



Nurse-Midwifery Advisory Committee Meeting

Board of Registered Nursing
Hearing Room
1747 North Market Blvd.
Sacramento, CA 95834
(916) 574-7600

AGENDA

April 5, 2017
2:30 p.m.

Wednesday, April 5, 2017 – 2:30 p.m.

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

10.01 Vote on Whether to Approve Committee Meeting Minutes: September 16, 2016

10.1 Items to be Discussed and Considered

1. Creating and Presenting an Informational Session for BRN Related to Nurse-Midwifery Practice
2. Feedback Received from Certified Nurse Midwifery Community Related to Expert Witness Participation
3. Status of Survey for Advanced Practice Nursing 2017; Information Only
4. Mission of Nurse Midwifery Advisory Committee and Reporting Relationship to the Board

10.2 Discussion and Consideration of Items Related to the Practice of Midwifery; Possible Recommendations to the Full Board

1. Discuss the Meeting Frequency and Disciplinary Issues Regarding Nurse-Midwives that Arose During the Sunset Review Process
2. Comparison of Midwifery in California of Certified Nurse Midwives and Licensed Midwives to Include Scope, Supervision, Education Preparation, and Predominant Location of Practice
3. Issues Regarding Physician Supervision and Prior Administrative Cases Related to Certified Nurse Midwifery and Licensed Midwife Practice
4. Recommendation for Revision to Business and Professions Code Section 2746.52 to Add Performance of an Episiotomy as an 'Urgent/Emergency Event' in the Home Setting and Repair of Laceration in Home as a Patient Safety Issue
5. Authority Conferred for Nurse Midwifery Scope of Practice in Business and Professions Code Section 2746.5 Regarding Whether Standardized Procedures are Necessary for Nurse Midwifery Practice
6. Recommendation for Revision to Business and Professions Code Sections 2746 through 2746.8 Relating to Whether California Certified Nurse Midwifery Practice Should Be Based on Standards for Practice of Midwifery and Core Competencies for Basic Midwifery Practice
7. Length of Time to Obtain Registered Nurse License and Nurse Midwifery Certification

10.3 Discuss Online License and Certificate Renewal Processes

10.4 Public Comment for Items Not on the Agenda

10.5 Adjournment

NOTICE: All times are approximate. Meetings may be canceled without notice. For verification of meeting, call (916) 574-7600 or access the Board's Web Site www.rm.ca.gov under "Meetings." The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting the Administration Unit at (916) 574-7600 or email webmasterbrn@dca.ca.gov or send a written request to the Board of Registered Nursing Office at 1747 North Market Suite 150, Sacramento, CA 95834. (Hearing impaired: California Relay Service: TDD phone (800) 326-2297). Providing your request at least five (5) business days before the meeting will help to ensure the availability of the requested accommodation.

Board members who are not members of this committee may attend meetings as observers only, and may not participate or vote. Action may be taken on any item listed on this agenda, including information only items. Items may be taken out of order for convenience, to accommodate speakers, or maintain a quorum. The public will be provided an opportunity to comment on each agenda item at the time it is discussed; however, the committee may limit the time allowed to each speaker.

BOARD OF REGISTERED NURSING
Nurse-Midwifery Committee
Agenda Item Summary

AGENDA ITEM: 10.1

DATE: April 5, 2017

ACTION REQUESTED: Items to be Discussed and Considered

REQUESTED BY:

BACKGROUND:

- 1. Creating and Presenting an Informational Session for BRN Related to Nurse-Midwifery Practice**

- 2. Feedback Received from Certified Nurse Midwifery Community Related to Expert Witness Participation**

- 3. Status of Survey for Advanced Practice Nursing 2017; Information Only**

- 4. Mission of Nurse Midwifery Advisory Committee and Reporting Relationship to the Board**

NEXT STEPS: Practice Committee

FISCAL IMPACT, IF ANY: None

PERSON(S) TO CONTACT: Janette Wackerly, RN, BSN, MBA
Supervising Nursing Education Consultant and
Liaison to the Practice Committee
(916)574-7686

BOARD OF REGISTERED NURSING
Nurse-Midwifery Committee
Agenda Item Summary

AGENDA ITEM: 10.1.3

DATE: April 5, 2017

ACTION REQUESTED: **Status of Survey for APRN 2017; Information Only**

REQUESTED BY: CNM Committee

BACKGROUND:

The BRN has commissioned the University of California San Francisco (UCSF), Center for the Health Professions to complete a survey of California Nurse Practitioners (NPs) and Certified Nurse-Midwives (CNMs). At the September 2016 Nurse-Midwifery Committee meeting, the Committee reviewed and provided feedback on the draft survey. Since that time, the survey was reviewed by another group that included additional nurse-midwives and nurse practitioners. The survey also went through testing, both a paper and online version to obtain feedback from individuals attempting to complete it. Revisions were made according to feedback and space availability with the goal of keeping the survey to 12 pages for cost effective printing and maximizing the sample size. A final copy of the survey is included as an attachment.

In December 2016, UCSF e-mailed a link to the survey to the selected survey sample of 2,500 NPs and CNMs in an attempt to obtain more online responses. As of January 24, 2017, prior to the hard copy surveys being mailed to those who had not responded online, UCSF had received 690 completed online survey responses (about 28% of the sample). As of March 24, 2017, UCSF has received a total of 1,367 completed surveys (552 by mail and 815 online) for a 54.7% response rate thus far.

