



BOARD OF REGISTERED NURSING
Advance Practice Registered Nursing
Advisory Committee Meeting

AGENDA

Board of Registered Nursing
1625 N. Market Blvd
HQ-1 Hearing Room, Ste. S-102
Sacramento, CA 95834
(916) 574-7600

September 26, 2019

TELECONFERENCE SITES
Petaluma Community Hospital

Karyn Karp, CRNA
Petaluma Valley Hospital, Room 269
400 N McDowell Blvd
Petaluma, CA 94954
(707) 778-1111

MEMBERS OF THE PUBLIC MAY LISTEN TO THE MEETING
BY CALLING: (877) 950-0357. USER ACCESS CODE: 2158678

Thursday, September 26, 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:

➤ June 27th, 2019

10.1 Discussion: Present and update to the APRN Advisory Committee regarding any new developments for legal parameters and guidance around requests for a BRN licensee list under the Information Practices Act.

10.2 Discussion and possible action: Discuss and present a draft letter to be submitted to the BRN Practice Committee seeking BRN support for AB890 which permits nurse practitioners full scope of practice authority in California. The purpose is to ensure BRN support as the bill proceeds and will be shared with Assembly Member Jim Woods if support is secured. This 2-year bill was approved by the Assembly Committee on Business and Professions and currently sits with the Appropriations Committee. The APRN Advisory Committee will vote to approve the letter to the BRN Board.

10.3 Discussion and possible action: Following a discussion at the June 27th, 2019 meeting it was recommended to draft revised language to the current statement on the BRN website and update the resources for First Assisting. The revisions take into consideration options for health-system

based training and competency versus the option of utilizing formal certification agency in standardizing core competency. Make a recommendation to the BRN Practice Committee and vote to adopt the language revision and updated resources to be presented at their next meeting.

- 10.4 Discussion only:** Present current status of the framework for an updated BRN workforce survey of all APRNs (NPs, CNSs, CRNAs, CNMs) that is more comprehensive than the 2017 NP/CNM Survey. APRN Advisory Committee requests oversight of survey content development. There will be a coordination of effort with other health care professionals not licensed by the BRN but will not be included in the BRN Survey. The purpose is to collect demographic as well as clinical site information and outcome metrics as possible. It would act as a partner document to the California Future Workforce Commission Report. The APRN Advisory Committee would like to participate in the survey question content and administration with the vendor.
- 10.5 Discussion only:** Request that the Executive Officer of the BRN initiate a conversation with the Executive Director of the Department of Health and Human Services regarding language revision to Title 22 of the California Code of Regulations (22 CCR Section 70703 (a) Organized Medical Staff that limits the inclusion, per interpretation of “Medical Staff” where it clearly states, medical staff are restricted to physicians and surgeons and where appropriate, dentists, podiatrists, and clinical psychologists. APRNs as part of the medical staff of health systems in California are required to meet the Bylaws of Medical Staff but have no voice or vote. This language is more restrictive than the Business and Professions language as noted in the resources of the AIS.
- 10.6 Discussion and action:** Request the BRN Practice Committee recommend a change to the BRN Board regarding the meeting schedule of the APRN Advisory Committee. It is requested to change the current schedule of 3 meetings per calendar year to 3 in-person meetings per calendar year plus 3 teleconference meetings per year as directed by the needs of the APRN Advisory Committee members and their agenda. The purpose is to provide greater flexibility in addressing more urgent agenda items as well as align with the BRN Board’s and Practice Committee’s meeting agenda submission deadlines.

10.7 Public Comment for Items Not on the Agenda

Note: The Committee may not discuss or act 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)).

10.8 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.rm.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. 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.

**STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
BOARD OF REGISTERED NURSING
ADVANCED PRACTICE REGISTERED NURSING
ADVISORY MEETING MINUTES**

DATE: June 27, 2019

DRAFT

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

COMMITTEE

MEMBERS: Mitchel Erickson, NP-Chair
Karyn Karp, CRNA-Vice Chair
Charlotte Gullap-Moore, NP
Garrett Chan, CNS
Sandra Bordi, CRNA
Danielle Blum, CNM
Ruth Rosenblum, NP
Hilary Reyes, CNM
Jane Perlas, NP
Elissa Brown, CNS

STAFF PRESENT: Joseph Morris, Ph.D., RN, MSN, Executive Officer
Ann Salisbury, DCA Legal Counsel
Thelma Harris, Chief of Legislation
Janette Wackerly, MBA, BSN, RN, SNEC-APRN Liaison

Thursday, June 27, 2019 11:00 am

10.0 Call to Order, Roll Call, and Establishment of a Quorum

Mitchel Erickson, NP-Chair, called the meeting to order at 11:04 a.m. and established a quorum.

PRESENT: Mitchel Erickson, NP-Chair
Karyn Karp, CRNA-Vice Chair
Charlotte Gullap-Moore, NP
Garrett Chan, CNS
Sandra Bordi, CRNA
Danielle Blum, CNM
Ruth Rosenblum, NP
Elissa Brown, CNS – via teleconference

NOT PRESENT: Hilary Reyes, CNM
Jane Perlas, NP

10.0.1 Review and Vote on Whether to Approve Minutes:

3.1 February 7, 2019 Meeting Minutes

Motion: Karyn Karp: Motion to approve meeting minutes after revision of name for Cheryl Goldfarb.

Second: Elissa Brown

Votes	ME	KK	GC	HR	CGM	JP	SB	DB	EB	RR
	Y	Y	Y	Absent	Y	Absent	Y	Y	Y	Y

No Public Comment

- 10.1 Discussion Only: Availability of a BRN licensee list to requestors upon payment to the BRN under the California Public Records Act.** - Garrett Chan, RN, CNS, PhD Presented report.

No Public Comment

- 10.2 Discussion Only: Whether committee supports AB 890 nurse practitioner full scope of practice** - Charlotte Gullap-Moore, MSN, ANP-BC Presented report.

No Public Comment

- 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.** - Mitchel Erickson, RN, NP Presented report.

No public comment

- 10.4 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.** Garrett Chan, RN, CNS, PhD Presented report.

Public comment: Shawn Collins

- 10.5 Discussion and Possible Action: Review the remaining 2019 BRN Board Meeting dates and determine the next APRN Advisory Committee meeting.** - Garrett Chan, RN, CNS, PhD Presented report.

Motion: Mitchel Erickson made motion for the APRN Advisory Committee meeting to meet on September 26, 2019 11:00 am-1 pm.

Second: Danielle Blum

Votes	ME	KK	GC	HR	CGM	JP	SB	DB	EB	RR
	Y	Y	Y	Absent	Y	Absent	Y	Y	Y	Y

No public comment

- 10.6 Public Comment for Items Not on the Agenda; Items for Future Agenda**

No public comment

10.7 Adjournment

The meeting adjourned at 12:56 pm.

Joseph Morris, PhD, MSN, RN
Executive Officer

Mitchel Erickson, NP
APRN Chair

BOARD OF REGISTERED NURSING
Advanced Practice Registered Nursing Committee
Agenda Item Summary

AGENDA ITEM: 10.1
DATE: September 26, 2019

ACTION REQUESTED: **Discussion Only:** Licensee List Availability and Parameters of Distribution by request and payment

REQUESTED BY: Garrett Chan, RN, CNS

BACKGROUND:

The purpose of this discussion is to provide an update to the APRN Advisory Committee and the Public around the status of administering this type of request for public information.

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.

RESOURCES:

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.)

NEXT STEPS: Board to review

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

Memo

Date: September 26th, 2019

To: Board of Registered Nursing
PO Box 944210
Sacramento, CA 94244-2100

From: Board of Registered Nursing Advanced Practice Registered Nurse Committee

Dear BRN Board Members,

The Board of Registered Nursing Advanced Practice Registered Nurse (APRN) Advisory Committee wishes to provide recommendations related to AB 890 (Wood) and to write a new letter to Assemblyman Wood.

As currently written, AB 890 will establish the Advanced Practice Registered Nursing Board within the Department of Consumer Affairs, which would consist of 9 members. Three members this board shall be physicians and surgeons licensed by the Medical Board of California or the Osteopathic Medical Board of California. At least one of the physicians and surgeon members shall work closely with a nurse practitioner. The remaining physician and surgeon members shall focus on primary care in their practice.

The BRN APRN Advisory Committee is asking the BRN to write an "oppose unless amended" letter recommending to Assemblyman Wood to amend AB890 by eliminating the creation of the new Advanced Practice Registered Nursing Board and replacing the oversight of nurse practitioner practice by the Board of Registered Nursing APRN Committee. Another nurse practitioner oversight alternative to creating a new APRN Board within the Department of Consumer Affairs and the BRN APRN Committee could be that one of the public member positions on the Board of Registered Nursing could be filled by a physician or surgeon. These two recommendations will allow the fiscal cost for AB890 to be significantly decreased and possibly move out of the Assembly Business and Appropriation Committee.

The APRN Advisory Committee consists of ten members professionally representing each APRN discipline and can help with identifying the many processes that already exist for licensees to practice in California.

