription forms. (SB 151, Burton 406 1/2004).

The Drug Enforcement Agency (DEA) monitors all prescribers who write for controlled substances. NPs, pursuant to Section 2836.1 of the Business and Professions Code, are legally authorized to furnish and “order” controlled substances, Schedule II, III, IV, V.

**Where can a nurse practitioner find information on controlled substances such as the Drug Enforcement Administration (DEA) and pharmacy laws? Phone numbers subject to change.**

DEA Main office, San Francisco: 1-888-304-3251
DEA Field office, San Diego: (858) 616-4329
DEA Field office, Los Angeles: (213) 621-6960
Board of Pharmacy: (916) 445-5014
Web: www.deadiversion.usdoj.gov
AGENDA ITEM: 10.3
DATE: October 9, 2014

ACTION REQUESTED: Information and discussion: California Association of Nurse Midwifery:
   a) Standardized Procedures related to ACNM Core Competencies for Basic Nurse-Midwifery Practice
   b) Out of Hospital CNM Practice and physician supervision
   c) Location of suturing and protection of public

REQUESTED BY: Trande Phillips RN Chair
               Practice Committee

BACKGROUND:
Kim Q Dau CNM Chair of Health Policy Committee submitted a number of documents they wish to discuss at the Practice Committee meeting.
1. Standardized Procedures related to ACNM Core Competencies
   a) CA SPs and ACNM Core Competencies
   b) BRN Advisory- RN Scope and SPs
   c) BRN Advisory-SP and CNM Practice
2. Out of hospital CNM practice and physician supervision
   a) MBC Sunset Report 2012 re: LM Supervision
3. Location of suturing and protection of the public
   a) History of NMAC

All documents are attached for review by committee members.

NEXT STEPS: Place on Board agenda.

FISCAL IMPACT, IF ANY: none

PERSON(S) TO CONTACT: Janette Wackerly, MBA, BSN, RN
                        Supervising Nurse Education Consultant
Standardized Procedures related to the American College of Nurse-Midwives’ Core Competencies for Basic Midwifery Practice

As acknowledged by the BRN Advisory on Standardized Procedures (SP), the Legislature recognized that nursing is a dynamic field, continually evolving to include more sophisticated patient care activities. In Section 2725(a), the Legislature expressly declared its intent to provide clear legal authority for functions and procedures which have common acceptance and usage. Registered nurses must recognize that the application of nursing process functions is common nursing practice which does not require a standardized procedure. In Section 2725(a), the Legislature referred to the dynamic quality of the nursing profession. This means, among other things, that some functions which today are considered medical practice will become common nursing practice and no longer require standardized procedures.

As an example – In 1988 at many hospitals in Orange County there was requirement of SP for nurses in L&D to be able to perform vaginal examination for cervical checks. It was determined with consult of the BRN that vaginal exams were part of the core education of registered nurses at the time of graduation. The SPs were eliminated because vaginal exams had become common nursing practice.

Since the enabling statute for nurse-midwifery, there are many clinical practices that have evolved and have become common midwifery practice. The document that describes common practice for midwifery is the ACNM core competencies for basic midwifery practice. It is a dynamic document reviewed and updated every five years and depicts the evolution of midwifery practice as a dynamic field in an ever-fluctuating health care setting.

The practice of nurse-midwifery is well-defined by the national core competencies set forth by the American College of Nurse-Midwives. This document is clearly recognized by the State as students that graduate from programs in California must meet the Core Competencies. Therefore the national Core Competencies should be the foundation for standard practice of nurse-midwifery in California, utilizing the workforce to full extent of their preparation and not promoting activities outside their preparation.
The Core Competencies for Basic Midwifery Practice include the fundamental knowledge, skills, and behaviors expected of a new practitioner. Accordingly, they serve as guidelines for educators, students, health care professionals, consumers, employers, and policy makers and constitute the basic requisites for graduates of all nurse-midwifery and midwifery education programs accredited/preaccredited by the Accreditation Commission for Midwifery Education (ACME), formerly the American College of Nurse-Midwives (ACNM) Division of Accreditation (DOA).

Midwifery practice is based on the Core Competencies for Basic Midwifery Practice, the Standards for the Practice of Midwifery, the Philosophy of the ACNM, and the Code of Ethics promulgated by the ACNM. Certified nurse-midwives (CNMs) and certified midwives (CMs) who have been certified by the ACNM or the American Midwifery Certification Board (AMCB), formerly the ACNM Certification Council, Inc. (ACC), assume responsibility and accountability for their practice as primary health care providers for women and newborns.

The scope of midwifery practice may be expanded beyond the core competencies to incorporate additional skills and procedures that improve care for women and their families. Following basic midwifery education, midwives may choose to expand their practice following the guidelines outlined in Standard VIII of the Standards for the Practice of Midwifery.

Midwifery education is based on an understanding of health sciences theory and clinical preparation that shapes knowledge, judgment, and skills deemed necessary to provide primary health care management to women and newborns. Midwives provide health care that incorporates appropriate medical consultation, collaborative management, or referral. Each education program is encouraged to develop its own method of addressing health care issues beyond the scope of the current core competencies, and each graduate is responsible for complying with the laws of the jurisdiction where midwifery is practiced and the ACNM Standards for the Practice of Midwifery.

ACNM defines the midwife's role in primary health care based on the Institute of Medicine's report, Primary Care: America's Health Care in a New Era,1 the Philosophy of the ACNM,2 and the ACNM position statement, “Midwives are Primary Care Providers and Leaders of Maternity Care Homes.”3 Primary health care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing the majority of health care needs, developing a sustained partnership with patients, and practicing within the context of family and community. As primary health care providers, CNMs and CMs assume responsibility for the provision of and referral to appropriate health care services, including prescribing, administering and dispensing of pharmacologic agents. The concepts, skills, and midwifery management processes identified...
below form the foundation upon which practice guidelines and educational curricula are built. The core competencies are reviewed and revised regularly to incorporate changing trends in midwifery practice. This document must be adhered to in its entirety and applies to all settings for midwifery care, including hospitals, ambulatory care settings, birth centers, and homes.

I. **Hallmarks of Midwifery**
The art and science of midwifery are characterized by the following hallmarks:

A. Recognition of menarche, pregnancy, birth, and menopause as normal physiologic and developmental processes
B. Advocacy of non-intervention in normal processes in the absence of complications
C. Incorporation of scientific evidence into clinical practice
D. Promotion of woman- and family-centered care
E. Empowerment of women as partners in health care
F. Facilitation of healthy family and interpersonal relationships
G. Promotion of continuity of care
H. Health promotion, disease prevention, and health education
I. Promotion of a public health care perspective
J. Care to vulnerable populations
K. Advocacy for informed choice, shared decision making, and the right to self-determination
L. Integration of cultural humility
M. Incorporation of evidence-based complementary and alternative therapies in education and practice
N. Skillful communication, guidance, and counseling
O. Therapeutic value of human presence
P. Collaboration with other members of the interprofessional health care team

II. **Components of Midwifery Care: Professional Responsibilities of CNMs and CMs**
The professional responsibilities of CNMs and CMs include but are not limited to the following components:

A. Promotion of the hallmarks of midwifery
B. Knowledge of the history of midwifery
C. Knowledge of the legal basis for practice
D. Knowledge of national and international issues and trends in women's health and maternal/newborn care
E. Support of legislation and policy initiatives that promote quality health care
F. Knowledge of issues and trends in health care policy and systems
G. Knowledge of information systems and other technologies to improve the quality and safety of health care
H. Broad understanding of the bioethics related to the care of women, newborns, and families
I. Practice in accordance with the ACNM Philosophy, Standards, and Code of Ethics
J. Ability to evaluate, apply, interpret, and collaborate in research
K. Participation in self-evaluation, peer review, lifelong learning, and other activities that ensure and validate quality practice
L. Development of leadership skills
M. Knowledge of licensure, clinical privileges, and credentialing

N. Knowledge of practice management and finances
O. Promotion of the profession of midwifery, including participation in the professional organization at the local and national level
P. Support of the profession’s growth through participation in midwifery education
Q. Knowledge of the structure and function of ACNM

III. Components of Midwifery Care: Midwifery Management Process
The midwifery management process is used for all areas of clinical care and consists of the following steps:

A. Investigate by obtaining all necessary data for the complete evaluation of the woman or newborn.
B. Identify problems or diagnoses and health care needs based on correct interpretation of the subjective and objective data.
C. Anticipate potential problems or diagnoses that may be expected based on the identified problems or diagnoses.
D. Evaluate the need for immediate intervention and/or consultation, collaborative management, or referral with other health care team members as dictated by the condition of the woman, fetus, or newborn.
E. In partnership with the woman, develop a comprehensive plan of care that is supported by a valid rationale, is based on the preceding steps, and includes therapeutics as indicated.
F. Assume responsibility for the safe and efficient implementation of a plan of care that includes the provision of treatments and interventions as indicated.
G. Evaluate the effectiveness of the care given, recycling appropriately through the management process for any aspect of care that has been ineffective.

IV. Components of Midwifery Care: Fundamentals

A. Anatomy and physiology, including pathophysiology
B. Normal growth and development
C. Psychosocial, sexual, and behavioral development
D. Basic epidemiology
E. Nutrition
F. Pharmacokinetics and pharmacotherapeutics
G. Principles of individual and group health education
H. Bioethics related to the care of women, newborns, and families
I. Clinical genetics and genomics
V. Components of Midwifery Care of Women

Independently manages primary health screening, health promotion, and care of women from the peri-menarcheal period through the lifespan using the midwifery management process. While the woman’s life is a continuum, midwifery care of women can be divided into primary, preconception, gynecologic, antepartum, intrapartum, and post-pregnancy care.

A. Applies knowledge, skills, and abilities in primary care that include but are not limited to the following:

1. Nationally defined goals and objectives for health promotion and disease prevention
2. Parameters for assessment of physical, mental, and social health
3. Nationally defined screening and immunization recommendations to promote health and to detect and prevent disease
4. Management strategies and therapeutics to facilitate health and promote healthy behaviors
5. Identification of normal and deviations from normal in the following areas:
   a. Cardiovascular and hematologic
   b. Dermatologic
   c. Endocrine
   d. Eye, ear, nose, and throat
   e. Gastrointestinal
   f. Mental health
   g. Musculoskeletal
   h. Neurologic
   i. Respiratory
   j. Renal
6. Management strategies and therapeutics for the treatment of common health problems and deviations from normal of women, including infections, self-limited conditions, and mild and/or stable presentations of chronic conditions, utilizing consultation, collaboration, and/or referral to appropriate health care services as indicated.

B. Applies knowledge, skills, and abilities in the preconception period that include but are not limited to the following:

1. Individual and family readiness for pregnancy, including physical, emotional, psychosocial, and sexual factors including
   a. Non-modifiable factors such as family and genetic/genomic risk
   b. Modifiable factors such as environmental and occupational factors, nutrition, medications, and maternal lifestyle
2. Health and laboratory screening
3. Fertility awareness, cycle charting, signs and symptoms of pregnancy, and pregnancy spacing

C. Applies knowledge, skills, and abilities in gynecologic care that include but are not limited to the following:
1. Human sexuality, including biological sex, gender identities and roles, sexual orientation, eroticism, intimacy, and reproduction
2. Common screening tools and diagnostic tests
3. Common gynecologic and urogynecologic problems
4. All available contraceptive methods
5. Sexually transmitted infections including indicated partner evaluation, treatment, or referral
6. Counseling for sexual behaviors that promote health and prevent disease
7. Counseling, clinical interventions, and/or referral for unplanned or undesired pregnancies, sexual and gender concerns, and infertility
8. Identification of deviations from normal and appropriate interventions, including management of complications and emergencies utilizing consultation, collaboration, and/or referral as indicated

D. Applies knowledge, skills, and abilities in the perimenopausal and postmenopausal periods that include but are not limited to the following:

1. Effects of menopause on physical, mental, and sexual health
2. Identification of deviations from normal
3. Counseling and education for health maintenance and promotion
4. Initiation or referral for age/risk appropriate periodic health screening
5. Management and therapeutics for alleviation of common discomforts

E. Applies knowledge, skills and abilities in the antepartum period that include but are not limited to the following:

1. Epidemiology of maternal and perinatal morbidity and mortality
2. Confirmation and dating of pregnancy
3. Promotion of normal pregnancy using management strategies and therapeutics as indicated
4. Common discomforts of pregnancy
5. Influence of environmental, cultural and occupational factors, health habits, and maternal behaviors on pregnancy outcomes
6. Health risks, including but not limited to domestic violence, infections, and substance use/abuse
7. Emotional, psychosocial, and sexual changes during pregnancy
8. Anticipatory guidance related to birth, breastfeeding, parenthood, and change in the family constellation
9. Deviations from normal and appropriate interventions, including management of complications and emergencies
10. Placental physiology, embryology, fetal development, and indicators of fetal well-being

F. Applies knowledge, skills, and abilities in the intrapartum period that include but are not limited to the following:
1. Confirmation and assessment of labor and its progress  
2. Maternal and fetal status  
3. Deviations from normal and appropriate interventions, including management of complications, abnormal intrapartum events, and emergencies  
4. Facilitation of physiologic labor progress  
5. Measures to support psychosocial needs during labor and birth  
6. Labor pain and coping  
7. Pharmacologic and non-pharmacologic strategies to facilitate maternal coping  
8. Techniques for  
   a. administration of local anesthesia  
   b. spontaneous vaginal birth  
   c. third stage management  
   d. performance of episiotomy repair of episiotomy and 1st and 2nd degree lacerations  

G. Applies knowledge, skills, and abilities in the period following pregnancy that include but are not limited to the following:  
1. Physical involution following pregnancy ending in spontaneous or induced abortion, preterm birth, or term birth  
2. Management strategies and therapeutics to facilitate a healthy puerperium  
3. Discomforts of the puerperium  
4. Self-care  
5. Psychosocial coping and healing following pregnancy  
6. Readjustment of significant relationships and roles  
7. Facilitation of the initiation, establishment, and continuation of lactation where indicated  
8. Resumption of sexual activity, contraception, and pregnancy spacing  
9. Deviations from normal and appropriate interventions including management of complications and emergencies  

VI. Components of Midwifery Care of the Newborn  
Independently manages the care of the newborn immediately after birth and continues to provide care to well newborns up to 28 days of life utilizing the midwifery management process and consultation, collaboration, and/or referral to appropriate health care services as indicated.  

A. Applies knowledge, skills, and abilities to the newborn that include but are not limited to the following:  
1. Effect of maternal and fetal history and risk factors on the newborn  
2. Preparation and planning for birth based on ongoing assessment of maternal and fetal status  
3. Methods to facilitate physiologic transition to extraterine life that includes but is not limited to the following:
a. Establishment of respiration
b. Cardiac and hematologic stabilization including cord clamping and cutting
c. Thermoregulation
d. Establishment of feeding and maintenance of normoglycemia
e. Bonding and attachment through prolonged contact with neonate.
f. Identification of deviations from normal and their management.
g. Emergency management including resuscitation, stabilization, and consultation and referral as needed

4. Evaluation of the newborn:
   a. Initial physical and behavioral assessment for term and preterm infants
   b. Gestational age assessment
   c. Ongoing assessment and management for term, well newborns during first 28 days
   d. Identification of deviations from normal and consultation, and/or referral to appropriate health services as indicated

5. Develops a plan in conjunction with the woman and family for care of the newborn for the first 28 days of life, including nationally defined goals and objectives for health promotion and disease prevention:
   a. Teaching regarding normal behaviors and development to promote attachment
   b. Feeding and weight gain including management of common breastfeeding problems
   c. Normal daily care, interaction, and activity including sleep practice and creating a safe environment
   d. Provision of preventative care that includes but is not limited to
      (1) Therapeutics including eye ointment, vitamin K, and others as appropriate by local or national guidelines
      (2) Testing and screening according to local and national guidelines
      (3) Need for ongoing preventative health care with pediatric care providers
   e. Safe integration of the newborn into the family and cultural unit
   f. Appropriate interventions and referrals for abnormal conditions:
      (1) Minor and severe congenital malformations
      (2) Poor transition to extrauterine life
      (3) Symptoms of infection
      (4) Infants born to mothers with infections
      (5) Postpartum depression and its effect on the newborn
      (6) End-of-life care for stillbirth and conditions incompatible with life
   g. Health education specific to the infant and woman’s needs:
      (1) Care of multiple children including siblings and multiple births
      (2) Available community resources
REFERENCES


Source: Basic Competency Section, Division of Education
Approved by the ACNM Board of Directors: December 2012
(Supersedes all previous ACNM Core Competencies for Basic Midwifery Practice)
AN EXPLANATION OF THE SCOPE OF RN PRACTICE INCLUDING STANDARDIZED PROCEDURES

The Legislature, in its 1973-74 session, amended Section 2725 of the Nursing Practice Act (NPA), amplifying the role of the registered nurse and outlining activities which comprise the practice of nursing.

LEGISLATIVE INTENT

The Legislature recognized that nursing is a dynamic field, continually evolving to include more sophisticated patient care activities. It declared its intent to recognize the existence of overlapping functions between physicians and registered nurses and to permit additional such sharing and to provide clear legal authority for those functions and procedures which have common acceptance and usage. Prior to this, nurses had been educated to assume advanced roles, and demonstration projects had proven their ability to do this safely and effectively. Thus, legal amplification of the role paralleled the readiness of nurses to assume the role and recognized that many were already functioning in an expanded role.

SCOPES OF PRACTICE

A knowledge of the respective scopes of practice of registered nurses and physicians is important in determining which activities overlap medical practice and therefore require standardized procedures. Failure to distinguish nursing practice from medical practice may result in the limitation of the registered nurse's practice and the development of unnecessary standardized procedures. Registered nurses are cautioned not to confuse nursing policies and procedures with standardized procedures.

1. Scope of Registered Nursing Practice

The activities comprising the practice of nursing are outlined in the Nursing Practice Act, Business and Professions Code Section 2725. A broad, all inclusive definition states that the practice of nursing means those functions, including basic health care, which help people cope with difficulties in daily living which are associated with their actual or potential health or illness problems, or the treatment thereof, which require a substantial amount of scientific knowledge or technical skill.

In Section 2725(a), the Legislature expressly declared its intent to provide clear legal authority for functions and procedures which have common acceptance and usage. Registered nurses must recognize that the application of nursing process functions is common nursing practice which does not require a standardized procedure. Nursing practice is divided into three types of functions, which are described below.