A report with descriptive information and findings will be completed by UCSF. Dr. Joanne Spetz from UCSF will attend a future Board meeting to provide a presentation of the highlights of the data and when finalized the report will be posted to the BRN website. Expected completion is late 2017.

Attachment: Final 2017 NP & CNM Survey

NEXT STEPS: **Practice Committee**

FISCAL IMPACT, IF ANY: **None**

PERSON(S) TO CONTACT: Janette Wackerly, RN, BSN, MBA
Supervising Nursing Education Consultant and
Liaison to the Practice Committee
(916)574-7686



California Board of Registered Nursing

Survey of Nurse Practitioners and Certified Nurse Midwives 2017

Conducted for the Board of Registered Nursing by

Philip R. Lee Institute for Health Policy Studies,
University of California, San Francisco

Here's how to fill out the Survey:

- Use pen or pencil to complete the survey.
- Please try to answer each question.
- Most questions can be answered by checking a box or writing a number or a few words on a line.
- Never check more than one box, except when it says **Check all that apply**.
- Sometimes we ask you to skip one or more questions. An arrow will tell you what question to answer next, like this:

₁ YES
₂ NO → **SKIP TO Question 23**

- If none of the boxes is just right for you, please check the one that fits you the best. Feel free to add a note of explanation. If you are uncomfortable answering a particular question, or can't answer it, feel free to skip it and continue with the survey.
- If you need help with the survey, call toll-free (877) 276-8277.
- **REMEMBER:** An online version of this survey is available. Follow the instructions in the cover letter that came with this questionnaire to access the online survey.

After you complete the survey, please mail it back to us in the enclosed envelope. No stamps are needed. Thank you for your prompt response.

**CALIFORNIA BOARD OF REGISTERED NURSING
2017 NURSE PRACTITIONER (NP) & CERTIFIED NURSE MIDWIFE (CNM) SURVEY**

SECTION A: EDUCATION AND LICENSURE INFORMATION

1. In which educational program(s) did you complete **any** NP and/or CNM preparation? **(Check all that apply, including both initial and advanced education.)**

	NP	Year completed	CNM	Year completed
Entry Level Master's Program (ELM, MEPN, etc.)	<input type="checkbox"/> _a	_____	<input type="checkbox"/> _a	_____
Master's Degree (MSN, non-ELM)	<input type="checkbox"/> _b	_____	<input type="checkbox"/> _b	_____
Post-master's Certificate	<input type="checkbox"/> _c	_____	<input type="checkbox"/> _c	_____
Certificate Program (no master's degree)	<input type="checkbox"/> _d	_____	<input type="checkbox"/> _d	_____
Doctor of Nursing Practice (DNP)	<input type="checkbox"/> _e	_____	<input type="checkbox"/> _e	_____
Other Doctorate (PhD, DNSc, etc.)	<input type="checkbox"/> _f	_____	<input type="checkbox"/> _f	_____
Other (Describe): _____	<input type="checkbox"/> _g	_____	<input type="checkbox"/> _g	_____

2. Please indicate **all additional** educational degrees you have earned. Do not include degrees indicated in Question 1.

- | | |
|---|--|
| <input type="checkbox"/> _a Diploma in Registered Nursing | <input type="checkbox"/> _f Master's degree in Nursing (MSN, MN) |
| <input type="checkbox"/> _b Associate degree in Nursing (AD) | <input type="checkbox"/> _g Other Master's degree (non-nursing) |
| <input type="checkbox"/> _c Other Associate degree (non-nursing) | <input type="checkbox"/> _h Doctorate of Nursing Practice (DNP) |
| <input type="checkbox"/> _d Baccalaureate of Science in Nursing (BSN) | <input type="checkbox"/> _i PhD or other Research Doctorate in Nursing |
| <input type="checkbox"/> _e Other Baccalaureate degree (non-nursing) | <input type="checkbox"/> _j Other Doctoral degree (non-nursing) |

3. In what **year** did you obtain your first RN license (in any state or country)? _ _ _ _

4. In what state or country did you first get licensed as an RN?

USA: _____ (2-letter state code) **OR** **Other country:** _____

5. Please indicate your clinical fields of NP and/or CNM **educational preparation.** **(Check all that apply.)**

- | | |
|---|--|
| <input type="checkbox"/> _a Family/individual | <input type="checkbox"/> _h Acute care – adult and/or geriatrics |
| <input type="checkbox"/> _b Adult primary care | <input type="checkbox"/> _i Acute care – pediatrics |
| <input type="checkbox"/> _c Geriatrics primary care | <input type="checkbox"/> _j Perinatal care |
| <input type="checkbox"/> _d Pediatrics primary care | <input type="checkbox"/> _k Oncology |
| <input type="checkbox"/> _e Women's health/gender-related | <input type="checkbox"/> _l Occupational health |
| <input type="checkbox"/> _f Neonatology | <input type="checkbox"/> _m Palliative care/hospice |
| <input type="checkbox"/> _g Psychiatric/mental health | <input type="checkbox"/> _n Midwifery |
| | <input type="checkbox"/> _o Other (specify): _____ |

