# Nurse Practitioner Advisory Committee Meeting

## SUPPLEMENTAL MATERIALS

Nurse Practitioner Advisory Committee (NPAC) Meeting | August 31, 2021

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# Agenda Item 2.0

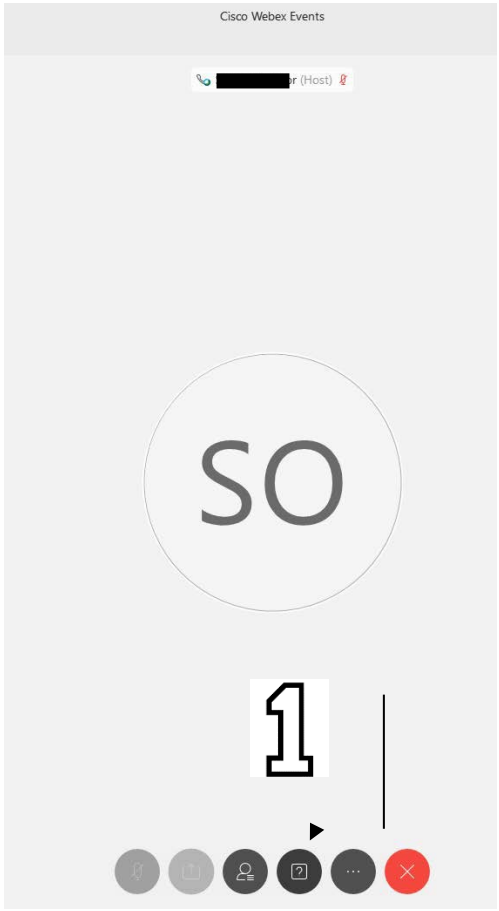
General instructions for the format of a teleconference meeting

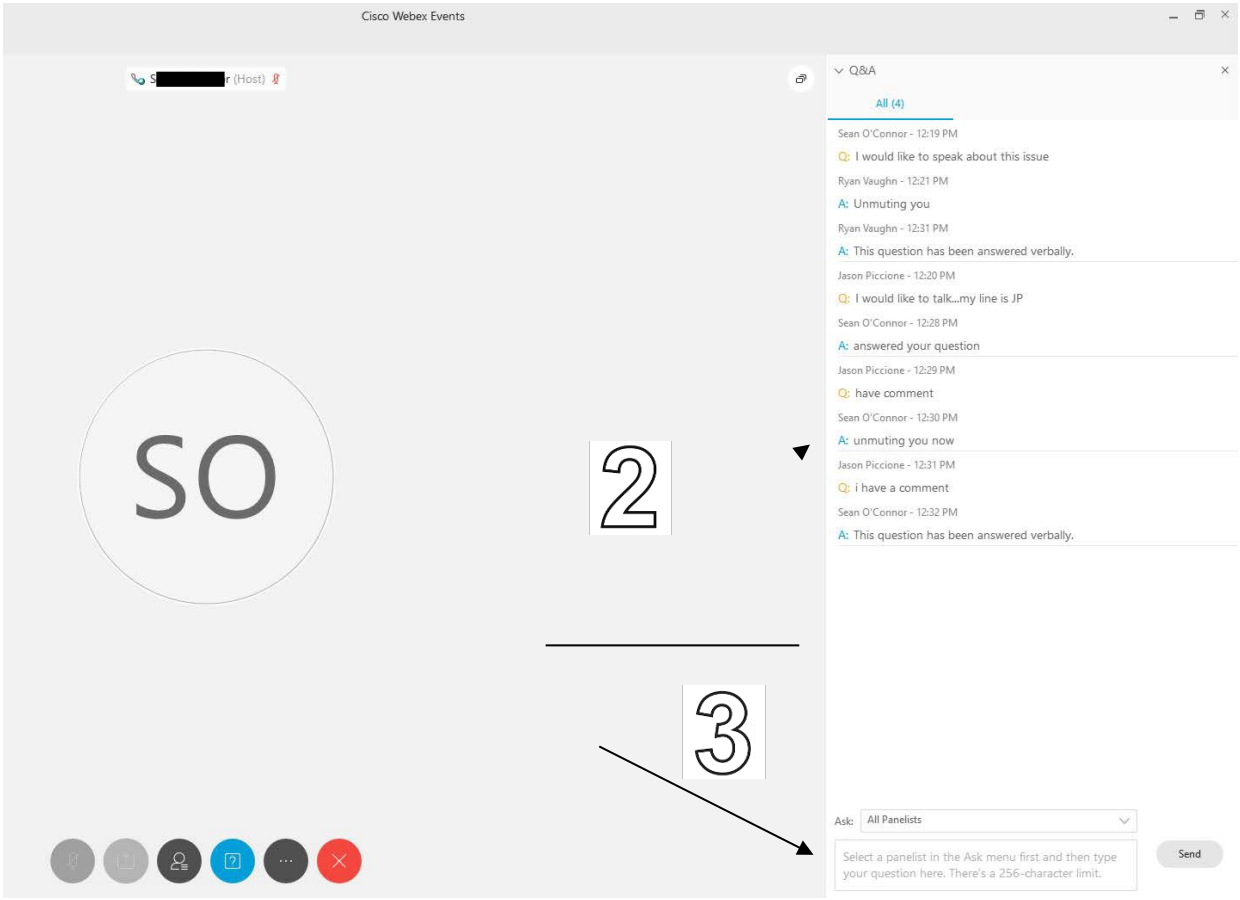
Nurse Practitioner Advisory Committee (NPAC) Meeting | August 31, 2021

# Participating During a Public Comment Period

If you would like to make a public comment:

1. Click on the ‘Q and A’ button near the bottom, center of your WebEx session.




2. The ‘Q and A’ chat box will appear.

3. ‘Send’ a request to ‘All Panelists’ stating “Comment Time Requested”. You will be identified by the name or moniker you used to join the WebEx session, your line will be opened, and you will have 2 minutes to provide comment.