A. Independent Functions

Subsection (b)(1) of Section 2725, authorizes direct and indirect patient care services that insure the safety, comfort, personal hygiene and protection of patients, and the performance of disease prevention and restorative measures. Indirect services include delegation and supervision of patient care activities performed by subordinates.

Subsection (b)(3) of Section 2725, specifies that the performance of skin tests, immunization techniques and withdrawal of human blood from veins and arteries is included in the practice of nursing.
Subsection (b)(4) of Section 2725, authorizes observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition and determination of whether these exhibit abnormal characteristics; and based on this determination, the implementation of appropriate reporting or referral, or the initiation of emergency procedures. These independent nursing functions have long been an important focus of nursing education, and an implied responsibility of the registered nurse.

B. Dependent Functions
Subsection (b)(2) of Section 2725, authorizes 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.

C. Interdependent Functions
Subsection (b)(4) of Section 2725, authorizes the nurse to implement appropriate standardized procedures or changes in treatment regimen in accordance with standardized procedures after observing signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and determining that these exhibit abnormal characteristics. These activities overlap the practice of medicine and may require adherence to a standardized procedure when it is the nurse who determines that they are to be undertaken.

2. Scope of Medical Practice
The Medical Practice Act authorizes physicians to diagnose mental and physical conditions, to use drugs in or upon human beings, to sever or penetrate the tissues of human beings and to use other methods in the treatment of diseases, injuries, deformities or other physical or mental conditions. As a general guide, the performance of any of these by a registered nurse requires a standardized procedure; however, activities within each of these categories have already become common nursing practice and therefore do not require standardized procedures; for example, the administration of medication by injection requires penetration of human tissue, and registered nurses have performed this function through the years.

In Section 2725(a), the Legislature referred to the dynamic quality of the nursing profession. This means, among other things, that some functions which today are considered medical practice will become common nursing practice and no longer require standardized procedures. Examples of medical functions which have evolved into common nursing functions are the measurement of cardiac output pressures, and the insertion of PICC lines.

STANDARDIZED PROCEDURES FOR MEDICAL FUNCTIONS
The means designated to authorize performance of a medical function by a registered nurse is a standardized procedure developed through collaboration among registered nurses, physicians and administrators in the organized health care system in which it is to be used. Because of this interdisciplinary collaboration, there is accountability on several levels for the activities to be performed by the registered nurse. Section 2725(a) defines "organized health care systems" to include, but are not limited to, licensed health facilities, clinics, home health agencies, physicians' offices, and public or community health services.

GUIDELINES FOR DEVELOPING STANDARDIZED PROCEDURES
Standardized procedures are not subject to prior approval by the boards that regulate nursing and medicine; however, they must be developed according to the following guidelines which were jointly promulgated by the Board of Registered Nursing and the Medical Board of California. (Board of Registered Nursing, Title 16, California Code of Regulations (CCR) section 1474; Medical Board of California, Title 16, CCR Section 1379.)

(a) Standardized procedures shall include a written description of the method used in developing and approving them and any revision thereof.

NPR-B-03 06/1995  AN EXPLANATION OF SCOPE OF RN PRACTICE INCLUDING STANDARDIZED PROCEDURES
REV. 07/1997, 01/2011
(b) Each standardized procedure shall:

1. **Be in writing, dated and signed by the organized health care system personnel authorized to approve it.**

2. Specify which standardized procedure functions registered nurses may perform and under what circumstances.

3. State any specific requirements which are to be followed by registered nurses in performing particular standardized procedure functions.

4. Specify any experience, training and/or education requirements for performance of standardized procedure functions.

5. Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform standardized procedure functions.

6. Provide for a method of maintaining a written record of those persons authorized to perform standardized procedure functions.

7. Specify the scope of supervision required for performance of standardized procedure functions, for example, telephone contact with the physician.

8. Set forth any specialized circumstances under which the registered nurse is to immediately communicate with a patient's physician concerning the patient's condition.

9. State the limitations on settings, if any, in which standardized procedure functions may be performed.

10. Specify patient record-keeping requirements.


An additional safeguard for the consumer is provided by steps four and five of the guidelines which, together, form a requirement that the nurse be currently capable to perform the procedure. The registered nurse who undertakes a procedure without the competence to do so is grossly negligent and subject to discipline by the Board of Registered Nursing.

**SUMMARY OF RN FUNCTIONS UNDER STANDARDIZED PROCEDURES**

Registered nursing functions under standardized procedures may be summarized as follows:

**WHO:** the registered nurse

**WHAT:** may perform a medical function beyond the usual scope of RN practice

**HOW:** in accord with a written standardized procedure developed by nursing, medicine and administration

**WHERE:** in an organized health care system

**WHEN:** after the RN has been evaluated and approved as having met the education and experience requirements specified in the procedure

**WHY:** because the standardized procedure authorizes the RN to exceed the usual scope of RN practice
TO DETERMINE IF A STANDARDIZED PROCEDURE IS REQUIRED

Ask each question below in the order presented. Continue only until your answer points to "S.P. required," or to "S.P. not required."

1. Is the function commonly recognized as nursing practice?
   
   NO  YES ⇒ S.P. not required

2. Is it the standard of practice in the community that RNs perform this function in the clinical area for which it is being considered?
   
   NO  YES ⇒ S.P. not required

3. Does the function require the nurse to:
   
   Diagnose disease,
   
   Prescribe medicine or treatment, or
   
   Penetrate or sever tissue?

   NO  YES ⇒ S.P. required

4. Does safe performance of the function require judgment based on medical knowledge beyond that usually possessed by the competent RN in the area for which it is being considered?

   NO  YES ⇒ S.P. required

   S.P. not required

WHO DEVELOPS STANDARDIZED PROCEDURES?

1. Organized Health Care Systems

   Health Facilities licensed by Dept. of Public Health

   Health Facilities not licensed (CCR 1470): Clinics, Home Health Agencies, Physicians Offices, Public or Community Health Services

2. Collaborating:

   Administrators, and Health Care Professionals, including

   REGISTERED NURSES

   PHYSICIANS
This paper describes requirements for Certified Nurse-Midwives (CNMs) to legally perform functions that are considered the practice of medicine through the mechanism of standardized procedures.

Standardized Procedures are authorized in the Business and Professions Code, Nursing Practice Act (NPA) Section 2725 and further clarified in California Code of Regulations (CCR 1474). Standardized Procedures are the legal mechanism for registered nurses, and thus authorize CNMs to perform functions that would otherwise be considered the practice of medicine. Standardized Procedures must be developed collaboratively by nursing, medicine, and administration in the organized health care system where they will be utilized.

Organized health care system means a health facility that is not licensed pursuant to Chapter 2 of the California Health and Safety Code and includes clinics, home health agencies, physician’s offices and public or community health services. Standardized Procedures means policies and protocols formulated by organized health care systems for the performance of standardized procedure functions.

Certified Nurse-Midwife Scope of Practice
California Code of Regulation: § Section 1463
The scope of nurse-midwifery practice:
(a) Provides necessary supervision, care, and advice in a variety of settings including women during the antepartal, intrapartal, postpartal, interconceptional periods, and with family planning needs.
(b) Conducting deliveries on his or her own responsibilities and caring for the newborn and the infant. This care includes preventive measures and the detection of abnormal conditions in the mother and child.
(c) Obtaining physician assistance and consultation when indicated.
(d) Providing emergency care until physician assistance can be obtained.
(e) Other practices and procedures may be included which the nurse-midwife and the supervising physician deem appropriate by using the standardized procedures as specified in Section 2725 of the Code.

Medical Practice Act
Business and Professions Code a Medical Practice Act authorizes physicians to diagnose mental and physical conditions, to use drugs in or upon human beings, to sever or penetrate the tissues of human beings and to use other methods in the treatment of
diseases, injuries, deformities, or other physical or mental conditions. As a general guide, the performance of any of these by a CNM requires a standardized procedure.

**CNMs Performing Medical Functions**

The means designated to authorize performance of a medical function by a registered nurse is a standardized procedure developed through collaboration among registered nurses, physicians and administrators in the organized health care system in which it is to be used. In facilities regulated by Title 22, the CNM performing the standardized procedures must be approved through the Interdisciplinary Practice Committee before the CNM is authorized to legally perform these functions. When the CNM overlaps into the practice of medicine, a standardized procedure must be adhered to. The following is a brief explanation of each of the functions.

- **Medical Diagnosis**
  The Legislature, in granting the CNM a scope of practice, recognized that nurse-midwifery practice is the independent management “of women during the antepartal, intrapartal, postpartal, interconceptional periods,” including family planning needs, and caring for the newborn and the infant. When CNMs diagnose conditions unrelated to CNM scope of practice, a standardized procedure is required.

- **Severing and Penetrating tissue**
  The NPA clearly states “the practice of nurse-midwifery does not include the assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any version.” The Board’s interpretation of this statute is that CNMs are not to perform vacuum extractions or use any mechanical means during childbirth. When CNMs assist in cesarean surgery, perform circumcision, perform episiotomies, or repair lacerations of the perineum, a standardized procedure is required.

- **Furnishing drugs and devices, including controlled substances**
  The drugs and devices furnished or ordered by a certified nurse-midwife must be in accordance with standardized procedures or protocols. If Schedule II or III controlled substances are furnished or ordered by a certified nurse-midwife, the controlled substance shall be furnished or ordered in accordance with patient-specific protocol approved by the treating or supervising physician and surgeon.

**GUIDELINES FOR DEVELOPING STANDARDIZED PROCEDURES**

Standardized Procedures are not subject to prior approval by the boards that regulate nursing and medicine; however, they must be developed according to the following guidelines which were jointly promulgated by the Board of Registered Nursing and the Medical Board of California. (Board of Registered Nursing, Title 16, California Code of Regulations (CCR) Section 1474; Medical Board of California, Title 16, CCR Section 1379.)

(a) Standardized Procedures shall include a written description of the method used in developing and approving them and any revision thereof.

(b) Each standardized procedure shall:
(1) Be in writing, dated, and signed by the organized health care system personnel authorized to approve it.
(2) Specify which standardized procedure functions registered nurses may perform and under what circumstances.
(3) State any specific requirements that are to be followed by registered nurses in performing particular standardized procedure functions.
(4) Specify any experience, training and/or educational requirements for performance of standardized procedure functions.
(5) Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform standardized procedure functions.
(6) Provide for a method of maintaining a written record of those persons authorized to perform standardized procedure functions.
(7) Specify the scope of supervision required for performance of standardized procedure functions. (ie: telephone contact with the physician).
(8) Set forth any specialized circumstances under which the registered nurse is to immediately communicate with a patient’s physician concerning the patient’s condition.
(9) State the limitations on settings, if any, in which standardized procedure functions may be performed.
(10) Specify patient record keeping requirements.

An additional safeguard for the consumer is provided by steps four and five of the guidelines that together form a requirement that the CNM be currently capable to perform the procedure. If a CNM undertakes a procedure without the competence to do so, such an act may constitute incompetence and the CNM would be subject to discipline by the Board of Registered Nursing.

GUIDELINES FOR DEVELOPING STANDARDIZED PROCEDURES FOR FURNISHING DRUGS OR DEVICES: Business and Professions Code: Nurse-midwives § 2746.51 (2), (3), (4)
The standardized procedure covering the furnishing or ordering of drugs and devices shall specify all of the following:
(A) Which certified nurse-midwife nurse midwife may furnish or order drugs and devices.
(B) Which drugs and devices may be furnished or ordered and under what circumstances.
(C) The extent of physician and surgeon supervision.
(D) The method of periodic review of the certified nurse-midwife’s competence, including peer review, and review of the provisions of the standardized procedure.

If Schedule II or III controlled substances are furnished or ordered by a certified nurse-midwife, the controlled substance shall be furnished or ordered in accordance with patient-specific protocol approved by the treating or supervising physician and surgeon.
For Schedule II controlled substance protocols, the provision for furnishing the Schedule II controlled substance shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is to be furnished. The furnishing or ordering of drugs and devices by a certified nurse-midwife occurs under physician and surgeon supervision. For purposes of this section, no physician and surgeon shall supervise more than four certified nurse-midwives at one time. Physician and surgeon supervision shall not be construed to require the physical presence of the physician but does include all of the following:

(A) Collaboration on the development of the standardized procedures and protocols.
(B) Approval of the standardized procedure or protocol.
(C) Available by telephone contact at the time of patient examination by the certified nurse-midwife.
A report to Senate Business, Professions and Economic Development Committee

MEDICAL BOARD OF CALIFORNIA

SUNSET REVIEW REPORT 2012

VOLUME I

Edmund G. Brown Jr., Governor
Sharon Levine, M.D., President, Medical Board of California
Linda K. Whitney, Executive Director, Medical Board of California
Appendix I

Midwifery Program

- Background and Description of Midwifery Program
- Performance Measures and Customer Satisfaction Surveys
- Fiscal and Staff Issues
- Licensing Program
- Enforcement Program
- Public Information Policies
- Online Practice Issues
- Workforce Development and Job Creation
- Current Issues
- Board Action and Response to Prior Sunset Issues
- New Issues
- Attachments
Section 11 – New Issues

Physician Supervision

Section 2057 of the B&P Code authorizes a licensed midwife, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother and immediate care for the newborn. B&P Code section 2507(f) requires the Board by July 1, 2003 to adopt regulations defining the appropriate standard of care and level of supervision required for the practice of midwifery. Due to the inability to reach consensus on the supervision issue, the Board bifurcated this requirement and in 2006 adopted Standards of Care for Midwifery (CCR section 1379.19). Three previous attempts to resolve the physician supervision issue via legislation and/or regulation have been unsuccessful due to the widely divergent opinions of interested parties and their inability to reach consensus.

Although required by law, physician supervision is essentially unavailable to licensed midwives performing home births, as California physicians are generally prohibited by their malpractice insurance companies from providing supervision of licensed midwives who perform home births. According to these companies if they supervise, or participate, in a home birth they will lose their insurance coverage resulting in loss of hospital privileges. The physician supervision requirement creates numerous barriers to care, in that if the licensed midwife needs to transfer a patient/baby to the hospital, many hospitals will not accept a patient transfer from a licensed midwife as the primary provider who does not have a supervising physician. California is currently the only state that requires physician supervision of licensed midwives. Among states that regulate midwives, most require some sort of collaboration between the midwife and a physician. For example, in New York, licensed midwives are required to establish and maintain a collaborative relationship with a physician. The midwife is required to maintain documentation of such collaborative relationships and make information about such collaborative relationships available to his or her patients. However, documentation of the collaborative relationship does not have to be submitted to the licensing authority.

In New Jersey, the licensed midwife is required to establish written clinical guidelines with the affiliated physician which outlines the licensee's scope of practice, circumstances under which consultation, collaborative management, referral and transfer of care of women between the licensee and the affiliated physician are to take place. Theses clinical guidelines must include provisions for periodic conferences with the affiliated physician for review of patient records and for quality improvements. The licensed midwife is required to provide this information to the licensing authority upon request. It is considered professional misconduct to practice without established clinical guidelines.

States such as Arkansas and South Carolina provide a very detailed list of situations where physician intervention or referral is required. Other states, such as Virginia and New Mexico, have laws requiring collaboration between a physician and a midwife, but limit physician liability, stating that any consultative relationship with a physician does not by itself provide the basis for finding a physician liable for any acts or omissions by a licensed midwife. New Mexico law requires that each woman
accepted for care must be referred at least once to a duly licensed physician within four (4) weeks of her initial midwifery visit. The referral must be documented in the chart.

The Board, through the Midwifery Advisory Council has held many meetings regarding physician supervision of licensed midwives and has attempted to create regulations to address this issue. The concepts of collaboration, such as required consultation, referral, transfer of care, and physician liability have been discussed among the interested parties with little success. There is disagreement over the appropriate level of physician supervision, with licensed midwives expressing concern with any limits being placed on their ability to practice independently. The physician and liability insurance communities have concerns over the safety of midwife-assisted homebirths, specifically delays and/or the perceived reluctance of midwives to refer patients when the situation warrants referral or transfer of care. It appears the physician supervision requirement needs to be addressed through the legislative process.

**Lab Orders and Obtaining Medical Supplies**

Licensed midwives have difficulty securing diagnostic lab accounts, even though they are legally allowed to have lab accounts. Many labs require proof of physician supervision. In addition, licensed midwives are not able to obtain the medical supplies they have been trained and are expected to use: oxygen, necessary medications, and medical supplies that are included in approved licensed midwifery school curriculum (CCR section 1379.30). The inability for a licensed midwife to order lab tests often means the patient will not obtain the necessary tests to help the midwife monitor the patient during pregnancy. In addition, not being able to obtain the necessary medical supplies for the practice of midwifery adds additional risk to the licensed midwife’s patient and child.

The Board, through the Midwifery Advisory Council held meetings regarding the lab order and medical supplies/medication issues and has attempted to create regulatory language to address this issue. However, based upon discussions with interested parties it appears the lab order and medical supplies/medication issues will need to be addressed through the legislative process.

**Midwife Students, Apprentices and Assistants**

Section 2514 of the B&P Code authorizes a “bona fide student” who is enrolled or participating in a midwifery education program or who is enrolled in a program of supervised clinical training to engage in the practice of midwifery as part of her course of study if: 1) the student is under the supervision of a physician or a licensed midwife who holds a clear and unrestricted California Midwife License and that midwife is present on the premises at all times client services are provided; and 2) the client is informed of the student’s status. There has been disagreement between the Board and some members of the midwifery community regarding what constitutes a “bona fide student”. However, the current statute is very clear regarding a student midwife.

Some members of the midwifery community hold that an individual who has executed a formal agreement to be supervised by a licensed midwife but is not formally enrolled in any approved midwifery education program qualifies the individual as a student in apprenticeship training. Many midwives consider that an individual may follow an “apprenticeship pathway” to licensure. The original legislation of the Midwifery Practice Act, included the option to gain midwifery experience that will then allow them to pursue licensure via the “Challenge Mechanism” detailed in B&P Code section 2513(a) which allows an approved midwifery education program to offer the opportunity for students
The following is a summarized transcription of materials received from the California Board of Registered Nursing (BRN) regarding the Nurse-Midwife Advisory Committee (NMAC), including meeting minutes, lists of committee members, correspondence and related materials during the active years of NMAC (1978-1995). The materials were summarized and placed in chronological order to give an overview of the activities of the committee. Not all forms were summarized such as curriculum vitae, individual applications, forms for applicants, guidelines for curricula, etc.

