Thursday, June 27, 2019 11:00am

10.0 Call to Order/Roll Call /Establishment of a Quorum/Approval of Minutes

10.0.1 Review and Vote on Whether to Approve Previous Meeting’s Minutes:
➢ Feb 7, 2019

10.1 Discussion Only: Availability of a BRN licensee list to requestors upon payment to the BRN under the California Public Records Act.

10.2 Discussion and Possible Action: Whether committee supports AB 890 [nurse practitioner independent practice].

10.3 Discussion and Possible Action: Whether to recommend to the BRN Nursing Practice Committee a minimum requirement for APRN First Assist Privileges through APRN specific didactic content with clinical hours to be obtained in the workplace through a privilege identified in a standardized procedure.

10.4 Discussion Only: APRN Advisory Committee’s oversight of a new workforce survey of all APRNs (NPs, CNSs, CRNAs, CNMs) that is more comprehensive than the 2017 NP/CNM Survey.

10.5 Discussion and Possible Action: Review the remaining 2019 BRN Board Meeting dates and determine the date for the next meeting.
10.6 Public Comment for Items Not on the Agenda

Note: The Committee may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting. (Government Code, Sections 11125 and 11125.7(a)).

10.7 Adjournment

NOTICE:
All times are approximate and subject to change. Items may be taken out of order to maintain a quorum, accommodate a speaker, or for convenience. The meeting may be canceled without notice. For verification of the meeting, call (916) 574-7600 or access the Board’s Web Site at http://www.rn.ca.gov. Action may be taken on any item listed on this agenda including information only items.

Public comments will be taken on agenda items at the time the item is heard. Total time allocated for public comment may be limited.

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 at 1747 N. Market Blvd., Ste. 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.
BOARD OF REGISTERED NURSING
ADVANCED PRACTICE REGISTERED NURSING
MEETING MINUTES

DATE: February 7, 2019

LOCATION: Board of Registered Nursing
1747 N. Market Blvd
HQ-2 Hearing Room, Ste. 186
Sacramento, CA 95834
(916) 574-7600

COMMITTEE MEMBERS: Mitchel Erikson, NP-Chair
Karyn Karp, CRNA-Vice Chair
Charlotte Gullap-Moore, NP
Garrett Chan, CNS
Hilary Reyes, CNM
Jane Perlas, NP
Sandra Bordi, CRNA
Danielle Blum, CNM – via teleconference
Elissa Brown, CNS – via teleconference

STAFF PRESENT: Dr. Joseph Morris, PhD, MSN, RN, Executive Officer
Janette Wackerly, MBA, BSN, RN, Supervising Nursing
Education Consultant - Nursing Practice Liaison
Long Dau, International Licensing Program Manager
Stacie Berumen, Assistant Executive Officer
Ronnie Whitaker, Licensee and Administrative Services Manager

NOT PRESENT: Ruth Rosenblum, NP

10.0 Call to Order/Roll Call/Establishment of a Quorum 11:01 am.

10.0.1 Review and Vote on Whether to Approve Previous Meeting’s Minutes:
➢ October 16, 2018

MOTION: Mitchel Erikson: Motion to approve previous meeting minutes after amendment.
SECOND: Karyn Karp


PUBLIC COMMENT: Elizabeth Woods; RN, FNP, MSN, BRN Nursing Practice Committee Chair.
10.1 Discussion Only: Request Board of Registered Nursing (BRN) Board Members to provide specific examples of the barriers or lack of transparency in application deficiencies encountered in the BREEZE system regarding the Advance Practice constituents in California and out-of-state endorsement, new applications and renewals.

BACKGROUND: As a constituent and user of the Breeze system for initial license, renewal of license, and endorsement from compact states there is an absence of transparency regarding deficiencies in an initial nursing and renewal application. It creates frustration and delays with applicant processing and renewing of registered nursing licenses.

Since all applications are reviewed for payment and other requirements, there needs to be a place within the online portal for the applicant to review and determine if they have failed to complete the license process correctly. It saves the Board of Registered Nursing and the BREEZE system from direct communication with thousands of licensees and creates a truly online experience where the applicant can clearly see any deficiencies in the review process. This goes beyond the way Breeze identifies their processing times from date of submission.

Healthcare facilities have had to suspend providers for failure of having an active license. After further investigation with the constituent, it was discovered that the licensee had failed to fully pay for all parts of their license or was somehow incomplete in their application submission.

No Public Comment

10.2 Discussion Only: Discuss and evaluate the classification of First Assist standardization of practice certification requirement.

BACKGROUND: Currently the BRN statement around RNFA has no requirements or guidelines or policy regarding the specifics of education requirement or certification to have the privilege or first assist in the OR. Since APRNs typically do not include this in their curricula it is important to establish some guidelines to ease the process within health systems tasked with credentialing and privileging APRNs under standardized procedures.

The National Institute of First Assisting, Inc. (NIFA) is a Colorado institution that specializing in health care education specific to operating room nurses and APRNs since 1995. The NIFA RN First Assistant Program for APRNs is presented through accredited colleges nationwide, overseen by their accredited nursing programs and meets all AORN Standards for RNFA Education.

This college RNFA online program addresses all the modules of the AORN Core Curriculum for RN First Assistants. In total, home studies would represent approximately 48 hours followed by a 140-hour internship which the student arranges at their facility.
Upon Graduation
Many APRN students graduate between 5-8 months after but have two years to complete the program. Graduates receive a Certificate verifying that they have successfully completed the RNFA program designed specifically for APRNs, meets all the standards as set forth by the AORN and is accepted by the Competency and Credentialing Institute leading qualified graduates to the national exam. Your NIFA certificate is recognized by all 50 Boards of Nursing.

UCLA’s program requires OR experience of 2 years or to take the one-day course before entry into the APRN FA program which is 52 hours of class room content then preceptorship. 120 hours of independent preceptorship is required prior to certification.