Should you have any additional questions, please contact Mr. Mitchel Erickson, Chair of the BRN APRN Committee. Thank you for your consideration.

Respectfully,

Mitchel Erickson
Chair
BRN APRN Advisory Committee



AB-890 Nurse practitioners. (2019-2020)

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Date Published: 02/20/2019 09:00 PM

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.

Executive Summary

For the past few decades, the United States has not produced enough primary care physicians. Moreover, too few physicians practice in rural and medically underserved areas, and the number of people lacking adequate access to primary care has increased. Meanwhile, studies have piled up pointing to the high quality of care that nurse practitioners (NPs) provide, and increasing numbers of policy-influencing bodies have recommended expanding the use of NPs in primary care. Yet, barriers to the expanded use of NPs persist, and, consequently, tens of millions of Americans lack adequate access to primary care services. This report describes and integrates new evidence from a research program focused on the primary care workforce, NPs' role in primary care, and the potential for NPs to help solve the problem of Americans' access to quality primary care.

Among other things, the research summarized in this report establishes that it is unrealistic to rely on the physician workforce alone to provide the primary care Americans need, particularly for Americans in rural areas, who are generally older, less educated, poorer, and sicker. Many primary care physicians are expected to retire over the next decade, while demand is increasing for primary care. So current shortages of primary care are projected to worsen, with even fewer physicians practicing in rural areas. And as the proportion of physicians who are married to highly educated spouses increases, the already formidable challenges of attracting physicians to Health Professional Shortage Areas will become even more daunting.

Our findings examine trends in the supply of NPs and physicians, showing that the NP workforce has increased dramatically and is projected to continue growing while the physician workforce will grow minimally. Further, we find, as do other studies, that compared to primary care medical doctors, primary care nurse practitioners (PCNPs) are more likely to

practice in rural areas, where the need for primary care is greatest.

Our research shows that people living in states with laws that reduce or restrict NPs' scope-of-practice had significantly less access to PCNPs. This finding indicates that such state regulations have played a role in impeding access to primary care. This alone should be cause for concern among policymakers seeking to improve public health.

Using different data and methods, the studies described in this report consistently show that NPs are significantly more likely than primary care physicians to care for vulnerable populations. Nonwhites, women, American Indians, the poor and uninsured, people on Medicaid, those living in rural areas, Americans who qualify for Medicare because of a disability, and dual-eligibles are all more likely to receive primary care from NPs than from physicians. NPs, whether they work independently of primary care physicians or with them, are more likely to accept Medicaid recipients, provide care for the uninsured, and accept lower payments than are physicians who do not work with NPs.

Another major finding is that, after controlling for differences in patient severity and sociodemographic factors, the cost of care provided to Medicare beneficiaries by NPs was significantly lower than primary care provided by physicians. Even after accounting for the lower payment NPs receive relative to physicians, the cost of NP-provided care was still significantly lower.

However, the viability of increased reliance on NPs still depends on the simple question at the core of this project: Can NPs provide health care of comparable quality to that provided by primary care physicians? Our studies showed that beneficiaries who received their primary care from NPs consistently received significantly *higher-quality* care than physicians' patients in several respects. While beneficiaries treated by

physicians received slightly better services in a few realms, the differences were marginal. These results held when vulnerable populations of Medicare beneficiaries were analyzed separately and compared to those cared for by physicians, aligning with the findings of many other studies conducted over the past four decades.

Furthermore, state-level NP scope-of-practice restrictions do not help protect the public from subpar health care. Analysis of different classifications of state-level scope-of-practice restrictions provided no evidence that Medicare beneficiaries living in states that imposed restrictions received better-quality care. Some physicians and certain professional medical associations have justified their support for state regulations to limit NP scope-of-practice on the grounds that they are necessary to protect the public from low-quality providers and to assert that physicians must be the leaders of the health care team. We found no evidence to support their claim.

Further, our analysis showed that Medicare beneficiaries living in states with reduced or restricted NP scope-of-practice were more likely to use more resources than were beneficiaries in states without such restrictions. This indicates that these beneficiaries had less access to the positive contributions of NPs.

Despite this body of evidence, our national survey of primary care clinicians revealed that around one-third of primary care physicians believe increasing the number of NPs would impair the safety and effectiveness of care. This could indicate that physicians are not aware of the findings of research. Or alternatively, it is an excuse for a barrier to entry, meant to protect some physicians' narrow interests at the expense of accessible primary care for many Americans who need it.

The evidence leads to three recommendations that can help overcome the growing challenges facing the delivery of primary care in the US. First, private policymakers such as hospital boards and credentialing bodies should allow NPs to practice to the fullest extent of their training and ability. Second, physicians must understand that NPs provide quality health care to those in need. NPs and physicians should work together to build relationships that allow for their respective roles and practices to evolve, respecting each other's strengths and ultimately leading to a workforce that is more responsive to communities' health needs. Third, public policymakers should remove restrictions on NPs that limit their scope-of-practice.

Nurse Practitioners

A SOLUTION TO AMERICA'S PRIMARY CARE CRISIS

Peter Buerhaus

The doctors are fighting a losing battle. The nurses are like insurgents. They are occasionally beaten back, but they'll win in the long run. They have economics and common sense on their side.

—Uwe Reinhardt, Professor of Economics at Princeton University¹

Nearly 30 years ago, in 1991, well-known physician and thought leader Gordon Moore wrote in the *Journal of the American Medical Association*: “Primary care is the most affordable safety net we can offer our citizens.”² The National Academy of Medicine defines primary care as “the provision of *integrated, accessible health care services* by clinicians who are *accountable* for addressing a large *majority of personal health care needs*, developing a *sustained partnership with patients*, and practicing in the *context of family and community*.”³

Primary care clinicians typically treat a variety of conditions, including high blood pressure, diabetes, asthma, depression and anxiety, angina, back pain, arthritis, thyroid dysfunction, and chronic obstructive pulmonary disease. They provide basic maternal and child health care services, including family planning and vaccinations. Primary care lowers health care costs, decreases emergency department visits and hospitalizations, and lowers mortality.⁴

Primary care is a crucial component of American health care, but it faces steep challenges, beginning with ever-increasing demand for primary care services. Demand for primary care has been growing for decades and is expected to increase.⁵ The Affordable Care Act (ACA) expanded the number of people with health insurance and increased access to primary care services by eliminating patient cost sharing for a wide array of preventive services and screenings.⁶

Demand for primary care will continue to increase as the 76 million baby boomers age into the Medicare program. Currently, 54 million people are enrolled in Medicare, the nation’s health insurance program for citizens 65 and older and those with end-stage renal disease and other qualifying disabilities. As baby boomers age, Medicare enrollment is expected to increase to 80 million by 2030.⁷

Not only are baby boomers expected to live longer than previous generations, but also the prevalence of multiple chronic diseases is increasing. By 2030, four in 10 baby boomers are expected to have heart disease or diabetes, and 25 percent will have cancer. The percentage of those enrolled in Medicare with three or more chronic diseases will increase from 26 percent in 2010 to 40 percent in 2030.⁸ Add to this the increasing number of people with Alzheimer’s disease (a leading cause of death in the US) and other dementias, and it is clear that the demand for primary care will increase in coming decades, especially the need for care geared toward the elderly.⁹

If the growth in demand for primary care is a challenge, the current and projected shortages of primary care physicians only make matters worse. The Association of American Medical Colleges (AAMC) estimates that by 2030 we will have up to 49,300 fewer primary care physicians than we will need (an even-larger estimate than the AAMC reported in 2016).¹⁰ Many specialist physicians also provide considerable primary

care, but projected shortages of such physicians (by as many as 72,700 by 2030) only adds to concerns over the adequacy of the primary care physician workforce.¹¹ Despite decades of effort, the graduate medical education system has not produced enough primary care physicians to meet the American population's needs.¹²

When geographic distribution of primary care medical doctors (PCMDs) is taken into account, the problem begins to feel like a crisis. In 2018 the federal government reported 7,181 Health Professional Shortage Areas in the US and approximately 84 million people with inadequate access to primary care, with 66 percent of primary care access problems in rural areas.¹³

Thankfully, there is a solution. Increasingly, researchers, workforce analysts, and organizations that influence health policy support expanding the role of nurse practitioners (NPs) to fill the void left by the lack of primary care physicians and to improve the uneven geographic distribution of primary care. This report presents results from original research projects that support this view and document the evidence base for an expanded role for NPs in remedying these pressing and growing access problems.

Nurse Practitioners: A Regulated Solution

After practicing as a professional nurse for several years, many registered nurses acquire advanced clinical knowledge, training, and patient care responsibilities to become nurse practitioners. In the words of the American Association of Nurse Practitioners (AANP): “All NPs must complete a master’s or doctoral degree program, and have advanced clinical training beyond their initial professional registered nurse preparation.”¹⁴ Didactic and clinical courses prepare NPs with specialized knowledge and clinical competency to practice in primary care, acute care, and long-term health care settings.