6. Are you currently certified as **both** an NP and a PA?

₁ Yes ₂ No **→ Skip to Question #8 on the next page**



7. In which certification field are you currently working? ₁ NP ₂ PA ₃ Neither ₄ Both

8. If you are **currently nationally** certified as an **NP or CNM**, by whom? **(Check all that apply.)**

- _a American Academy of Nurse Practitioners (AANP) _c National Certification Corporation (NCC) _e American Midwifery Certification Board (AMCB) / ACNM
- _b American Nurses Credentialing Center (ANCC) _d Pediatric Nursing Certification Board (PNCB) _f AACN Credentialing Corporation (acute care adult/gero NP)
- _g Other (specify below) _____

9. Are you **currently** enrolled in a graduate, advanced degree, or specialty certificate program?

- ₁ Yes ₂ No → **Skip to Question #11 below.**



10. What is your **degree objective**? (Check all that apply.)

- _a Master's degree in nursing _d Doctor of Nursing Practice (DNP)
- _b Master's degree in non-nursing field _e PhD or other Research Doctorate in Nursing
- _c Non-degree specialty certification program _f Other Non-Nursing Doctoral degree

11. If you ever pursued a degree beyond your NP/CNM education, or are seeking one now, why? (Check all that apply.)

- _a Higher salary _d Personal growth/development
- _b Required for my NP/CNM position _e To seek new job opportunities
- _c Required for billing purposes _f Interest in becoming faculty
- _g Other (specify: _____)

12. Are you **currently working for pay** in **any job** that requires your NP or CNM certification?

- ₁ **Yes** ₂ **No, I am not working as an NP or CNM.**



Continue below to Section B.



Skip to page 10, Section D.

SECTION B: FOR NURSES CURRENTLY EMPLOYED AS AN NP OR CNM

*Please complete this section if you have any job (clinical or not) that requires your **California** NP or CNM certification. If you are **NOT** working in a paid position that requires your NP or CNM certification, please **SKIP** to page 10, Section D.*

13. In how many **NP/CNM** positions do you currently work for pay?

- ₁ One ₂ Two ₃ Three ₄ Four or more

Please complete the following questions for the top two NP/CNM positions according to where you spend most of your working time.

14. How many **months per year** do you work in your NP/CNM position(s)?

Primary NP/CNM position: _____ # months/year

Second NP/CNM position: _____ # months/year

15. How many **hours per week** do you work (on average) in your NP/CNM position(s)?

Primary NP/CNM position: _____ # hours per week

Second NP/CNM position: _____ # hours per week

16. How are you paid in your **primary** NP/CNM position? (Select one.)

- ₁ Annual salary ₃ Percentage of Billing
₂ By the hour ₄ Base salary with bonus (based on billing, quality, etc.)
₅ Other (specify: _____)

17. Indicate the zip codes for **each** site you work at in your top two NP/CNM position(s).

Primary NP/CNM position: _____ site 1 zip _____ site 2 zip _____ site 3 zip

Second NP/CNM position: _____ site 1 zip _____ site 2 zip _____ site 3 zip

18. How long have you worked with your **current employer**?

Primary NP/CNM position: _____ years & _____ months

Second NP/CNM position: _____ years & _____ months

19. Which one of the following best describes the **job title** of your **NP/CNM position(s)**?
(Check one for each applicable position.)

	Primary NP/CNM position	Second NP/CNM position
Nurse Practitioner	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁
Nurse-Midwife	<input type="checkbox"/> ₂	<input type="checkbox"/> ₂
Management / Administration	<input type="checkbox"/> ₃	<input type="checkbox"/> ₃
Faculty in NP education program	<input type="checkbox"/> ₄	<input type="checkbox"/> ₄
Faculty in CNM education program	<input type="checkbox"/> ₅	<input type="checkbox"/> ₅
Faculty in RN education program	<input type="checkbox"/> ₆	<input type="checkbox"/> ₆
Other (specify: _____)	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈

20. Approximately what percentage of your time is spent on each of the following functions during a **typical week** in your NP/CNM position(s)?

	Primary NP/CNM position	Second NP/CNM position
Patient care (including patient and family education, record keeping, communications regarding patient care)	_____ %	_____ %
Administration, management, or organizational support (such as quality improvement, peer review, committee service)	_____ %	_____ %
Teaching/precepting for a pre-licensure nursing education program	_____ %	_____ %
Teaching/precepting for a NP/CNM education program	_____ %	_____ %
Research	_____ %	_____ %
Other (specify: _____)	_____ %	_____ %
	100%	100%

21. Please estimate the **total annual earnings** for your NP/CNM position(s) **in 2016**, before deductions for taxes, social security, etc.

Primary NP/CNM position: \$_____,_____ per year

Second NP/CNM position: \$_____,_____ per year

22. Which of the following **best** describes the type of **setting** of your NP/CNM position(s)?
 (Check only one setting for each position based on where you spend the most time.)