The California Nurse-Midwives Association (CNMA) urges the BRN to reconvene the NMAC. NMAC was composed of at least one nurse-midwife knowledgeable about nurse-midwifery practice and education, one physician who practices obstetrics, one RN familiar with nurse-midwifery practice, and one public member. It is authorized by statute under B&P Section 2746.2 and California Code of Regulations, Title 16, section 1461: "The board shall appoint a committee comprised of at least one nurse-midwife and one physician... [whose] purpose is to advise the board on all matters pertaining to nurse-midwifery as established by the board."

1978 NMAC Members
Doreen Chan RN N.E.C
Julia O’Bosky RN, Supervising NEC
Kathleen Miller RN, NEC
Maggie Secretary

Peggy Emrey CNM, Dept. of Health, Maternal and Infant Health Section
Connie Ament CNM
Carmella Cavero CNM
Sister Ann Keating CNM
Karen Laing CNM
Vanda Lops CNM
Wanda Mulder CNM
Patricia O’Malley NP
Richard Sweet MD
Ezra Davidson MD
Irene Matousek

July 8, 2014----California Nurse-Midwives Association----california.midwife.org
9/20-21 1979 BRN meeting
Under other business:
Old – committees: Nurse Midwife and Nurse Practitioner Committee: Board approve the Nurse Midwifery report, including the test plan and the suggested evaluation tool
That the board approve the report of the NP Committee, that the staff continue developing the evaluation position that is outlined in the report and that Patty Majcher participate in the evaluation process
Nurse Midwife, Implementation of Regulations, effective 5/7/1979:
Step by step instructions for reviewing applications for certification
1. Valid current RN from CA and graduated from approved program will be certified sec. 1460 (a) (1) (a&b)
2. Valid current RN in CA, program not on list of approved programs but certified and NM by national or state organization whose standards deemed acceptable to BRN, certificate issued (sec. 1460 (a) (2) (b)
3. If 1 or 2 are not met, clerical staff to compare transcripts submitted with application to curriculum checklist on evaluation form (A) and identify areas of deficiency. Candidate would be notified and given options:
   a. Option 1: candidate to provide official transcripts of work completed to correct deficiencies from Board approved NM program
   b. Option 2: provides evidence of successful challenge of Board approved program’s curriculum and verification of clinical competency by board approved CNMs/physician
   c. Option 3: candidate who has post-licensure training and experience in maternal and child care (OB/GYN NP provide evidence of remediation of areas of deficiency in a board approved NM program
   d. Option 4: completion of examination provided by Board with a satisfactory passing score and completion/verification of clinical competency by Board approved CNMs/physician
4. Application abandoned if not achieved within 2 years of initial application
Attached are case summary for each applicant, form letters when criteria not met

1/4/1980 Memorandum
To: Members of BRN
From: BRN – Antonia Gifford RN, Nursing Education Consultant
Subject Final Report: Nurse Midwifery Committee
NMC has completed the preparation of lists and evaluation tools as directed by Board at 9/20, 21 1979 board meeting
   1. list of board approved programs in nurse-midwifery
   2. process for evaluating nurse-midwife applicants for deficiencies
   3. list of national and state organizations certifying nurse-midwives which meet board standards
   4. adoption of examination
   5. develop mechanism for determining competency

July 8, 2014----California Nurse-Midwives Association----california.midwife.org
a. following persons contacted and asked to submit curriculum vitae to serve as a committee for evaluation of applications:
   i. Connie Ament RN, CNM
   ii. Sister Ann Keating RN CNMM
   iii. Jane Sievers Netz
   iv. Dr. Green MD
   v. Dr. Jane Patterson MD

Submitted by Nurse Midwife and Nurse Practitioner Committee:
Tomasa Long RN, Chairman
Sister Ann Keating RN CNM
Virginia Cassidy-Brinn, RN
Patricia Majcher RN
Michael Buggy RN
Julia O'Bosky RN
Kathleen Miller RN, Carol Henriksen RN
Antonia Gifford, RN

Attachment I:
Schools compliant with standards specified in Section 1462, Title XVI of California Administrative Code
1. Columbia University Graduate Program in Maternity Nursing and Nurse-Midwifery
2. Frontier School of Midwifery and Family Nursing
3. Georgetown University School of Nursing
4. The Johns Hopkins University
5. Medical University of South Carolina
6. Meharry Medical College
7. St. Louis University
8. State University of New York
9. United States Air Force
10. University of California at San Diego
11. UCSF
12. University of Illinois at the Medical Center
13. University of Kentucky
14. University of Miami
15. University of Mississippi
16. University of Utah
17. College of Medicine and Dentistry of New Jersey

Approved refresher programs
1. Booth Maternity Center
2. University of Mississippi

Attachment II: Approved organizations or agencies for certification:
American College of Nurse Midwives
State boards of nursing: Alabama, Alaska, Arizona, Georgia, Idaho, Louisiana, Massachusetts, Montana, North Carolina, South Carolina

Attachment III: Clinical Performance Evaluation
7/17/1980 NMAC Meeting Minutes
Members Present: Patricia Majcher, RN, President, Ginny Cassidy-Brinn, RN, Chairperson, Abby Haight Board member, Sister Ann Keating RN, CNM, Gary Richwald MD, David Hoskinson, Nancy Yagi, Eric Werner, Manager, Central Testing Unit, Carol Henriksen, RN, NEC, Kathleen Miller RN NEC
1. Comments and observations on proposals submitted for the development of a valid midwifery exam
2. PSI (Psychological Services Inc.), AR (applied Research Consultants) Sacramento, NES (National Evaluation Systems), PES (Professional Examination Service), SCC (Selection Consulting Center), PC (Psychological Corporation)
3. Budget
4. Test developed by BRN and CTU
5. Negotiation of Contract
6. Publicity
7. Discussion of Concerns
8. Refining
9. Job Analysis
10. Committee for Job Analysis
11. Job Analysis Committee Meeting
12. Date for Meeting of Item Writers
13. Place to Meet
14. Payment for Item Writers and Job Analysis Experts

10/20/1980 Memorandum
To: Virginia Cassidy-Brinn
From: BRN – Antonia J Gifford, RN, Nursing Education Consultant
Subject Nurse Practitioner Evaluation
- Copy of letter written to UCSF in September 1980, updated report on status of NP evaluations, listing of schools meeting the standards of section 1484 and organizations which certify NPs and meet standards
- Process of evaluation
- Worksheet for NP minimum training standards, NP program evaluation

1981 Board of Directors of the Consortium for Nurse Midwifery, Inc.
President: Sister Ann Keating CNM
Vice-President: Kenneth E. Bell MD
Secretary: Renee Halstead CNM
Treasurer: Margie Downing, CNM
Diane Angelini CNM
Shirley Fischer CNM
R. Marshall Jelderks MD
Peggy Kaiser

July 8, 2014——California Nurse-Midwives Association——california.midwife.org
1/13/1981 Memorandum
From: BRN/Nurse Practitioner/Nurse Midwife Committee
Subject: Nurse Practitioner Evaluation Process – proposed procedure

1/14/1981 Memorandum
To: Members of BRN
From: BRN Antonia Gifford RN Nursing Education consultant
Subject: Report Regarding Evaluation of Nurse Practitioners
- Report on applications for practicing as NP, types of specialty areas requested, curriculum of programs evaluated

2/6/1981 NMAC Meeting Minutes
Present: Abby Haight, Chairperson, Ginny Cassidy-Brinn, Board Member, Carol Henriksen RN, Nursing Education Consultant, Mary Ann Rhode, Ann Keating, Nancy Yagi, Gary Richwald, David Hoskinson

1. NMAC Purpose
   a. BRNs’ purpose in appointing the Advisory Committee needs clarification
      i. The charge to the advisory committee is to advise the BRN on:
         Implementation of midwifery law/regulation, promotion of midwifery services
      ii. Objectives: coordinate BRN activities with those of other concerned groups and in the community to publicize BRN action and identify problems which the BRN might assist in solving

2. BRN Communication with Advisory Committee Members

3. Standardized Procedures
   a. Use of standardized procedures by RNs to practice midwifery
   b. Recommendation for the BRN: That the BRN assess the area of standardized procedures in relation to maternity care in California and provide a statement for appropriate public bodies

4. Agencies with whom BRN might coordinate some activities
   a. DCAs Midwifery Advisory Council
   b. The Consortium for Nurse-Midwifery, Inc (CNMI)

5. Keene Midwifery Bill to be written

July 8, 2014-----California Nurse-Midwives Association-----california.midwife.org
6. Obstacles to Consumer Access to Midwifery Services
   a. CMA is expressing its intent to oppose lay midwifery, homebirths, specific use of standardized procedures by RNs for practice of midwifery
   b. Few midwives are being granted hospital privileges
   c. Insurance companies do not provide reimbursement for midwifery care
7. Public Hearings to Identify Obstacles and Consumer Access to Midwifery
   a. At its 1/1981 meeting the BRN voted “that the nurse midwifery advisory committee hold meetings in several areas of state and present a structured report to the BRN on problems in consumer access to midwifery services
8. Co-Sponsors of Hearings
9. Access Issues
   a. Hospital privileges for NMs, reimbursement, restrictions in hospitals, out of hospital practice and MD back-up, denial of malpractice insurance to supportive MDs, limitations on the number of nurse midwives who can be taught, federal agencies, violations of FTC, title XXII-Hill Burton, UC Health Plan and HAS
10. New West Magazine Article
11. Next Meetings of NMAC

3/10/1981 Letter
   - BRN Department of Consumer Affairs: Letter to Editor of New West Magazine commending magazine for article by Mark Hunter, Mothers and Outlaws (December 22, 1980). Abby Haight Public Member Board of Registered Nursing

3/27/1981 BRN NMAC Minutes(subcommittee of Nursing Practice Committee)
Advisory Members Present: L. Bennett, A Keating, M. Rhode, G Richwald,
Board Members Present: G. Cassidy-Brinn, Co-Chairperson, A. Haight, Co-Chairperson
Staff Attending: C. Henriksen
   1. Nurse Midwife Exam
      a. Work started on preparing exam March 12 and will meet again April 22
   2. Medi-Cal Reimbursement
      a. BRN voted to adopt the committee’s 2/6/1981 recommendation to write to Beverlee Myers urging implementation of regulations that permit Med-Cal Reimbursement to midwives
   3. State Insurance Commissioner
      a. BRN voted to adopt the committee’s 2/6/1981 recommendations to request the State Insurance Commissioner to Report to the BRN on
the status of reimbursement for nurse-midwives and its rationale for non-reimbursement
b. Letter to be written to insurance commissioner regarding this subject
4. Letter of appreciation to New West Magazine
5. Nurse-midwifery Hearings
   a. “Nurse midwifery advisory council members are the logical choice to act as a response to panel for the hearings”
   b. Testimony at the hearings to be solicited regarding issues in access to midwifery services suggested I committee minutes 26/1981 p 4, 5.
      Revised and more clearly defined: hospital privileges; restrictions in hospitals; out of hospital practice with physician back up – question arises is nurse-midwife an employee of physician or an independent practitioner?; limits on number of nurse-midwives who can be educated/insufficient obstetrical facilities, faculty, lack of funding;
   c. Issues in reimbursement for nurse midwives
d. Malpractice insurance issues
e. Can any Hill-Burton funded hospital legally deny privileges to nurse-midwives
f. Have health services agencies played a role in development of nurse-midwife services
6. AB 1592 – Moorhead
   a. Bill introduced on 3/25/1981 to revise definition of midwifery by deleting supervision by a physician. Weaken position of standardized procedures by putting into law functions which already can be done by RNs under standardized procedures, permits erection of an artificial barrier to nurse-midwives obtaining staff privileges in a clinical teaching facility in that it states that it does not prohibit the facility from requiring that a nurse-midwife have a faculty teaching appointment as a condition for eligibility for staff privileges in that facility
   b. Also incorporates AB 370 which prohibits insurance plans from excluding the services of a CNM
   c. AB 1592 and SB 670 should be supported together
d. Title XXII should be amended to state that facilities “cannot deny the nurse-midwife privileges.”
e. Abby Haight to take to Legislative Committee the above and:
   i. Faculty requirement for a midwife in a clinical teaching facility
   ii. Effect on standardized procedures of putting into nurse-midwife law, functions which are already standardized procedures
   iii. Definition of high-risk pregnancy
   iv. Effect on present midwifery practice if the law is re-opened
   v. Possibility of amending NPA regulation 1464 to delete the requirement for MD supervision

July 8, 2014-----California Nurse-Midwives Association-----california.midwife.org
April 9, 1981 Update - Nurse Practitioners
- Approx. 408 requests received from RNs for evaluation since initiate of evaluation program in fall of 1979. AJG: drk

4/10/1981
List of programs offering curriculum for the preparation of nurse practitioners which met the standards specified in Title XVI, Chapter 14, Section 1484:
FNP/Primary Care NP/Associate:
CSU, Sonoma; UCSF; CSU, Fresno; UC Davis; Stanford; CSU, Long Beach; UCSD; UCLA
Medical NP/Adult NP:
CSU, Long Beach; UCSD; Loma Linda University; UCLA; UCSF; Sothern California Permanente Medical Group
Pediatric NP:
CSU, Fresno; Valley Medical Center; CSU, Long Beach; UCSD; Loma Linda University;
UCLA; LAC – University of Southern California; UCSF
Neonatal NP:
County of Ventura- General Hospital
OBGYN NP/Maternity/Family Planning:
UCSD; UCLA – Harbor General Hospital; Southern California Permanente Medical Group; UCSF
Geriatric Nurse Practitioner:
Spinal Cord Injury NP:
Psychiatric/Mental Health NP:
CSU, Long Beach
NP for Faculty:
UCLA
College Health NP:
UCLA
Programs no longer being offered but graduates meet criteria:
CSU, Chico – FNP; CSU, Long Beach – Primary Care NP; CSULA, Olive View Medical Center – FNP; Northern California Permanente Medical Group – Medical NP,
Pediatric NP, OBGYN NP; Southern California Permanente Medical Group – Pediatric NP; CSULA, Martin Luther King - Adult NP; Cal Poly, San Luis Obispo
Out of State:
Brigham young University – Primary Care NP, College Health NP; Texas Women’s University – Geriatric NP; University of Miami – Geriatric NP, Family NP, Pediatric NP; Linehard School of Nursing – Primary Care NP; University of Rochester – Family Health NP; New York University – FNP; University of Kentucky – FNP; University of Arizona – FNP; University of Colorado – Adult/Geriatric NP, Pediatric NP, FNP,
School NP
Certification by State Boards accepted: Arkansas, Florida, New Mexico
Certification by national organizations accepted: NAPNAP, NAACOG, ANA – Adult NP, Pediatric NP, FNP

July 8, 2014-----California Nurse-Midwives Association-----california.midwife.org
4/10/1981 Letter
To: California State Insurance Commissioner
Attn: J. Sandoval, Press Officer
From: Abby Haight
- Regarding insurers reimbursement of nurse-midwives and requesting information
  o Laws/regulations pertinent to issue of reimbursement
  o Names of all insurers and of those insurers which have provisions for direct reimbursement of NMs
  o Methods for requiring private insurers to reimburse NMs
  o Policies of insurers of state, county, and municipal employees regarding reimbursement of NMs and influence the State Insurance Commissioner
  o Information concerning denial of malpractice insurance to NMs and/or physicians associated with nurse midwives
  o Also invited representative from office to report on above items to NMAC meeting 5/22/1981

5/22/1981 NMAC Meeting Minutes
Members Present: D. Hoskinson, A Keating, G Richwald
Board Members: G. Cassidy-Brinn
Staff: C. Henriksen
1. Issues in Reimbursement of Nurse-Midwives
2. Medi-Cal Regulations and Reimbursement of Midwives
3. Nurse Midwifery Hearings
4. Issues in Access to Midwifery Services
5. Consultant for Hearings
6. AB 1592 – develop recommendation for BRN consideration
   a. Committee supports and recommends the BRN support
   b. Invite Assemblywoman Jean Moorhead to next meeting
7. Nurse Midwifery Equivalency Examination Development

5/26/1981 Letter
To: Beverlee Myers, Director of Department of Health Services
From: Ginny Cassidy-Brinn, Vice-President of BRN
- Regarding direct reimbursement to nurse-midwives under Medicaid
- Rapid implementation of Federal Public Law 96-499 (budget reconciliation act)
- Request a representative at NMAC in Sacramento July 17, 1981

Response:
- Clarifies that PL 96-499 mandates provision of midwifery services but does not require direct payment to the midwife, but does allow it

July 8, 2014-----California Nurse-Midwives Association-----california.midwife.org
- Confirming this with Ms. Jean Hoodwin of Health Care Financing Administration
- States a mechanism for direct payment to midwives under Medi-Cal would be difficult and costly to implement, require extensive changes in regulations and to contract with Computer Sciences Corporation
- Happy to send representative from Benefits Branch, Jennifer Tachera for July 17.
- May contact Elisabeth H. Lyman, Deputy Director From Beverlee A. Myers, Director

7/17/1981 NMAC Meeting Minutes
Board Members: A. Haight
Advisory Members: D. Hoskinson, A Keating, G. Richwald
Guests: Jennifer Tachera, Medi-Cal Policy Analyst, Peggy Emrey CNM DHS, Tom Green Attorney, DCA Legislative Office, Laura Kaplan Attorney DCA, Division of Consumer Services
1. Medi-Cal Regulations and Reimbursement of Midwives
2. Nurse-Midwifery Hearings – Planning
   a. Purpose of hearings is to assist in implementing the nurse-midwife law
3. Insurance
4. Nurse Midwife Exam
5. Clinical Performance for Nurse-Midwife Equivalency

8/21/1981 NMAC Meeting Minutes
Board Members: G. Cassidy-Brinn, A. Haight
Advisory Members: D. Hoskinson, G. Richwald, N. Yagi, MA Rhode
Staff: J. O’Bosky, supervising NEC, C. Henriksen NEC, Liaison
Invited Guest: Cheryl Mahaffey, Psychological Services, Inc.
1. Nurse Midwife Equivalency Exam

10/19/1981 NMAC Members
Linda Bennett
David Hoskinson
Sr. Ann Keating
Gary Richwald
Nancy Yagi
Mary Ann Rhode
Ginny Cassidy-Brinn
Abby Haight
Carol Henriksen, Liaison

July 8, 2014-----California Nurse-Midwives Association-----california.midwife.org
10/30/1981 NMAC Meeting Minutes 10/30/1981
Board Members: A. Haight, Chairperson
Advisory Members: D. Hoskinson, A. Keating, MA Rhode, G Richwald
BRN Staff: C. Henriksen, NEC, Committee Liaison
   1. Nurse Midwife Equivalency Exam
   2. Midwifery Hearings
   3. Midwife Reimbursement
      a. Questionnaire for insurance companies on midwife reimbursement
      b. Medi-Cal Reimbursement for NMWs
      c. PERS