NOTE: Please submit a new request for each topic on which you would like to comment.

# Agenda Item 4.0

**Review and vote on whether to approve minutes from previous meeting(s)**

Nurse Practitioner Advisory Committee (NPAC) Meeting | August 31, 2021

DRAFT

**STATE OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**CALIFORNIA BOARD OF REGISTERED NURSING**
**NURSE PRACTITIONER ADVISORY COMMITTEE**
**MEETING MINUTES**

**Date:** May 11, 2021

**Start Time:** 2:00 pm

**Location:** **NOTE:** Pursuant to the provisions of Governor Gavin Newsom's Executive Order N-29-20, dated March 17, 2020, a physical meeting location was not provided.

**The Nurse Practitioner Advisory Committee (NPAC) of the Board of Registered Nursing held a public meeting via a teleconference platform.**

**Tuesday, May 11, 2021 - 2:00 PM – 3:30 PM**

**1.0** **Call to Order/Roll Call/Establishment of a Quorum**
Samantha Gambles Farr called the meeting to order at 2:01 pm. All members present.

**Members:**
Sally Pham, MSN, RN FNP-BC
Jan Johnson Griffin, MSN, APRN
Andrea Espinosa, MD
Betha Schnelle, MBA, MPH
Edward Ray, MD, FACS
Kevin Maxwell, PhD, DNP, FNP-BC, RN
Samantha Gambles Farr, RN, MSN, FNP-C, CCRN, RNFA

**BRN Staff:**
Loretta Melby, MSN, RN, BRN Executive Officer
Reza Pejuhesh, DCA Legal Attorney
Evon Lenerd Tapps, BRN Assistant Executive Officer

2:02 pm **2.0** **General Instructions provided for the Format of a Teleconference Call**

2:05 pm **3.0** **Public Comment for Items Not on the Agenda; Items for Future Agendas**

**Public Comment for Agenda Item 3.0:** No public comments.

2:06 pm **4.0** **Review and Vote on Whether to Approve Previous Meetings' Minutes**

**Discussion:** **Andrea Espinosa:** Provided clarification for item 6.0 that it was two weeks not two months.

**Public Comment for Agenda Item 4.0:** No public comment.

**Motion:** **Edward Ray:** Motioned to accept the minutes with the correction noted by Andrea Espinosa.

**Second:** **Andrea Espinosa**

| Vote | SP | JJG | AE | BS | ER | KM | SGF |
|---|---|---|---|---|---|---|---|
| | Y | Y | Y | Y | Y | Y | Y |
| **Key: Yes: Y \| No: N \| Abstain: A \| Absent for Vote: AB** | | | | | | | |

2:13 pm **5.0** **Presentation and Update from the Department of Consumer Affairs, Office of Professional Examination Services (OPES), regarding occupational analysis mandated under Business and Professions Code (BPC) section 2837.105 - Informational Only**

**Discussion:** Presentation by Dr. Tracy Montez from OPES.

**Public Comment for Agenda Item 5.0:**

**Garrett Chan:** Commented on the State versus National Exam and that there is no State level. Further questioned what the value added was for people who are outside the nursing profession.

**Stephanie Dittmer:** Asked how we are going to compare NP and independent practice and other independent clinicians.

**Sharon Vogan:** Explained that OPES is not comparing to inpatient as AB 890 does not require that. She further expressed concerns that people outside of the nursing profession being considered SMEs as they look at things differently. The standard of care needs to be kept in the focus of who made the decision.

**Laura Strarvh:** Asked what the process/person in place to ensure the exam is not a barrier to practice as an NP.

**Dr. Tracy Montez:** Explained that it's up to the Board and that it will be fair, practical and legally defensible.

**Susani Kwan:** Asked why there would be a State exam when there already is a National exam.

**Cynthia Jovanov:** Requested that when the assessment by the SMEs is done, take into consideration NPs who are already managing physician owned clinics.

**Sharon Vogan:** Asked when OPES expects to be done.

**Dr. Tracy Montez:** Explained that the contract is about a year and per statute OPES has until January 2023.

3:05 pm **6.0** **Discussion and Possible Action Regarding Holding Interested Parties Meetings Regarding Implementation of AB 890 (Reg. Sess. 2019-2020)**

**Discussion:** Reza Pejuhesh introduced the agenda item and explained that the interested parties meeting could be structured similar to this meeting and the public would be involved.

**Edward Ray:** Asked if all be present without any other agenda items.

**Reza Pejuhesh:** Clarified that there could me a meeting in July expanding the discussion.

**Public Comment for Agenda Item 6.0:**

**Stephanie Dittmer:** Supports the meeting and requests for the opportunity to submit written comments in advance of the meeting.

**Loretta Melby:** Explained that any comments submitted prior to the posting of the materials would be reviewed and included, if approved.

**Yvonne Choong:** Thanked NPAC for scheduling a meeting in July to discuss preliminary language.

**Shakeh Agnazarian:** Supports decision for an Interested Parties Meeting early on.

**Garrett Chan:** Stated he was unclear on the intent of the Interested Parties Meeting and further stated that an agenda with the discussion items would be helpful. He further explained that only one way to engage the public is not helpful and recommended we look at the Board of Pharmacy.

**Motion:** **Betha Schnelle:** Motioned to accept the scheduling of the July Interested Parties Meeting.

**Second:** **Edward Ray**

| Vote | SP | JJG | AE | BS | ER | KM | SGF |
|---|---|---|---|---|---|---|---|
| | Y | Y | Y | Y | Y | Y | Y |
| **Key: Yes: Y \| No: N \| Abstain: A \| Absent for Vote: AB** | | | | | | | |

3:54 pm **7.0** Discussion and Possible Action Regarding Subcommittee Assignments

**Discussion:** Three subcommittees will be formed 1) BCP 2837.101 Transition to Practice 2) BCP 2837.103 and 3) BCP 2837.104 to update regulations.