PUBLIC COMMENT: Cynthia Jovino

10.3 Discussion Only: Discuss nursing practice curricula for nurse practitioners and the length of residency requirements of all students and applicants.

BACKGROUND:
Various health systems across the state of California that feel nurse-practitioner graduates are not prepared and students feeling the need, especially outside of primary care but even in the primary care setting. Additional information will be presented during the Advance Practice Registered Nursing Advisory Committee meeting for discussion only.

While PAs need to accumulate over 1000 hours of clinical, most FNP nursing programs only need about 600 +/- hours of clinical hours to graduate. Furthermore, the quality and number of hours in their area of specialty are often fragmented, limited and differs from individual experiences. Whereas in the past most graduate FNP students are experienced RNs (about 5 years of active nursing practice), the current generation of new graduates are going straight into graduate FNP curriculum without or very limited RN experience. Therefore, one can no longer argue that what RNs lack in clinical hours is compensated by the numbers of years they have practiced as a RN.

PUBLIC COMMENT: Patty Gulney; California Association for Nurse Practitioners.

10.4 Discussion Only: Discuss and analyze standard clinical hour requirements for Doctor of Nursing (DNP) programs in California.

BACKGROUND:
The fairly new doctoral degree in nursing, the DNP is a clinical focused doctoral degree as compared to the research focus PhD degree. However, it is noted that DNP programs throughout the Bay Area and/or even nationally focus on research rather than clinical. Furthermore, there seems to be no uniform requirement for DNP clinical hours. In addition, in most programs, most faculties are with PhD degrees rather than DNP.

Mitchel Erickson, Advance Practice Registered Nursing Advisory Committee Member Chair, will present additional information during the Advance Practice
Advisory Committee meeting for discussion of standard clinical hour requirements for Doctor of Nursing Practice (DNP) programs in California.

NO PUBLIC COMMENT:

10.5 Discussion Only: Review 2019 Board and Committee meeting schedule to establish future meeting schedules for APRN meetings and determine agenda submission deadlines.

BACKGROUND:

In order to ensure a timely submission of agenda items to meet both State and BRN deadline requirements a schedule of defined dates must be created to alert Advance Practice Advisory Committee Members.

Each agenda item must also have an associated agenda item summary and resource attachment(s) if applicable. The Advance Practice Advisory Committee Members need to have defined submission deadlines to avoid cancellation or rescheduling of committee meetings. Once dates for meetings are scheduled then the deadlines for agenda items and agenda item summaries, along with supporting resources will be defined based on the scheduled meeting dates.

10.6 Public Comment for Items Not on the Agenda

PUBLIC COMMENT: Sheryl Goldfarb, California Clinical Nurse Specialist

10.7 Adjournment 1:13 pm

Submitted by: Approved by:

_______________________________________ __________________________________________
Date: __________________________________ Date: _____________________________________
Mitchel Erickson, Chair, NP ACNP-C Janette Wackerly, MBA, BSN, RN
Chair - Advance Practice Advisory Committee Supervising Nursing Education Consultant
Liaison-Nursing Practice Committee
AGENDA ITEM: 10.1  
DATE: June 27, 2019

<table>
<thead>
<tr>
<th>ACTION REQUESTED:</th>
<th>Discussion Only: Discuss the availability of a BRN licensee list to requestors upon payment to the BRN under the Information Practices Act.</th>
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<td>REQUESTED BY:</td>
<td>Garrett Chan, RN, CNS</td>
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BACKGROUND:
In the February 7, 2019 Advanced Practice Registered Nurse Committee, there was a request from a public member about getting email addresses along with the names and mailing addresses when purchasing a Licensee List from the Board of Registered Nursing according to the Information Practices Act, Civil Code Section 1798.61 and Business and Professions Code Section 161, that states that the Licensee List is public information.

The Business and Professions Code Section 161 states:

> The department, or any board in the department, may sell copies of any part of its respective public records, or compilations, extracts, or summaries of information contained in its public records, at a charge sufficient to pay the actual cost thereof. Such charge, and the conditions under which sales may be made, shall be determined by the director with the approval of the Department of General Services.  
> *(Amended by Stats. 1965, Ch. 371.)*

The Civil Code Section 1798.61 states:

> (a) Nothing in this chapter shall prohibit the release of only names and addresses of persons possessing licenses to engage in professional occupations.  
> (b) Nothing in this chapter shall prohibit the release of only names and addresses of persons applying for licenses to engage in professional occupations for the sole purpose of providing those persons with informational materials relating to available professional educational materials or courses.  
> *(Amended by Stats. 2000, Ch. 962, Sec. 1. Effective January 1, 2001.)*

RESOURCES:

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<th>NEXT STEPS:</th>
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<td>None</td>
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| 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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<td>Charlotte Gullap-Moore, MSN, ANP-BC</td>
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<td>BACKGROUND:</td>
<td>The submission of AB890 represents the ongoing struggle for APRNs to seek full scope of practice authority in California. This discussion will provide reference around some of the looming concerns around health care professional workforces, access to health care in California, and health delivery solutions.</td>
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Phone: 916-574-7686  
Email: janette.wackerly@dca.ca.gov |
AB-890 Nurse practitioners. (2019-2020)

CALIFORNIA LEGISLATURE— 2019–2020 REGULAR SESSION

ASSEMBLY BILL No. 890

Introduced by Assembly Member Wood
(Coauthors: Assembly Members Aguiar-Curry, Eggman, Friedman, Gallagher, and Gipson)
(Coauthors: Senators Caballero, Hill, Leyva, and Stone)

February 20, 2019

An act to add Section 2837.1 to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL’S DIGEST

AB 890, as introduced, Wood. Nurse practitioners.

Existing law, the Nursing Practice Act, provides for the certification and regulation of nurse practitioners by the Board of Registered Nursing. Existing law authorizes the implementation of standardized procedures that authorize a nurse practitioner to perform certain acts, including certifying disability after performing a physical examination and collaboration with a physician and surgeon. A violation of the act is a misdemeanor.