NPs assess patients, order and interpret diagnostic tests, make diagnoses, and initiate and manage treatment plans.¹⁵ They also prescribe medications, including controlled substances, in all 50 states and DC, and 50 percent of all NPs have hospital-admitting privileges.¹⁶

The AANP reports that the nation’s 248,000 NPs (87 percent of whom are prepared in primary care) provide one billion patient visits yearly.¹⁷ NPs are prepared in the major primary care specialties—family health (60.6 percent), care of adults and geriatrics (21.3 percent), pediatrics (4.6 percent), and women’s health (3.4 percent)—and provide most of the same services that physicians provide, making them a natural solution to the physician shortage.¹⁸ NPs can also specialize outside primary care, and one in four physician specialty practices in the US employs NPs, including psychiatry, obstetrics and gynecology, cardiology, orthopedic surgery, neurology, dermatology, and gastroenterology practices.¹⁹

Further, NPs are paid less than physicians for providing the same services. Medicare reimburses NPs at 85 percent the rate of physicians, and private payers pay NPs less than physicians.²⁰ On average, NPs earn \$105,000 annually.²¹

NPs’ role in primary care dates to the mid-1960s, when a team of physicians and nurses at the University of Colorado developed the concept for a new advanced-practice nurse who would help respond to a shortage of primary care at the time.²² Since then, numerous studies have assessed the quality of care that NPs provide (see Appendix A), and several policy-influencing organizations (such as the National Academy of Medicine, National Governors Association, and the Hamilton Project at the Brookings Institution) have recommended expanding the use of NPs, particularly in primary care.²³ Even the Federal Trade Commission recognizes the role of NPs in alleviating shortages and expanding access to health care services.²⁴ Most recently, the US Department of Veterans Affairs amended its regulations to permit its nearly 5,800 advanced-practice-registered nurses to practice to the full extent of their education, training, and certification regardless of state-level restrictions, with some exceptions pertaining to prescribing and administering controlled substances.²⁵

Nonetheless, physicians have met such efforts with mixed response. Many physicians favor the use of NPs, at least in theory. A 2012 national survey of PCMDs found that 41 percent reported working in

collaborative practice with primary care nurse practitioners (PCNPs) and 77 percent agreed that NPs should practice to the full extent of their education and training. Additionally, 72.5 percent said having more NPs would improve timeliness of care, and 52 percent reported it would improve access to health services.

However, about one-third of PCMDs said they believe the expanded use of PCNPs would impair the quality and effectiveness of primary care.²⁶ The survey also found that 57 percent of PCMDs worried that increasing the supply of PCNPs would decrease their income, and 75 percent said they feared NPs would replace them.

Although PCMDs generally favor using NPs at current levels, they seem to fear that increased PCNP-based care will usurp them or make them obsolete. These PCMDs are rationally self-interested, and understandably so. But for the good of patients around the country, hospital boards and state lawmakers should prioritize patients over PCMDs' concerns and relieve the shortage of primary care providers with PCNPs.

Current Restrictions on PCNP Practice

To protect the interests of PCMDs, the American Medical Association, American Academy of Family Physicians, and some state and county medical associations favor state-level legal restrictions on the services that an NP may provide, whether in primary care or acute care delivery settings. In fact, many states impose varying degrees of legal restrictions on NPs, which the AANP has classified as follows.²⁷

- **Full Practice.** State practice and licensure laws allow all NPs to evaluate patients, diagnose patients, order and interpret diagnostic tests, and initiate and manage treatments—including prescribing medications and controlled substances—under the exclusive licensure authority of the state board of nursing. The National Academy of Medicine and National Council of State Boards of Nursing recommend this model.
- **Reduced Practice.** State practice and licensure laws reduce NPs' ability to engage in at least one element of NP practice. State law limits the setting of one or more elements of NP practice or requires a career-long regulated collaborative agreement with another health care provider in order for the NP to provide patient care.
- **Restricted Practice.** State practice and licensure laws restrict NPs' ability to engage in at least one element of NP practice. State law requires career-long supervision, delegation, or team management by another health care provider in order for the NP to provide patient care.

Over the past two decades, the trend among states has been to remove scope-of-practice restrictions.²⁸ As shown in Table 1, in 2018, 23 states allowed the full practice of NPs, 16 states reduced certain areas of NP practice, and 12 states were classified as restricting NP practice.²⁹

These restrictions infringe on the clinical activities NPs are trained to perform. In 1992, Yale Law School Associate Dean Barbara Safriet made a compelling case for increasing NPs' roles in primary care:

Advanced practice nurses have demonstrated repeatedly that they can provide cost-effective, high-quality primary care for many of the neediest members of society, but their role in providing care has been [*sic*] severely limited by restrictions on their scope of practice, prescriptive authority, and eligibility for reimbursement. Eliminating these restriction [*sic*] would enable advanced practice nurses to increase access to health care while preserving quality and reducing costs.³⁰

Safriet contends that scope-of-practice restrictions on NPs impede their ability to practice to the full extent of their education and training, which is undesirable for both NPs and PCMDs. Eighteen years later, she again argued for removing these regulatory obstacles to allow Americans better access to care at a more affordable cost and to reform the health care regulatory framework to enhance all providers' abilities and

Table 1. State-Level Scope-of-Practice Regulatory Restrictions on Nurse Practitioners, 2018

Full Practice	Reduced Practice	Restricted Practice
Alaska	Alabama	California
Arizona	Arkansas	Florida
Colorado	Delaware	Georgia
Connecticut	Illinois	Massachusetts
District of Columbia	Indiana	Michigan
Hawaii	Kansas	Missouri
Idaho	Kentucky	North Carolina
Iowa	Louisiana	Oklahoma
Maine	Mississippi	South Carolina
Maryland	New Jersey	Tennessee
Minnesota	New York	Texas
Montana	Ohio	Virginia
Nebraska	Pennsylvania	
Nevada	Utah	
New Hampshire	West Virginia	
New Mexico	Wisconsin	
North Dakota		
Oregon		
Rhode Island		
South Dakota		
Vermont		
Washington		
Wyoming		

Source: American Association of Nurse Practitioners, "State Practice Environment," <https://www.aanp.org/legislation-regulation/state-legislation/state-practice-environment/66-legislation-regulation/state-practice-environment/1380-state-practice-by-type-restricted-practice>.

competencies.³¹ This report builds on Safriet's argument and adds a potential framework for reform that would allow NPs to best practice according to their abilities and allow Americans more affordable access to health care, especially in rural areas.

Research

The concept of expanding the use of NPs and removing restrictions on their practice has gained traction since the ACA was being developed. Health workforce analysts have long been concerned with the shortage of primary care physicians and the persistent inability of graduate medical education programs to produce

enough physicians to make up the difference. Indeed, the ACA contains many provisions aimed at addressing these and other workforce-supply problems.

One such provision was the establishment of the National Health Care Workforce Commission to advise Congress and the administration on national health workforce policy. I was appointed to the commission and agreed to serve as its chairman. Anticipating that the commission would be asked to address the shortage of primary care physicians, I assembled teams of investigators to assess the feasibility and desirability of expanding PCNPs' roles in primary care.

The workforce issues discussed most frequently among health policymakers, members of Congress, state legislators, and their staffs concern the quality

and costs of NPs and their potential to alleviate the shortage of primary care physicians. These issues guided the assessment of whether NPs can fix the labor supply problems among primary care providers. The specific questions on the minds of the policy community included:

- Geographically, where do primary care physicians practice, and where do PCNPs practice?
- How large are current shortages of primary care physicians? Will the primary care physician workforce increase or decrease in the future?
- Will the NP workforce grow in the future?
- Are PCNPs willing to accept people enrolled in Medicaid?
- How do the services that PCNPs provide compare to the services that PCMDs provide?
- Are there differences in the characteristics of people who are treated by PCNPs and PCMDs?
- What is the potential for NPs to increase access to primary care and help alleviate shortages and uneven distribution of primary care physicians?
- Do state-level regulatory restrictions placed on NPs limit Americans' access to primary care?

The answers to the above questions will help bring us toward a framework for more effective primary care.

This report describes key results of research conducted since 2011 that aimed to answer these questions. It integrates the studies' findings with the results of other published research and makes recommendations for both public and private policymakers on improving the capacity of the nation's primary care workforce. The results of these studies are presented as further proof of the benefits of using NPs to provide more Americans in more places with the primary care they need.

Solutions: Study Results

To address these questions, the research was divided into three areas of analysis: (1) assessing the contributions of NPs providing primary care, (2) projecting the supply of physicians and NPs while assessing the geographical disparities of the primary care workforce, and (3) revealing perceptions of the PCNP workforce. Each area focused on a different element of primary care shortages and how well NPs could address them. The focuses of each of these areas parallel the questions we set out to answer:

- The analysis of NP contributions identified the types, quantity, costs, and quality of primary care that NPs and physicians provide to Medicare beneficiaries. It also assessed whether state-level NP scope-of-practice restrictions affect the quality of primary care that Medicare beneficiaries receive.
- The projections and geographical analyses examined the geographic locations of the primary care physician and NP workforce, investigated barriers physicians face in locating their practice in rural locations, and projected the future supply of physicians and NPs.
- Assessing perceptions of NPs involved conducting a national survey of PCMDs and PCNPs to identify their practice characteristics and examine their attitudes, knowledge, and behavior on various themes, including shortages of primary care professionals, expanding the number of PCNPs, quality of care provided by PCNPs, responsibility for providing specific services and procedures, and career recommendations.