**Andrea Espinosa:** Explained that if there are three subcommittees there will not be enough physicians to cover all subcommittees.

**Loretta Melby:** Explained cross-communication concerns and that only two NPAC members could be on each subcommittee.

**Kevin Maxwell:** Requested subcommittee 2837.104.

**Andrea Espinosa:** Requested subcommittee 2837.103.

**Edward Ray:** Requested the subcommittee on transition to practice.

**Motion:** **Sally Pham:** Motioned to create the three following subcommittees:
1) 2837.101 TTP – Edward Ray and Betha Schnelle
2) 2837.103 – Andrea Espinosa and Sally Pham
3) 2837.104 – Kevin Maxwell and Jan Johnson Griffin

**Second:** **Edward Ray**

**Public Comment for Agenda Item 7.0:**

**Garrett Chan:** Thanked the NPAC for forming subcommittees and expressed concerns that there was not an NP represented on the Transition to Practice subcommittee.

**Stephanie Dittmer:** Requested an NP be on each of the subcommittees.

**Katherine Hughes**: Stated that an NP needs to be on the Transition to Practice subcommittee.

**Sharon Vogan:** Agrees with the other commenters. Expressed her concern that a Committee Member emphasized there needs to be a physician on every subcommittee and would like personal feelings to be removed.

**Theresa Ullrich:** Agreed that there should be an NP on the Transition to Practice subcommittee.

**Cynthia Jovanov:** Echoed all the concerns stated about and explained that she does not support the subcommittees.

**Further Discussion:**

**Samantha Gambles Farr:** Agrees that there should be an NP on the transition to practice.

**Sally Pham:** Agreed to move to Transition to Practice and

**Betha Schnelle:** Agreed to the 104 subcommittee.

**2nd Motion:** **Samantha Gambles Farr:** Amended the prior motion to create the three following subcommittees:
1) 2837.101 – Edward Ray and Sally Pham
2) 2837.103 – Andrea Espinosa and Jan Johnson Griffin
3) 2837.104 – Kevin Maxwell and Betha Schnelle

**2nd Second:** **Edward Ray**

| Vote | SP | JJG | AE | BS | ER | KM | SGF |
|---|---|---|---|---|---|---|---|
| | Y | Y | Y | Y | Y | Y | Y |
| **Key: Yes: Y \| No: N \| Abstain: A \| Absent for Vote: AB** | | | | | | | |

4:02 pm **8.0** **Presentation and Update from Board staff on the Regulatory Process and Development**

| | | |
|---|---|---|
| | **Discussion:** | This agenda item was not heard, and the PowerPoint will be posted on the website. Reordered the agenda to discuss agenda item 9.0. |
| 4:07 pm | **9.0** | **Discussion and possible action regarding defining minimum standards for "transition to practice" (BPC 2837.101(c))** |
| | **Discussion:** | **Andrea Espinosa:** Explained that it's difficult to talk about transition to practice without the OPES recommendation.<br><br>**Edward Ray:** Thinks the subcommittee work should be considered.<br><br>**Sally Pham:** Explained that statute lists items needed for transition to practice and the language serves as a template for the public.<br><br>**Edward Ray:** Stated that more work is needed and that their role is to inform the Board.<br><br>**Reza Pejuhesh:** Explained that the exam is different than the transition to practice standards. Further explained that the law does provide items but the NPAC should define these in regulations and the NPAC's task is to consider if other items should be added to transition to practice.<br><br>**Sally Pham:** Stated that there should be a discussion of the physician exam process compared to the NP process.<br><br>**Samantha Gambles Farr:** Explained that it continues to come back to the comparison of physicians and NPs but we need to keep in mind that these are two different professions and the law has passed.<br><br>**Andrea Espinosa:** Explained that the NP has been under supervision or in collaboration with a physician and there has been overlap. Expressed concerns that NPAC should learn from both sides as the physicians have knowledge and the NPs need to feel safe/comfortable transitioning to independent practice. Further explained that rural and urban are different for both professions. |
| | **Public Comment for Agenda Item 9.0:** | **Cynthia Jovanov:** Thanked the Chair and expressed that the practice of NPs and physicians are different, and we need to keep moving forward.<br><br>**Laura Starrh:** Stated that other states allow and California can learn from their successes.<br><br>**Theresa Ullrich:** Explained that transition to practice has been proved to make safer and NCSBN should be used as a guide.<br><br>**Sharon Vogan:** Supports the other comments made. |
| | **10.0** | **Adjournment**<br>Samantha Gambles Farr – Chair, adjourned the meeting at 4:30 pm. |

**Submitted by:**

**McCaulie Feusahrens**

Chief of Licensing
Licensing Division
California Board of Registered Nursing

**Accepted by:**

**Samantha Gambles Farr, RN, MSN, FNP-C, CCRN, RNFA**
Chair
Nurse Practitioner Advisory Committee

**Loretta Melby, MSN, RN**
Executive Officer
California Board of Registered Nursing

# Agenda Item 5.0

**Report from "2837.101" subcommittee and discission of minimum standards to transition to practice without standardized procedures as outlined in BPC section 2837.101(c)**

Nurse Practitioner Advisory Committee (NPAC) Meeting | August 31, 2021

**BOARD OF REGISTERED NURSING**
**Nurse Practitioner Advisory Committee Meeting**
**Agenda Item Summary**

**AGENDA ITEM:** 5.0
**DATE:** August 31, 2021

**ACTION REQUESTED:** Report from "2837.101" subcommittee and discussion of minimum standards to transition to practice without standardized procedures as outlined in BPC 2837.101(c)

**REQUESTED BY:** Samantha Gambles Farr, RN, MSN, FNP-C, CCRN, RNFA
NPAC Chair

**BACKGROUND:**

The members of the "2837.101" subcommittee will present their recommendations on the minimum standards to transition to practice without standardized procedures as outlined in BPC 2837.101(c) for NPAC discussion.