This bill would authorize a nurse practitioner who holds a certification as a nurse practitioner from a national certifying body to practice without the supervision of a physician and surgeon if the nurse practitioner meets specified requirements, including having practiced under the supervision of a physician and surgeon for an unspecified number of hours. The bill would authorize a nurse practitioner to perform specified functions in addition to any other practices authorized by law, including ordering and interpreting diagnostic procedures, certifying disability, and prescribing, administering, dispensing, and administering controlled substances. Because the bill would expand the scope of a crime, the bill would impose a state-mandated local program.

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

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

Vote: majority  Appropriation: no  Fiscal Committee: yes  Local Program: yes
THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 2837.1 is added to the Business and Professions Code, to read:

2837.1. (a) Notwithstanding any other law, a nurse practitioner who holds a certification as a nurse practitioner from a national certifying body may practice under this section without supervision by a physician and surgeon if the nurse practitioner has practiced under the supervision of a physician and surgeon for at least ____ hours.

(b) In addition to any other practices authorized by law, a nurse practitioner may do all of the following without supervision by a physician and surgeon:

(1) Conduct an advanced assessment.

(2) Order and interpret diagnostic procedures.

(3) Establish primary and differential diagnoses.

(4) Prescribe, order, administer, dispense, and furnish therapeutic measures, including, but not limited to, the following:

(A) Diagnose, prescribe, and institute therapy or referrals of patients to health care agencies, health care providers, and community resources.

(B) Prescribe, administer, dispense, and furnish pharmacological agents, including over-the-counter, legend, and controlled substances.

(C) Plan and initiate a therapeutic regimen that includes ordering and prescribing nonpharmacological interventions, including, but not limited to, durable medical equipment, medical devices, nutrition, blood and blood products, and diagnostic and supportive services, including, but not limited to, home health care, hospice, and physical and occupational therapy.

(5) After performing a physical examination, certify disability pursuant to Section 2708 of the Unemployment Insurance Code.

(6) Delegate tasks to a medical assistant pursuant to Sections 1206.5, 2069, 2070, and 2071, and Article 2 (commencing with Section 1366) of Chapter 3 of Division 13 of Title 16 of the California Code of Regulations.

(7) Perform additional acts that require education and training and that are recognized by the nursing profession as appropriate acts to be performed by a nurse practitioner.

(c) A nurse practitioner shall refer a patient to a physician and surgeon or other licensed health care provider if a situation or condition of a patient is beyond the scope of the education and training of the nurse practitioner.

(d) A nurse practitioner practicing under this section shall maintain professional liability insurance appropriate for the practice setting.

SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.
Scope of Practice Laws in Health Care: Exploring New Approaches for California

Overview
In health care, scope of practice (SOP) laws establish the legal framework that controls the delivery of medical services. They dictate which professions may provide specific services, the settings in which they may provide them, and the parameters of their professional activities. The reach of SOP laws stretches from physicians to physical therapists, podiatrists to dental hygienists.

With few exceptions, determining SOP laws is the work of state governments. State legislatures consider and pass the statutes that govern health care practices. Regulatory agencies, such as medical and other health profession boards, implement those statutes, through the writing and enforcement of rules and regulations.

Due to the individualized, state-specific nature of this process, SOP laws and regulations vary widely among the health care professions. Some states allow individual professions broad latitude in the services they may provide, while others employ strict SOP limits. In some states, certain professions are not recognized at all.

Influencing the design of these legal frameworks is the large number of interest groups involved in SOP decision-making. These constituencies each bring their own goals, biases, and agendas to a process that is often highly politicized and lacking in standardized guidelines. This has resulted in episodic, and at times seemingly intractable, political battles over modifications to SOP laws, both in California and nationwide.

The cumulative effects of legal SOP boundaries are substantial, and not limited to market share or inter-professional competition. SOP laws can facilitate or hinder patients’ ability to see a particular type of provider, which in turn influences health care costs, access, and quality.

Key Findings
- In California, the state legislature enacts scope of practice (SOP) laws, and all major changes to those laws;
- Most of the health professions boards, which implement the laws through regulation, function under the administrative oversight of state agencies such as the Department of Consumer Affairs, the Department of Public Health, or the Emergency Medical Services Authority;
- Policy and political battles over SOP laws have arisen in numerous state legislatures;
- The states of Iowa, Minnesota, New Mexico, and Virginia, and the province of Ontario, have established or are implementing processes to review changes to SOP laws. In addition, a bill in Texas proposing a new SOP review mechanism was recently defeated; and
- These processes have met with varying degrees of success, but have garnered positive evaluations from policymakers who have employed them in their SOP decision-making.
The Center for the Health Professions at the University of California, San Francisco has identified a number of relevant models for reviewing and modifying SOP laws. The analysis, completed in November 2007, was funded by the California HealthCare Foundation.

This issue brief highlights those models, comparing and contrasting SOP review programs and statutes across the United States and Canada. These review programs seek to complement legislative SOP decision-making with formal review processes, additional expertise, and the use of empirical evidence.

The issue brief also compares California SOP laws for four professions to those of other state and federal programs that offer broader, more expansive practice provisions. Given the often contentious nature of SOP discussions, the models presented here offer California ideas on how to approach the SOP review process in a more impartial manner.

The full UCSF analysis, Promising Scope of Practice Models for the Health Professions, is available online at http://futurehealth.ucsf.edu/pdf_files/Scope%20Models%20Fall%202007.pdf.

Professional Regulation and Scope of Practice Decision-Making: The California Experience

In California, as in most states, the state legislature makes SOP laws, and major modifications to those statutes. SOP laws, once enacted, come under the administrative authority of one of the following: the Department of Public Health (CDPH); the Emergency Medical Services Authority (EMSA); or the boards, bureaus, and committees housed in the Department of Consumer Affairs.