	Primary NP/CNM position	Second NP/CNM position
Hospital Setting		
Hospital, acute/critical care	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁
Hospital, emergency room/urgent care	<input type="checkbox"/> ₂	<input type="checkbox"/> ₂
Hospital, labor and delivery	<input type="checkbox"/> ₃	<input type="checkbox"/> ₃
Hospital, outpatient services	<input type="checkbox"/> ₄	<input type="checkbox"/> ₄
Ambulatory Setting		
Private physician-led practice	<input type="checkbox"/> ₅	<input type="checkbox"/> ₅
HMO-based practice	<input type="checkbox"/> ₆	<input type="checkbox"/> ₆
NP/CNM-led health clinic	<input type="checkbox"/> ₇	<input type="checkbox"/> ₇
Community Health Center/FQHC	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈
Family Planning Center	<input type="checkbox"/> ₉	<input type="checkbox"/> ₉
Rural Health Center	<input type="checkbox"/> ₁₀	<input type="checkbox"/> ₁₀
Occupational/Employee health center	<input type="checkbox"/> ₁₁	<input type="checkbox"/> ₁₁
Public Health clinic	<input type="checkbox"/> ₁₂	<input type="checkbox"/> ₁₂
Retail based clinic	<input type="checkbox"/> ₁₃	<input type="checkbox"/> ₁₃
Urgent Care	<input type="checkbox"/> ₁₄	<input type="checkbox"/> ₁₄
College health service	<input type="checkbox"/> ₁₅	<input type="checkbox"/> ₁₅
School-based health center	<input type="checkbox"/> ₁₆	<input type="checkbox"/> ₁₆
VA health center (outpatient)	<input type="checkbox"/> ₁₇	<input type="checkbox"/> ₁₇
Maternal Child Health Setting		
Freestanding Birthing Center	<input type="checkbox"/> ₁₈	<input type="checkbox"/> ₁₈
Home birth	<input type="checkbox"/> ₁₉	<input type="checkbox"/> ₁₉
Other Setting		
Academic education program	<input type="checkbox"/> ₂₀	<input type="checkbox"/> ₂₀
Correctional system	<input type="checkbox"/> ₂₁	<input type="checkbox"/> ₂₁
Extended care/long term facility	<input type="checkbox"/> ₂₂	<input type="checkbox"/> ₂₂
HMO/Managed care company (no patient care)	<input type="checkbox"/> ₂₃	<input type="checkbox"/> ₂₃
Mental Health Facility	<input type="checkbox"/> ₂₄	<input type="checkbox"/> ₂₄
Public Health Department (not a health center)	<input type="checkbox"/> ₂₅	<input type="checkbox"/> ₂₅
Home Health agency	<input type="checkbox"/> ₂₆	<input type="checkbox"/> ₂₆
Hospice/Palliative care	<input type="checkbox"/> ₂₇	<input type="checkbox"/> ₂₇
Other (Specify) _____	<input type="checkbox"/> ₂₈	<input type="checkbox"/> ₂₈

23. Are you doing volunteer work in your capacity as an NP/CNM? ₁ Yes ₂ No

If Yes, how many hours per month _____

24. Do you precept NP, CNM, MD, and/or PA students through direct clinical observation?

_a No

_b Yes, NP students _____# per month _c Yes, CNM students _____# per month

_d Yes, MD students _____# per month _e Yes, PA students _____# per month

25. Which of the following **barriers**, if any, do you face regarding precepting **NP/CNM students** from **California-based programs**? (Check all that apply.)

- _a Not interested in precepting
- _b Lack of physical space for students
- _c Lack of time due to clinical demands
- _d Too much paperwork required
- _e Administrative constraints on accepting students
- _f Competition for spots from non-NP/CNM students
- _g Competition from out-of-state programs
- _h Other (specify): _____

26. Are you required to maintain **national** certification in your NP/CNM role for your position?

- ₁ Yes
- ₂ No
- ₃ Unsure

27. In which clinical fields do you **most frequently** provide direct patient care in your top two paid NP/CNM position(s)? (**Check all that apply for each position.**)

_a **Not** involved in patient care for both positions → **Skip to Question #42**

	Primary NP/CNM position	Second NP/CNM position
Not involved in patient care for this position	<input type="checkbox"/> _a	<input type="checkbox"/> _a
Ambulatory/outpatient	<input type="checkbox"/> _b	<input type="checkbox"/> _b
Cardiology	<input type="checkbox"/> _c	<input type="checkbox"/> _c
Community/public health	<input type="checkbox"/> _d	<input type="checkbox"/> _d
Corrections/prison	<input type="checkbox"/> _e	<input type="checkbox"/> _e
Emergency/trauma	<input type="checkbox"/> _f	<input type="checkbox"/> _f
Endocrine/diabetes	<input type="checkbox"/> _g	<input type="checkbox"/> _g
Geriatrics/gerontology	<input type="checkbox"/> _h	<input type="checkbox"/> _h
Gynecology/women's health	<input type="checkbox"/> _i	<input type="checkbox"/> _i
Home health	<input type="checkbox"/> _j	<input type="checkbox"/> _j
Hospice/palliative care	<input type="checkbox"/> _k	<input type="checkbox"/> _k
Intensive care/critical care	<input type="checkbox"/> _l	<input type="checkbox"/> _l
Medical-surgical	<input type="checkbox"/> _m	<input type="checkbox"/> _m
Neonatal intensive care	<input type="checkbox"/> _n	<input type="checkbox"/> _n
Obstetrics/intrapartum	<input type="checkbox"/> _o	<input type="checkbox"/> _o
Oncology	<input type="checkbox"/> _p	<input type="checkbox"/> _p
Orthopedics	<input type="checkbox"/> _q	<input type="checkbox"/> _q
Newborn/Pediatrics	<input type="checkbox"/> _r	<input type="checkbox"/> _r
Psychiatry/mental health	<input type="checkbox"/> _s	<input type="checkbox"/> _s
School health (K-12 or college)	<input type="checkbox"/> _t	<input type="checkbox"/> _t
Surgery/pre-op/post-op/ PACU/anesthesia	<input type="checkbox"/> _u	<input type="checkbox"/> _u
Other (Specify: _____)	<input type="checkbox"/> _v	<input type="checkbox"/> _v

Skip to question #42 if you do not provide patient care in your top two NP/CNM positions.