| |
|---|
| **Committee Member Name:** Edward Ray, MD, FACS and Sally Pham, MSN, RN FNP-BC |
| **Bill/Statute Provision**: BPC 2837.101 |
| **RULE** (1 to 2 sentences):<br>AB 890 requires that the board shall, by regulation, define minimum standards for transition to practice without standardized procedures. According to the language of AB 890, these minimum standards include, but are not limited to, additional clinical experience and mentorship, managing a panel of patients, working in a complex health care setting, interpersonal communication, interpersonal collaboration and team-based care, professionalism, and business management of a practice. |
| **REASON(S):**<br>Defining minimum standards is critical to the mission of the DCA to protect the public interest by ensuring that practitioners provide advice and care within their training and scope of practice. This is especially important because unlike Medicine where the ACGME has specific criteria for the postgraduate training of physicians, widely accepted standards of training independent nurse practitioners have not been defined outside the areas covered by national certification (i.e., by the ANCC, ANPP, NCC, AACN or PNCB).<br>The subcommittee recommends that minimum standards shall include (1) testing to demonstrate an appropriate fund of knowledge for independent practice, (2) training and national certification in the area of clinical independent practice, (3) training should include a minimum period of patient contact and mentorship in the clinical area of independent practice. Mentorship should be required under the supervision of a licensed healthcare practitioner and in an environment that provides healthcare in the clinical area of certification. The subcommittee recommends using regulatory language that emphasizes the concept of scope of practice, under the area within which a nurse practitioner has received training and has achieved national certification. |

**RESOURCES:**

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=BPC&sectionNum=2837.101.

BPC section 2837.101(c):
(c) "Transition to practice" means additional clinical experience and mentorship provided to prepare a nurse practitioner to practice independently. "Transition to practice" includes, but is not limited to, managing a panel of patients, working in a complex health care setting, interpersonal communication, interpersonal

collaboration and team-based care, professionalism, and business management of a practice. The board shall, by regulation, define minimum standards for transition to practice. Clinical experience may include experience obtained before January 1, 2021, if the experience meets the requirements established by the board.

**NEXT STEPS:**

**FISCAL IMPACT, IF ANY:** None

**PERSON(S) TO CONTACT:**

McCaulie Feusahrens
Chief of the Licensing Division
California Board of Registered Nursing
mccaulie.feusahrens@dca.ca.gov


# Agenda Item 6.0

**Report from "2837.103" subcommittee and discussion of criteria/terms delineated in BPC section 2837.103**

Nurse Practitioner Advisory Committee (NPAC) Meeting | August 31, 2021

**BOARD OF REGISTERED NURSING**
**Nurse Practitioner Advisory Committee Meeting**
**Agenda Item Summary**

**AGENDA ITEM:** 6.0
**DATE:** August 31, 2021

**ACTION REQUESTED:** Report from "2837.103" subcommittee and discussion of criteria/terms delineated in BPC section 2837.103

**REQUESTED BY:** Samantha Gambles Farr, RN, MSN, FNP-C, CCRN, RNFA
NPAC Chair

**BACKGROUND:**

The members of the "2837.103" subcommittee will present their recommendations on the criteria/terms delineated in BPC section 2837.103 for NPAC discussion.

**Committee Member Name:** Jan Johnson Griffin, MSN, APRN

**Bill/Statute Provision**: BPC 2837.103

**RULE** (1 to 2 sentences):

NP has completed a transition to practice in California of a minimum of three full-time equivalent years of clinical practice or 4600 hours within the past five years guaranteed by the signature of an MD or NP mentor. The mentor whose signature guarantees those clinical hours must have been practicing in California for a minimum of five years and have the education, training and experience, and an active practice that corresponds with the role and population focus of the nurse practitioner. The nurse practitioner shall submit written evidence to the board of the required clinical experience.

**REASON(S):**

Within the past 5 years: High quality care is achievable in a rapidly evolving field such as healthcare when the provider is aware of best practices, community standards of care, and recent research. Therefore, recent clinical practice is of the utmost importance in seeking to establish the qualifications to practice without standardized procedures. Therefore the 4600 hours or three years of full-time equivalent clinical practice should be required to have been within the five years preceding the application for 103 status.

Signature guarantee / Written evidence: Documentation of the hours completed for 103 status is a key component of assuring that no shortcuts have been taken and that the applicant meets the qualifications for 103 status. An attestation of supervision form is proposed; such form may be modeled after forms used in other states for this purpose. Among the suggestions that have been made regarding the certification of hours is that the NP also provide documentation such as pay stubs to clarify the actual clinical hours, not just compensated hours of employment. An example given was that in certain organizations vacation in the amount of a month or more each year would significantly decrease the number of clinical hours especially when combined with contractual holidays, sick leave and continuing education days.

SAMPLE ATTESTATION OF SUPERVISION FORM

Nurse Practitioner's Name
Phone [H] and [W]
Address
NP License #
Specialty

Current NP National Certification
Certifying Body
Certification #
Date Issued
Expiration Date

I, hereby request and authorize my employer / former employer to release the information requested on this form to the California Board of Registered Nursing for Licensure purposes.

Signature Date

To be completed by supervising physician, or nurse practitioner qualified under Business and Professions Code section 2837.103(a)(1)(D).

I, the undersigned, declare and affirm that, according to our records and to the best of my knowledge and belief, the above-named individual has practiced in the role of a licensed nurse practitioner

FROM

TO

TOTAL NUMBER OF CLINICAL PRACTICE HOURS

I, the undersigned, declare and affirm the information provided above for purpose of licensure is true and correct.

MD / NP signature Date

Name of Employer:
Address
Telephone

| |
|---|
| **Committee Member Name:** Andrea Espinosa, MD |
| **Bill/Statute Provision**: BPC 2837.103(c) |
| **RULE** (1 to 2 sentences):<br>NPs can only practice with expanded authority in the practice area of their education and training, including completing a transition to practice in that practice area. If an NP wants to practice in an area outside of their education and training, they shall undergo the necessary education and training, including completing a transition to practice, for that new practice area. |
| **REASON(S):**<br>To ensure NPs have the competency and ability to perform the functions in B&P Code § 2837.103(c) without standardized procedures within a practice area, they should have the education and training, including completing a transition to practice, in that practice area. |

**RESOURCES:**

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=BPC&sectionNum=2837.103.