NMAC Minutes 12/4/1981
Board Members: A. Haight, Chairperson
Advisor Members : D. Hoskinson, A. Keating, N. Yagi, G. Richwald
BRN staff: C. Henriksen, NEC Committee Liaison
Invited Guest: William Anderson of PERS
   1. Nursing Midwifery Hearings
   2. Midwife Reimbursement
      a. Anderson presented information from PERS regarding reimbursement
      b. Committee agreed a letter to be sent to Bob Wilson, Health Benefits Committee Chief requesting time on agenda for NMWAC (NMAC)
      c. Questionnaires for insurance companies on midwife reimbursement
      d. UC system insurance plans
      a. Tool given final consideration for making changes/recommendations to Nursing Practice Committee
   4. NMW Exam Development – PSI
   5. Goals and Activities of the NMWAC (NMAC)

12/31/1981 Letter
To: Abby Haight
From: DH Marshall Assistant Chief, Health Benefits Division
   - Regarding meeting time for health benefits committee/agenda

1/6/1982 Memorandum
To: NMAC members
From: BRN, Carol Henriksen RN, NEC
Subject: 1/15 meeting
   - 1/15 meeting cancelled d/t no major progress reported on items from 12/4 meeting
   - Meeting will be scheduled when there are matters which require the attention of the committee

July 8, 2014-----California Nurse-Midwives Association-----california.midwife.org
2/10/1982 Memorandum
To: NMAC Members
From: BRN, Carol Henriksen RN, NEC
Subject: NMAC will meet in LA 4/5

3/29/1982 Memorandum
To: NMAC Members
From: BRN, Carol Henriksen RN NEC, Committee Liaison
Subject: Cancellation of April 5 Meeting
- Due to orders to reduce travel and other expenses to minimum as well as other state agencies

No Date, Announcement
To: nurse-midwives, physicians familiar with midwifery and consumer needs, members of the public interested in midwifery
From: BRN
Subject: Selection of Nurse-Midwifery Committee (as required by section 1461)
- “BRN is now taking applications from nurse-midwives, physicians and members of the public to comprise a nurse-midwifery committee
- The committee’s purpose shall be to evaluate applications for registered nurses for eligibility for the certification or examination for nurse-midwives and submit recommendations to the BRN

No Date Announcement
- April, 1982 is the target date for the first administration of the California Nurse-Midwifery Examination for nurses seeking to qualify for certification via an equivalency route.
- If you or a qualified...
- Members of the Nurse-Midwifery Committee will be reimbursed at prevailing State rates for authorized travel and per diem expenses

7/15/1982 Memorandum
To: NMAC Members
From: Carol Henriksen
Subject: Meeting
- First meeting of NMAC will be held 9/14/1982

8/17/1982 Memorandum
To: NMAC Members
From: Carol Henriksen
Subject: Meeting Announcement: 9/14/1982
- Reviewed pay, reimbursement, transportation for meeting
Attached: Nurse-midwifery examination announcement/info; application for nurse-midwife certification by examination; curriculum for nurse midwifery programs

9/14/1982 NMAC Meeting Minutes
Board members: Abby Haight, chairperson; Ginney Cassidy-Brinn RN
Staff: Barbara Brusstar, Carol Henriksen
Members of Committee: CNMs: Lorie Brilliner, Mary Colton, Tertia Heath, Ann Keating, Tekoa Lee King Physicians: George Kibler, Joel T. O'Rea, Gary Richwald, RNs: Mary Mangini, Debbie Stuart-Smalley, Frances Wright Public Members: Edith Berg, Francis Hornstein, David Hoskinson
1. Self introductions
2. Review of law, regulations, history pertaining to nurse-midwifery in CA
3. Charge to the committee
4. Explanation of regulations and process of applying for certifications by various methods
5. Guidelines for make-up courses in family planning/genetics developed by staff for foreign-trained midwives seeking to remediate deficiencies
6. Correspondence between BRN and Department of Health Services regarding reimbursement of CNMs by Medi-Cal
7. Process of reviewing applications of persons applying for certification by method 6 discussed:
   a. Passing California BRN Nurse-Midwife Examination
   b. Documenting advanced training and education beyond basic nursing
   c. Certification of clinical competency by CNM and physician
   d. After completion of these requirements, a quorum (2 CNMs, 1 physician, 1 RN) will meet to evaluate their files/make recommendations to Nursing Practice Committee regarding certification
8. Review of per diem and expense forms for committee members

2/4/1983 Goals and Objectives of the Nursing Practice Committee
1. Certified nurse-midwife attended birth, in any setting, will be a feasible choice for the consumer with a normal pregnancy
   a. Amend nurse-midwifery regulations taking into consideration the nurse-midwifery job analysis, deleting any program standards and practice requirements which are not related to competence, and requiring experience in a variety of settings including homes
   b. Specify content of required nurse-midwifery courses
   c. Work with perinatal regionalization project planners to include nurse-midwives in the plan

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d. Deal with restraint-to-trade violations committed by MDs against CNMs

e. Provide a means of informing public regarding availability and appropriate use of nurse-midwifery services and how to locate such services in their areas

f. Develop a contact system between providers of NMW courses and RNs requiring remediation courses

g. Encourage California nurse-midwifery programs to cooperate with equivalency applicants requiring make-up courses

h. Work with DHS to influence development of Medi-Cal Reimbursement of CNMs

i. Develop and implement a system for evaluating California nurse-midwifery programs

j. Conduct no-expense hearings on nurse-midwifery where needs arise

2. The law enforcement program will be revised to be more efficient and to be fair and respectful to registered nurses involved in the process

3. Consumers will have access to those medications which registered nurses are authorized by standardized procedures to manage and to transmit to pharmacies

4. The evaluation procedure for NPs will be developed more completely and as a system for gathering data about NPs will be devised

Instructions for applying for certification as a nurse midwife

A. The completed applications form

B. A photocopy of your California RN license

C. The fee of $ __________

D. Documentations, depending on the method by which you are qualifying

Method 1:  a. official transcript of program

Method 2:  a. official transcript of program

b. official transcript of courses taken to correct deficiencies or official transcript showing successful completion of courses approved by Board

Method 3:  a. letter of verification of certification by certifying organization

Method 4:  a. official transcript of courses successfully challenged in Board approved program

Method 5:  a. BRN form “post-licensure training and Practice in Maternal and Child Care”

b. official transcript of courses taken to correct deficiencies

Method 6:  a. completed BRN form “post-licensure training and practice in maternal and child care”

b. verification by a CNM and by a physician of applicant’s clinical competency in management of normal labor and delivery “evaluation of Midwifery Clinical Competency”
c. successful completion of California BRN’s exam in Nurse-Midwifery

Curriculum for Nurse-Midwifery Programs

Post-Licensure Training and Practice in Maternal and Child Care

Evaluation of Midwifery Clinical Competency

6/10/1983 Letter
To: Kristie Brandt
From: Frances Wright RN, Nursing Education Consultant from BRN
    - Regarding applications for certification

No Date: NMAC Members
CNMs: Lorie Brillinger, Mary M Colton, E. Tertia Heath, Ann Keating, Tekoa Lee King, Karen M Laing
Physicians: George K. Kibler, Joel T. O’Rea, Gary Richwald
Public: Edith Berg, Francie Hornstein, David Hoskinson
RNs: Maria V. Mangini, Debbie Stuart Smalley, Frances Wright
Board Staff: Abby Haight, Barbara M. Brusstar, Carol Henriksen

7/2/1984 NMAC Meeting Minutes
Board Members: Abby Haight, Patricia Hunter
Committee Members: Karen Laing, CNM, Debbie Stuart Smalley, CNM, Gary Richwald MD, Edith Berg, Public Member, George Kibler, MD, Martha Hall Stewart RN

1. Introduction and explanation of the procedure to be followed
2. Files of applicants for certification considered by Committee: 4 certified, 1 needed further evaluation/f/u
3. Recency Issue: when requirements met but have not practiced x 15-20 years
4. Refresher/Remediation Issue
   a. Lack of such courses

8/20/1985 NMAC Meeting Minutes
Members: Karen Laing, CNM, Suellen Miller CNM, Francie Hornstein, public member, Lori Nairne, RN

1. Approval of minutes of 6/26/1985

July 8, 2014-----California Nurse-Midwives Association-----california.midwife.org
2. Consideration of candidates for certification by equivalency
   a. Of note applications from Ethiopian Nurse Midwife Refugee
   b. Decision that she needed remediation of fetal monitoring and be
      allowed to sit for California Nurse- Midwife Examination and certified
      if pass
3. Malpractice insurance crisis
4. Deletion of Sections 1464 and 1465 regarding supervising physician
5. Availability of Medi-Cal Provider numbers to CNMs
6. Budget constraints prevent convening the entire committee

1989-1990, An Introduction to Continuing Competency Assessment Program
- Core Competencies in Nurse-Midwifery
- Criteria for Pre-accreditation of basic certificate, basic graduate and
  precertification nurse midwifery education programs, Revised 4/1988
- Guidelines for documenting Criteria for Pre-accreditation of basic certificate,
  basic graduate and precertification nurse midwifery education programs,
  Revised 4/1988

3/1990 BRN Meeting
- 7.1 approve/not approve that the Nurse Midwifery Certification Exam be
  given once a year
- 3.0 NMAC – approval of applicants for membership

3/9/1990
To: Catherine Puri
From: Carol Henriksen
Subject: Logistics of CNM Exam Administration

5/21/1990 Letter
To: Marcia Manley of BRN Specialized Licensing Section
From: Maria Bedroni RN of BRN
- in response to her letter 5/15/1990 regarding clarification of lay midwifery
  (illegal) and investigations into lay midwifery by medical board if lay person
  and by BRN if RN
- Attached: “How to find a Real Midwife with Real training and a real license”
  by Best Start Birth Center, San Diego CA

7/19/1990 NMAC Meeting Minutes
Committee Members: Susan Detwiler RN, George Kibler MD, Karen Laing CNM,
Maria Mangini CNM, Suellen Miller CNM
Staff: Maria Bedroni, Carol Henriksen, Janette Wackerly, Gabrielle Underwood, Usrah Claar-Rice

1. Announcements: travel reimbursement, alternate committee members
2. Standard of Practice for treating vaginal beta-hemolytic streptococcus at 3 months gestation (question asked to committee members)
3. Guidelines for evaluation of clinical performance
4. California educational requirements for Nurse-midwifery program
5. Remediation guidelines
6. Suggestions for updating the reference list on the applications for nurse midwifery certifications were received
7. A draft of a BRN position paper titled “Midwifery Practice Under Standardized Procedures Prohibited” was presented to the Advisory committee by Carol Henriksen

 Standards for the Practice of Nurse-Midwifery
1. Nurse-midwifery care is provided by qualified practitioners
2. Nurse-midwifery care supports individual rights and self-determination within boundaries of safety
3. Nurse midwifery care is comprised of knowledge, skills, and judgments that foster the delivery of safe and satisfying care
4. Nurse midwifery care is based upon knowledge, skills and judgments which are reflected in written policies
5. Nurse-midwifery care is provided in a safe environment
6. Nurse-midwifery care occurs interdependently within the healthcare system of the community, using appropriate resources for referrals to meet psychosocial, economic and culture or family needs
7. Nurse-midwifery care is documented in legible, complete health records
8. Nurse midwifery care is evaluated according to an established program for quality assessment that includes a plan to identify and resolve problems

Criteria for pre-accreditation of Basic Certificate, Basic Graduate, and Pre-Certifications Nurse Midwifery Education Programs Revised April 1988

7/1991
Charge to NMAC
Purpose: Committee is appointed to advise the BRN on matters relating to nurse-midwifery, develop necessary standards related to educational requirements and provide such assistance as ay be required in the evaluation of applications for nurse-midwifery certification
Authority: Section 2742.2 of B&P Code
Membership: 6 CNMs, 1 physician, 1 RN, 1 member of the public
Terms: 3 years
Relationships: committee is advisory to BRN through Nursing Practice Committee, reports from NMAC will be submitted to Nursing Practice Committee
Quorum: 5 committee members, 2 of which are CNMs

July 8, 2014----California Nurse-Midwives Association----california.midwife.org
5/26/1993 Memorandum
To: NMAC members
From: Alice Takahashi
Subject: June Committee Meeting
Scheduled 6/8/1993
Agenda:
1. Review charge to committee
2. Consider method six applicants (2)
3. Consider foreign applicant for method 3
4. Review and revise guidelines for remediation
5. Review/revise management of routine gynecological care and family planning
6. Member terms, next meeting
7. Other
Attachments:
1. Charge to the NMAC:
   Purpose: advise the board on matters relating to nurse-midwifery, develop the necessary standards related to educational requirements, and to provide such assistance as may be required in the evaluation of applications for nurse-midwifery certification
   Authority: Section 2742.2 of Business and Professions Code
   Membership: 6 CNMs, 1 physician, 1 RN, 1 member of the public
   Term: 3 years
   Relationships: advisory to the Board through its Nursing Practice Committee, reports from NMAC sent to Nursing Practice Committee Meetings: meet as necessary to carry out its assigned tasks
   Quorum: 5 committee members, 2 of which are nurse-midwives
2. California Educational Requirements for Nurse-Midwifery Programs
3. Administration of Perineal Anesthesia Remediation Guidelines
4. Episiotomy Remediation Guidelines
5. Remediation Guidelines for Courses in Family Planning
7. Repair of episiotomy and Lacerations Remediation Guidelines
8. Remediation Guidelines for Courses in Genetics

6/8/1993 BRN, NMAC Agenda Item Summaries
- California Educational Requirements for Nurse-Midwifery Programs
- 1991 Application for Nurse-Midwife Certification
- Subject Content of Advanced Experience in Maternal and Child Care Revised 1985
- Evaluation of Nurse-Midwifery Clinical Competency
- Guidelines for Evaluation of Clinical Performance - Nurse Midwifery

July 8, 2014-----California Nurse-Midwives Association-----california.midwife.org
6/8/1993 NMAC Minutes
Attending: Gretchen Andrews, IBCLC- The Lactation Connection, Susan Detwiler, RN, Ilene Gelbaum CNM, Laura Romero CNM, Gwen Spears CNM
Staff: Maria Bedroni, Alice Takahashi

Agenda:
1. Review charge to the NMAC
2. Credential review of applicant “A” for certification as a nurse-midwife through equivalency method six
3. Credential review of foreign applicants “B”, “C” and “D” for certification as a nurse-midwife through equivalency method 2
4. Review and update section (E) of California education requirements for nurse midwifery programs, “Management of Routine Gynecological Care and Family Planning”
5. Update on use board approved nurse-midwifery exam as equivalency exam: information only

Attachments: Remediation guide Nurse-midwifery management process, guidelines for evaluation for clinical performance nurse midwifery, remediation guidelines: administration of perineal anesthesia, episiotomy, repair of episiotomy and lacerations, family planning, genetics

6/18/1993 Memorandum
To: NMAC
From: Alice Takahashi
   - Enclosed minutes from 6/8/1993 meeting, revised remediation guidelines, clinical performance evaluation

No Date: NMAC List
Gretchen Andrews – public member; term expires 9/1994
Sue Detwiler, RN; term expires 9/1992
Ilene Gelbaum, CNM; term expires 9/1994
George Kibler, MD; term expires 9/1994
Karen Laing, CNM; term expires 9/1992
Maria Victoria Mangini, CNM; term expires 9/1993
Suellen Miller, CNM; term expires 9/1992
Laura Romero, CNM; term expires 9/1994
Gwendolyn V. Spears, CNM; term expires 9/1994

9/1993 NMAC Member List:
Gretchen Andrews – public member; term expires 9/1994
Sue Detwiler, RN; term expires 9/1992
Ilene Gelbaum, CNM; term expires 9/1994
George Kibler, MD; term expires 9/1994
Andrea Dixon, CNM; term expires 9/1996

July 8, 2014-----California Nurse-Midwives Association-----california.midwife.org
6/30/1994 NMAC Minutes
Attending: Ilene Gelbaum, CNM, Lindy Johnson, CNM, George Kibler, MD, Laura Romero, CNM, Susan Detwiler, RN, Gwendolyn Spears, CNM, Gretchen Andrews, pubic members
Staff: Maria Bedroni, Alice Takahashi, Marlene Bowman, Gabriele Underwood
Others; Todd Gastal, DC
Lynette Allen, Student NMW
1. Review charge to the NMAC
2. Review minutes of 6/8/1993
3. Review methods of certification for nurse-midwives
4. Review and update remediation guidelines
5. Review and recommend changes if appropriate to California education requirements for nurse-midwifery program listing
6. Information only: discuss SB 305, Killia’s Licensed Midwifery Act and its relation to RNs
   a. Passed 1/1/1994
   b. View of NMAC that it does not relate to RNs d/t law requires nurses who are midwives to be CNMs
7. Discussion on future direction of nurse-midwifery
   a. Reimbursement
   b. Physician supervision
   c. Difficulty in obtaining hospital privileges
8. Information only: Review term expirations
Attachments: Remediation Guidelines, Clinical Evaluations, California Educational Requirements for Nurse-Midwifery Programs

1/1995
Charge to the NMAC
Purpose: committee is appointed to advise the Board on matters relating to nurse-midwifery, develop necessary standards related to educational requirements and to provide such assistance as may be required in the evaluation of applications for nurse-midwifery certification
Authority: section 2746.2 of business and professions code
Membership: committed shall be composed of 6 CNMs, 1 physician, 1 RN, 1 member of the public
Term: 3 years
Relationships: committee is advisory to the Board through its education/licensing committee. Reports of n NMAC with be submitted to the education/licensing committee

July 8, 2014----California Nurse-Midwives Association----california.midwife.org
Meetings: Shall meet as necessary to carry out its assigned tasks
Quorum: 5 committee members, 2 shall be CNMs

1995 NMAC List of Members
Gretchen Andrews – public member; term expires 1/1/1998
Sue Detwiler, RN; term expires 1/1/1996
Andrea Dixon CNM; term expires 1/1/1997
Ilene Gelbaum, CNM; term expires 1/1/1998
Betsy Greulich, CNM term expires 1/1/1998
Lauren Hunter CNM; term expires 1/1/1998
Linda Johnson, CNM; term expires 1/1/1997
George Kibler, MD; term expires 1/1/1997
Jeanne Rous, CNM term expires 1/1/1997