28. In your **NP/CNM practice**, please estimate what percent of your patients:

	Primary NP/CNM position	Second NP/CNM position
A. Are covered by Medicare fee-for-service?	_____ %	_____ %
B. Are covered by Medicaid fee-for service?	_____ %	_____ %
C. Are covered by private insurance?	_____ %	_____ %
D. Worker's compensation?	_____ %	_____ %
E. Other government program (e.g., VA, IHS)	_____ %	_____ %
F. Uninsured?	_____ %	_____ %

29. Please **estimate what percent** of your patients are in a Managed Care plan or Accountable Care Organization (ACO), for any type of insurance program?

_____ % in managed care or ACO

30. Which types of new patients is your practice **currently** accepting?
(Check all that apply.)

	Primary NP/CNM position	Second NP/CNM position
A. Covered by Medicare	<input type="checkbox"/> _a	<input type="checkbox"/> _a
B. Covered by Medicaid	<input type="checkbox"/> _b	<input type="checkbox"/> _b
C. Covered by private insurance	<input type="checkbox"/> _c	<input type="checkbox"/> _c
D. Worker's compensation	<input type="checkbox"/> _d	<input type="checkbox"/> _d
E. Other government program (e.g., VA, IHS)	<input type="checkbox"/> _e	<input type="checkbox"/> _e
F. Uninsured	<input type="checkbox"/> _f	<input type="checkbox"/> _f

31. For billing/reimbursement in your NP/CNM position(s), do you have a Medicare provider number/NPI?

₁ Yes ₀ No → **Skip to #33 below.**



32. If you care for Medicare/Medi-Cal patients in your NP/CNM position(s), how are your services billed?

	Primary NP/CNM position	Second NP/CNM position
Medicare	<input type="checkbox"/> ₁ Bill as primary provider <input type="checkbox"/> ₂ Incident to physician <input type="checkbox"/> ₃ Don't know <input type="checkbox"/> ₄ Not applicable	<input type="checkbox"/> ₁ Bill as primary provider <input type="checkbox"/> ₂ Incident to physician <input type="checkbox"/> ₃ Don't know <input type="checkbox"/> ₄ Not applicable
Medi-Cal	<input type="checkbox"/> ₁ Bill as primary provider <input type="checkbox"/> ₂ Incident to physician <input type="checkbox"/> ₃ Don't know <input type="checkbox"/> ₄ Not applicable	<input type="checkbox"/> ₁ Bill as primary provider <input type="checkbox"/> ₂ Incident to physician <input type="checkbox"/> ₃ Don't know <input type="checkbox"/> ₄ Not applicable

33. Are you recognized as a primary care provider (PCP) in those insurance networks in which your practice(s) participate?

₁ Yes ₀ No or unsure → **Skip to #34 below.**



If Yes, indicate by marking all that apply below.

	Primary NP/CNM position	Second NP/CNM position
Aetna	<input type="checkbox"/> _a	<input type="checkbox"/> _a
Anthem Blue Cross	<input type="checkbox"/> _b	<input type="checkbox"/> _b
Blue Shield	<input type="checkbox"/> _c	<input type="checkbox"/> _c
Cigna	<input type="checkbox"/> _d	<input type="checkbox"/> _d
Health Net	<input type="checkbox"/> _e	<input type="checkbox"/> _e
Kaiser	<input type="checkbox"/> _f	<input type="checkbox"/> _f
United Healthcare	<input type="checkbox"/> _g	<input type="checkbox"/> _g
LA Care	<input type="checkbox"/> _h	<input type="checkbox"/> _h
Other (specify):	_____	_____

34. Indicate if you have the following privileges at **any hospital** for your NP/CNM position(s).

(Check all that apply.)

	Primary NP/CNM position	Second NP/CNM position
Rounding on patients	<input type="checkbox"/> _a	<input type="checkbox"/> _a
Write orders <u>without</u> physician co-signature	<input type="checkbox"/> _b	<input type="checkbox"/> _b
Write orders <u>with</u> physician co-signature	<input type="checkbox"/> _c	<input type="checkbox"/> _c

35. Do you work in **primary care**, involving common health problems and preventive measures, in your NP/CNM position(s)?

Primary NP/CNM position: ₀ No ₁ Yes → Percent of time: _____%

Second NP/CNM position: ₀ No ₁ Yes → Percent of time: _____%

36. In your NP/CNM position(s), are you...

	Always	Almost always	To a considerable degree	Occasionally	Seldom	Never
Allowed to practice to the fullest extent of the legal scope of practice in California?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Using your NP/CNM skills fully?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Contributing to the development or revision of standardized procedures?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
Working with underserved populations?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

37. Are you considering applying for a waiver to prescribe buprenorphine? ₁ Yes ₂ No ₃ Unsure

38. Do you have a **panel of patients** for whom you are the **main** care provider and that you **manage on an ongoing basis**? ₁ Yes ₂ No

If Yes, how many hours per month _____

If Yes, how many patients are in your panel? _____

39. Where is your collaborating/supervising physician located? (Check all that apply.)

	Primary NP/CNM position	Second NP/CNM position
Physician is in another practice/system than mine	<input type="checkbox"/> _a	<input type="checkbox"/> _a
Physician is at another site within the same practice/system	<input type="checkbox"/> _b	<input type="checkbox"/> _b
Physician is on site	<input type="checkbox"/> _c	<input type="checkbox"/> _c

40. How often is a **physician present on site** to discuss patient problems as they occur in your principal NP/CNM positions? (Check one for each applicable position.)