BPC section 2837.103:
(a) (1) Notwithstanding any other law, a nurse practitioner may perform the functions specified in subdivision (c) pursuant to that subdivision, in a setting or organization specified in paragraph (2) pursuant to that paragraph, if the nurse practitioner has successfully satisfied the following requirements:

(A) Passed a national nurse practitioner board certification examination and, if applicable, any supplemental examination developed pursuant to paragraph (3) of subdivision (a) of Section 2837.105.

(B) Holds a certification as a nurse practitioner from a national certifying body accredited by the National Commission for Certifying Agencies or the American Board of Nursing Specialties and recognized by the board.

(C) Provides documentation that educational training was consistent with standards established by the board pursuant to Section 2836 and any applicable regulations as they specifically relate to requirements for clinical practice hours. Online educational programs that do not include mandatory clinical hours shall not meet this requirement.

(D) Has completed a transition to practice in California of a minimum of three full-time equivalent years of practice or 4600 hours.

(2) A nurse practitioner who meets all of the requirements of paragraph (1) may practice, including, but not limited to, performing the functions authorized pursuant to subdivision (c), in one of the following settings or organizations in which one or more physicians and surgeons practice with the nurse practitioner without standardized procedures:

(A) A clinic, as defined in Section 1200 of the Health and Safety Code.

(B) A health facility, as defined in Section 1250 of the Health and Safety Code, except for the following:

(i) A correctional treatment center, as defined in paragraph (1) of subdivision (j) of Section 1250 of the Health and Safety Code.

(ii) A state hospital, as defined in Section 4100 of the Welfare and Institutions Code.

(C) A facility described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(D) A medical group practice, including a professional medical corporation, as defined in Section 2406, another form of corporation controlled by physicians and surgeons, a medical partnership, a medical

foundation exempt from licensure, or another lawfully organized group of physicians and surgeons that provides health care services.

(E) A home health agency, as defined in Section 1727 of the Health and Safety Code.

(F) A hospice facility licensed pursuant to Chapter 8.5 (commencing with Section 1745) of Division 2 of the Health and Safety Code.

(3) In health care agencies that have governing bodies, as defined in Division 5 of Title 22 of the California Code of Regulations, including, but not limited to, Sections 70701 and 70703 of Title 22 of the California Code of Regulations, the following apply:

(A) A nurse practitioner shall adhere to all applicable bylaws.

(B) A nurse practitioner shall be eligible to serve on medical staff and hospital committees.

(C) A nurse practitioner shall be eligible to attend meetings of the department to which the nurse practitioner is assigned. A nurse practitioner shall not vote at department, division, or other meetings unless the vote is regarding the determination of nurse practitioner privileges with the organization, peer review of nurse practitioner clinical practice, whether a licensee's employment is in the best interest of the communities served by a hospital pursuant to Section 2401, or the vote is otherwise allowed by the applicable bylaws.

(b) An entity described in subparagraphs (A) to (F), inclusive, of paragraph (2) of subdivision (a) shall not interfere with, control, or otherwise direct the professional judgment of a nurse practitioner functioning pursuant to this section in a manner prohibited by Section 2400 or any other law.

(c) In addition to any other practices authorized by law, a nurse practitioner who meets the requirements of paragraph (1) of subdivision (a) may perform the following functions without standardized procedures in accordance with their education and training:

(1) Conduct an advanced assessment.

(2) (A) Order, perform, and interpret diagnostic procedures.

(B) For radiologic procedures, a nurse practitioner can order diagnostic procedures and utilize the findings or results in treating the patient. A nurse practitioner may perform or interpret clinical laboratory procedures that they are permitted to perform under Section 1206 and under the federal Clinical Laboratory Improvement Act (CLIA).

(3) Establish primary and differential diagnoses.

(4) Prescribe, order, administer, dispense, procure, 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.

(d) A nurse practitioner shall verbally inform all new patients in a language understandable to the patient that a nurse practitioner is not a physician and surgeon. For purposes of Spanish language speakers, the nurse practitioner shall use the standardized phrase "enfermera especializada."

(e) A nurse practitioner shall post a notice in a conspicuous location accessible to public view that the nurse practitioner is regulated by the Board of Registered Nursing. The notice shall include the board's telephone number and the internet website where the nurse practitioner's license may be checked and complaints against the nurse practitioner may be made.

(f) 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.

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

(h) Any health care setting operated by the Department of Corrections and Rehabilitation is exempt from this section.

**NEXT STEPS:**

**FISCAL IMPACT, IF ANY:** None

**PERSON(S) TO CONTACT:**

McCaulie Feusahrens
Chief of the Licensing Division
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mccaulie.feusahrens@dca.ca.gov

# Agenda Item 7.0

**Report from "2837.104" subcommittee and discussion of criteria/terms delineated in BPC section 2837.104**

Nurse Practitioner Advisory Committee (NPAC) Meeting | August 31, 2021

**BOARD OF REGISTERED NURSING**
**Nurse Practitioner Advisory Committee Meeting**
**Agenda Item Summary**

**AGENDA ITEM:** 7.0
**DATE:** August 31, 2021

**ACTION REQUESTED:** Report from "2837.104" subcommittee and discussion of criteria/terms delineated in BPC section 2837.104

**REQUESTED BY:** Samantha Gambles Farr, RN, MSN, FNP-C, CCRN, RNFA
NPAC Chair

**BACKGROUND:**

The members of the "2837.104" subcommittee will present the recommendations on the criteria/terms delineated in BPC section 2837.104 for NPAC discussion.