The most obvious and crucial question is whether NPs can provide the same quality and types of care that physicians currently provide. Driving down the cost of and increasing accessibility to health care is a worthwhile goal. But if the quality of primary care

provided by PCNPs is not up to par, they present a far less attractive remedy.

For these reasons, this report begins with the findings of the NP analysis team, which asked: What are the types, costs, and quality of primary care services provided by PCNPs, and how do they compare to the primary care provided by PCMDs? Are there differences in the characteristics of people treated by PCNPs versus PCMDs? And do state-level scope-of-practice restrictions on PCNPs affect the quality of primary care?

While hundreds of studies have assessed different ways that NPs contribute to providing primary care, there are lingering questions about the costs and quality of NP-provided care, questions not fully answered by prior studies. Consequently, it is difficult to generalize the results from many of these studies to broader populations, let alone make apples-to-apples comparisons between the care provided by NPs and physicians. In all, despite the large number of studies that showed favorable results for the care delivered by NPs (see Appendix A), there is room to learn more, improve and expand the measurement of primary care, make more direct comparisons between primary care clinicians, use different data to enable better generalization of results, and apply advanced statistical techniques to overcome methodological shortcomings.

What Types of Primary Care?

The analysis of NP contributions to primary care began with using Medicare claims and other Medicare administrative data to identify the number and distribution of PCNPs throughout the US who billed for care provided to Medicare beneficiaries. This was then used to describe the types, quantities, and overall costs of services that PCNPs provide and compare them to those that PCMDs provide.³²

Results showed that in 2008 approximately 45,000 NPs were providing services to Medicare beneficiaries and billing under their own national provider identification (NPI) number. NPs in rural states had the highest rates of billing under their own NPI numbers.

Findings also indicated that just over 80 percent of the payments that both PCNPs and PCMDs received were for evaluation and management services (i.e., new patient and established patient office visits, home visits, and nursing home visits). Relative to PCMDs, NPs had a significantly greater proportion of payments associated with procedures (9.1 vs. 4.6 percent), billed for fewer tests (4.8 vs. 5.8 percent), and had a lower proportion of their payments associated with imaging (1.3 vs. 3.9 percent). Overall, findings indicated there was great overlap in the types of primary care provided.

Who—what kind of American—was receiving PCNP-provided primary care through Medicare? Compared to beneficiaries receiving primary care from PCMDs, beneficiaries receiving primary care from PCNPs were significantly more likely to be female, younger, American Indian, nonwhite, dually eligible for Medicare and Medicaid (an important proxy for poverty), and qualified for Medicare due to a disability.

And where are these patients and providers located? The study revealed that PCNPs caring for Medicare beneficiaries were significantly more likely to practice in a federally designated Health Professionals Shortage Area and in rural areas compared to PCMDs. These findings are supported by the results of other investigators (see Appendix A), who have also found that NPs provide primary care to vulnerable populations and that PCNPs are more likely to practice in rural and underserved areas.

Costs of Primary Care

Because enrollment in Medicare will expand rapidly as baby boomers age, total Medicare spending will increase substantially in the years ahead. Consequently, providing access to health care without bankrupting the Medicare program is a growing concern.

The next study was undertaken to determine whether PCNPs can help address this concern, aiming to compare the costs of PCNPs and PCMDs providing primary care to Medicare beneficiaries. The study analyzed Medicare payment claims during a 12-month

period (2010), including claims for inpatient and outpatient care. It examined five measures of the cost of care, adjusted for differences in payment rates and severity of a patient's health condition.³³

Across all five measures, the study found that the cost of PCNP-provided care ranged between 11 percent and 29 percent less than the cost of PCMD-provided care. The gap was most pronounced for evaluation and management services—composing 80 percent of claims that PCMDs and PCNPs bill to Medicare. Beneficiaries treated by PCNPs who received such services cost Medicare 29 percent less than beneficiaries who received their primary care from PCMDs. The large differences in costs between PCNPs and PCMDs persisted even after taking into account that Medicare pays NPs at 85 percent of the rate of physicians for the same services.

Due to limitations inherent in using claims data, we could not fully investigate the reasons for the differences in costs. But we believe they may be explained in part by differences in the style of NP practice, as NPs tend to provide more holistic care relative to the more disease-and-cure orientation of many physicians. Preliminary evidence from ongoing analysis also suggests that PCNPs order about one-third fewer services, and they are more likely than physicians to use less expensive services.³⁴ Of course, if that reflected decreased quality of care, it would be a major problem for a proposal to expand NP practice.

As noted in Appendix A, this study is not the first to find that NPs provide cost-effective care.

Quality of Care

While numerous studies have concluded that NP-provided care is comparable and in some cases better than PCMD-provided care (see Appendix A), some of these studies analyzed a limited number of clinical conditions, did not adequately control for patient-selection biases and disease severity, and assessed quality measures over brief time periods, which makes it difficult to generalize results to broader populations. To address these concerns, the next study used national Medicare claims data from

2012 and 2013 to assess 16 indicators of the quality of primary care that PCNPs and PCMDs provided to Medicare beneficiaries. To include beneficiaries who may have received care by a team of PCNPs and PCMDs, the analysis covered a third group of beneficiaries who had received primary care services from both types of clinicians over a 12-month period.³⁵

Across all five measures, the study found that the cost of PCNP-provided care ranged between 11 percent and 29 percent less than the cost of PCMD-provided care.

Overall, study findings indicated that specific types of care were better when provided by PCNPs, and others were better when provided by PCMDs. For example, Medicare beneficiaries who received primary care from PCNPs were less likely than those cared for by PCMDs to have preventable hospital admissions, all-cause hospital readmissions within 30 days of being discharged, inappropriate emergency department visits, and low-value MRIs associated with low back pain. On the other hand, beneficiaries who received their primary care predominantly from PCMDs were more likely to receive slightly more of recommended chronic disease management services and cancer screenings (such as mammography screenings for breast cancer and colonoscopies for colorectal cancer).

The third group of beneficiaries, which received primary care from both PCNPs and PCMD, was expected to have received higher-quality care than those who received care from either a PCNP or PCMD alone. However, results indicated that in only one measure

was primary care improved: cancer screening. This suggests that the care these beneficiaries received was fragmented and not well coordinated.

Quality of Care Provided to Vulnerable Medicare Beneficiaries

As noted above, the first study using Medicare claims data found that PCNPs were significantly more likely than PCMDs to provide primary care to beneficiaries who had a disability or who were dually eligible for Medicaid and Medicare, a strong indicator of poverty.³⁶ With approximately 38 million Americans living with disabilities and several million in poverty, providing high-quality health care at a reasonable cost to the poor and disabled is a major and growing challenge.³⁷

Medicare and Medicaid often work in tandem to pay for dually eligible Americans. This kind of health care is disproportionately expensive: Dually eligible beneficiaries make up 20 percent of the Medicare population, but they account for 34 percent of Medicare spending.³⁸ They are also at increased risk of serious health problems, as they are more likely to have multiple comorbidities, such as diabetes, chronic lung disease, and Alzheimer's disease, and to self-report lower health status.³⁹

For all these reasons, the need for effective and cost-efficient solutions for primary care is particularly salient for dually eligible patients, whether disabled or simply low income. People with disabilities are less likely to receive recommended preventive care such as screenings for breast and cervical cancer.⁴⁰ On average, people with disabilities receive differential treatment for cancer and are more likely to receive potentially inappropriate medications.⁴¹ Similarly, low-income patients face significant access barriers to care and receive fewer screenings (such as colonoscopies) and preventive services (such as vaccinations).⁴²

Could increased practice by PCNPs help remedy this inequity? This question was addressed by using 2012 and 2013 Medicare claims data to identify and compare the quality of care provided by PCNPs and

PCMDs and received by beneficiaries in three subpopulations: (1) those who initially qualified for Medicare based on a disability, (2) dually eligible beneficiaries, and (3) beneficiaries who qualified initially by having a disability and were also dually eligible for Medicare and Medicaid.⁴³ The quality of primary care that these subpopulations received was examined across the same four domains of primary care noted above: chronic disease management, the incidence of adverse outcomes, preventable hospitalizations, and cancer screenings.

Results showed that when PCNPs cared for Medicare beneficiaries who were dually eligible or qualified for Medicare due to a disability, the beneficiaries had similar results to the larger study of Medicare beneficiaries reported above. Specifically, these vulnerable Medicare beneficiaries had a lower risk of preventable hospitalizations and emergency department use than those cared for by PCMDs. They also used fewer of other health care resources such as low-value imaging for low back pain. In addition, being managed by a PCNP helped beneficiaries in the area of chronic disease management, as these beneficiaries were no less likely than those treated by PCMDs to receive health care services consistent with established guidelines.