	Primary position	Second position
Never (0% of the time)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁
Seldom (1%-25% of the time)	<input type="checkbox"/> ₂	<input type="checkbox"/> ₂
Sometimes (26%-50% of the time)	<input type="checkbox"/> ₃	<input type="checkbox"/> ₃
Usually (51%-75% of the time)	<input type="checkbox"/> ₄	<input type="checkbox"/> ₄
Nearly always (76%-100% of the time)	<input type="checkbox"/> ₅	<input type="checkbox"/> ₅

41. What type of **professional relationship do you have with the physician(s)** in your NP/CNM practice? (Check all that apply.)

	Primary NP/CNM position	Second NP/CNM position
Equal colleagues/no hierarchy	<input type="checkbox"/> _a	<input type="checkbox"/> _a
S/he is the medical director who oversees all of our practice and I am accountable to the medical director, as are all other providers	<input type="checkbox"/> _b	<input type="checkbox"/> _b
Hierarchical/supervisory in which I must accept his/her clinical decision about the patients I see	<input type="checkbox"/> _c	<input type="checkbox"/> _c
Physician sees and signs off on the patients I see	<input type="checkbox"/> _d	<input type="checkbox"/> _d
Other (please describe: _____)	<input type="checkbox"/> _e	<input type="checkbox"/> _e

42. Are you certified in California as a **nurse mid-wife**?

₁ Yes ₀ No → **Skip to Section C on the next page.**

43. Are you employed in a **nurse mid-wife** role? ₂ No ₁ Yes → skip to #45 below

44. How important are each of the following factors for **not practicing nurse-midwifery**?

	Not important	Somewhat important	Important	Very important	Does not apply
A. Childcare/family responsibilities	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
B. Stress specific to CNM role	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
C. Dissatisfied with CNM salaries	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
D. Dissatisfied with the CNM profession	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
E. Inconvenient schedules	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
F. Overall lack of CNM jobs	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
G. Lack of CNM jobs/practice opportunities in desired location	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
H. Denied CNM job due to lack of experience or qualification	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
I. Challenges associated with scope of practice restrictions for CNMs / physician supervision	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
J. Dissatisfaction with the degree of collaboration with other providers	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
K. Liability insurance or concerns	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
L. Cost of business is too high	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
M. Other	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀

(Specify: _____)

45. Do you **attend births** in your CNM position(s)?

₀ No ₁ Yes → Number per month: _____

46. Do you participate as an RN **first assistant in Cesarean deliveries** in your CNM position(s)?

₀ No ₁ Yes → Number per month: _____

SECTION C: SATISFACTION WITH NP/CNM PRACTICE

47. How satisfied are you with your NP and/or CNM career?

Very dissatisfied Dissatisfied Neither satisfied nor dissatisfied Satisfied Very satisfied
₁ ₂ ₃ ₄ ₅

48. How much of a problem is each of the following issues with regard to your ability to provide quality care?

	Not a problem	Minor problem	Major problem	Not applicable
A. Inadequate time with patients	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₀
B. Difficulties communicating with patients due to language or cultural barriers	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₀
C. Lack of qualified specialists in your area	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₀
D. Not getting timely reports from other providers and facilities	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₀
E. Denial of coverage/care decisions by insurance companies	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₀
F. Scope of practice restrictions/lack of full practice authority	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₀
G. Quality issues outside of your control	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₀
H. Patients' inability to receive needed care because of inability to pay	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₀
I. Insufficient income in my practice to support quality	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₀
J. Too little involvement in decisions in your organization	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₀
K. Non-paying patients/bad debt	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₀
L. High liability insurance rates	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₀
M. Non-reimbursable overhead costs	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₀
N. Lack of call coverage	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₀
O. Lack of administrative support	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₀
P. Lack of ancillary clinical support (such as MAs)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₀
Q. Lack of access/support for educational advancement	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₀
R. Varying degrees of collaboration	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₀
S. Inadequate or slow 3 rd party payment	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₀
T. Other	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₀

(Specify: _____)

49. In the last three years, indicate if you have you encountered either of the following obstacles to practicing as an NP/CNM? **(Check all that apply.)**

_a Difficulty finding employment as an NP/CNM _b Lack of adequate mentoring

50. Has your NP/CNM **employment changed** during the last three years? **(Check all that apply.)**

_a Increased NP/CNM hours _d Added services in a practice _g Opened practice(s)
_b Decreased NP/CNM hours _e Ceased offering specific services _h Changed roles at same employer
_c Changed employer(s) _f Closed practice(s) _i No change in NP/CNM employment
_i Other (specify: _____)

51. Within the **next five years**, what are your intentions regarding your NP/CNM employment?
(Check all that apply.)

- _a Plan to increase hours of NP/CNM work
- _b Plan to work approximately as much as now
- _c Plan to reduce hours of NP/CNM work
- _d Plan to leave nursing entirely but not retire
- _e Plan to retire
- _f Plan to move to another state for NP/CNM work

(PLEASE SKIP TO PAGE 11, SECTION E)

SECTION D: FOR PERSONS NOT EMPLOYED IN AN NP/CNM ROLE

If you **ARE** working in a paid position in which you utilize your NP/CNM training and skills, please **SKIP** to page 11, Section E.