**Committee Member Name:** Kevin Maxwell, PhD, DNP, FNP-BC, RN

**Bill/Statute Provision**: BPC 2837.104

**RULE** (1 to 2 sentences):

Nurse Practitioners who have earned a clinical Doctor of Nursing practice degree who have the requisite number of direct patient contact hours (currently 1080) as defined by the CA BRN in the course of their education experience and have practiced as a nurse practitioner in good standing have the requirement of three years of practice as a nurse practitioner in good standing, not inclusive of the transition to practice (BPC 2837.104(b)(1)(C)), lowered to 1 year or less.

**REASON(S):**
It is the intent of the Legislature that the requirements under this article shall not be an undue or unnecessary burden to licensure or practice. The requirements are intended to ensure the new category of licensed nurse practitioners has the least restrictive amount of education, training, and testing necessary to ensure competent practice.

Requiring the same number of additional hours of Advanced Practice nurses who have attained the DNP would place them at a disadvantage as compared to those with a Master's level degree and not taking their additional training into account would result in a more restrictive environment which is contrary to the stated intent of the bill.

**Background Information**
Multiple studies done since the 1970s have shown the effectiveness of the Advanced Practice Nurse (APN). Studies in outpatient settings have shown APNs can manage a wide variety of problems and achieve similar patient outcomes as physicians (Knickman et al., 1992). Care from an APN has advantages. APNs use an holistic approach, spend more time with patients, and are less costly than physicians (Mundinger, 1994). Patients receiving care from an APN may be linked to improvements in compliance and satisfaction (Thompson et al., 1982).

When comparing the care delivered by APNs either independently or as part of a team of providers, in Advanced Practice Nurse Outcomes 1990-2008: A Systematic Review, Newhouse et al. were able to show that APNs play an important role in improving patient care quality and provide effective high-quality care in the United States. APNs can augment physician efforts and expand access to care (Newhouse et al., 2011). Outcomes were similar and in some instances they were better when APN's were involved versus care provided by physicians alone. (Newhouse et al., 2011). APNs have a commitment to building

healthier communities with expertise and a skill set geared toward health promotion and teaching which is tailored to patient traits, living situation, and community health (Flynn, B.C., 1997).

As part of the VA's evidence-based synthesis program, a review was conducted investigating the quality of care provided by APNs. The team sought to examine studies comparing APN care versus physician care across multiple settings with the purpose of investigating the validity of the assertions that APN care and physician care are equivalent. Their findings support and reinforce the belief that there is no difference in outcomes across multiple settings, patient status, or mortality. Although the strength of the evidence was variable, findings state that it should not lead one to conclude additional randomized control trials would be necessary to support that APN care is comparable. Provider data routinely collected at the VA where independent APNs provide care should improve the accuracy of these assertions and be a better source of information (McCleery et al., 2011). APNs did not use more resources than physicians and provider type was not associated with elevated creatinine or blood pressures in patients with diabetes or hypertension. HbA1c was also not significantly different in VA patients with diabetes seen by APNs (McCleery et al., 2011). Further discussion of this review is detailed in the subheading "inpatient care" below.

Existing literature can be separated into four broad categories. Rural healthcare where there has been the greatest need for primary care providers, emergency/urgent care, inpatient settings, and occupational health care. Overall, the trend remains the same - NPs provide care that is equivalent to that of physicians.

Rural Healthcare

A systematic review of literature published between 1990-2009 conducted by Stanik-Hutt et al. which compares multiple outcome measures between APNs and MDs found similar outcomes for health status, functional status, lipid management, glucose management, blood pressure control and satisfaction. Mortality, ED visits and hospitalization rates were similar between the two groups of providers (Stanik-Hutt et al., 2013). Spetz et al. (2017) identified differences in practice patterns, with APNs comprising a larger and larger percentage of rural healthcare providers. Specifically, primary care services have been provided by 50,000 APNs according to the Agency for Healthcare Research & Quality as of 2010 (Agency for Healthcare Research and Quality (AHRQ), 2012).

Emergency Care

Multiple studies in the UK, Australia and the United States have explored the effectiveness and high quality of the care delivered by APNs in Emergency and Urgent care environments. Rural emergency departments are another venue seeing an increase in the number of practicing APNs. Roche et al. (2017) conducted a prospective longitudinal nested cohort study of rural emergency departments in Queensland, AU examining outcomes in patients presenting with chest pain seen by APNs vs physicians. No difference was found between groups lending support to the idea that APNs are effective and safe providers, delivering high levels of diagnostic accuracy in an acute care environment beyond simple presentations of minor illness and injury (Roche et al., 2017).

Inpatient Care

In hospital settings across the country, APNs typically function as part of multidisciplinary teams in collaboration with physicians (Naylor & Kurtzman, 2010). There are very few comparisons of outcomes among autonomous APNs and physicians (McCleery et al., 2011). The VHA Office of Quality, Safety, and Value commissioned the creation of an evidence brief to evaluate the most recent original studies examining health outcomes (McCleery et al., 2011). Past studies conducted in the 1970s demonstrated APNs' outcomes in primary care were comparable to those of physicians, namely the Burlington Randomized Trial of the Nurse Practitioner and the St. John's Randomized Trial of Care. Outcomes were similar (Sharples, 2002). Studies included in the evidence brief from the VHA include four controlled trials in urgent care settings, three controlled trials in primary care, and three observational studies. Across the studies examined, they found no difference in the four measures identified (health status, quality of life, mortality, and hospitalizations). In the VHA evidence brief, one study was held out as the best available evidence comparing relatively autonomous APNs and physician residents. Mundinger et al. (1994) examined the effectiveness of independent APNs caring for patients on an APN run ward compared to

patients managed on a physician run ward. Scores on the Medical Outcomes Study Short-Form Health Survey (SF-36) found no difference between the physician scores or the APN scores (APN group 40.53; physician group 40.60; *p*=0.92) (Mundinger, 1994). Strengths of the Mundinger study include the number of subjects (1,316), randomization, and APNs had the same ability to admit prescribe, consult, and refer, limitations of the study include 6 months duration, loss of randomization for follow up evaluation, and the data is now almost 25 years old (McCleery et al., 2011).