However, diabetic patients across these subpopulations who were cared for by PCNPs were less likely than those cared for by PCMDs to have eye screenings. The subpopulations served by NPs also received fewer cancer screenings.⁴⁴ These findings may be explained by unmeasured differences in patient characteristics, preferences for clinician type, clinician practice style, geographical access to screening technology (such as ease of obtaining mammograms in rural areas), care delivery patterns, organizational characteristics, and performance incentives that could not be measured and analyzed in the Medicare claims data.

Overall, the study's results suggest that increasing PCNP involvement in care could be a key policy strategy to expand access to primary care at a lower cost while not compromising quality for Medicare's most vulnerable beneficiaries.

Forecasts of Primary Care Workforce Supply and Location

The key findings of the studies we conducted, briefly summarized in this section, are:

- On the eve of the 2014 ACA insurance expansions, rural areas throughout the country had the highest numbers of uninsured people, particularly in non-Medicaid-expanding states.
- PCNPs, though fewer in number than PCMDs, are more likely to practice in rural areas than are physicians.
- People living in states that do not restrict NP scope-of-practice had significantly greater geographic access to primary care.
- Between 2016 and 2030, the size of the NP workforce will increase dramatically, growing 6.8 percent annually, compared to 1.1 percent growth of the physician workforce. Combined, the physician and NP workforce will increase by approximately 400,000 by 2030. NPs will account for 61 percent of this growth (240,000 workers).
- The number of physicians practicing in rural areas has been decreasing since 2000, and this decline will continue through 2030 while rural populations age and need more health care.
- The proportion of physicians married to highly educated spouses has grown dramatically over the past 50 years, and these physicians are significantly less likely to practice in rural shortage areas.
- The supply of physicians practicing in rural areas decreased by 15 percent between 2000 and 2016 and is forecasted to decline further through 2030.

Can PCNPs help remedy the acute shortage of primary care in rural areas? The first study conducted to

answer this question focused on identifying the geographic location of individuals who were newly eligible for the ACA's insurance expansions starting in January 2014. It assessed whether geographic access to primary care clinicians differed across urban and rural areas and across states with varying scope-of-practice laws.⁴⁵ The study also constructed a detailed understanding of the geographic location of primary care clinicians—physicians, NPs, and physician assistants (PAS)—on the eve of the ACA's insurance expansions.

Findings showed that, in 2014, large urban areas had 131 uninsured people per primary care clinician, whereas the most rural areas of the country had 357 uninsured people per primary care clinician. The number of uninsured was considerably higher in the states that did not expand Medicaid enrollment as of January 2015: Rural areas of non-expanding states averaged 441.1 uninsured per primary care clinician compared with 192.8 per primary care clinician in similar areas of Medicaid-expanding states. Furthermore, and importantly for our policy prescriptions, primary care physicians were more likely to be concentrated in urban areas, while PCNPs were more likely to be located in rural areas with more uninsured people.

Finally, geographic access to primary care was significantly higher in states that did not restrict NP scope-of-practice compared to those that did: 63 percent of people living in nonrestrictive states had geographic access to counties with a high capacity of primary care clinicians compared to 34 percent of people living in states that restricted NP scope-of-practice. Results also showed that states with restricted NP scope-of-practice had 40 percent fewer NPs compared to those without. These findings suggest that lifting state-level scope-of-practice restrictions on NPs would, over time, increase access to primary care, particularly in rural areas. As shown in Appendix A, other studies have also reported similar findings.

Two additional economic studies focused on projecting the future national supply of physicians and NPs. Applying a peer-reviewed cohort supply model developed in 2000 and used in many studies of the nurse and physician workforces, we analyzed trends

since 2000 in the supply of physicians, NPs, and PAs, and forecasted changes in the supply of each profession through 2030.⁴⁶

Results show healthy numbers of NPs entering the workforce, with minimal growth in the physician population. The study found that between 2010 and 2016, the rate of growth for NPs accelerated to 9.4 percent annually, while growth in the number of PAs slowed to 2.5 percent. During this same period, annual growth in the number of physicians dropped to 1.1 percent. Since 2001, the combined number of NPs and PAs per 100 physicians nearly doubled, increasing from 15.3 to 28.2.⁴⁷

Results also showed that states with restricted NP scope-of-practice had 40 percent fewer NPs compared to those without.

As for the future, regarding the physician shortage that concerns workforce analysts, we found that, between 2016 and 2030, the number of physicians is expected to grow slightly more than 1 percent annually due to the aging and retirement of the physician workforce and the lack of younger physicians to replace them. However, the number of NPs and PAs is projected to grow 6.8 percent and 4.3 percent, respectively, due largely to the number of young people entering these professions. As a result, the workforce will add an estimated combined 477,000 physicians, NPs, and PAs. NPs will contribute nearly 50 percent of this total growth. The combined number of NPs and PAs per 100 physicians will double to about 56.4 by 2030.⁴⁸

In a different study, we focused on the location of the physician workforce, examining a different factor:

whether a physician has a highly educated spouse and whether such physicians were less likely to work in rural and underserved areas.⁴⁹ Guiding the study was the hypothesis that highly educated dual-career households would more easily accommodate both spouses in large metropolitan areas.

Analyzing data going back to 1960, the study found that physicians were increasingly likely to be married to highly educated spouses—those with an M.D., Ph.D., or graduate degree. The proportion of married physicians whose spouse was highly educated increased steadily from 9 percent in 1960 to 54 percent in 2010. In every year over this period, approximately one-third of physicians' spouses who held graduate degrees were themselves physicians. The increased likelihood of having a spouse with a graduate degree occurred partly because women were a growing proportion of married physicians (from 4 percent in 1960 to 31 percent in 2010) and because female physicians were far more likely than male physicians to be married to a spouse with a graduate degree (68 percent of women versus 48 percent of men in 2010).

Study results showed that physicians married to a highly educated spouse were significantly less likely to live and practice in rural shortage areas. Further, the study found that younger physicians were more likely to be married to a highly educated spouse than physicians born before the 1980s.⁵⁰ Taken together, these findings point to an increasingly strong demographic headwind facing rural health workforce policy. Overcoming the challenges in enticing physicians to move to rural and medically underserved areas will be an increasingly steep uphill climb.

The final physician forecasting study that the economics team conducted examined trends in the number of physicians who practice in rural versus non-rural areas.⁵¹ Results showed that the number of physicians per capita in rural areas declined 15 percent between 2000 and 2016 compared to 8 percent growth in non-rural areas.

This is due largely to the aging of physicians working in rural areas and the scarcity of new, younger physicians in rural areas. The number of physicians under 50 practicing in rural areas declined from 9.4 physicians per 10,000 residents to 5.6 physicians

per 10,000 people, a decrease of over 40 percent. As a consequence, the number of physicians practicing in rural areas decreased from 14 per 10,000 people in 2000 to 12 per 10,000 people in 2016.

Looking ahead, we forecast that the number of physicians practicing in rural areas will continue decreasing to 9.0 physicians per 10,000 people in 2030, a drop of 35 percent from 2000 and 23 percent relative to 2016 when the rate was 11.7 physicians per 10,000 people. Meanwhile, the number of non-rural physicians is projected to remain steady at just under 31 per 10,000 people, roughly the same proportion observed for 2016.

How Do State-Level Restrictions Affect Access to and Quality of Care?

Health care economist Paul Feldstein describes at least five types of legislative or regulatory strategies a health care professional association may pursue to further its members' self-interest. These strategies include (1) securing policies that increase demand for services provided by its members, (2) maximizing reimbursement or payment for services provided by its members, (3) decreasing the price or increasing the quantity of complementary health professionals, (4) decreasing the availability or increasing the price of substitute providers, and (5) restricting the supply of professions that may compete with its members. These policies are often justified on the grounds of protecting the public from low-quality health care.⁵²

Regarding NPs, this framework suggests that some primary care physicians would conceivably support state regulations that limit the supply of NPs, restrict the types of services NPs provide to decrease possible competition with physicians, and require that physicians supervise NPs, so that NPs practice as an economic complement rather than as a substitute. A new study on physician political spending and state-level occupational licensing supports these hypotheses. Results showed that increased spending by physician interest groups increased the probability that a state maintains licensing laws that restrict NPs' practice.⁵³

This conceptual framework led us to investigate two means by which a state's NP scope-of-practice laws could influence the quality of care that PCNPs provide. First, the study assessed whether the quality of primary care provided by PCNPs was better in states that either reduced or restricted NP practice than in states with no such restrictions. Higher-quality care in reduced and restricted states would suggest that restrictions do protect quality of care—a position that some physician groups advocate. Drawing on the above studies—which found that beneficiaries receiving care from NPs had lower rates of preventable hospitalization, hospital readmissions, emergency department visits, and low-value care—this study also investigated whether beneficiaries living in restrictive states would have less access to NP-provided primary care and more preventable hospital admissions, readmissions, emergency department use, and low-value care than those living in nonrestrictive states.⁵⁴

We used the AANP's system to divide states into the three aforementioned categories: full practice for NPs, reduced practice, and restricted practice. The AANP classification system is useful for several reasons. It is well established, is updated annually or more often, uses generally consistent definitions of a regulation's level of restrictiveness over time, started in the same year (2013) as the Medicare claims data used in the study, and captures the full range of activities and supervision requirements states have regulated.