6/15/1995 NMAC Meeting Minutes
Members: Susan Detweiler RN, Ilene, Gelbaum CNM, Betsy Greulich CNM, Lindy
Johnson CNM, Jeanne Rous CNM
Staff: Alice Takahashi, Janette Wackerly, Cindy Flores
1. Approval of 6/30/1994 minutes
2. Review of charge to NMAC
   a. Change: make recommendations through education/licensing
      committee d/t majority of items referred to education issues, matters
      regarding practice can still go t the nursing practice committee
3. Discussion of results of BRN CNM questionnaire
   a. Recurring issues found: reimbursement, restraint of trade, physician
      supervision, malpractice insurance, hospital admitting privileges,
      changes practice from nurse midwifery to increasing area of women’s
      health
4. Action items for discussion
   a. Revision of remediation guidelines
   b. Approve proposed new guidelines for gynecology fetal well being,
      laboratory, and diagnostic tests
5. Policy

10/14/1995 NMAC Meeting Minutes
Members: Andrea Dixon CNM, Ilene Gelbaum CNM, Betsy Greulich CNM, Lauren
Hunter CNM, George Kibler MD, Jeanne Rouse CNM, Gretchen Andrews public
members, Sue Detweiler RN, Lindy Johnson CNM
Staff: Alice Takahashi, Janette Wackerly, Gabriele Underwood, Maria Bedroni, Usrah
Claar-Rice
1. Approval of 6/10/1995 minutes
2. Discussion of attorney general opinion 94-1011, performance of an
   episiotomy by a CNM

July 8, 2014-----California Nurse-Midwives Association-----california.midwife.org
a. Concluded 7/31/1995 that a nurse midwife may not perform an episiotomy pursuant to a standardized procedure, and it is not within scope of practice of CNM
b. Stated for CNMs to lawfully perform episiotomy, statue requires amendment

3. Remediation guidelines update; guidelines for a CNM on probation
4. Discuss the CNMs role in primary care
5. Review existing statues and regulations for nurse-midwifery, recommend additions, revisions
   a. Title protection
   b. Episiotomy
   c. Qualifications for certification
      i. decision to retain methods 1,2,3 and delete 4,5,6
   d. standards for education
      i. revisions and proposed changes will be place din appropriate format by staff and prepared for Board approval process

10/23/1995 Letter
To: Alice Takahashi
From: Betsy Greulich
1. Request for NMAC Members
2. Reports at last chapter meeting and CNMA board meeting NPA should not be changed
3. Deadline for deletion of method 6 d/t nurse wanting to be certified through this method
AGENDA ITEM: 10.4
DATE: October 9, 2014

ACTION REQUESTED: Information: Drug Enforcement Administration Publishes Final Rule Rescheduling Hydrocodone Combination Products from Schedule III to Schedule II Controlled Substances

REQUESTED BY: Trande Phillips, RN
Chair Practice Committee

BACKGROUND:
The Drug Enforcement Administration will publish in the Federal Register the Final Rule moving hydrocodone combination products (HCPs) from Schedule III to more restrictive Schedule II as recommended by the Assistant Secretary for Health of the U.S. Department of Health and Human Services (HHS). The Federal Register has made the Final Rule available for preview on its website http://go.usa.gov/mc8d

The BRN has been contacted by nurse practitioners who have Schedule III-V Controlled Substances DEA registration. If a NP wants to prescribe Schedule II, there is an additional requirement for education which must be met

NEXT STEPS: Place on Board agenda.

FISCAL IMPACT, IF ANY:

PERSON(S) TO CONTACT: Janette Wackerly, MBA, BSN, RN
SNEC
916-574-7686
DEA to Publish Final Rule Rescheduling Hydrocodone Combination Products

AUG 21 (WASHINGTON) - On Friday the U.S. Drug Enforcement Administration (DEA) will publish in the Federal Register the Final Rule moving hydrocodone combination products (HCPs) from Schedule III to the more-restrictive Schedule II, as recommended by the Assistant Secretary for Health of the U.S. Department of Health and Human Services (HHS) and as supported by the DEA's own evaluation of relevant data. The Federal Register has made the Final Rule available for preview on its website today at http://go.usa.gov/mcBd.

This Final Rule imposes the regulatory controls and sanctions applicable to Schedule II substances on those who handle or propose to handle HCPs. It goes into effect in 45 days.

The Controlled Substances Act (CSA) places substances with accepted medical uses into one of four schedules, with the substances with the highest potential for harm and abuse being placed in Schedule II, and substances with progressively less potential for harm and abuse being placed in Schedules III through V. (Schedule I is reserved for those controlled substances with no currently accepted medical use and lack of accepted safety for use.)

HCPs are drugs that contain both hydrocodone, which by itself is a Schedule II drug, and specified amounts of other substances, such as acetaminophen or aspirin.

"Almost seven million Americans abuse controlled-substance prescription medications, including opioid painkillers, resulting in more deaths from prescription drug overdoses than auto accidents," said DEA Administrator Michele Leonhart, "Today's action recognizes that these products are some of the most addictive and potentially dangerous prescription medications available."

When Congress passed the CSA in 1970, it placed HCPs in Schedule III even though it had placed hydrocodone itself in Schedule II. The current analysis of HCPs by HHS and the DEA shows they have a high potential for abuse, and abuse may lead to severe psychological or physical dependence. Adding nonnarcotic substances like acetaminophen to hydrocodone does not diminish its abuse potential. The many findings by the DEA and HHS and the data that support these findings are presented in detail in the Final Rule on the website. Data and surveys from multiple federal and non-federal agencies show the extent of abuse of HCPs. For example, Monitoring the Future surveys of 8th, 10th, and 12th graders from 2002 to 2011 found that twice as many high school seniors used Vicodin®, an HCP, nonmedically as used OxyContin®, a Schedule II substance, which is more tightly controlled.

In general, substances placed under the control of the CSA since it was passed by Congress in 1970 are scheduled or rescheduled by the DEA, as required by the CSA and its implementing regulations, found in Title 21 of the Code of Federal Regulations. Scheduling or rescheduling of a substance can be initiated by the DEA, by the HHS Assistant Secretary of Health, or on the petition of any interested party. (Detailed information on the scheduling and rescheduling process can be found beginning on page 8 of Drugs of Abuse on the DEA’s website at http://www.justice.gov/dea/pr/multimedia-library/publications/drug_of_abuse.pdf.)

The rescheduling of HCPs was initiated by a petition from a physician in 1999. The DEA submitted a request to HHS for a scientific and medical evaluation of HCPs and a scheduling recommendation. In 2013, the U.S. Food and Drug Administration held a public Advisory Committee meeting on the matter, and the committee voted to recommend rescheduling HCPs from Schedule III to Schedule II by a vote of 19 to 10. Consistent with the outcome of that vote, in December of 2013 HHS sent such a recommendation to the DEA. Two months later, on February 27, the DEA informed Americans of its intent to move HCPs from Schedule III to Schedule II by publishing a Notice of Proposed Rulemaking in the Federal Register, outlining its rationale and the proposed changes in detail and soliciting public comments on the proposal, of which almost 600 were received. A small majority of the commenters supported the proposed change.
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Public Record Actions

Administrative Disciplinary Actions
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Court Order
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License Issued with Public Letter of Reprimand
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https://www.breeze.ca.gov/datamart/detailsCADCA.do?selector=false&sele... 9/25/2014
Assembly Bill 1196, (Montanez), Chapter 748 was signed by Governor Gray Davis on October 9, 2003 and became effective January 1, 2004. The new law amends Business and Professions Code, BPC, Section 2836.1 Furnishing. This amended law expands the certified nurse practitioner furnishing authority to include pharmaceutical drugs that are classified as Schedule II controlled substance under the California Uniform Controlled Substance Act. The new law requires the BRN certified nurse practitioners with an active furnishing number and registration with the United States Drug Administration. The furnishing nurse practitioner with a DEA registration may by approved standardized procedure or protocol furnish or order Schedule II controlled substances. The furnishing nurse practitioner must complete a BRN approved continuing education course that includes Schedule II controlled substances prior to receiving her DEA authority for Schedule II controlled substances.

The following is a summary of the changes to BCP 2836.1 and the entire Section 2836.1 follows with the changes underlined and highlighted:

- **Schedule II controlled substance protocols**, the provision for furnishing Schedule II controlled substances shall address the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.

- **Drugs and devices furnished or ordered by a nurse practitioner may include Schedule II through V controlled substances under the California Uniform Controlled Substance Act (Division 10 (commencing with Section 1100) of the Health and Safety Code and shall be further limited to those drugs and devices agreed upon by the nurse practitioner and physician and surgeon and specified in the standardized procedure.**

- **Schedule II or III controlled substances furnished or ordered by the nurse practitioner, furnished or ordered in accordance with a patient specific protocol approved by the treating or supervision physician.**

- **NPs who are BRN certified and with an active furnishing number, authorized by approved standardized procedure or protocols to furnish Schedule II controlled substances, and registered with the United States Drug Enforcement Administration, DEA, shall complete, as part of their continuing education requirements, a course including Schedule II controlled substances based on the standards developed by the board.**
2836.1. Neither this chapter nor any other provision of law shall be construed to prohibit a nurse practitioner from furnishing or ordering drugs or devices when all of the following apply:

(a) The drugs or devices are furnished or ordered by a nurse practitioner in accordance with standardized procedures or protocols developed by the nurse practitioner and the supervising physician and surgeon under any of the following circumstances:

(1) When furnished or ordered incidental to the provision of family planning services.
(2) When furnished or ordered incidental to the provision of routine health care or prenatal care.
(3) When rendered to essentially healthy persons.

(b) The nurse practitioner is functioning pursuant to standardized procedure, as defined by Section 2725, or protocol. The standardized procedure or protocol shall be developed and approved by the supervising physician and surgeon, the nurse practitioner, and the facility administrator or the designee.

(c) (1) The standardized procedure or protocol covering the furnishing of drugs or devices shall specify which nurse practitioners may furnish or order drugs or devices, which drugs or devices may be furnished or ordered, under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the nurse practitioner's competence, including peer review, and review of the provisions of the standardized procedure.
(2) In addition to the requirements in paragraph (1), for Schedule II controlled substance protocols, the provision for furnishing Schedule II controlled substances shall address the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.

(d) The furnishing or ordering of drugs or devices by a nurse practitioner occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include (1) collaboration on the development of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by telephonic contact at the time of patient examination by the nurse practitioner.

(e) For purposes of this section, no physician and surgeon shall supervise more than four nurse practitioners at one time.

(f) (1) Drugs or devices furnished or ordered by a nurse practitioner may include Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and shall be further limited to those drugs agreed upon by the nurse practitioner and physician and surgeon and specified in the standardized procedure.
(2) When Schedule II or III controlled substances, as defined in Sections 11055 and 11056, respectively, of the Health and Safety Code, are furnished or ordered by a nurse practitioner, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. A copy of the section of the nurse practitioner's standardized procedure relating to controlled substances shall be provided, upon request, to any licensed pharmacist who dispenses drugs or devices, when there is uncertainty about the nurse practitioner furnishing the order.

(g) (1) The board has certified in accordance with Section 2836.3 that the nurse practitioner has satisfactorily completed (1) at least six month's physician and surgeon-supervised experience in the furnishing or ordering of drugs or devices and (2) a course in pharmacology covering the drugs or devices to be furnished or ordered under this section.
(2) Nurse practitioners who are certified by the board and hold an active furnishing number, who are authorized through standardized procedures or protocols to furnish Schedule II controlled substances, and who are registered with the United States Drug Enforcement Administration, shall complete, as part of their continuing education requirements, a course including Schedule II controlled substances based on the standards developed by the board. The board shall establish the requirements for satisfactory completion of this subdivision.

(h) Use of the term "furnishing" in this section, in health facilities defined in subdivisions (b), (c), (d), (e), and (i) of Section 1250 of the Health and Safety Code, shall include (1) the ordering of a drug or device in accordance with the standardized procedure and (2) transmitting an order of a supervising physician and surgeon.

(i) "Drug order" or "order" for purposes of this section means an order for medication which is dispensed to or for an ultimate user, issued by a nurse practitioner as an individual practitioner, within
the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription of the supervising physician; (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by nurse practitioners; and (3) the signature of a nurse practitioner on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

SB 151 (Burton) Chapter 406 was signed by Governor Gray Davis on September 16, 2003 to become effective January 1, 2003. The bill amends existing law that provides for electronic monitoring of prescribing and dispensing of Schedule II controlled substances pursuant to the Controlled Substance Utilization Review and Evaluation System (CURES) program. By increasing the scope of Nursing Practice Act, the violation of which is a misdemeanor, the bill would impose a state-mandated local program. SB 151, Burton, Chapter incorporates additional changes to Section 11165 of the Health and Safety Code.
AGENDA ITEM: 10.5  
DATE: October 9, 2014

ACTION REQUESTED: Community Paramedicine- Office of Statewide Planning and Development Pilot Project 173

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

BACKGROUND:

Emergency Medical Services Authority (EMSA) submitted a proposal for community paramedicine projects to the Office of Statewide Planning & Development (OSHPD). The proposal details plans to conduct 12 community paramedicine (CP) projects across California to test a new health care delivery model which will expand the paramedic scope of practice. Selected paramedics will receive additional training to provide services beyond their customary roles in emergency response and transport. Tentative date for the decision will be October/November.

Dr. Kizer, Director, Institute for Population Health Improvement, UC Davis Health System, Dr. Shore, Senior Policy Analyst, Institute for Population Health Improvement, UC Davis Health System, and Dr. Moulin, Assistant Professor, Department of Emergency Medicine, UC Davis School of Medicine authors of the Community Paramedicine: A Promising Model for Integrating Emergency and Primary Care report (2013). Community paramedicine pre-hospital and post-hospital or community health services include the following six components:

1. Transport patients with specified conditions not needing emergency care to non-ED locations (“alternate locations”),
2. After assessing and treating as needed, determine whether it is appropriate to refer or release an individual at the scene of an emergency response rather than transport the person to a hospital ED
3. Assist frequent 911 callers or frequent visitors to EDs to access primary care and other social services
4. Provide support for persons who have been recently discharged from the hospital and are at increased risk of a return visit to the ED or readmission to the hospital.
5. Provide support for persons who have been recently discharged from the hospital and are at increased risk of a return visit to the ED or readmission to the hospital.
6. Partner with community health workers and primary care providers in underserved areas to provide preventive care

RESOURCES:

Office of Statewide Health Planning & Development (OSHPD) Community Paramedicine Pilot Project

NEXT STEPS: Place on Board agenda.

FISCAL IMPACT, IF ANY: None

PERSON(S) TO CONTACT: Janette Wackerly, MBA, BSN, RN
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Nursing Practice Committee Meeting
October 9, 2014
Community Paramedicine Project Briefs
Project Briefs

1. Transport patients with specified conditions to alternate locations that can be managed in
health care settings other than an acute care emergency department, such as an urgent
care or general medical clinic.
2. Address the needs of frequent 9-1-1 callers or frequent visitors to emergency departments
by helping them access primary care and other social or psychological services.
3. Provide short-term home follow-up care for persons recently discharged from the hospital
and at increased risk of a return visit to the emergency department or readmission to the
hospital with referral from the hospital, clinic, or medical provider.
4. Provide short-term home support for persons with diabetes, asthma, congestive heart
failure, AMI, Sepsis or multiple chronic conditions with referral and under protocol from
the medical home clinic or provider.
5. Partner with public health, community health workers, and primary care providers in
underserved areas to provide preventive care.

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<td>Direct observed therapy</td>
<td>CP005</td>
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<tr>
<td>Hospice support</td>
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1. **CP 001** Proposal for alternate transport destination for communities in **Los Angeles County**.
   This proposal will allow paramedics to transport patients with a specified conditions not needing
   emergency care to alternate, non-emergency department locations.

2. **CP 002** Proposal is for Paramedics in **Glendale & Burbank** to reduce heart failure
   readmissions. The proposal is for post-hospital follow-up care for chronic conditions.
   Paramedics will determine whether patients are within individualized clinical benchmarks and
   can wait their follow-up office visit, demonstrating sign/symptoms suggesting the need for same-
   day physician consultation/intervention or showing signs of imminent decompensation requiring
   urgent transportation for medical intervention.

3. **CP 003** Proposal is for Paramedics in **Orange County** to triage and transport patients to
   alternative destinations. The paramedic is to determine the acuity status and potential for
   transportation to an alternate location such as urgent care clinics or mental health clinics.

4. **CP 004** Proposal is for Paramedics in **Butte County** to assess the safety and value of
   modifying the Paramedic Scope of Practice. To achieve this, paramedics will provide follow-up
assistance for patients with a post hospital discharge diagnosis of Acute Myocardial Infarction or Heart Failure and care for chronic conditions to reinforce primary care provider instructions for patients with heart failure. Paramedics will provide a follow-up telephone within 48 hours of discharge to obtain a status report on their current medical condition.

5. **CP 005** Proposal is for Paramedics in **Ventura County** to expand their services to Direct Observed Therapy (DOT) to administer TB medications, assess patients for disease progression or medication reaction and to treat reactions with Diphenhydramine, Ondansetron, or other medications.

6. **CP 006** Proposal is for paramedics in **Santa Barbara and Ventura County** to provide hospice comfort and supportive care and administer medications, provide grief and crisis support for patient, family and friends until the hospice clinicians can take over.

7. **CP 007** Proposal is for paramedics in **Alameda County** to connect patients with their primary health care providers proactively and avoid unnecessary EMS transports, ED visits, and hospitalizations. According to the proposal, there is no service that provides this level of pre-hospital assessment and care for non-acute medical conditions.

8. **CP 008** Proposal is for paramedics in **San Bernardino County** to provide follow-up post-hospital or emergency department discharge to augment discharge planning and promote treatment plan compliance by identifying these patients who do not have access to home health or other discharge follow-up.

9. **CP 009** Proposal is for paramedics in **Carlsbad** to transport patients with specified conditions not needing emergency care to alternate, non-emergency department locations such as local medical offices.

10. **CP 010** Proposal is for paramedics in **San Diego** to manage frequent 911 callers, assess, treat and refer after appropriate assessment and treatment, transport to alternate locations, post-hospital or emergency department follow-up, care for chronic conditions- reinforce primary care provider instructions.

11. **CP 011** Proposal is for paramedics in **Stanislaus County** to assess, treat, and transport behavioral health patients to appropriate alternate care at behavioral health treatment facilities.