A similar study examined outcomes of patients in the inpatient setting where patients were randomized to an APN run ward and compared to a physician run ward in an academic teaching hospital. Once again, no statistically significant differences were identified between the two groups. APN and resident managed patients had similar outcomes ($p > 0.1$) regarding resource utilization (length of stay, total charges, and ancillary charges), hospital costs (radiology, laboratory, respiratory therapy, and pharmacy), and rates of specialist consultation. Between the two groups, adverse event rates were similar. Of the patients returning home following hospitalization (90%), NPs arranged more home health services than physicians ($p$=0.046). None of the endpoints of this study showed a difference between the two groups (Pioro et al., 2001).

Occupational Healthcare

Occupational healthcare is another setting seeing an increase in the utilization of APNs as primary care providers, either in collaboration with or in place of physicians. There are a variety of roles for APNs in the occupational health setting. Primary care provider is a role that has been expanding since the American Association of Occupational Health Nurses (AAOHN) first commented on the developing opportunities in 1999. An updated report published in 2007, further reinforces the role of APN as primary care provider (AAOHN, n.d.). Of note, many of these studies were conducted when the DNP degree was in its infancy with few APN providers having a clinical doctorate. No studies have been identified comparing outcomes between master's trained APNs and DNPs. It is estimated that the doubling time of medical knowledge in 1950 was 50 years; in 1980, 7 years; and in 2010, 3.5 years. In 2020 it is projected to be 0.2 years—just 73 days (Densen, 2011). DNP training and education focuses on the ability to critically review and assimilate current evidence and its application to practice. They are uniquely positioned in this regard. A brief review of training and educational rigor follow.

DNP training hours from AACN

In many institutions, advanced practice registered nurses (APRNs), including Nurse Practitioners, Clinical Nurse Specialists, Certified Nurse-Midwives, and Certified Registered Nurse Anesthetists, are prepared in master's-degree programs that often carry a credit load equivalent to doctoral degrees in the other health professions. AACN's position statement calls for educating APRNs and other nurses seeking top leadership/organizational roles in DNP programs.

DNP curricula build on traditional master's programs by providing education in evidence-based practice, quality improvement, and systems leadership, among other key areas.

The DNP is designed for nurses seeking a terminal degree in nursing practice and offers an alternative to research-focused doctoral programs. DNP-prepared nurses are well-equipped to fully implement the science developed by nurse researchers prepared in PhD, DNS, and other research-focused nursing doctorates.(*AACN Fact Sheet - DNP*, n.d.)

The eight DNP essentials prepare graduates to function at the highest level of clinical nursing expertise. The number of clinical hours required to be awarded a DNP in California is currently 1,080, roughly double the number of clinical hours a master's trained NP is required to complete. Taking this additional training into account helps to justify a reduction in the number of hours required for a DNP to fulfill the requirements of section 2837.104 of AB 890, which states in pertinent part:

> (b)(1) The board shall issue a certificate to perform the functions specified in subdivision (c) of Section 2837.103 pursuant to that subdivision outside of the settings and organizations specified under subparagraphs (A) to (F), inclusive, of paragraph (2) of subdivision (a) of Section 2837.103, if the nurse practitioner satisfies all of the following requirements:
>
> …

(C) Has practiced as a nurse practitioner in good standing for at least three years, not inclusive of the transition to practice required pursuant to subparagraph (D) of paragraph (1) of subdivision (a) of Section 2837.103. The board may, at its discretion, lower this requirement for a nurse practitioner holding a Doctorate of Nursing Practice degree (DNP) based on practice experience gained in the course of doctoral education experience.

**Committee Member Name:** Betha Schnelle, MBA, MPH

**Bill/Statute Provision**: BPC 2837.104

**RULE** (1 to 2 sentences):

Requirement for DNP to practice as a nurse practitioner in good standing for at least three years, not inclusive of the transition to practice required pursuant to subparagraph (D) of paragraph (1) of subdivision (a) of Section 2837.103.

**REASON(S):**
Based on my experience managing NPs and physicians, I have seen that worked clinical hours/experience are the critical component leading to quality of care and practitioner competence. There is a dearth of evidence/research to support a minimum number of clinical hours that would provide a baseline level of clinical competence to assume independence from physician supervision/presence (although there are multiple studies that do support the volume-outcome relationship in clinical procedural practice). Therefore, I default to the current bill language requiring an additional 3 years for section 2837.104 NPs to work in settings without physicians. In a comparable situation, many medical residencies more comparable to practices in which a DNP will be more likely to work including family practice, internal medicine and pediatrics are generally 3 years in length on top pf the 6,000 hours of medical school clinical training. Therefore, using the medical residency as the model, I would recommend that DNPs be held to the bill's standard of clinical practice hours of 3 additional years or supervised clinical practice in good standing.

A DNP doctoral program may entail 500-600 additional clinical practice hours above the master's level NP. I would recommend that these additional clinical hours obtained during the doctoral degree coursework may be applied to (deducted from) the total 3-year requirement of working in good standing. As the goal of the additional years is to achieve clinical competency to the degree that allows independence, I would also recommend that regulators look into the creation of a validated competency/skills test that may allow the DNP to waive out of the additional years of experience to achieve autonomy.

Special notes to consider:

Protocols – AB 890 requires independent DNP/NPs to adopt protocols for their practices. While not strictly a licensing issue, this is a critical piece to ensure quality and protect consumer safety. I highly recommend that standards be set for the adoption of protocols including a requirement for the standards to be peer reviewed, evidenced based, reviewed periodically, and based on the most current guidelines. I also recommend that audit systems be put in place to ensure adoption and maintenance of protocols.