Overall, using the AANP classification system, results provided no evidence that state-level scope-of-practice restrictions were related in any consistent or discernable way to the quality of care that PCNPs provide. There was no difference in the quality of care that Medicare beneficiaries received between states that reduced or restricted NP scope-of-practice and states that did not restrict NP scope-of-practice. To ensure the robustness of this result, a sensitivity analysis using each of five different scope-of-practice classification systems reported in the literature also found no consistent or discernable pattern.

Finally, study results showed greater use of outpatient services for beneficiaries cared for by both

PCNPs and PCMDs in full practice states, as well as lower rates of hospitalization, readmission, and emergency department use.⁵⁵ These findings provide further evidence that beneficiaries living in full scope-of-practice states have greater access to care.

The Future of Primary Care Providers: Attitudes, Knowledge, and Behavior

Understanding the future of PCMDs and NPs relies on projections for their fields: What kind of people are, and will grow to be, PCMDs and NPs? Where, how much, and for what pay do they work?

Our national survey of PCNPs and PCMDs (the first national survey of both types of clinicians) provides information to help address these questions.⁵⁶ The survey (61.2 percent response rate) gathered information on the practice characteristics of PCNPs and PCMDs. It also collected data on the attitudes, knowledge, and behavior of both types of clinicians toward shortages in the primary care workforce, the impact of expanding the number of PCNPs, NP scope-of-practice, quality of care, responsibility for providing specific services and procedures, job satisfaction, willingness to recommend a career in health care, and other issues. Key characteristics of sampled PCNPs and PCMDs include:

- On average, PCNPs are older but have five fewer years of experience than PCMDs.
- PCNPs work in a greater variety of health care delivery settings (community clinics, schools and universities, offices, parishes, prisons, etc.) than do PCMDs.
- The majority of PCNPs (81 percent) reported working with PCMDs, while 13 percent work independently of physicians. Additionally, 41 percent of PCMDs said they work with PCNPs.
- On average, PCNPs work fewer hours per week than PCMDs (37 hours versus 46 hours) and see fewer patients per week (67 patient visits versus 89 patient visits).

- PCNPs, alone and working with PCMDs, are more likely to treat vulnerable populations, including those on Medicaid, and to accept new Medicaid patients.
- Both types of primary care clinicians spend their time in nearly identical ways and provide similar services, but 56 percent of PCNPs received a fixed salary versus 24 percent of PCMDs. Only 14 percent of PCNPs had their salary adjusted for productivity or quality performance, whereas 50 percent of PCMDs received such salary adjustments.
- PCNPs reported that government and local regulations impede their ability to admit patients to hospitals, make hospital rounds on patients, and write treatment orders in hospitals and long-term care facilities.

In several areas, survey results indicated that physicians' attitudes as individuals do not match their behaviors as a group. Regarding NP scope-of-practice, most PCMDs (77 percent) agree that PCNPs should practice to the full extent of their education and training. However, they do not agree that a primary care practice led by an NP should be eligible to be certified as a medical home, that NPs should be legally allowed to have hospital-admitting privileges, or that they should be paid the same as physicians for providing the same services.

Asked whether expanding the supply of NPs would affect quality of care (measured by the Institute of Medicine's six aims for improving quality of health care and Triple Aim goals), large majorities of PCNPs reported that all dimensions of quality would be better. PCMDs' responses were more diverse and less enthusiastic, with about one-third saying that expanding the supply of NPs would make the safety and effectiveness of care worse. Surprisingly, when asked, "Given what you know about the state of health care, would you advise a qualified high school or college student to pursue a career as a PCNP or PCMD?" PCMDs were more likely to recommend being a PCNP than they would a PCMD (65 versus

51 percent), possibly reflecting physician burnout and dissatisfaction. But perhaps the survey finding that tells the story best is this: When asked how increasing the number of NPs would affect physician employment, 57 percent of PCMDs said their income would decrease, and three-quarters agreed they could be replaced by PCNPs.

Why Removing Restrictions on NPs Helps Remedy the Primary Care Shortage

From this overview of the research program conducted on the primary care NP and physician workforces, supported by the studies listed in Appendix A, several conclusions and observations are apparent.

First, it is unrealistic to rely on or expect the physician workforce alone to provide the primary care Americans need. Significant time, effort, and resources have been spent over many decades on various public and private policies to increase the supply and geographic reach of primary care physicians, yet today there is a growing national shortage of such physicians and continued uneven geographic distribution of primary care. These realities mean tens of millions of Americans lack adequate access to beneficial primary care services, often enduring significant delays before obtaining care. Hit particularly hard are people in rural and underserved areas, who are generally older, less educated, poorer, and sicker—the very populations who need primary care the most.

As large numbers of primary care physicians retire over the next decade and demand increases for primary care, current shortages of primary care are projected to worsen, and fewer physicians will be practicing in rural areas. The even-larger projected shortage of specialist physicians will only make matters worse, as many specialists provide considerable amounts of primary care. And, as the proportion of physicians who are married to highly educated spouses increases, the already formidable challenges of attracting physicians to rural and Health Professional Shortage Areas will become even more daunting.

In contrast, studies of the PCNP and PCMD workforces find that the number of PCNPs has been growing much more quickly than the physician workforce.

The number of PCNPs will increase dramatically, while the number of PCMDs will grow little through 2030. And PCNPs are more likely to practice in rural areas, where the need is greatest.

When assessing state-level restrictions on NPs, our study showed that populations in states with reduced or restricted practice of NPs had significantly less geographic access to PCNPs. This finding has also been reported by others, indicating the role state regulations have in influencing access to primary care (Appendix A).⁵⁷ Clearly, state-level restrictions impede access to and quality of primary care. This alone should be cause for concern among policymakers seeking to improve public health.

Using different data and methods, the studies described in this report consistently show that PCNPs are significantly more likely than PCMDs to care for vulnerable populations. Nonwhites, women, American Indians, the poor and uninsured, people on Medicaid, those living in rural areas, Americans who qualified for Medicare as a disability, and dual-eligibles are all more likely to receive primary care from PCNPs than from PCMDs. PCNPs working independently of PCMDs and those working with them are more likely to accept Medicaid recipients, take care of those without insurance, and accept lower payments than are PCMDs who do not work with PCNPs.

Another major finding of this body of research is that, after controlling for differences in patient severity and sociodemographic factors, the cost of care provided to Medicare beneficiaries by PCNPs was significantly lower than primary care provided by PCMDs. Even after accounting for the lower payment PCNPs receive relative to PCMDs, the cost of PCNP-provided care was still significantly lower. Taken together, these findings paint a favorable picture of PCNPs' contributions.

However, the viability of increased reliance on PCNPs still depends on the simple question at the core of this project: Can PCNPs provide health care of comparable quality to that provided by PCMDs? Our studies showed that beneficiaries who received their primary care from PCNPs consistently received significantly higher-quality care than PCMDs' patients with respect to decreasing hospital admissions,

readmissions, emergency department use, and ordering of low-value care (specifically, MRI images for low back pain). While beneficiaries treated by PCMDs received slightly more services involved in managing chronic diseases than those receiving primary care from PCNPs, the differences were marginal.

State-level NP scope-of-practice restrictions do not help protect the public from subpar health care.

These results held when vulnerable populations of Medicare beneficiaries were analyzed separately and compared to those cared for by PCMDs. In fact, the differences in quality of chronic disease management between PCMDs and PCNPs narrowed considerably, and some disappeared altogether. These results align with the findings of many other studies conducted over the past four decades.

Furthermore, state-level NP scope-of-practice restrictions do not help protect the public from subpar health care. Analysis of different classifications of state-level scope-of-practice restrictions provided no evidence that Medicare beneficiaries living in states that imposed restrictions received better quality of care.⁵⁸ Some physicians and certain professional medical associations have justified their support for state regulations to limit NP scope-of-practice on the grounds that they are necessary to protect the public from low-quality providers and to assert that physicians must be the leaders of the health care team. We found no evidence to support their claim, as others have also recently reported.⁵⁹ Further, our analysis showed that Medicare beneficiaries living in states with reduced or restricted NP scope-of-practice used more resources (hospitalizations, readmissions, and emergency department admissions sensitive to

primary care) than did beneficiaries living in states without such restrictions, indicating that these beneficiaries had less access to the positive contributions of PCNPs.