12. **CC 012** Proposal is for paramedics in **Solano County** to provide post-hospital discharge follow-up, treatment and referral of patients with a confirmed diagnosis of chronic obstructive pulmonary disease, congestive heart failure, or at risk of medical, non-compliance, or rapid decompensation by providing post-hospital discharge home visits coordination of follow-up care necessary/appropriate transportation and medication reconciliation and make referrals to a licensed healthcare provider when an intervention could prevent an exacerbation of a medical condition.
Community Paramedicine: A Promising Model for Integrating Emergency and Primary Care

AUTHORS

Kenneth W. Kizer, MD, MPH
Distinguished Professor, UC Davis School of Medicine (Department of Emergency Medicine) and Betty Irene Moore School of Nursing; Director, Institute for Population Health Improvement, UC Davis Health System

Karen Shore, PhD
Senior Policy Analyst, Institute for Population Health Improvement, UC Davis Health System

Aimee Moulin, MD
Assistant Professor, Department of Emergency Medicine, UC Davis School of Medicine

Report prepared for the California HealthCare Foundation and California Emergency Medical Services Authority in partial fulfillment of the Leveraging EMS Assets and Community Paramedicine Project funded by the California HealthCare Foundation (Grant Number 17119, Regents of the University of California).
Introduction

Community paramedicine (CP) is a new and evolving model of community-based health care in which paramedics function outside their customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care resources and/or enhance access to primary care for medically underserved populations. CP programs have been independently developed in a number of states and countries, and thus are varied in nature. These programs typically have been designed to address specific local problems and to take advantage of locally developed collaborations between and among emergency medical services (EMS) and other health care and social service providers. Interest in this model of care has grown substantially in recent years in the belief that it may improve access to and quality of care while also reducing costs.

Historically, EMS has focused on providing emergency treatment for persons suffering acute medical problems in community settings, while transporting such persons to a hospital emergency department (ED), and when needed, in the ED until care is taken over by hospital staff. EMS personnel also have been utilized to transport ill or injured persons between hospitals.

The inherent nature of emergency care makes it more expensive than many other types of health care services. EMS systems and hospital EDs must be prepared to handle a wide array of routine and unusual problems that occur unexpectedly and often require a rapid response with specialized skills and equipment because the problems are serious and sometimes life threatening. Consequently, the fixed costs associated with operating and maintaining emergency care services are high.

As concern about rising health care costs has grown in recent years, increased efforts have been directed at ensuring that expensive emergency care resources are optimally utilized. Also, because the overwhelming majority of EMS systems rely on fire departments and other publicly funded agencies to provide at least some services, and because most local governments are under significant financial strain, local EMS providers have increasingly sought to secure additional sources of financial support. Early experiences with CP programs suggest that they may lead to more optimal use of EMS assets and offer some potential for diversification of the EMS funding base. In particular, CP programs may result in:

1. More appropriate use of emergency care services. Perhaps the best demonstrated benefit of CP programs has been in getting persons who have accessed the EMS system, but do not have a medically emergent condition, to more appropriate destinations than a hospital ED. This may yield financial savings and, in some cases, improve the coordination and continuity of care.

2. Increased access to primary care for medically underserved populations. Some CP programs have provided solutions to primary care problems that were otherwise not being well addressed. For example, some CP programs provide short-term (e.g., within 72 hours of discharge) follow-up home visits for patients who have just been discharged from a hospital or ED until other providers are able to provide the home visits or other follow-up care. Such follow-up care may help prevent ED or hospital readmissions.

3. Enhanced opportunities for EMS personnel skills development and maintenance. CP programs aimed at providing primary care for medically underserved populations may also provide opportunities for EMS personnel in low-call-volume settings (e.g., rural areas) to further develop patient assessment skills, as well as more frequently utilize their basic skills. This helps them maintain their skills and expand their clinical experience.

Recognizing the widening gap between the demand for health care services and California’s supply of health care workers, and of the need for health care resources to be optimally utilized, including providers working as much as possible at the top of their skills, the California HealthCare Foundation and California Emergency Medical Services Authority (EMSA) asked the Institute for Population Health Improvement (IPHI), University of California Davis Health System, to assess the feasibility of developing community paramedicine programs in California. They asked IPHI to explore whether use of paramedics in expanded roles might be a practical option for California communities to consider when addressing health care needs in coming years.

This report provides a brief history of EMS systems and paramedicine in California, a broad overview of the development
of community paramedicine in other states and countries, a summary of current perspectives on CP in the state based on interviews with key stakeholders, and a discussion of the barriers to implementing CP programs in California. We conclude the report with several recommendations for further exploration of the role of community paramedicine in California.

The Evolution of Emergency Medical Services in California

The term paramedicine refers to public health or health care–related activities performed by nonphysicians working as adjuncts or assistants to doctors. Paramedicine has been used most often to refer to emergency medical care provided outside of hospitals, although it is by no means limited to emergency care. The history of emergency care paramedicine is especially linked to military medicine and dates back to the Roman legions, when aging centurions no longer able to fight were used to provide aid to and remove wounded warriors from the battlefield.

The evolution of modern paramedicine and EMS in California began in the late 1960s, concomitant with the growing awareness in the state and nation of the alarmingly high number of out-of-hospital deaths from trauma and cardiac arrest.1 A pilot project using mobile intensive care paramedics was formally launched in Los Angeles County in early 1970. The Wedworth-Townsend Paramedic Act, which defined the role and scope of practice of mobile intensive care paramedics and nurses, was signed into law by then governor Ronald Reagan on July 14, 1970. It made California the first state to adopt legislation permitting paramedics to provide advanced medical life support.2 The LA County paramedic pilot program was expanded in 1972, and other California counties soon began to develop EMS programs.

Responsibility for coordinating EMS development in the state was initially assigned to the EMS Section of the then California Department of Health Services (DHS). However, the department did not place a high priority on EMS and found itself increasingly at odds with the state’s growing EMS community. DHS abolished

![Timeline of EMS Milestones in the US and California](image-url)

**FIGURE 1. Timeline of EMS Milestones in the US and California**

**California**

Note: EMCC = emergency medical care committee, LEMSA = local EMS agency.
its EMS Section in 1979, resulting in counties becoming the focal point of EMS systems development and leading to enactment of legislation in 1980 creating a new standalone EMS Authority within the then California Health and Welfare Agency. EMSA was charged with being the lead state agency for emergency and disaster medical services, although DHS retained responsibility for many aspects of emergency and disaster public health and medical response.

State regulations establishing training and other standards for paramedics were promulgated by EMSA in 1983. These were followed in 1984 by statewide guidelines for local EMS systems, standards for local trauma care systems, and training standards for other EMS providers. These standards and guidelines have been incrementally revised and updated over the years, but the regulatory framework established in the early 1980s has remained the basic foundation for the state’s EMS systems. Figure 1 (page 3) provides a timeline of key EMS milestones in the US and California.

EMS activities in California are regulated at the state level by EMSA pursuant to Division 2.5, California Health and Safety Code, and Division 9, Title 22, California Code of Regulations. EMSA is one of 13 departments administered by the California Health and Human Services Agency. Day-to-day EMS activities are governed by local EMS agencies, which follow state regulations and standards established by EMSA. Currently, there are 25 single-county and 7 multicounty local EMS agencies in California (see Appendix A).

EMSA is statutorily authorized to develop and implement regulations governing the medical training and scope of practice for emergency medical care personnel, including emergency medical technicians (EMTs), public safety personnel (e.g., firefighters, law enforcement officers, lifeguards), and mobile intensive care nurses, among others. EMTs are trained according to state standards and then licensed (paramedics) or certified (basic and advanced EMTs) to render emergency medical care in pre- and inter-hospital settings.

There are three levels of EMTs in California: basic (EMT), advanced (A-EMT), and paramedic (EMT-P). Paramedics are trained and licensed in advanced life support skills, including endotracheal intubation and selected other invasive procedures, as well as the intravenous and intramuscular administration of medications. They are typically employed by public safety agencies (e.g., fire departments) or private ambulance companies. Requirements for EMT and paramedic initial training and continuing education are listed in Figure 2, and the skills and activities in the scope of practice for EMTs and paramedics is summarized in Figure 3.

**FIGURE 2. Education and Training Requirements for California EMTs**

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<td>160 hours of training:</td>
<td>160 hours of training:</td>
<td>1,090 hours of training:</td>
</tr>
<tr>
<td></td>
<td>• 136 didactic</td>
<td>• 80 didactic and skills lab</td>
<td>• 450 didactic and skills lab</td>
</tr>
<tr>
<td></td>
<td>• 24 clinical</td>
<td>• 40 clinical</td>
<td>• 160 clinical</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 40 field internship</td>
<td>• 480 field internship</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15 Advanced Life Support patient contacts (minimum)</td>
<td>40 Advanced Life Support patient contacts (minimum)</td>
</tr>
<tr>
<td><strong>Exams</strong></td>
<td>National Registry of EMTs, written and skills</td>
<td>Local EMS agency, written and skills</td>
<td>National Registry of EMTs, written and skills</td>
</tr>
<tr>
<td><strong>Certification / License</strong></td>
<td>Certified by local EMS agency or public safety agency, recognized statewide</td>
<td>Certified by local EMS agency, only valid locally</td>
<td>Licensed by EMS Authority, recognized statewide</td>
</tr>
<tr>
<td></td>
<td>Accreditation by local EMS agency</td>
<td></td>
<td>Accreditation by local EMS agency</td>
</tr>
<tr>
<td><strong>Renewal</strong></td>
<td>Recertification every 2 years by:</td>
<td>Recertification every 2 years by:</td>
<td>License renewal every 2 years by:</td>
</tr>
<tr>
<td></td>
<td>• 24-hour refresher course, or</td>
<td>• 36 hours continuing education units and 6 skills competencies</td>
<td>• 48 hours continuing education units</td>
</tr>
<tr>
<td></td>
<td>• 24 hours continuing education units and 10 skill competencies</td>
<td></td>
<td>Note: Certified paramedics in other states or counties or NREMT registries must provide documentation and fill out an application to become a licensed California paramedic</td>
</tr>
</tbody>
</table>

Source: EMSA, 2013.
Services by EMTs and paramedics are provided under medical control (typically by an emergency physician) through pre-established, locally approved medical policies and protocols and through direct linkage to locally designated hospital EDs (base hospitals). These services are typically initiated by a telephone call to 911 or other emergency telephone number. See Appendix B for a depiction of the current typical EMS response to a 911 call for emergency assistance.

Paramedics became a statewide licensed health care practitioner in California in 1994. Licenses are issued by EMSA and are valid statewide, but paramedics must be accredited by a local EMS agency before practicing. Licensure by EMSA must be renewed every two years. In contrast, EMTs and A-EMTs are certified by local EMS agencies, and they must be recertified every two years. EMT certifications are valid statewide, but EMTs can only work in areas after they are certified by a local EMS agency.

Paramedics are now widely distributed throughout California but are more prevalent in urban areas. In 2010, there were approximately 19,000 licensed paramedics and nearly 60,000 EMTs in California. Nationally, there were approximately 826,000 credentialed EMS professionals in 2011, including EMTs (64%), advanced EMTs (6%), and paramedics (24%).

EMS systems are universally regarded as being an essential part of the health care delivery system today. However, they operate at the intersection of health care, public health, and public safety and generally have not been well integrated into the health care system.

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**DEFINITION: SCOPE OF PRACTICE**

Refers to the “defined parameters of various duties or services that may be provided by an individual with specific credentials. Whether regulated by rule, statute, or court decision, it represents the limits of services an individual may legally perform.”

— NHTSA REPORT: NATIONAL EMS SCOPE OF PRACTICE MODEL (2005)

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**FIGURE 3. Skills and Activities Included in the Scope of Practice for California EMTs**

**EMT**

**MINIMUM SCOPE**  Authorized to do the following during training, at the scene of an emergency, or during transport of patients:
- Patient assessment
- Advanced first aid
- Use of adjunctive breathing aid and administration of oxygen
- Automated external defibrillator
- Cardiopulmonary resuscitation
- Transportation of ill and injured persons
- EMT Basic Life Support
- Assist patients with the administration of physician-prescribed devices

**OPTIONAL SKILLS** (added at the LEMSA level under supervision of the LEMSA medical director; additional added medications must be approved by the CA EMS Authority):
- Perilaryngeal airways
- Epi pens
- Duodote kits
- Naloxone

**Advanced EMT**

**MINIMUM SCOPE**  Authorized to do the following while caring for patients in a hospital during training under physician or RN supervision, at the scene of an emergency, or during transport of patients:
- All EMT skills
- Perilaryngeal airways
- Intravenous infusion
- Obtaining venous blood
- Glucose measuring
- Additional medications that vary by LEMSA
- AEMT Limited Advanced Life Support

**OPTIONAL SKILLS (LOCAL)**  A LEMSA with an EMT-II program effective 1/1/94 may establish policies and procedures for local accreditation for performance of additional optional skills:
- Previously certified EMT-IIs have additional medications approved by the LEMSA Medical Director
- Medications may include lidocaine, hydrochloride, atropine sulfate, sodium bicarbonate, furosemide, and epinephrine

**Paramedic**

**MINIMUM SCOPE**  Authorized to do the following while caring for patients in a hospital during training under physician, RN, or PA supervision, at the scene of an emergency, during transport of patients, or while working in a small and rural hospital:
- All EMT and AEMT skills and medications
- Laryngoscope
- Endotracheal (ET) intubation (adults, oral)
- Valsalva’s Maneuver
- Needle thoracostomy and cricothyroidotomy
- Paramedic Advanced Life Support

**OPTIONAL SKILLS** (added at the LEMSA level by approval of the LEMSA medical director):
- Local EMS agencies may add additional skills and medications if approved by the CA EMS Authority
health care delivery system because of their overlapping roles and responsibilities. The Institute of Medicine highlighted this problem in a 2006 report, noting that “local EMS systems are not well integrated with any of these groups and therefore receive inadequate support from each of them.” The incentives for care coordination and greater use of community-based care provided by the Affordable Care Act present an opportunity for greater integration of EMS into the health care delivery system through new models of care such as community paramedicine.

**Funding for Local EMS Services**

Funding to support local EMS services comes from diverse public and private sources, including state and municipal taxes, state and federal grants, philanthropic and charitable donations, in-kind contributions, subscription programs, individual self-payment, and fee-for-service payments from Medicare, Medicaid, and private health insurance. In addition to the above sources, California counties may designate a portion of traffic fines to support EMS services for uninsured persons — known as the Maddy EMS fund. Funding for local EMS agencies is often derived primarily from revenues generated from patient transport, and is therefore dependent on the number of transports and the payer mix. One national estimate of funding sources indicated that “an average EMS agency receives 42% of its operating budget from Medicare fees, 19% from commercial insurers, 12% from Medicaid, and 4% from private pay; it requires approximately 23% in additional subsidization, most often provided by local taxes.” There is no central data source that tracks funding sources for California’s local EMS agencies, so California-specific data are not readily available.

Payments from commercial payers, and to a lesser extent Medicare, have historically been used to subsidize the costs of treating Medicaid and uninsured patients. Medicare plays a significant role both in revenues for local EMS agencies and in payment policy. Because individuals age 65 and over are four times more likely to use EMS services than younger individuals, Medicare represents a large proportion of utilization and revenues for local EMS agencies. In California, for example, Medicare patients account for about 35% of all ambulance transports and 25% of reimbursements. Medi-Cal patients account for about 21% of ambulance transports and only 5% of reimbursements. Much of the cross-subsidization in California comes from commercial health plans, whose patients represent 18% of transports and 38% of reimbursements. Medicare has shaped the provision of EMS through policies requiring patient transport for payment, a practice other payers have followed.

“At the very broadest level, the health care system is ill-equipped to take care of the volume of patients and provide the care needed. We have to deliver health care and bring about health in new ways.”

— STATE AGENCY OFFICIAL

**Changing EMS and Health Care Environments in California**

The overall health care environment of California and the state’s health care delivery system are rapidly changing due to efforts to control health care costs, improve care quality and service, deploy health information and advanced telecommunication technologies, and implement the Affordable Care Act, among other reasons. A description of the myriad activities in this regard is beyond the scope of this report; however, the widening gap between the demand for health care services and the supply of physicians and other health care workers to provide such services is especially pertinent to the consideration of community paramedicine.

California has experienced and for the next few years will continue to experience a significantly increased demand for health care services. This increased demand is being driven primarily by population growth and aging, the rising prevalence of chronic diseases, and increased health insurance coverage consequent to the Affordable Care Act. An additional 3.4 million Californians are expected to be covered by health insurance by 2016. At the same time that the demand for health care services is sharply rising, the workforce to supply those services is shrinking due to aging, health care cost control strategies, and growing dissatisfaction with private practice among physicians,
among other causes. The number of physicians graduating from the state’s eight medical schools has not materially increased in recent years, and about a third of California’s physicians are age 60 or over. Some counties are anticipating that a quarter or more of currently practicing physicians will retire in the next five years. The gap between health care service demand and health care provider supply is widening the most in rural and other medically underserved communities. This growing gap raises the specter of an impending health care access crisis. Ironically, instead of being driven by the lack of health insurance, this impending access crisis is due in significant part to the increased availability of insurance.

To mitigate the gap between the demand for services and the workforce available to provide those services, it is essential to optimally utilize all caregivers. This will require that all providers work at the top of their training and skills. In addition, more needs to be done to coordinate and integrate services across the continuum of care and to increase the number of caregivers. Using paramedics in expanded roles to address locally determined community health needs may be a promising opportunity to leverage an existing caregiver resource to address identified needs and provide overall greater value.

History and Development of Community Paramedicine
In recent years, a number of community-based programs have been developed that utilize paramedics in roles or settings outside their traditional emergency response and transport roles. These CP programs have been implemented in a number of states in the US (e.g., Colorado, Minnesota, Texas) and other countries, including Canada, England, and Australia. The implementation, operational costs, and outcomes of these programs in the US are still being assessed, and little data is available at this time. There is a longer history and more literature on the outcomes of CP programs in other countries, but differences in methods of financing and delivering care in these countries make it difficult to generalize the findings to the US. Interest in developing CP programs has been especially high in rural and other medically underserved areas.

Utilizing paramedics in expanded roles is attractive because they are already trained to perform patient assessments and to recognize and manage life-threatening conditions in out-of-hospital settings. They are accustomed to providing care in home and community settings under relatively austere medical care conditions, are available 24/7/365, and are widely trusted and respected by the public. Further, paramedics are accustomed to collaborating with other health care providers in a variety of settings.

There are multiple definitions of community paramedicine, but most embrace three key tenets:
1. CP programs begin with a community-specific health care needs assessment.
2. Community paramedics are specially trained to provide services to meet those local needs.
3. Community paramedics provide services under clear medical control (i.e., under a physician’s direction and supervision).