52. What was the last year you worked for pay as an NP/CNM? __ __ __ __ or Never

53. How important are each of the following factors in your not being employed as an NP/CNM?

	Not important	Somewhat important	Important	Very important	Does not apply
A. Retired	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
B. Childcare/family responsibilities	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
C. Moving to a different location	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
D. Stress on the job	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
E. Illness/injury	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
F. Dissatisfied with benefits/salary	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
G. Dissatisfied with NP/CNM profession	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
H. Wanted to try another occupation	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
I. Inconvenient schedules	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
J. Overall lack of NP/CNM jobs	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
K. Lack of NP/CNM jobs/practice opportunities in desired location	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
L. Lack of NP/CNM jobs in desired type of facility	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
M. Lack of NP/CNM jobs in desired specialty	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
N. Denied NP/CNM job due to lack of experience or qualification	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
O. Dissatisfaction with ability to practice at the NP/CNM level	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
P. Dissatisfaction with the degree of collaboration with other providers	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
Q. Liability insurance or concerns	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
R. Lack of good management/ leadership	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
S. Difficulty managing the practice	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
T. Cost of business is too high	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀
U. Other	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₀

(Specify: _____)

54. Which of the following best describes your **current intentions regarding work** as an NP/CNM?
(Check only one.)

- | | |
|---|--|
| <input type="checkbox"/> ₁ Currently seeking employment as an NP/CNM | <input type="checkbox"/> ₄ Plan to return to NP/CNM practice in more than 3 years |
| <input type="checkbox"/> ₂ Plan to return to NP/CNM practice within 1 year | <input type="checkbox"/> ₅ Definitely will not return to or seek NP/CNM position |
| <input type="checkbox"/> ₃ Plan to return to NP/CNM practice in 1-3 years | <input type="checkbox"/> ₆ Undecided at this time
↓
What would affect your decision?

_____ |

55. Are you doing volunteer work as an NP/CNM? ₂ No ₁ Yes → Hours per month: _____

SECTION E: EMPLOYMENT OUTSIDE NP/CNM ROLES

56. Are you currently working for pay **as an RN (not as an NP or CNM)**?

- ₁ Yes ↓
₂ No → Skip to the **Question #63** on the next page

57. How many nursing (**non-NP/CNM**) positions do you hold? ₁ One ₂ Two or more

58. How many **months per year** do you work as an RN (non-NP/CNM)? _____ # months per year

59. How many **hours per week** do you normally work in any RN position? _____ # hours per week

60. Please estimate the **total annual earnings** for all of your **RN (non-NP/CNM)** positions **in 2016** combined, before deductions for taxes, social security, etc. \$_____

61. Which of the following best describes the **type of setting(s)** of your **RN (non-NP/CNM)** position(s)? **(Check all that apply.)**

- | | | |
|--|--|---|
| <input type="checkbox"/> _a Hospital (any department) | <input type="checkbox"/> _e Medical practice, clinic, surgery center | <input type="checkbox"/> _h School health service (K-12 or college) |
| <input type="checkbox"/> _b Home health agency / home health service | <input type="checkbox"/> _f Public health or community health | <input type="checkbox"/> _i University or college (faculty or administration) |
| <input type="checkbox"/> _c Nursing home, extended care, or skilled nursing facility | <input type="checkbox"/> _g Government agency | <input type="checkbox"/> _j Case management/disease management |
| <input type="checkbox"/> _d Mental health / substance abuse | <input type="checkbox"/> _k Other (specify: _____) | |

62. Which one of the following best describes your **job title** in your **RN (non-NP/CNM)** nursing position(s)? **(Check all that apply.)**

- | | | |
|---|---|--|
| <input type="checkbox"/> _a Staff nurse/direct care nurse | <input type="checkbox"/> _e Nurse Coordinator | <input type="checkbox"/> _h Patient educator |
| <input type="checkbox"/> _b Clinical Nurse Specialist | <input type="checkbox"/> _f Quality Improvement nurse, utilization review | <input type="checkbox"/> _i Educator, academic setting (professor, instructor) |
| <input type="checkbox"/> _c Patient care coordinator/ case manager/ discharge planner | <input type="checkbox"/> _g Telenursing | <input type="checkbox"/> _j Educator, service setting (in-service educator) |
| <input type="checkbox"/> _d Management / administration | <input type="checkbox"/> _k Other (specify: _____) | |