Despite this body of evidence, our national survey of primary care clinicians revealed that around one-third of PCMDs believe increasing the number of PCNPs would impair the safety and effectiveness of care. This could indicate that physicians are not aware of the findings of research. Alternatively, it should be called what it is: an excuse for a barrier to entry, meant to protect some physicians' narrow interests. And it comes at the expense of effective primary care for many Americans who need it.

The evidence leads to three recommendations that can help overcome the growing challenges facing the delivery of primary care in the US. Each recommendation is geared toward a different group: public policymakers, private policymakers, and PCMDs and PCNPs themselves.

1. Private policymakers—including hospital boards of directors, established and emerging integrated health care–delivery systems (e.g., large hospital-based systems and accountable care organizations), private commercial and not-for-profit insurers, health care and hospital associations, health education associations, and health care foundations—should develop forums to bring PCNPs, PCMDs, and their respective state and local associations together to engage in meaningful dialogue. Hospital boards and credentialing bodies should allow NPs to practice to the fullest extent of their training and ability. The evidence suggests this will be a great service to people lacking access to care and to the solvency of Medicare. Doctors (as individuals) overwhelmingly favor allowing NPs to practice to the full extent of their education and training. This can become a reality on a hospital-to-hospital, health-system-to-health-system basis.
2. Physicians must understand that NPs, too, are providing health care to those in need. NPs and physicians should work together to better

understand each other. It may behoove individual physicians and nurses to discuss how, together, disagreements can be better managed, even resolved. This could be a first step toward building a relationship that allows for roles and practices to evolve—that *respects* each other’s strengths and ultimately leads to a workforce that is *more responsive* to communities’ health needs, particularly in rural and underserved areas and among vulnerable populations.

3. Public policymakers: Drop the restrictions on PCNP scope-of-practice! These are regressive policies aimed at ensuring that doctors are not usurped by NPs, which is not a particularly worthwhile public policy concern, especially if it comes at the expense of public health. The evidence presented here suggests that scope-of-practice restrictions do not help keep patients safe. They actually decrease quality of care overall and leave many vulnerable Americans without access to primary care. It is high time these restrictions are seen for what they are: a capitulation to the interests of physicians’ associations.

Conclusion

The evidence discussed in this report points to a commonsense solution to primary care workforce-supply problems. The NP workforce is growing, far outpacing

the growth of the primary care physician labor force. NPs are more likely to work in rural areas, which already do and will increasingly need more primary care providers. They are more likely to serve poor and vulnerable Americans, and their services cost less. Most importantly, they provide primary care of equal or better quality compared to physicians.

For all those reasons, scope-of-practice restrictions should be lifted in states across the country, and health care administrators should allow NPs to take on expanded roles in primary care settings. For the health of Medicare and millions of people, NPs must be allowed to provide primary care to more Americans.

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Appendix A

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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.

Source: California Department of Consumer Affairs. "DCA Boards/Bureaus." www.dca.ca.gov/about_dca/entities.shtml; California Department of Public Health. www.cdph.ca.gov/certlic/occupations/Pages/default.aspx; California Emergency Medical Services Authority. www.emsa.ca.gov; California Board of Chiropractic Examiners. www.chiro.ca.gov.

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.⁴ 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.⁵

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.⁸

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.⁹

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.¹⁰

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.

PAs may receive prescribing privileges, based on their education and clinical competencies, and further, may prescribe controlled substances if authorized by the facility. IHS PA policy notes that, although PAs employed by IHS need not be licensed by the state in which they are practicing, U.S. Drug Enforcement Agency regulations require that PAs be authorized to prescribe controlled substances by the state in which they are licensed to practice.

The IHS recognizes that its PAs are often required to practice in isolated settings, where on-site physician consultation is not always available. IHS practice policy allows PAs to practice at remote sites, or after hours, without a supervising physician on site, as long as telephone or two-way radio contact with an advising physician is available. The advising physician may be either the PA's clinical supervisor, or a designated alternative. Notably, accountability for physician supervision may be determined prospectively, by scheduling, or retrospectively, by chart reviews, as determined by the physician-PA team.

Other States: More Expansive Prescribing Authority

According to the American Academy of Physician Assistants, four states (Alabama, Florida, Kentucky, and Missouri) do not allow PAs to prescribe controlled substances. The remaining states authorize PAs to prescribe controlled substances, to varying degrees. For example, Schedule II prescriptions by PAs in North Carolina and South Dakota are limited to 30-day supplies. Other states, such as Colorado, Georgia, Kansas, and Mississippi, do not have similar restrictions. The New York legislature recently passed legislation giving PAs broader authority to prescribe controlled substances.

4. Paramedics and Administration of Intravenous Infusions

California: Local Scope of Practice Variations

Paramedics are specially trained and licensed to render immediate medical care in the pre-hospital setting to the seriously ill or injured. They are typically employed by public safety agencies, such as fire departments, and by private ambulance companies. California has three levels of emergency providers: Emergency Medical Technician (EMT -I (Basic ; EMT-II (Intermediate ; and EMT-P (Paramedic . Paramedics have the highest degree of training, as well as corresponding SOP authority. Paramedics are trained and licensed in advanced life support ALS practices, which include the use of a laryngoscope, endotracheal and nasogastric intubation, and the administration of 21 drugs.¹⁵

California's SOP protocols for paramedics are particularly complex. Not only do they differ from other states, they also vary from county to county within the state. Paramedics come under the jurisdiction of the state Emergency Medical Service (EMS) Authority, which implements regulations governing paramedic training, scope of practice, and licensure. However, actual day-to-day emergency medical service operations are the responsibility of local county or multi-county EMS agencies.

Notably, while paramedic licensure is valid statewide, paramedics also must have local agency accreditation to practice in the area where they are employed. This involves adhering to local agency protocols, and training in any "local optional scope of practice," or specific medical tasks performed by EMS personnel in that jurisdiction, that is required by the local EMS agency.

In addition to the state's basic SOP, paramedics may perform other procedures or administer other medications deemed appropriate by the medical director of the local EMS agency, and approved by the director of the state EMS Authority. Further, the state EMS Authority can approve the use of additional skills, and the administration of additional medications by paramedics, upon request by a local EMS medical director.

Local agencies also may constrict SOPs of paramedics. For example, under the state SOP, paramedics may monitor and adjust intravenous solutions containing potassium, equal to or less than 20 milli-equivalents per liter (mEq/L). However, this procedure is not permitted in Sacramento, San Mateo, Santa Clara, and Santa Cruz counties, although it is allowed in Marin, San Francisco, and Solano counties.

Paramedics Nationwide: Wide Variations in Scopes of Practice

The wide variability nationwide in laws and regulations affecting paramedics and other emergency professionals prompted the National Highway Traffic Safety Administration (NHTSA) to issue its National Emergency Medical Services Scope of Practice Model, designed as a guide for states in developing their scope of practice legislation. NHTSA issued findings that the "patchwork of EMS personnel certifications has created considerable problems, including but not limited to: public confusion; reciprocity challenges; limited professional mobility; and decreased efficiency due to duplication of efforts." NHTSA's national practice model would include intravenous infusion in the paramedic's scope of practice.¹⁶

Conclusions

When health care practitioners are not being used to their full capacity in terms of their education, training, and competence, systemic inefficiencies inevitably occur. These inefficiencies may manifest themselves in higher costs, insufficient access to practitioners, and concerns over quality and safety.

Efforts to address the mismatches between SOPs and competence, and the lack of uniformity among the states, have been limited. Some states' efforts are still in an early stage, and their impact has yet to be determined.

California policymakers recently have shown some willingness to seek complementary support for their SOP decision-making. ABX1 1, the failed comprehensive health care reform bill by Assembly Speaker Fabian Núñez, included a proposal to establish a Task Force on Nurse Practitioner Scope of Practice.

States that have attempted to de-politicize the SOP modification process with clearly delineated review programs appear to be making headway. These programs can equip policymakers with the unbiased professional analysis that will help them make difficult, often technical decisions on important public health issues.

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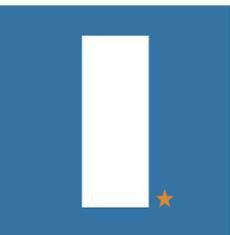
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THE STEINBERG INSTITUTE SUPPORTS AB 890 TO GRANT FULL PRACTICE AUTHORITY TO NURSE PRACTITIONERS

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.”

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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

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BOARD OF REGISTERED NURSING
Advanced Practice Registered Nursing Committee
Agenda Item Summary

AGENDA ITEM: 10.3
DATE: September 26, 2019

ACTION REQUESTED: **Discussion and Action:** Recommend to the BRN Nursing Practice Committee, adoption of the following guidance language revision for health systems, RNs, and APRN in seeking first assist privileges. Although not required, it is recommended a determination of competency be established within health systems via workplace training or via a First Assist didactic certification program. This would ensure a standardized approach to core content and gaining the privilege within the workplace or via certification. Several resources exist that provide nationally recognized accrediting and didactic content. No existing APRNs or RN with RNFA privileges would be impacted.