Scope of Practice Laws in California: Health Care Professions

The state of California administers scope of practice laws for a broad range of health care professionals. Regulated professions include:

- Acupuncturists;
- Audiologists;
- Behavioral sciences (marriage and family therapists, licensed clinical social workers, etc.);
- Chiropractors;
- Dentists, dental assistants and dental hygienists;
- Hearing aid dispensers;
- Home health aides;
- Laboratory professionals;
- Medical assistants;
- Midwives (nurse midwives and direct entry midwives);
- Naturopaths;
- Occupational therapists and occupational therapist technicians;
- Optometrists and opticians;
- Orthodontists and oral surgeons;
- Osteopaths;
- Paramedics and emergency medical technicians;
- Pharmacists and pharmacy technicians;
- Physical therapists and physical therapy assistants;
- Physicians (including psychiatrists, ophthalmologists, etc.);
- Physician assistants;
- Podiatrists;
- Psychiatric technicians and psychological assistants;
- Psychologists;
- Radiologic technologists;
- Registered nurses (including nurse practitioners), nursing assistants, and licensed vocational nurses;
- Respiratory care practitioners; and
- Speech pathologists.

These agencies provide administrative and regulatory oversight of the respective professions under their authority. This includes:

- Establishing minimum qualifications and levels of competency for licensure;
- Licensing, registering, and certifying practitioners; and
- Investigating complaints and disciplining violators.

The DCA has 15 boards, two bureaus, and two committees, which regulate the majority of the medical and behavioral science professions. The boards and bureaus are semi-autonomous bodies, with members appointed by the governor and the legislature; the department provides administrative support. The committees are under the purview of the bureaus in which they are housed.¹

The CDPH regulates a smaller number of professions, including home health aides, radiologic technologists, and laboratory technicians; EMSA regulates paramedics, while local EMS agencies regulate emergency medical technicians (EMTs); and chiropractors fall under the Board of Chiropractic Examiners.

Given the role of the state legislature in SOP decision-making, changes to these laws are largely a function of the political process. Interest groups with strong lobbies play a significant role in shaping or blocking legislation. This has spawned numerous inter-professional battles, some of which have continued for years.

For example, psychiatrists and psychologists have clashed repeatedly over legal authority to prescribe psychotropic drugs. Both professions may treat patients through individual and group therapy, but psychologists do not have drug-prescribing authority. Psychologists have long sought to add drug prescribing to their practice scope, but psychiatrists, who may prescribe psychotropic drugs, have consistently fought this SOP expansion. In 2007, SB 993, authored by Sen. Sam Aanestad, R-Penn Valley, and Sen. Ron Calderon, D-Montebello, would have allowed psychologists to prescribe drugs. However, the bill faced opposition from organizations representing psychiatrists and other medical professionals with prescribing authority, and the bill failed to clear the Senate Business, Professions, and Economic Development Committee.²

The competition between physicians and nurse practitioners (NPs) is another policy area of significant legislative activity. NPs are registered nurses with advanced clinical training, who serve as primary care providers in a broad spectrum of acute and outpatient settings. The two professions have a long and contentious history concerning practice boundaries.

In 2007, two bills sought to expand SOP laws for NPs, in particular, allowing NPs to prescribe drugs without physician oversight. Physician lobbying organizations opposed both bills. One, AB 1643, authored by Assemblymember Roger Niello, D-Sacramento, was not scheduled for a committee hearing, and the author decided not to pursue the bill. The second bill, SBX1 24, by Sen. Roy Ashburn, R-Bakersfield, was removed at the author's request prior to its scheduled hearing before the Senate Health Committee; as of late February, a hearing had yet to be scheduled.³

Eye and vision care is another area where competition among professions has occurred. Ophthalmologists and optometrists have found themselves on opposite sides of debates on whether optometrists, whose SOP is generally the more restricted of the two, should be allowed to expand their SOP into areas such as diagnosis and treatment of glaucoma, and the prescription of medications.

In 2000, SB 929, by then-Sen. Richard Polanco, D-Los Angeles, expanded the SOP of optometrists to allow the treatment of additional diseases and conditions. The bill also declared a moratorium on further optometry SOP modifications until Jan. 1, 2009. That modification
process is now under way. SB 1406, introduced in February 2008 by Sen. Lou Correa, D-Santa Ana, would expand optometrists’ SOP. It would permit optometrists to diagnose and treat the eyes, or any part of the visual system, for all conditions for which they are trained and authorized by the state Board of Optometry.

Scope of Practice Decision-Making: Other States, Other Models
Several state governments have begun to establish independent review committees to evaluate SOP modification proposals. These committees, using standardized review mechanisms and expert staff, evaluate proposals and transmit their findings to legislators. Policymakers then have objective, evidence-based reviews on which to draw in their deliberations. As illustrated by the brief descriptions that follow, four states and one Canadian province have established flexible, transparent review processes to support legislative decision-making.

Minnesota: Health Occupations Review Program
In 2001, Minnesota established the state Health Occupations Review Program, to provide legislators with impartial information on SOP modification proposals. The program reviews legislation on SOP changes, and emerging professions, at the request of state policymakers.

The program serves in an advisory capacity only, but generates important background information that helps legislators make informed decisions. The program helps frame issues; develops benchmark research that places proposals in context of other states’ decisions; examines other professions in the state for standard practices; and raises questions for legislators to consider when reviewing SOP proposals.

The program consists of representatives from existing state health licensing boards. Initial review panels are composed of six members of those boards, with review processes taking an average of three to nine months.

Legislators have given the program favorable reviews, including one policymaker who suggested that all health care profession bills go through program reviews.

In one example of the review process, a program panel evaluated a 2006 proposal to expand SOP for athletic trainers. The panel provided valuable analysis on key elements of the proposal, including:

- The plan to rename trainers’ clients as “patients,” as opposed to “athletes,” would make Minnesota the first state to do so, but Michigan previously had changed its definition of “athlete” to “individual;”
- The plan to reduce from one year to six months the period of temporary trainer registration, which covers the time between completion of education and passage of the state credentialing exam, would be consistent with state rules for physician assistants and respiratory therapists;
- The plan to provide a three-month grace period for new trainers to be employed without a physician protocol (a formal physician-generated treatment guideline) in place was illogical, because this would make the standard for new trainers less stringent than that for trainers who are already registered, and who must work with physician protocols; and
- Athletic trainers are allied health professionals and should be required to adhere to HIPAA regulations.