DEFINITION: MEDICAL CONTROL

Physician direction over prehospital activities to ensure efficient and proficient trauma triage, transportation, and care, as well as ongoing quality management

— NHTSA REPORT: TRAUMA SYSTEM AGENDA FOR THE FUTURE (2002)

In this report, the following working definitions are used:

- **Community paramedicine** is a locally designed, community-based, collaborative model of care that leverages the skills of paramedics and EMS systems to address care gaps identified through a community-specific health care needs assessment.

- A **community paramedic** is a paramedic with additional standardized training who works within a designated community paramedicine program under local medical control as part of a community-based team of health and social services providers.
A number of principles underlie the structure and goals of CP programs. These principles are briefly described below:

- Community paramedicine programs are not intended to duplicate or compete with other community health care services, but rather are intended to fill identified gaps in care working in collaboration and partnership with existing health care providers.

- Community paramedics would be licensed, as are all paramedics in California. They would not be independent practitioners, but rather would work under approved protocols and a physician’s direction (i.e., under “medical control”).

- Community paramedics would undergo additional education and training, the exact requirements of which would depend, in part, on the objectives and scope of the CP program. At least one standardized curriculum for community paramedics is publicly available. Communities also could tailor additional education to address local needs. Training would occur in the various settings in which community paramedics would potentially work with collaborating providers, including primary care clinics, physician offices, nursing homes and other long term care facilities, substance abuse treatment programs, and mental health facilities, among others.

- It is expected that the additional training will provide community paramedics with enhanced decision-making skills to prepare them for expanded clinical decision-making responsibilities. When they are providing services in the community, they would be supported through protocols, and direct online (telephone or video) medical control would be available.

- It is likely that only a small percentage of more experienced paramedics would become community paramedics.

- Medical control for community paramedics may involve other types of physicians (e.g., general internists, family practitioners, pediatricians, geriatricians) in addition to emergency medicine physicians, depending on the type of services being provided in the CP program.

- The goal of CP programs would be to get the patient to the right care, delivered by the right provider, at the right time, resulting in the best outcomes and most efficient use of the region’s health care resources, as specified in the Affordable Care Act.

**Components of Community Paramedicine Programs**

A variety of services and activities have been included in CP programs in other states and countries. Six services have been selected for this report, and these can be divided between prehospital and post-hospital or community health services (see Figure 4). Each is described in detail in Figures 5–10.

**Prehospital Services**

- Transport patients with specified conditions not needing emergency care to alternate, non-emergency department locations.

- After assessing and treating as needed, determine whether it is appropriate to refer or release an individual at the scene of an emergency response rather than transporting them to a hospital emergency department.

- Address the needs of frequent 911 callers or frequent visitors to emergency departments by helping them access primary care and other social services.

**Post-Hospital or Community Health Services**

- Provide follow-up care for persons recently discharged from the hospital and at increased risk of a return visit to the emergency department or readmission to the hospital.

- Provide support for persons with diabetes, asthma, congestive heart failure, or multiple chronic conditions.

- Partner with community health workers and primary care providers in underserved areas to provide preventive care.
Prehospital Services

1. Transport patients with specified conditions not needing emergency care to non-ED locations ("alternate locations") such as a mental health facility, sobering center, urgent care clinic, or primary care physician's office. A program in San Francisco to address the needs of chronic inebriates is described in Case Study 1 (page 14). Figure 5 summarizes the opportunities and challenges associated with this activity.

2. After assessing and treating as needed, determine whether it is appropriate to refer or release an individual at the scene of an emergency response rather than transport the person to a hospital ED.

In the 1990s, the Orange County EMS agency in North Carolina had a treat-and-release policy, so for situations not requiring emergency care, patients could either be treated at home and follow up with their doctor, or the paramedics would arrange for alternative care. Current

FIGURE 5. Community Paramedics (CPs) Transporting Patients to Locations Other Than the Hospital Emergency Department

Opportunities

OVERARCHING: Method for getting right level of care to patients in an efficient, effective, and timely manner. May reduce crowding in some emergency rooms.

- Many patients may be treated appropriately in a location other than a hospital emergency department (e.g., patients with minor upper respiratory infections, chronic inebriates).
- Means of getting patients to services they need more quickly and efficiently. Reduction and/or elimination of secondary transfers or referrals if the individual is taken to the most appropriate treatment facility initially.
- May reduce overcrowding in EDs if fewer patients with non-emergent conditions are there, potentially reducing costs and making more efficient use of ED resources. May also reduce ED diversion rates and EMS wait times.
- CPs would be connected to other community resources where appropriate treatment could be obtained by patients not needing ED level of care.
- Use of technology such as telehealth consultations could help to ensure accurate assessment of patients, particularly in rural, underserved areas.
- Patients may prefer being taken to a facility where they can immediately obtain the appropriate level and type of care, and they may perceive improvements in the quality of service.

Challenges

OVERARCHING: CPs must be well trained to assess patients in the field using protocols and must have access to online medical experts, and state regulations must be changed.

- CPs will need additional training and protocols for patient assessment, along with greater online medical control for consultation on patients, since potential for error is greater than current practice of transporting all patients to EDs, where they are evaluated by ED staff.
- Need for viable alternate locations for patients to be transported to; often, there are limited resources in communities for mental health care, substance abuse treatment, urgent care, and primary care. Need exchange of data with all providers and quality assurance/improvement processes in place.
- Need appropriate medical condition evaluation prior to transport to an alternate facility.
- Difficult to accurately assess complex patients (e.g., those with psychological or substance abuse issues) with the potential of underlying medical conditions.
- Because the current system takes everybody to a hospital ED, transport to alternate locations may be seen by patients as lower-quality care. Appropriate education is needed so the public accepts that this approach is beneficial.
- May result in overutilization of transportation resources by patients.
- Need to change statute and regulations to allow transport of patients to non-ED locations and to allow community paramedics to practice in locations other than those currently specified.
EMS practice at times involves a form of treat and release where 911 callers decline transport against medical advice, sometimes apparently at the informal suggestion of emergency responders. However, adequate records are not kept to indicate how widespread this practice is. See Figure 6 for the opportunities and challenges associated with this activity.

3. **Assist frequent 911 callers or frequent visitors to EDs to access primary care and other social services**, as this will improve the efficiency of 911 service. A program in San Diego that leverages technology to help connect frequent 911 callers to health care and social services is described in Case Study 2 (page 14). See Figure 7 (page 11) for the opportunities and challenges associated with this activity.

**Post-Hospital or Community Health Services**

4. **Provide support for persons who have been recently discharged from the hospital and are at increased risk of a return visit to the ED or readmission to the hospital.** Some recently discharged patients may have difficulty following their medical care regimen and for various reasons do not have family or other social services support. These patients may suffer from congestive heart failure, diabetes, asthma, or multiple chronic conditions and would benefit from close monitoring to prevent readmission or need for emergency intervention. See Figure 8 (page 11) for the opportunities and challenges associated with this activity.

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**FIGURE 6. Assess, Treat as Needed, and Refer or Release by Community Paramedics**

**Opportunities**

**OVERARCHING:** Improve patient care by treating at home or at incident site, and then releasing patient or referring for additional care in non-ED setting; potential for systemwide cost savings when patient is not transported to an emergency department.

- Ambulances are often sent in response to nonemergency situations; community paramedics could assess patients, treat and release them if appropriate, or if needed, refer patients to providers other than the ED.
- For nonemergency situations, care may be administered appropriately in settings other than the ED that are less expensive. There would potentially be lower costs for patients, insurers, and the health care system overall.
- Frees up resources for patients in the ED who need emergency care.
- CPs would be connected to other community resources where they could refer patients not needing ED level of care for appropriate treatment.
- Provides formal policy and protocols with training and accountability for CPs working with patients in nonemergency situations, versus current informal suggestions that these patients decline transport against medical advice (AMA).

**Challenges**

**OVERARCHING:** Risk and liability associated with inaccurate evaluations by CPs. Need for protocols to ensure that all patients are treated equally and that none are denied care.

- CPs will need protocols for patient assessment, along with greater online medical control for consultation on patients, since potential for error is greater than current practice of transporting all patients to EDs, where they are evaluated by ED staff.
- Can be challenging to make accurate patient assessment with incomplete information about patient’s condition. Electronic transfer of health information would help improve decision-making related to patient assessment.
- Necessary for CPs to be sufficiently trained and know limitations of decision-making and liability. Medical directors may incur extra liability.
- Patients and families could think care is being inappropriately denied, potentially based on patient characteristics. CPs will need to be alert to equity in patient care.
- Need to change statute and regulations to allow community paramedics to treat and release or refer and to change policies to allow payment for care that does not involve transport of patients to EDs.
FIGURE 7. Community Paramedics Addressing Needs of Frequent 911 Callers

Opportunities
OVERARCHING: Potential to improve patient care and reduce inappropriate use of EMS resources.

- Paramedics are often very familiar with frequent 911 callers, who in addition to their medical conditions, often have mental health or substance abuse issues, are homeless, or are in need of other social services.
- CPs would be connected to other community resources where patients could obtain assistance to address basic needs such as housing, food, and utilities, as well as to obtain care for their medical, mental health, or substance abuse conditions.
- Patients whose basic needs are met would potentially be better able to interact with the health care system and to manage their own care. Lower and more appropriate use of EMS resources, through fewer 911 calls and fewer ED visits, could result.

Challenges
OVERARCHING: Assessment and treatment of patients with complex social and medical care needs requires additional training and collaboration with a wide variety of providers.

- CPs will need additional training with protocols for patient assessment, and greater online medical control will be needed for consultations on patients with complex social and medical care needs.
- Extensive coordination will be required so that assessment, treatment, and referral efforts by CPs, hospital discharge planners/social workers, and social service employees are complementary and not duplicative. Electronic systems to allow for identification of frequent users and for exchange of medical records will be needed.
- These services should be structured so as to not detract or interfere with rapid response to 911 calls.
- Need to change statute and regulations to allow community paramedics to determine to transport 911 callers to alternative destinations and to refer them to other providers, and change policies to allow payment for care that does not involve transport of patients to EDs.

FIGURE 8. Community Paramedics Providing Follow-Up Care for Patients Recently Discharged from the Hospital

Opportunities
OVERARCHING: Potential to improve patient care and reduce hospital readmissions by bridging gaps in care.

- CPs can serve as an integral part of the patient's care transition team. Patients recently discharged from a hospital may benefit from assistance prior to regular scheduled follow-up care in understanding post-discharge instructions, medications, self-care, and the timing and importance of follow-up appointments. CPs could review these with patients and, if applicable, their families. The CP could ensure there is a safe home environment for the patient to recover in, and could provide feedback to primary care and emergency care providers about the patient's function at home. These types of activities could improve patient follow-up and integration in the health care system and overall quality of patient care, and may reduce 911 calls, ED visits, and hospital readmissions.
- Patients and their families would have a resource (CP or 911) for any immediate needs.
- Care provided by CPs would be ordered by the discharging physician and designed to complement care from other health care providers, with the goal of improved communication and coordination among providers, leading to better patient care.

Challenges
OVERARCHING: Management of patients with complex medical conditions requires extensive collaboration and communication with other providers.

- CPs will need additional training with protocols for patient assessment, and there will need to be greater, and potentially additional types of online medical control (i.e., emergency physicians and primary care physicians or other specialists) for consultation on patients with complex medical conditions.
- Electronic systems to allow for exchange of records and other information between CPs and other primary care, specialty care, and emergency care providers will be needed. Exchange of information across state lines may be challenging.
- Need to change statute and regulations allowing community paramedics to provide services in additional situations, and change policies to allow payment for care that does not involve transport of patients to EDs.
5. Provide support for persons with congestive heart failure, diabetes, asthma, or multiple chronic conditions by making periodic checks and providing education about how to proactively manage the conditions when regular home health services are not available. A program in Ft. Worth, Texas, to address the needs of patients with congestive heart failure is described in Case Study 3 (page 15). See Figure 9 for the opportunities and challenges associated with this activity.

6. Partner with community health workers and primary care providers in underserved areas to provide preventive care such as flu vaccines, blood pressure monitoring, selected disease screening tests, and basic education about illness, injury prevention, and disease risk reduction. See Figure 10 (page 13) for the opportunities and challenges associated with this activity.

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**FIGURE 9. Community Paramedics Providing Care for Patients with Chronic Conditions**

**Opportunities**

**OVERARCHING: Potential to bridge gaps between primary care and emergency care, reduce volume of 911 calls, and reduce readmissions.**

- Could be a new resource for people with serious chronic conditions who have limited access to primary care, and for patients newly diagnosed with a chronic condition who may need additional help with care management, and could serve as a bridge between emergency and follow-up care.
- CPs could evaluate patients with chronic conditions and review medications and care instructions to ensure that patients and, if applicable, their families, understand them. CPs could also consult with a patient’s physician to address any needs identified during a visit (e.g., to adjust medication).
- Effective care management could reduce 911 calls, ambulance transport, ED visits, hospitalizations, and rapid ED returns/rehospitalizations. CPs could serve as provider extenders in underserved areas.
- Quality of care may be higher through enhanced one-on-one care, coordination of care, and communication about care with other health care providers. Care could be more timely if complications are detected early that require additional primary or emergency care.
- Cost-effective way to integrate EMS assets into the health care delivery system. Should be designed so that care provided by CPs is complementary to and does not supplant services provided by the broader medical community.
- In some jurisdictions, may increase operational efficiency of paramedics by providing a beneficial community service between calls and allowing paramedics to maintain and improve their skills.

**Challenges**

**OVERARCHING: Need rules and guidelines for this type of care provided by CPs. Costs will need to be offset by savings in ED and hospital readmissions.**

- CPs will need additional training to learn about care for people with chronic conditions. Because this type of care is different from emergency care, it may require a different or additional type of medical supervision (i.e., by emergency physicians and primary care physicians or other specialists).
- Need rules and guidelines regarding the types of chronic care CPs provide.
- Need electronic systems to allow for exchange of records and other information between CPs and other primary care, specialty care, and emergency care providers.
- Patients may perceive there are tiers of care or lower levels of care being provided by the CP if the patient is accustomed to receiving care from doctors or nurses.
- May increase health care costs depending on the amount of time spent with patients, extra travel costs, etc.
- These services should be structured so as to not detract or interfere with rapid response to 911 calls.
- Need to change statute and regulations allowing community paramedics to provide services in additional situations, and change policies to allow payment for care that does not involve transport of patients to EDs.
Opportunities

OVERARCHING: Uses skills paramedics already have and increases ability to reach communities that have little access to health care.

- Paramedics already provide services in a variety of home and community settings, including high-risk neighborhoods and medically challenged settings (e.g., streets and businesses).
- Paramedics currently give injections, check blood pressure, and assess home environments for safety, so very little additional training will be required for CPs to provide preventive services such as administering flu shots, screening for diseases, and educating patients about how to avoid asthma triggers or prevent falls.
- These types of services would be particularly beneficial to medically underserved communities that are not reached by standard health care resources.
- May be especially useful in rural areas and could be provided when doing follow-up care after patient is discharged from ED or hospital.

Challenges

OVERARCHING: Nontraditional role for paramedics. CPs will need additional training to learn about preventive care and need to exchange information with other providers to ensure patient safety.

- Because this type of care is divergent from the primary mission of EMS, it may require a different or additional type of medical supervision (e.g., by primary care physicians, extended practice nurses).
- Preventive care services should be structured so as to not detract or interfere with rapid response to 911 calls.
- Systems to allow for exchange of records and other information between CPs and other primary care, specialty care, and emergency care providers will be needed.
- Need to address organizational issues of when and where these services would be provided (e.g., at doctor’s request vs. regularly scheduled, at patient’s home vs. at fire station).
- Costs will need to be offset by health care savings or assumed as part of basic primary care.
- Need to change statute and regulations allowing community paramedics to provide services in additional situations, and change policies to allow payment for care that does not involve transport of patients to EDs.
CASE STUDY 1
San Francisco Program to Address the Needs of Chronic Inebriates

San Francisco developed a program to appropriately address the needs of chronic inebriates — The San Francisco Fire Department (SFFD) Homeless Outreach & Medical Emergency (HOME) Team. The program was developed in response to a small number of individuals who were chronic inebriates that frequently called 911, had extensive ED use, and incurred high uncompensated health care costs.

The San Francisco HOME Team was designed to connect at-risk individuals with a system of care to better serve their needs and to stop the unproductive cycle of ambulance transports and hospital stays. Analysis by the HOME Team found that heavy EMS system users are typically 40- to 60-year-old homeless male chronic inebriates who have comorbid mental illness and medical conditions, and high mortality rates. Prior to this program, San Francisco General Hospital estimated a total of $12.9 million in annual uncompensated charges associated with 225 frequent users.

The HOME Team program started in October 2004 under the SFFD EMS through a joint effort of SFFD, San Francisco Department of Public Health, and San Francisco Human Services Agency. The team was led by one paramedic captain and included intensive case managers or outreach workers as well as nurse practitioners. Typical response involved outreach to find all frequent users, connect them to community-based care (typically, substance abuse treatment and medical detoxification), and advocate for long term care when necessary. The program was able to develop a web of resources and partners including case workers, mental health professionals, primary care providers, housing resources, substance abuse treatment programs, and law enforcement. These partners came together to create and evaluate systems of care for the frequent users. This clinical planning brought forth new long term care placement options for dual-diagnosis patients with both mental health and substance abuse conditions, including locked programs and boarding programs with care management. Over an 18-month period, there were reductions in ambulance activity for high users and a decrease in ED diversion rates at local hospitals. The HOME Team was funded by the San Francisco Department of Public Health at approximately $150,000 annually; however, funding was rescinded due to the department having other budget priorities, and the program has been on hiatus since June 2009.


CASE STUDY 2
San Diego Program Leveraging Technology to Better Serve Frequent 911 Callers

A program designed to address the needs of individuals who repeatedly call 911 in San Diego began in 2008 as a collaboration between the San Diego Fire-Rescue Department and Rural/Metro Ambulance. The San Diego Resource Access Program (RAP) is coordinated by a paramedic and integrates health information technology with real-time EMS and computer-aided device surveillance.

A unique element of San Diego’s approach is its integration of technology into the RAP program. As part of the San Diego region’s $15-million Beacon Community grant for health information exchange (HIE) development from the Office of the National Coordinator, there is information exchange between EMS and hospitals. This exchange facilitates detection of abnormal patterns of activity, both by repeat users of 911 and by equally vulnerable but less noticeable individuals. Algorithms are used to identify frequent users of the EMS system and to engage them through a patient-centered case management system involving RAP and other social and judicial systems.

Essential for RAP’s success are the partnerships with related stakeholders including law enforcement, the courts, homeless outreach teams, social workers, and housing providers.