Codification Contractual/Referral Relationship – Experience in managing supervisory relationships between advanced practice clinicians and physicians leads me to state that the lack of any specifications around the supervisory relationship renders the requirement useless. Since there are no standards or requirements for what is involved when a physician agrees to supervise a nurse practitioner, these relationships are often ones that largely exist “on paper” in order to meet the regulatory requirement, and provide no additional guarantees around quality assurance or consumer safety.
While most clinicians operate/are employed in a larger system in which quality and performance management are inherent, section 2837.104 must contemplate the fully autonomous DNP/NP working in a solo setting. Therefore, I believe that a fully defined contractual relationship with a consulting physician is a critical piece of this bill that requires further clarification and codification.

Additional Studies – Perhaps one of the most challenging aspects of making recommendations around transition to practice relates to the lack of studies around quality and patient access once DNPs/NPs are fully independent. While there are a host of studies showing comparable quality and improved access to care from NPs compared to physicians, few are based on the model of a fully independent NP. Additionally, some studies found increases in unnecessary referrals and overprescribing in NP practices.

Due to the lack of evidence around quality and access outcomes in fully independent NP practices, I strongly recommend additional studies be conducted at regular intervals once NP/DNPs have transitioned to practice such that if quality or outcomes suffer, these standards set forth in AB 890 can be revisited. As several constituents voiced during the July NPAC meeting, this attention to quality and outcomes in NP/DNP driven practices is especially critical, as it is believed that these newly independent DNP/NPs will serve a disproportionate share of underserved/rural CA residents and we must not create a second-tier system for these patients as a matter of health equity and social justice.

**RESOURCES:**

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=BPC&sectionNum=2837.104.

BPC section 2837.104:
(a) Beginning January 1, 2023, notwithstanding any other law, the following apply to a nurse practitioner who holds an active certification issued by the board pursuant to subdivision (b):

(1) The nurse practitioner may perform the functions specified in subdivision (c) of Section 2837.103 pursuant to that subdivision outside of the settings or organizations specified under subparagraphs (A) to (F), inclusive, of paragraph (2) of subdivision (a) of Section 2837.103.

(2) Subject to subdivision (f) and any applicable conflict of interest policies of the bylaws, the nurse practitioner shall be eligible for membership of an organized medical staff.

(3) Subject to subdivision (f) and any applicable conflict of interest policies of the bylaws, a nurse practitioner member may vote at meetings of the department to which nurse practitioners are assigned.

(b) (1) The board shall issue a certificate to perform the functions specified in subdivision (c) of Section 2837.103 pursuant to that subdivision outside of the settings and organizations specified under subparagraphs (A) to (F), inclusive, of paragraph (2) of subdivision (a) of Section 2837.103, if the nurse practitioner satisfies all of the following requirements:

(A) The nurse practitioner meets all of the requirements specified in paragraph (1) of subdivision (a) of Section 2837.103.

(B) Holds a valid and active license as a registered nurse in California and a master's degree in nursing or in a clinical field related to nursing or a doctoral degree in nursing.

(C) Has practiced as a nurse practitioner in good standing for at least three years, not inclusive of the transition to practice required pursuant to subparagraph (D) of paragraph (1) of subdivision (a) of Section 2837.103. The board may, at its discretion, lower this requirement for a nurse practitioner holding a Doctorate of Nursing Practice degree (DNP) based on practice experience gained in the course of doctoral education experience.

(2) The board may charge a fee in an amount sufficient to cover the reasonable regulatory cost of issuing the certificate.

(c) A nurse practitioner authorized to practice pursuant to this section shall comply with all of the following:

(1) The nurse practitioner, consistent with applicable standards of care, shall not practice beyond the scope of their clinical and professional education and training, including specific areas of concentration and shall only practice within the limits of their knowledge and experience and national certification.

(2) The nurse practitioner shall consult and collaborate with other healing arts providers based on the clinical condition of the patient to whom health care is provided. Physician consultation shall be obtained as specified in the individual protocols and under the following circumstances:

(A) Emergent conditions requiring prompt medical intervention after initial stabilizing care has been started.

(B) Acute decompensation of patient situation.

(C) Problem which is not resolving as anticipated.

(D) History, physical, or lab findings inconsistent with the clinical perspective.

(E) Upon request of patient.

(3) The nurse practitioner shall establish a plan for referral of complex medical cases and emergencies to a physician and surgeon or other appropriate healing arts providers. The nurse practitioner shall have an identified referral plan specific to the practice area, that includes specific referral criteria. The referral plan shall address the following:

(A) Whenever situations arise which go beyond the competence, scope of practice, or experience of the nurse practitioner.

(B) Whenever patient conditions fail to respond to the management plan as anticipated.

(C) Any patient with acute decomposition or rare condition.

(D) Any patient conditions that do not fit the commonly accepted diagnostic pattern for a disease or disorder.

(E) All emergency situations after initial stabilizing care has been started.

(d) A nurse practitioner shall verbally inform all new patients in a language understandable to the patient that a nurse practitioner is not a physician and surgeon. For purposes of Spanish language speakers, the nurse practitioner shall use the standardized phrase “enfermera especializada.”

(e) A nurse practitioner shall post a notice in a conspicuous location accessible to public view that the nurse practitioner is regulated by the Board of Registered Nursing. The notice shall include the board’s telephone number and internet website where the nurse practitioner’s license may be checked and complaints against the nurse practitioner may be made.

(f) A nurse practitioner practicing pursuant to this section shall maintain professional liability insurance appropriate for the practice setting.

(g) For purposes of this section, corporations and other artificial legal entities shall have no professional rights, privileges, or powers.

(h) Subdivision (g) shall not apply to a nurse practitioner if either of the following apply:

(1) The certificate issued pursuant to this section is inactive, surrendered, revoked, or otherwise restricted by the board.

(2) The nurse practitioner is employed pursuant to the exemptions under Section 2401.

**NEXT STEPS:**

**FISCAL IMPACT, IF ANY:** None

**PERSON(S) TO CONTACT:**

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