New Mexico: Scope of Practice Review Commission
In 2007, the New Mexico Legislature passed House Joint Memorial 71, and House Memorial 88, requesting that the Interim Legislative Health and Human Services Committee establish an empirical process to provide legislators with objective information when deciding on proposed SOP changes. The committee will begin its study in the summer of 2008, as part of the state’s health care reform initiative.
Texas: Scope of Practice Review Bill Fails to Clear the Legislature

In an example of the difficulties associated with modifying the scope of practice (SOP) review process, Texas state Rep. Dianne Delisi saw her second attempt to establish a formal review mechanism go down to defeat in the 2007 legislative session.

Delisi authored a bill in 2005 to create a Health Professions Scope of Practice Review Commission, which would evaluate proposed changes to SOP laws. The bill failed, and Delisi re-introduced it in the 2007 session.

The proposal called for a nine-member commission, including two public representatives and one representative from the Health, Law and Policy Institute at the University of Houston, as well as formal process protocols to evaluate proposed SOP changes. These protocols included an examination of other states that have implemented similar SOP review processes, with evaluations of subsequent impacts on access to care.

Further, the bill included notice requirements for committee meetings that are similar to those of corporate boards; made commission meetings open to the public; and articulated quorum requirements for commission votes.

The bill was referred to the House Public Health Committee in late March, 2007, where it died without receiving a hearing; Delisi plans to retire at the end of 2008.

Iowa: Reviewing Committees

In 1997, the Iowa General Assembly established a three-year pilot program to review SOP processes, after a state task force found that the existing system for resolving inter-professional conflicts was inadequate.

The pilot program instituted SOP review committees. These committees conducted impartial assessments of proposed changes in health profession regulations, used objective criteria to evaluate proposals, and developed non-binding recommendations for legislators. The program sought to enhance both consumer protection and choice.

Under the program, committees received proposals for review in two ways, either by a request from the Iowa General Assembly, or a recommendation from the state Public Health Department. Reviews had to be completed within nine months. Review committees commonly had five members:

- One member representing the profession seeking a change in scope of practice;
- One member of the health profession directly affected by, or opposed to, the proposed change;
- One impartial health professional, whose constituency would not be affected by the proposed change; and
- Two members of the general public.

The program was well-received by the constituencies that interacted with it. Based on the pilot project's success, legislators extended the program twice—first until 2002, then until 2007.

Between 1997 and 2002, committees reviewed four proposals, two each from the General Assembly and the Public Health Department. The review process provided policymakers with information to aid their efforts to resolve conflicts among health professions:

- The Dubuque District Dental Assistant Society requested mandatory certification of dental assistants (DAs), which at the time were not governed by formal state regulation. The reviewing committee found that the lack of formal regulation could constitute a consumer protection issue, and that the lack of education or training requirements meant there were no minimum competency standards. The committee also found that there could be more cost-effective methods to regulate the profession than mandatory certification. The committee recommended that all DAs be required to register with the Board of Dental Examiners, and that the board should establish education and examination requirements. This recommendation became law in 2000, and the governor vetoed a bill in 2004 that would have eliminated the new exam requirements;
The Iowa Midwives’ Association requested formal recognition of direct entry midwifery, through legislative recognition of the Certified Professional Midwife credential established by the North American Registry of Midwives, and the establishment of a Board of Certified Professional Midwife Examiners within the state Public Health Department. Direct entry midwifery, also known in some states as lay midwifery, is performed by trained midwives who do not have a formal nursing degree or registered nurse license. The review committee recommended that legislators reject the association’s request, but recommended legalization of direct entry midwifery. It further recommended that the state establish a Midwifery Advisory Council, composed of a range of professionals currently in clinical practice, to formulate regulations and clinical protocols for the profession.

The Iowa Optometric Association requested that optometrists receive approval to use all classifications of pharmaceutical agents to diagnose and treat the eye. The review committee tapped the Des Moines University Osteopathic Medical Center to assist in its evaluation. University personnel attended committee meetings, evaluated laws in other states, reviewed clinical studies, and examined the curricula of Iowa optometry schools. The committee ultimately recommended against the association’s request; and

A committee reviewed the adequacy of existing nurse’s aide education and competency testing regulations, recommending that all candidates for the nurse’s aide registry be required to take a 75-hour training course.

Program reviews were positive. A survey of the initial pilot program, which queried review committee members, health care professionals, legislators, administrators, and program staff found that respondents felt the program had had a positive impact on health care policy, and 75 percent indicated that the review process should be continued.

Likewise, a 2002 evaluation identified a number of important program benefits:

- It had provided a mechanism to impartially review legitimate public policy issues outside the political arena;
- It helped give a voice to previously disenfranchised constituencies;
- It delivered legitimate public policy recommendations;
- It was cost-effective—all four reviews cost less than $20,000; and
- It was still needed, as SOP disputes among health professionals would continue to occur, demonstrating the need for a formal resolution mechanism.

The program ended in 2007; the Public Health Department is not aware of any effort to reinstate it.

Virginia: Board of Health Professions

Virginia employs 13 health boards to regulate their respective professions. In addition, a separate Board of Health Professions evaluates and makes recommendations to the state legislature on SOP regulatory issues. The board consists of 18 members, one from each of the 13 regulatory boards, and five citizens (consumers), all appointed by the governor.