63. Are you currently employed in a **non-nursing position** (that does not require an RN license)?

₁ Yes

₂ No

Skip to Section F below. →

64. Does your position utilize any of your nursing knowledge? ₁ Yes ₂ No

SECTION F: DEMOGRAPHIC INFORMATION

65. Gender ₁ Female ₂ Male ₃ Other

66. Year of birth 19 ____

67. Are you currently married or in a domestic partner relationship? ₁ Yes ₂ No

68. What is your ethnic/racial background (select the **one** with which you most strongly identify)?

₁ African American/Black/African

₂ Caucasian/White/
European/Middle Eastern

₃ American Indian/Native
American/Alaskan Native

₄ Other
or Mixed

Asian		Latino/Hispanic		Native Hawaiian/Pacific Islander	
<input type="checkbox"/> ₅ Cambodian	<input type="checkbox"/> ₁₀ Korean	<input type="checkbox"/> ₁₅ Central American		<input type="checkbox"/> ₂₀ Fijian	<input type="checkbox"/> ₂₅ Tongan
<input type="checkbox"/> ₆ Chinese	<input type="checkbox"/> ₁₁ Laotian/Hmong	<input type="checkbox"/> ₁₆ South American		<input type="checkbox"/> ₂₁ Filipino	<input type="checkbox"/> ₂₆ Other
<input type="checkbox"/> ₇ Indian	<input type="checkbox"/> ₁₂ Pakistan	<input type="checkbox"/> ₁₇ Cuban		<input type="checkbox"/> ₂₂ Guamanian	
<input type="checkbox"/> ₈ Indonesian	<input type="checkbox"/> ₁₃ Thai	<input type="checkbox"/> ₁₈ Mexican		<input type="checkbox"/> ₂₃ Hawaiian	
<input type="checkbox"/> ₉ Japanese	<input type="checkbox"/> ₁₄ Vietnamese	<input type="checkbox"/> ₁₉ Other Hispanic		<input type="checkbox"/> ₂₄ Samoan	

69. In what languages, other than English, do you have medical fluency? (Check all that apply.)

_a None

_b Spanish

_e Tagalog/other Filipino dialect

_h Mandarin

_c Korean

_f French

_i Cantonese

_d Vietnamese

_g Hindi/Urdu/Punjabi/other South
Asian language

_j Other Chinese dialect

_k Other (**Please describe:** _____)

70. Do you have children living at home with you? ₁ Yes ₂ No

If Yes, **how many** are:

a) 0-2 years ____

b) 3-5 years ____

c) 6-12 years ____

d) 13-18 years ____

e) 19+ years ____

71. Home Zip Code: _____, City: _____, State: _____ or

If you reside outside of the country, please specify what country: _____

72. Which category best describes how much income your **total household** received last year? This is the before-tax income of **all** persons living in your household, including yourself:

₁ Less than \$50,000

₄ \$100,000 – 124,999

₇ \$175,000 – 199,999

₂ \$50,000 - 74,999

₅ \$125,000 – 149,999

₈ \$200,000 or more

₃ \$75,000 - 99,999

₆ \$150,000 – 174,999

Thank you for completing the survey.

Please return the questionnaire in the postage-paid envelope provided

If you have additional thoughts or ideas about the nursing profession in California, please write them below. You may include your email address if you would like an email notification when the report on this survey is published.

What information or activities could the CA Board of Registered Nursing provide to assist or support your practice in the state of California?

Comments:

Yes, I would like to be notified when the report is published.

My email address is: _____

BOARD OF REGISTERED NURSING
Nursing Practice Committee
Agenda Item Summary

AGENDA ITEM: 10.2
DATE: April 5, 2017

ACTION REQUESTED: **Discussion and Consideration of Items Related to the Practice of Midwifery; Possible Recommendations to the Full Board**

REQUESTED BY:

BACKGROUND:

1. Discuss the Meeting Frequency and Disciplinary Issues Regarding Nurse-Midwives that Arose During the Sunset Review Process

2. Comparison of Midwifery in California of Certified Nurse Midwives and Licensed Midwives to Include Scope, Supervision, Education Preparation, and Predominant Location of Practice

3. Issues Regarding Physician Supervision and Prior Administrative Cases Related to Certified Nurse Midwifery and Licensed Midwife Practice

4. Recommendation for Revision to Business and Professions Code Section 2746.52 to Add Performance of an Episiotomy as an 'Urgent/Emergency Event' in the Home Setting and Repair of Laceration in Home as a Patient Safety Issue

5. Authority Conferred for Nurse Midwifery Scope of Practice in Business and Professions Code Section 2746.5 Regarding Whether Standardized Procedures are Necessary for Nurse Midwifery Practice

6. Recommendation for Revision to Business and Professions Code Sections 2746 through 2746.8 Relating to Whether California Certified Nurse Midwifery Practice Should Be Based on Standards for Practice of Midwifery and Core Competencies for Basic Midwifery Practice

7. Length of Time to Obtain Registered Nurse License and Nurse Midwifery Certification

NEXT STEPS:

FISCAL IMPACT, IF ANY:

PERSON(S) TO CONTACT:

Janette Wackerly, MBA, BSN, RN
Supervising Nursing Education Consultant
Janette.Wackerly@dca.ca.gov
(916) 574-7686

Julie Campbell-Warnock
Research Program Specialist
Julie.Campbell-Warnock@dca.ca.gov
(916) 574-7681

BOARD OF REGISTERED NURSING
Nursing Practice Committee
Agenda Item Summary

AGENDA ITEM: 10.3

DATE: April 5, 2017

ACTION REQUESTED: **Discuss Online License and Certificate Renewal Processes**

REQUESTED BY:

BACKGROUND:

NEXT STEPS:

FISCAL IMPACT, IF ANY:

PERSON(S) TO CONTACT:

Janette Wackerly, MBA, BSN, RN
Supervising Nursing Education Consultant
Janette.Wackerly@dca.ca.gov
(916) 574-7686

Julie Campbell-Warnock
Research Program Specialist
Julie.Campbell-Warnock@dca.ca.gov
(916) 574-7681