An evaluation involving 51 individuals enrolled in RAP over a 31-month period from 2006 to 2009 found several positive outcomes, most notably in EMS and ED use:

- EMS encounters decreased by 38%, EMS charges by 32%, EMS task time by 40%, and EMS mileage by 48%.
- ED encounters at the participating hospital decreased by 28%, and ED charges decreased 12%.
- The number of inpatient admissions decreased by 9%, and inpatient charges decreased by 6%.
- Hospital length of stay decreased by 28%.
- Across all services, charges declined by over $314,000.

One of RAP’s goals is to create bidirectional data sharing with all stakeholders and to link to the HIE being developed as part of the Beacon grant. With such a system, RAP will be able to move beyond serving its most frequent users to help others in the community with disproportionate health burdens.

Perspectives on Community Paramedicine: Findings from Stakeholder Interviews

As part of this project, interviews were conducted with stakeholders from 37 organizations, including EMS associations (e.g., firefighters and paramedics), health care providers, health plans, and payers. Using a combination of predetermined and situation-specific questions, interviewees were asked about their knowledge of community paramedicine and their thoughts about its potential for use in the six specific health care situations described above. See Appendix C for a list of organizations represented in the interviews. Several themes emerged:

- **There is limited understanding of community paramedicine.** CP is a largely unknown model of care in California. There was a wide range of familiarity with the concept among interviewees, ranging from none at all to extensive. A few interviewees had substantial personal experience in implementing and evaluating CP programs. Several interviewees expressed uncertainty about what community paramedics might actually do, and some expressed concern about how community paramedics would interface or interact with the existing health care delivery system.

- **There is limited understanding of the EMS system.** Some interviewees noted that relatively few physicians and nurses (other than emergency physicians and nurses) have significant understanding of how the EMS system operates (and, in turn, what paramedics do and how they work) or how the EMS system interacts with the health care delivery system generally. Attitudes about how well the EMS system and paramedics function appear to be substantially influenced by the extent and quality of an individual practitioner’s experience with EMS providers.

- **EMS is essential to the health care system but is not well integrated.** While the EMS system is generally perceived to be an important part of the health care delivery system, it is not perceived to be an integrated part of the system, since EMTs and paramedics currently work closely with only a small subset of health care providers and in a small subset of environments. EMS has been on the periphery of the health care reform conversation, and some interviewees expressed the belief, or assumption, that EMS would just keep doing what it
has always done despite the myriad changes in the health care system at large.

• **There is support for specific CP activities.** When asked about specific services that community paramedics could potentially provide, interviewees said the need for additional training, protocols to guide decision-making, increased availability of physicians or nurses to consult with paramedics in the field, and increased electronic information exchange were essential. With these elements in place, many interviewees expressed enthusiasm for specific CP activities, to be delivered in accordance with the needs of individual communities.

• **Additional payment is needed for CP services.** Commonly voiced was the sentiment that there will need to be additional payment for any additional services provided by CPs. While it is unclear who will pay, there seemed to be a shared belief that payment should be apportioned among all the entities that may benefit from the provision of these services.

• **It is essential to measure CP program outcomes and to ensure that high-quality care is delivered.** Most interviewees opined that if CP programs were to be implemented, it would be important to measure quality and cost outcomes. This would influence future investment in such programs. It was noted that there is much variation in quality assurance (QA) and relatively few quality improvement (QI) activities within EMS today; it will be important to incorporate enhanced QA and QI activities for community paramedics to ensure that they are providing high-quality care.

• **There may be different needs and solutions for urban versus rural areas.** Concern was expressed about the different roles and capacities of paramedics in rural versus urban areas and the different logistics that might be involved in developing and implementing CP programs in these settings. It was noted that there are relatively fewer paramedics practicing in rural California.

• **There is a need for better and ideally electronic exchange of information.** Some concern was expressed that paramedics would need to be more involved in patient information exchange with other health care providers in order to provide more services than paramedics currently do. Several interviewees indicated that electronic systems would best support timely and complete exchange of data.

• **There are concerns about paramedic skills and training.** Several interviewees expressed uncertainty and concern about paramedics having the skills to provide nonemergency services, despite being told that paramedics would have additional training before practicing as community paramedics.

• **There are concerns about paramedic capacity.** Some concern was expressed about the capacity of EMS providers to do more than what they already do. Some interviewees felt that paramedics are already working at or near maximum capacity, particularly in urban areas, and that they probably could not do any more. A number of stakeholders expressed that they would not want any new roles to distract paramedics from performing their basic first responder and other lifesaving functions.

• **There are alternatives to supporting development of CP.** A few stakeholders who did not offer much support for the proposed CP services cited concerns over quality of care, decision-making authority of community paramedics, fragmentation of care, and the potential additional liability for those providing medical control, and opined that it may be better to put more resources into the existing non-EMS delivery system.

• **Vigilance must be maintained for possible unintended consequences, especially for safety-net providers.** Some interviewees expressed that, to minimize unintended consequences, care should be taken to anticipate what effects any changes to the EMS system would have on both emergency services and other components of the health care system. It was noted that the EMS system is part of the health care safety net, and the safety net must be preserved. Some interviewees emphasized that all patients should be treated equally by the EMS system, regardless of their ability to pay, and this principle should apply to any new activities that fall under the CP umbrella.
EMS Regulations, Statutes, and Other Barriers to CP Program Implementation

Three aspects of California’s current EMS statutes and regulations preclude the development and implementation of CP programs:

1. The requirement that callers to 911 must be taken to an acute care hospital having a basic or comprehensive ED (Health & Safety Code Division 2.5, section 1797.52).

2. The locations where paramedics can practice — i.e., at the scene of a medical emergency, during transport to an acute care hospital with a basic or comprehensive emergency department, during interfacility transfer, while in the ED of an acute care hospital until responsibility is assumed by hospital staff, or while working in a small and rural hospital pursuant to sections 1797.52, 1797.195, and 1797.218 (California Code of Regulations [CCR], title 22, section 100145, and Health & Safety Code 2.5, section 1797).

3. The specification of the paramedic scope of practice. Specific procedures and medications approved for use are contained in regulation (CCR, title 22, section 100145 and Health & Safety Code 2.5, section 1797).

It is important to note that the paramedic scope of practice in California is explicitly defined in both statute and regulation as referring to a set of authorized skills and activities that emergency medical personnel may perform and the places in which those skills and activities may be performed. This is unusual in that most scope of practice definitions specify skills and activities but not location. California’s dual definition means that any of the potential CP scenarios described in this report would require a statutory change to one or more aspects of the paramedic scope of practice. This is further discussed below.

Prehospital Services

- **Transport to alternate destinations.** Regulations and statutes would need to be changed to allow community paramedics to: 1) transport patients to a destination other than a general acute care hospital with a basic or comprehensive ED, and 2) practice in locations other than those currently specified (assuming community paramedics would continue to care for patients at an alternate destination prior to responsibility being assumed by staff at the alternate destination). Medical specialists other than emergency physicians would likely need to become involved in medical control.

- **Assess, treat as needed, and refer or release.** Additional training and protocols would need to be developed. Medical control would always be required. A change in regulations and statutes would be required to allow community paramedics to refer or release patients instead of transporting them to an ED.

- **Addressing the needs of frequent 911 callers.** Since community paramedics may transport these patients to non-ED destinations, may coordinate their care with other social service providers, or may not transport the patients, regulatory and statutory changes would be needed. Additional medical specialists other than those in emergency medicine would likely become involved in medical control and care coordination.

Post-Hospital or Community Health Services

Because paramedics are currently authorized to function only in prehospital emergency and other specified settings, post-hospital services such as chronic care management, provision of preventive services, and conducting home visits
post-hospitalization are prohibited, so regulatory and statutory changes would be needed. Also, changes in scope of practice regarding specific skills and activities may be necessary for new diagnostic or therapeutic interventions. Increased or additional types of medical control also may be necessary.

Payment for Emergency Medical Services
Another potential barrier to the implementation of CP programs in California relates to the current EMS payment structure, which revolves around patient transport. EMS providers receive payment for advanced life support or basic life support transport to a hospital ED. This payment structure reimburses paramedics for responding to 911 calls and transporting the patient to an ED, and it encourages return to service as quickly as possible. A payment model for CP programs would likely need to separate payments for components such as assessment, treatment, and transport. Payment models such as those used by accountable care organizations (ACOs) that put a premium on efficient use of health care resources merit exploration as a source of revenue for CP programs.

Conclusion and Policy Options
Community paramedicine offers a potentially promising solution for addressing some types of health care gaps in California, and based on comments voiced at a February 2013 stakeholder meeting and a subsequent survey of local EMS agencies, there appears to be substantial support for exploring this new model of community-based care.26 However, CP involves a number of complicated issues and is currently precluded by statute.

Widespread development of community paramedicine in California will require more clarity about a number of issues, including CP program purpose and the associated need for education, training, scope of practice, and medical supervision. CP programs developed in other states and countries have had varied purposes, typically being developed to address specific local needs and unique collaborations, partnerships, and other circumstances. As there is heterogeneity in the design and purpose of these other CP programs, California will need to specify a standardized CP training curriculum, scope of practice, and prescription for appropriate medical supervision.

While at their core these programs all leverage the training and experience that paramedics already possess, they vary in how they do so. This is in contrast to current EMS systems, for which there is a more singular goal (i.e., to bring potentially lifesaving care to an ill or injured person in the prehospital setting and to transport the person to a hospital ED) and a more defined portfolio of needed skills and commensurate training for EMS personnel. Some of the potential CP program scenarios would require little additional training and a change in scope of practice only with regard to where the patient might be transported (e.g., to allow transport of certain types of patients to destinations other than an ED), while other scenarios might require substantially more education and training for enhanced decisionmaking and more significant changes in scope of practice (e.g., for primary care outreach activities). Some of the potential CP scenarios also raise a question about the utility of developing an EMT- or paramedic-like primary care technician as a new type of health care worker that would function within a formally designed primary care system much the way that paramedics function in an EMS system. However, this possibility is not the subject of this report and was not examined in detail.

For the above reasons, we recommend that further development of community paramedicine in California be done through pilot or demonstration projects so that issues related to education and training, medical supervision, scope of practice, and impact on local EMS systems, among others, can be further evaluated. To this end, two alternative pathways are available. Pilot projects could be undertaken consequent to new legislation authorizing a CP demonstration program, or pilot projects could be undertaken pursuant to the Office of Statewide Health Planning and Development’s (OSHPD’s) Health Workforce Pilot Projects Program (HWPP).27, 28 The latter would be the most expedient.

We do not recommend changing California’s EMS-related statutes and regulations to broadly authorize CP programs at this time. While we believe that CP has considerable promise, we also believe that more information is needed to determine the appropriate role of these programs in California and how best to operationalize them.

If CP pilot projects were to be undertaken, we believe that as many as 10 to 12 would be needed to provide sufficient diversity of program focus, geography, demography, and community partnerships to answer the many outstanding questions about these programs. If pilots were implemented, we further
recommend that EMSA and an advisory board composed of experts in emergency medicine, primary care, public health, behavioral health, and nursing, among other areas of expertise, be involved in the review, approval, monitoring, and evaluation of the projects.

Pilot projects would need to address a number of issues in the project proposal, including:

- A description of the specific need that the pilot project would address, how this need was selected, and exactly how the project would address the identified need
- A detailed explanation about how the community paramedics would be trained and would maintain their skills
- A description of how appropriate medical supervision would be assured
- A description of how data to evaluate quality assurance and quality improvement activities would be obtained and monitored
- An evaluation plan for assessing the impacts on quality and cost of care, and how the local EMS agency will ensure that all patients are treated equally regardless of insurance status and health condition, among other factors
- A plan for integrating the CP program with other community-based health care and social service programs and for analyzing the potential impacts of the CP program on these providers, including safety-net providers
- Funding sources and financial sustainability
- The role of health information exchange (HIE), telehealth, and possibly mobile-health technologies
- How to leverage the potential of electronic health records (EHRs) and HIE to facilitate communication between community paramedics and other health care providers

“Emergency medical services (EMS) of the future will be community-based health management that is fully integrated with the overall health care system. It will . . . provide acute illness and injury care and follow-up, and contribute to treatment of chronic conditions and community health monitoring. . . . It will improve community health and result in more appropriate use of acute health care resources. EMS will remain the public’s emergency medical safety net.”

— EMS AGENDA FOR THE FUTURE, NHTSA, 1996
ENDNOTES

1. The commonly used term “paramedic” technically refers to an emergency medical technician-paramedic (EMT-P), the most highly trained category of emergency medical technician (EMT). The three levels of EMTs in California are described on page 4, and their training and scopes of practice are shown in Figures 2 and 3.


7. All ambulance attendants are required by California law to be trained and certified to the EMT level (basic life support, or BLS), and many fire agencies require firefighters to be EMT certified.

8. EMSA. 2013.


19. The shortage of primary care physicians contrasts with an oversupply of specialists in California, particularly in urban areas, although there are distribution issues with both primary care physicians and specialists.


22. From, for example, the DHHS Human Resources and Services Administration (HRSA), Rural and Frontier EMS Agenda for the Future, International Roundtable of Community Paramedicine, and Minnesota Community Healthcare and Emergency Cooperative.

23. The Community Healthcare and Emergency Cooperative developed a standardized curriculum that colleges in any state, province, or nation can customize for their own certification programs. The curriculum has two phases: Phase 1 — Foundational Skills (approximately 100 hours based on prior experience), comprehensive didactic instruction in advocacy, outreach and public health, performing community assessments, and developing strategies for care and prevention; and Phase 2 — Clinical Skills (15 to 146 hours based on prior experience), supervised training by medical director, nurse practitioner, physician assistant, and/or public health provider.
24. Most 911 contracts have clauses requiring certain staffing and response times. If unmet, the provider agency can be fined.

25. California Health & Safety Code, Chapter 2, Sections 1797.52, 1797.84, and 1797.194e, and California Code of Regulations, Title 22, Division 9, Chapter 4, Sections 100139 and 100145.

26. Eleven of 15 respondents to this EMSA-conducted survey expressed interest in participating in a CP pilot or demonstration project.

27. Maine has adopted this approach, allowing for up to 12 pilot projects that develop and evaluate a community paramedicine program.

28. OSHPD's HWPP program allows organizations to test, demonstrate, and evaluate new or expanded roles for health care professionals or new health care delivery alternatives before changes in licensing laws are made by the Legislature. Various organizations use HWPP to study the potential expansion of a profession's scope of practice to facilitate better access to health care; to expand and encourage workforce development; to demonstrate, test, and evaluate new or expanded roles for health care professionals or new health care delivery alternatives; and to help inform the Legislature when considering changes to existing legislation in the Business and Professions code.
APPENDIX A. California Local Emergency Medical Services Agencies

Source: EMSA, 2013.
APPENDIX B. 911 Emergency Response in California

In Case of Emergency: Dial 9-1-1

911 Calls received by Public Service Access Points (PSAP)
PSAPs route 911 call to emergency medical dispatchers for medical crises; dispatchers then respond by protocol of the local regulations (Emergency Medical Dispatch Protocol Reference Systems vary by LEMSA).

Tiered Response

Triage Evaluation
- During 911 call, dispatcher asks standardized questions.
- Criteria are used to quickly determine level of care needed and to prioritize response. Levels are non-emergency, BLS, and ALS.

Appropriate Responder Dispatch
- Select and assign appropriate EMS response resource.
- Dispatch and communicate with emergency responders.
- Responders include personnel at ALS or BLS levels and certified emergency transport vehicles including ambulances, aircraft, and other emergency vehicles.

First Responder Dispatch
- First response vehicle arrives at scene.
- Patient assessment is performed.
- Treatment (focusing on airway, breathing, and circulation) is administered.
- Report is made to EMS crew (enroute).

EMS Arrival
- EMS arrives with emergency vehicles capable of both BLS and ALS care.

EMS Treatment
- EMS responders assess and treat patient at the scene according to scope of practice.

Patient Transport
- Patient is transported to hospital with emergency department.

Non-tiered Response

EMS Response Dispatch
- Dispatcher responds to medical emergency call and sends EMS resources to scene.

First Responder Dispatch
- First response vehicle arrives at scene.
- Patient assessment is performed.
- Treatment (focusing on airway, breathing, and circulation) is administered.
- Report is made to EMS crew (enroute).

EMS Arrival
- EMS arrives with emergency vehicles capable of both BLS and ALS care.

EMS Treatment
- EMS responders assess and treat patient at the scene according to scope of practice.

Patient Transport
- Patient is transported to hospital with emergency department.

Emergency Medical Dispatchers
Trained dispatcher who processes emergency medical 911 calls, determines severity and prioritizes response, and coordinates sending appropriate emergency responders to the scene.

First Responders
Dispatched to scene first, by closest/most available; member of local certified first-response agency (fire department, police, private ambulance, EMS, industrial emergency team, etc.) able to provide BLS and sometimes ALS.

EMS Responders/Transport
Emergency and non-emergency vehicles, must have BLS or ALS capabilities when appropriate; certified EMT, A-EMT, or licensed paramedic responder (LEMSA approved private or county ambulance or emergency transport vehicle)
APPENDIX C. Organizations with Representatives Participating in Stakeholder Interviews

1. Alameda County EMS Agency
2. Alameda County Health Care Services Agency
3. AMR
4. Association of State and Territorial Health Officials
5. California Ambulance Association
6. California Association for Health Services at Home
7. California Chapter of ACEP (Cal/ACEP)
8. California Conference of Local Health Officers (CCLHO)
9. California Department of Health Care Services
10. California Department of Public Health
11. California Fire Chiefs Association, EMS Section
12. California Hospital Association
13. California Medical Association
14. California Nurses Association
15. California Professional Firefighters
16. California Rescue and Paramedic Association
17. Centers for Medicare & Medicaid Services, Region 9, Department of Health and Human Services
18. El Dorado EMS Agency
19. Emergency Nurses Association
20. Kaiser Permanente
21. Los Angeles County Department of Health Services
22. Los Angeles County EMS Agency
23. Mayo Clinic Medical Transport
24. MedStar
25. National Association of State EMS Officials
26. NorCal EMS Agency
27. North Coast EMS Agency
28. Orange County EMS Agency
29. Regional Emergency Medical Services Authority, Reno
30. Santa Clara EMS Agency
31. San Diego City EMS Agency
32. San Diego County EMS Agency
33. San Francisco EMS Agency
34. San Francisco Fire Department
35. Sierra/Sacramento Valley EMS Agency
36. WellPoint
37. Western Eagle County Ambulance District