In a 2000 study, for example, the state legislature requested that the board examine the appropriate level of regulation for certified occupational therapy assistants (COTAs). The board’s examination included:

- A public hearing;
- A survey of all states that regulate occupational therapists or COTAs, showing aggregate numbers of complaints, disciplinary actions, and malpractice claims over a two-year period; and
- A survey of occupational therapists in Virginia, detailing supervision and delegation patterns for COTA activities.
The legislature, following the recommendations in the board report, decided that COTAs needed no additional regulatory oversight in 2000.6

Ontario: The Regulated Health Professions Act
The Regulated Health Professions Act of 1991 (RHPA) established a common framework for the regulation of Ontario’s 23 health professions, and the 21 “colleges” (similar to state boards in the United States) that regulate them, and provides provincial policymakers with enhanced flexibility in health care planning and delivery.

While the Ministry of Health is responsible for the overall administration of RHPA, the act also established the Health Professions Regulatory Advisory Council (HPRAC), which plays a key role in delivering analyses on SOP modifications. HPRAC reviews all proposals for new professions to come under RHPA regulation, as well as SOP modifications to currently regulated professions, and makes recommendations to the ministry on how to proceed.

As part of the review process, proposed SOP regulations pass through a process of “consultation.” The ministry must notify every college of the proposal and permit each college’s regulatory council to submit arguments to HPRAC. In addition, the registrar of each college also must notify its respective members of all proposals.

HPRAC consists of five to seven individuals, made up entirely of members of the public, who are recommended for their posts by the ministry. Public sector employees, current and former members of all regulated professions, and all former HPRAC members are ineligible to serve on the council.7

In its 17-year history, HPRAC has provided analysis on issues as diverse as studies on whether to regulate naturopathy, acupuncture, and traditional Chinese medicine; SOP expansion proposals for dental hygienists and nurse practitioners; proposals to allow optometrists to prescribe medications; and a broad-based review of the regulatory framework for diagnostic imaging and MRI professionals.

Scope of Practice Laws: Four Professions, Differing Approaches
Nationwide, SOP laws for the health professions vary widely from state to state, despite relatively standard education, training, and certification programs. A comparison of specific practice authorities of four important professions in California to more expansive authorities in other states highlights the variability of specific services that these professionals may provide, regardless of the fact that their education and training prepares these professionals to provide them.

The four examples of professions whose SOP could be expanded include:
1. Nurse practitioners and independent practice;
2. Physical therapists and the authority to refer and diagnose;
3. Physician assistants and the prescription of controlled substances; and
4. Paramedics and the administration of intravenous infusions.

The successful implementation of expansive SOPs for these four professions, in state-by-state comparisons with California, illustrates how some practitioners may be used more productively, without compromising patient safety and quality of care. Further, these examples illustrate how SOP modifications can have an impact on health care cost and access. Given the often contentious nature of SOP expansion proposals, these practice authority examples from other states provide California an opportunity to review its proposals in a more impartial fashion.
1. Nurse Practitioners and Independent Practice

Nurse practitioners (NPs) are registered nurses who receive advanced training that allows them to serve as primary care providers. Although most states now require NPs to be certified by a national certification body, SOPs vary widely. For example, most states require NPs to practice in collaboration with a physician, but some states permit NPs to practice independently, without physician involvement. Significant variation also exists in NP authority to diagnose, order tests, make patient referrals to other providers, and prescribe drugs and controlled substances.

California: Mandated Physician Collaboration

NPs in California do not have a formal SOP beyond that of registered nurses. NPs may exceed the SOP of a registered nurse through individual “standardized procedures;” NPs must develop these procedures in collaboration with physicians under a written, jointly developed practice protocol. NPs may practice only in collaboration with physicians, and individual physicians may supervise no more than four drug-prescribing NPs. If a standardized procedure protocol specifically permits it, NPs also may diagnose, order tests and durable medical equipment, refer patients to other providers according to their practice protocol, and “furnish” or “order” drugs, including Schedules II-V controlled substances.

Other States: Greater Autonomy for Nurse Practitioners

NPs are explicitly authorized to practice independently without physician oversight in 10 states and the District of Columbia; the states include Alaska, Arizona, Idaho, Iowa, Maine, Montana, New Hampshire, New Mexico, Oregon, and Washington. In all these states, the authority of NPs to practice independently includes the authority to prescribe drugs without physician involvement.

Elsewhere in the United States, NPs practice with varying degrees of physician oversight. For example, stricter states, such as Oklahoma and Virginia, require NPs to practice under direct physician supervision. Most states, on the other hand, require NP-physician collaboration.

States may also require ranging levels of physician involvement depending on geographical location: some states require differing levels of physician oversight, depending on location (such as inner cities or rural areas), practice setting (nursing homes, hospitals, etc.), and specific medical service.

For a more complete discussion of NP scopes of practice, the UCSF analysis, *Overview of Nurse Practitioner Scopes of Practice in 50 States*, chart and discussion, is available online at http://futurehealth.ucsf.edu; and the CHCF issue brief, *Scope of Practice Laws in Health Care: Rethinking the Role of Nurse Practitioners*, is available online at www.chcf.org/topics/view.cfm?itemID=133568.

2. Physical Therapists and the Authority to Refer and Diagnose

According to the Bureau of Labor Statistics, physical therapists (PTs) “provide services that help restore function, improve mobility, relieve pain, and prevent or limit permanent physical disabilities of patients suffering from injuries or disease.” PTs are licensed in all states, based on completion of an accredited PT program and a licensure exam. There is broad variation, nationwide, in the ability of PTs to:

- Treat patients without a referral from another provider;
- Initiate treatments without a referral;
- The categories of providers that may make a referral to a PT;
- Restrictions in the time before direct patient access can be made; and
- Specific diagnoses that allow direct access to a PT without a referral.
California: Regulation of Physical Therapists
PTs in California must possess a post-baccalaureate degree in physical therapy, pass the National Physical Therapy Examination (NPTE), and pass the California Law Examination. California PTs enjoy a comparatively broad SOP, and are not required to have a referral from a physician to provide treatment. However, although PTs are authorized to perform physical therapy evaluations and treatment planning, they are not permitted to diagnose patients—and under California law, a disease or other physical condition cannot be treated without a diagnosis. Thus, PTs may not treat a patient without a prior diagnosis by a physician.11

Illinois’ Alternative: Physical Therapists Enjoy Broad Practice Authorities
There are nuanced differences among the states in SOP laws for PTs. For example, Illinois SOP laws for PTs could be considered broader than California’s. PTs in Illinois may not treat patients without a referral, but the group of providers that may refer patients to PTs extends significantly beyond physicians; the list includes dentists, advanced practice nurses, physician assistants, and podiatrists. Oral referrals from these providers constitute sufficient authorization, and while PTs are not permitted to diagnose patients, a diagnosis is not a prerequisite to PT treatment.12

Overall, 19 states allow patients unlimited, direct access to PTs, while another 31 states allow limited direct access, depending on factors such as the patient’s condition.