REQUESTED BY: Mitchel Erickson, RN, NP

BACKGROUND:
Revision language:

AORN Standards for APRN/RN First Assistant are the basis for most first assist certification curricula. The purpose of this policy statement is to provide guidelines to health systems and nursing professionals around the acquisition of the core competencies in the role of first assistant (such as: aseptic technique, retraction and cutting tissue, hemostasis, suturing and other wound management, and other surgical tasks). Acquisition of the core competencies in the role of first assistant would occur through health system training or formal certification. The first assistant may provide other advanced assistance, such as mobilization of tissue, patient positioning and directing other surgical team members with specific individual tasks. The first assistant functions intraoperatively in a coordinated manner with the surgeon while using instruments and medical devices. The first assistant must have acquired the specific knowledge, skills and judgment to perform this role. To perform these functions, considered to be first assistant to the surgeon, the RN/APRN must adhere to the privilege outlined in their standardized procedures. The first assistant may not perform the functions of the scrub or circulating nurse while functioning as the surgical first assistant. Resources are identified below for RN and APRN professionals seeking certification or for health systems wanting to develop their own internal core competencies.

RESOURCES:

Current BRN Language

<https://www.rn.ca.gov/pdfs/regulations/npr-b-18.pdf>

Resources:

Association of periOperative Registered Nurses, AORN Standards and Recommended Practices:

<https://www.aorn.org/>

AORN Course Curriculum:

<https://www.aorn.org/education/facility-solutions/periop-101/course-outcomes#OR>

National Institute of First Assisting (NIFA)

http://www.nifa.com/index_current.html

AORN - APRNs in the Perioperative Environment

<https://www.aorn.org/-/media/aorn/guidelines/position-statements/posstat-rnfa-advanced-practice-rn.pdf>

AORN – RN First Assistants

https://www.aorn.org/-/media/aorn/guidelines/position-statements/aorn_position_statement_rnfa.pdf

NEXT STEPS:

Practice Committee to review and approve and submit to the BRN Board for approval and posting

FISCAL IMPACT, IF ANY:

None

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BOARD OF REGISTERED NURSING
Advanced Practice Registered Nursing Committee
Agenda Item Summary

AGENDA ITEM: 10.4
DATE: September 26, 2019

ACTION REQUESTED: **Discussion and Possible Action:** 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. Recommend engagement of survey vendor to begin content build and provide updates on the current status of the survey.

REQUESTED BY: Garrett Chan, RN, CNS, PhD

BACKGROUND:

On June 27, 2019, the BRN APRN Committee discussed and recommended to the BRN that Clinical Nurse Specialists and Certified Registered Nurse Anesthetists be included in the next BRN Nurse Practitioner (NP) and Certified Nurse-Midwife (CNM) survey in collaboration with the UCSF Workforce Center. 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. Category of questions for the next survey should focus on APRN perceptions of the work environment, scope of practice, population foci, practice site information, satisfaction with advanced practice, reasons for not working in advanced practice, work relationships, education, and plans for future employment. The cadence of the survey should mirror the cadence of the survey of registered nurses (RNs), which is every two (2) years in the even-numbered years.

The recent report from the California Future Health Workforce Commission (<https://futurehealthworkforce.org/our-work/finalreport/>) has identified the healthcare needs of California will not be met without investment of resources to educate more healthcare providers. 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.

RESOURCES:

Summary of report:

<https://futurehealthworkforce.org/wp-content/uploads/2019/02/ExecutiveSummaryFinalReportCFHWC.pdf>

Full report:

<https://futurehealthworkforce.org/wp-content/uploads/2019/03/MeetingDemandForHealthFinalReportCFHWC.pdf>

Past survey:

<https://rn.ca.gov/pdfs/forms/survey2017npcnm-final.pdf>

NEXT STEPS:

Following APRN Advisory Committee discussion will request the Practice Committee forward the solicitation of a vendor request to the BRN Board for a more comprehensive survey of

APRN licensees and the APRN Advisory Committee will provide oversight of the survey content with vendor under the BRN authority. The Practice Committee and BRN Board will final review authority over the survey. The APRN Advisory Committee will work with the vendor to draft categories of questions.

FISCAL IMPACT, IF ANY:

If approved the BRN will need to appropriate funds for the cost of survey design, distribution, and data analysis

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BOARD OF REGISTERED NURSING
Advanced Practice Registered Nursing Committee
Agenda Item Summary

AGENDA ITEM: 10.5
DATE: September 26, 2019

ACTION REQUESTED: **Discussion Only:** Request that the Executive Officer of the BRN initiate a conversation with the Executive Director of the Department of Health and Human Services regarding language amendment to Title 22 of the California Code of Regulations (22 CCR Section 70703 (a) Organized Medical Staff that limits the inclusion, per interpretation of “Medical Staff” which currently clearly states that medical staff are restricted to physicians and surgeons and where appropriate, dentists, podiatrists, and clinical psychologists. APRNs as part of the medical staff of health systems and are required to meet the details of the Bylaws of Medical Staff but have no voice or vote. This restriction is not consistent with other states in the US where APPs are voting members. Title 22 section also is inconsistent with the less restrictive B & P language.

REQUESTED BY: Mitchel Erickson, ACNP, Chair

RESOURCES:

Title 22 of the California Code of Regulations (22 CCR Section 70703 (a) Organized Medical Staff
[https://govt.westlaw.com/calregs/Document/IE030AF205F7A11DFBF84F211BF18441D?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=\(sc.Default\)&bhcp=1](https://govt.westlaw.com/calregs/Document/IE030AF205F7A11DFBF84F211BF18441D?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)&bhcp=1)

22CCR Section 70706 Interdisciplinary Practice and Responsibility for Patient Care outlines the requirement for an Interdisciplinary Practice Committee to credential and privilege RNs who are functioning in APRN roles.
[https://govt.westlaw.com/calregs/Document/IE0BF0C705F7A11DFBF84F211BF18441D?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=\(sc.Default\)](https://govt.westlaw.com/calregs/Document/IE0BF0C705F7A11DFBF84F211BF18441D?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default))

22 CCR Section 70706.1 Granting of Nonphysician Privileges outlines the responsibility for IDP committees regarding RNs and PAs.
[https://govt.westlaw.com/calregs/Document/IAB1281B0941F11E29091E6B951DDF6CE?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=\(sc.Default\)](https://govt.westlaw.com/calregs/Document/IAB1281B0941F11E29091E6B951DDF6CE?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default))

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

SECTION 1.

Section 2282 of the Business and Professions Code is amended to read:

2282. The regular practice of medicine in a licensed general or specialized hospital having five or more physicians and surgeons on the medical staff, which does not have rules established by the board of directors thereof of the hospital to govern the operation of the hospital, which rules include, among other provisions, all the following, constitutes unprofessional conduct:

- (a) Provision for the organization of physicians and surgeons licensed to practice in this state who are permitted to practice in the hospital into a formal medical staff with appropriate officers and bylaws and with staff appointments on an annual or biennial basis.
- (b) Provision that membership on the medical staff shall be restricted to physicians and surgeons and other

licensed practitioners competent in their respective fields and worthy in professional ethics. In this respect, the division of profits from professional fees in any manner shall be prohibited and any such division shall be cause for exclusion from the staff.

NEXT STEPS:

Following APRN Advisory Committee discussion will defer to the BRN Executive Director to report back to this Committee on any progress with the discussion.

FISCAL IMPACT, IF ANY:

None

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BOARD OF REGISTERED NURSING
Advanced Practice Registered Nursing Committee
Agenda Item Summary

AGENDA ITEM: 10.6
DATE: September 26, 2019

ACTION REQUESTED: **Discussion and Possible Action:** Review the 2020 Practice Committee and BRN Board Meeting dates and times and coordinate the APRN Advisory Committee Meeting dates and times accordingly. In 2020 there are 5 BRN committee meetings that will meet in Jan/Mar/May/August/October.

REQUESTED BY: Mitchel Erickson RN, NP

BACKGROUND: The APRN Advisory Committee needs to establish a meeting schedule for the remainder of 2019 and 2020 to enhance agenda planning and opportunity for public attendance and input. The current mandate of 3 meetings per calendar year is too restrictive and Advisory Committee seeks approval from the BRN Board via the Practice Committee to create greater flexibility by approving Option 1): 4 quarterly in person meetings per year and 2 optional teleconference meetings TBA or Option 2) 3 in person meetings per year and 3 optional teleconference meetings TBA.

RESOURCES: APRN Advisory Committee will establish the dates for 2020 which was originally based on the availability of BRN funding support for a 3 in person meeting per year schedule and available meeting room. We are proposing a change to quarterly and option for 2 teleconference meetings per year based on APRN Advisory Committee request or option of 3 meetings and 3 teleconference meetings per request.

BRN Board and Committee Meeting Schedule for 2020

<https://www.rn.ca.gov/pdfs/meetings/2020meetings.pdf>

NEXT STEPS: Review quorum attendance requirements and vote on the selected Committee desired option 1) or 2) and to vote on the dates for 2020.

FISCAL IMPACT, IF ANY: Travel expenses for committee membership attendance at the in-person meetings

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