3. Physician Assistants and Prescription of Controlled Substances
Physician Assistant (PA) programs require candidates to complete an accredited education program, and pass a national exam. PAs provide diagnostic, therapeutic, and preventive health care services under physician supervision, but again, specific laws and regulations vary among the states. For example, in some states, PAs may be principal care providers in rural or inner-city clinics, where a physician is present for only one or two days a week. The duties of PAs are determined by the supervising physician and by state law.13

California: Limited Advances in Prescribing Authority
In October 2007, the California legislature passed AB 3, which expanded PA prescribing authority. Under AB 3, PAs may now order controlled substances without advance approval by a supervising physician, if the PA completes specified training and meets other requirements. However, California PAs do not have complete independence when prescribing drugs. PAs still must be supervised by physicians, and an individual physician may supervise a maximum of four PAs. In addition, under AB 3, each supervising physician who delegates the authority to issue a drug order to a PA must first prepare general written formularies and protocols that specify all criteria for the use of a particular drug. Protocols for Schedule II controlled substances, which generally have the highest potential for abuse and dependence, also must address the diagnosis for which the drug is being issued.

Indian Health Service’s Alternative: Facility-Specific Prescribing
PAs have worked in the Indian Health Services (IHS) since the mid-1970s. Approximately 160 PAs nationwide work in IHS federal, urban, and tribal health facilities. In the IHS, PAs play a significant role in relieving physician shortages in primary care.14 While grounded in the core requirement that a PA must be supervised by a medical doctor, the IHS policy on PAs recognizes the value of tailored SOPs, to meet individual and site-specific needs. All PAs must have a supervising physician, and each facility must outline the scope of work for PAs employed at that facility. Facility medical managers determine individual PA clinical privileges, which are based on the individual PA’s education, training, experience, and current competence. The supervising physician must meet with the PA in person on a periodic basis to discuss patient management.
THE STEINBERG INSTITUTE SUPPORTS AB 890 TO GRANT FULL PRACTICE AUTHORITY TO NURSE PRACTITIONERS

Posted on Thursday, February 21, 2019

Proposed law follows release of groundbreaking report recommending an end to outdated regulations so California can fill growing healthcare workforce gaps

SACRAMENTO, CA – The Steinberg Institute hails AB 890 by Assemblymember Jim Wood (D-Santa Rosa) as an important bill that would help California meet patient mental health needs by giving nurse practitioners, including psychiatric specialists, the ability to work to the full extent of their training.

California needs fully empowered nurse practitioners to help alleviate a “looming crisis” of inadequate access to quality, affordable care, particularly in the area of mental health as the state is facing a growing shortage of psychiatrists, according to a report released this month by the California Future Health Workforce Commission.

Yet California is the only western state that still restricts nurse practitioners by requiring that they only practice and prescribe with physician oversight, said the commission, which was co-chaired by University of California President Janet Napolitano and Dignity Health President and CEO Lloyd Dean. Twenty two other states don’t have such restrictions.

“The time has come for California to stop letting its citizens suffer from preventable or treatable illnesses just because qualified and highly trained nurse practitioners are shackled by outdated rules,” said Steinberg Institute Executive Director Maggie Merritt. “Let nurse practitioners do their jobs.”
Freeing up nurse practitioners from unnecessary physician oversight – as AB 890 would do, following a transitional period of physician supervision – can help address the gap in mental health services, particularly in rural and underserved areas, and their numbers should be increased, the commission said. A large body of research, meanwhile, has linked restrictions on nurse practitioners with keeping their numbers down.

Those who argue for the status quo regulatory regime for nurse practitioners say physician oversight is necessary to ensure quality of care, but dozens of studies demonstrate that the quality of nurse practitioner care is comparable to that of physician care and that there is no difference in the quality of care when there are no physician oversight requirements, the commission said.

Studies have also found that allowing nurse practitioners full practice authority is associated with greater access to care and lower costs. So reported the prestigious Bay Area Council Economic Institute in 2014.

Regarding mental healthcare, the need for psychiatric nurse practitioners will only grow, the commission warned, as the Healthforce Center at UCSF projected a 34 percent decrease in the number of psychiatrists in California between 2016 and 2028. Nearly 17 percent of California’s population has mental health needs and one in 20 suffers from serious mental illness, but half of the people with mental illness receive no care, the commission said.

AB 890 will be heard in the Assembly Business and Professions Committee next month.

For more information: Patrick Hoge (office) 916-297-4494, (cell) 510-435-2320, patrick@steinberginstitute.org

Please follow and like us:
**AGENDA ITEM:** 10.3  
**DATE:** June 27, 2019

<table>
<thead>
<tr>
<th>ACTION REQUESTED:</th>
<th>Discussion and Possible Action: Whether to recommend to the BRN Nursing Practice Committee a minimum requirement for APRN First Assist Privileges through APRN specific didactic content with clinical hours to be obtained in the workplace through a privilege identified in a standardized procedure.</th>
</tr>
</thead>
<tbody>
<tr>
<td>REQUESTED BY:</td>
<td>Mitchel Erickson, RN, NP</td>
</tr>
<tr>
<td>BACKGROUND:</td>
<td>The Committee will have a follow-up discussion that was placed on the February 7, 2019’s Advance Practice Agenda under agenda item 10.2:</td>
</tr>
<tr>
<td></td>
<td>The National Institute of First Assisting, Inc. (NIFA) is a Colorado institution that specializing in health care education specific to operating room nurses and APRNs since 1995. The <strong>NIFA RN First Assistant Program for APRNs is presented through accredited colleges nationwide, overseen by their accredited nursing programs and meets all AORN Standards for RNFA Education.</strong></td>
</tr>
<tr>
<td></td>
<td>This college RNFA online program addresses all the modules of the AORN Core Curriculum for RN First Assistants. In total, home studies would represent approximately 48 hours followed by a 140-hour internship which the student arranges at their facility.</td>
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<td><strong>Upon Graduation</strong></td>
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<td></td>
<td>Many APRN students graduate between 5-8 months after but have two years to complete the program. Graduates receive a Certificate verifying that they have successfully completed the RNFA program designed specifically for APRNs, meets all the standards as set forth by the AORN and is accepted by the Competency and Credentialing Institute leading qualified graduates to the national exam. Your NIFA certificate is recognized by all 50 Boards of Nursing.</td>
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<td></td>
<td>UCLA’s program requires OR experience of 2 years or to take the one-day course before entry into the APRN FA program which is 52 hours of class room content then preceptorship.  120 hours of independent preceptorship is required prior to certification.</td>
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<tr>
<td>RESOURCES:</td>
<td>APRNs will have to review the current survey and draft categories of questions. Also, if approved, the BRN will need to appropriate funds for this survey.</td>
</tr>
<tr>
<td>NEXT STEPS:</td>
<td>Board</td>
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<tr>
<td>FISCAL IMPACT, IF ANY:</td>
<td>None</td>
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</tbody>
</table>
| PERSON(S) TO CONTACT: | Janette Wackerly, MBA, BSN, RN  
Supervising Nursing Education Consultant  
Phone: 916-574-7686  
Email: janette.wackerly@dca.ca.gov |
**AGENDA ITEM:** 10.4  
**DATE:** June 27, 2019

<table>
<thead>
<tr>
<th>ACTION REQUESTED:</th>
<th>Discussion Only: Discuss committee support for the APRN Advisory Committee’s oversight of a new workforce survey of all APRNs (NPs, CNSs, CRNAs, CNMs) that is more comprehensive than the 2017 NP/CNM Survey. The purpose is to collect demographic as well as clinical site information and outcome metrics as possible.</th>
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<tr>
<td>REQUESTED BY:</td>
<td>Garrett Chan, RN, CNS, PhD</td>
</tr>
<tr>
<td>BACKGROUND:</td>
<td>In 2010 and 2017, the BRN worked with the UCSF Workforce Center to conduct a statewide survey of nurse practitioner and certified nurse-midwives. The purpose of the 2017 Survey of Nurse Practitioners and Certified Nurse Midwives was to collect and evaluate nursing workforce data to understand their demographics, education, and employment. In 2010, NPs and CNMs who also held certificates as Clinical Nurse Specialists (CNSs) or Certified Registered Nurse Anesthetists (CRNAs) were excluded from the survey; in 2017 these NPs and CNMs were included. Questions about perceptions of the work environment, scope of practice, satisfaction with advanced practice, reasons for not working in advanced practice, and plans for future employment are included in the surveys. The BRN APRN Advisory Committee may want to consider including all APRN categories in the next survey, think about categories of questions for the next survey, and the cadence of the survey. With the known current and forecasted lack of future health care providers, growing California population, limited access to health care educational opportunities, lack of health care provider diversity equaling the diverse California population, and underutilization of full scope of practice for existing health care professionals; how will California support the health care needs of its residents. The following report highlights the issues and possible strategies to mitigate these concerns. The value of a repeat and more current comprehensive survey of the APRNs in California may shed additional light on the future availability of these professionals to meet the future and current health care needs of Californians.</td>
</tr>
</tbody>
</table>
| RESOURCES:        | Summary of report:  
Full report:  
Past survey:  
[https://rn.ca.gov/pdfs/forms/survey2017npcnm-final.pdf](https://rn.ca.gov/pdfs/forms/survey2017npcnm-final.pdf) |
| NEXT STEPS:       | Following APRN Advisory Committee discussion will defer to the BRN on whether to move forward on a repeat and more comprehensive survey of APRN licensees with the APRN |
Advisory Committee providing oversight. The Committee will have to review the current survey and draft categories of questions.

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<tr>
<th>FISCAL IMPACT, IF ANY:</th>
<th>If approved the BRN will need to appropriate funds for the cost of survey design, distribution, and data analysis</th>
</tr>
</thead>
</table>
| PERSON(S) TO CONTACT: | Janette Wackerly, MBA, BSN, RN  
 Supervising Nursing Education Consultant  
 Phone: 916-574-7686  
 Email: janette.wackerly@dca.ca.gov |
**AGENDA ITEM:** 10.5  
**DATE:** June 27, 2019

<table>
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<tr>
<th>ACTION REQUESTED:</th>
<th><strong>Discussion and Possible Action:</strong> Review the remaining 2019 BRN Board Meeting dates and determine the next APRN Advisory Committee meeting.</th>
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<tbody>
<tr>
<td>REQUESTED BY:</td>
<td>Garrett Chan, RN, CNS, NP</td>
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</table>
| **BACKGROUND:**   | The Advance Practice Advisory Committee members will review the remaining BRN Board and Committee meeting dates to determine whether an additional meeting will occur.  
August 15– Committee, September 11-12 – Board, October 17 – Committee, November 13-14, 2019-Board. |
| **RESOURCES:**    | APRNs will have to review the current survey and draft categories of questions. Also, if approved, the BRN will need to appropriate funds for this survey. |
| **NEXT STEPS:**   | Board                                                                                                                            |
| **FISCAL IMPACT, IF ANY:** | None                                                                                                                            |
| **PERSON(S) TO CONTACT:** | Janette Wackerly, MBA, BSN, RN  
Supervising Nursing Education Consultant  
Phone: 916-574-7686  
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