Nurse Practitioner Advisory Committee Meeting

SUPPLEMENTAL MATERIALS

Nurse Practitioner Advisory Committee (NPAC) Meeting | September 21, 2021

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General instructions for the format of a teleconference meeting

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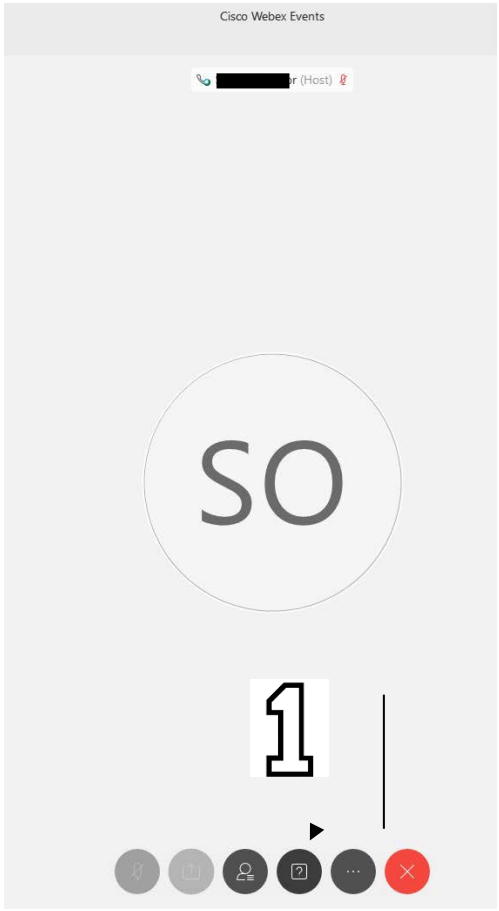
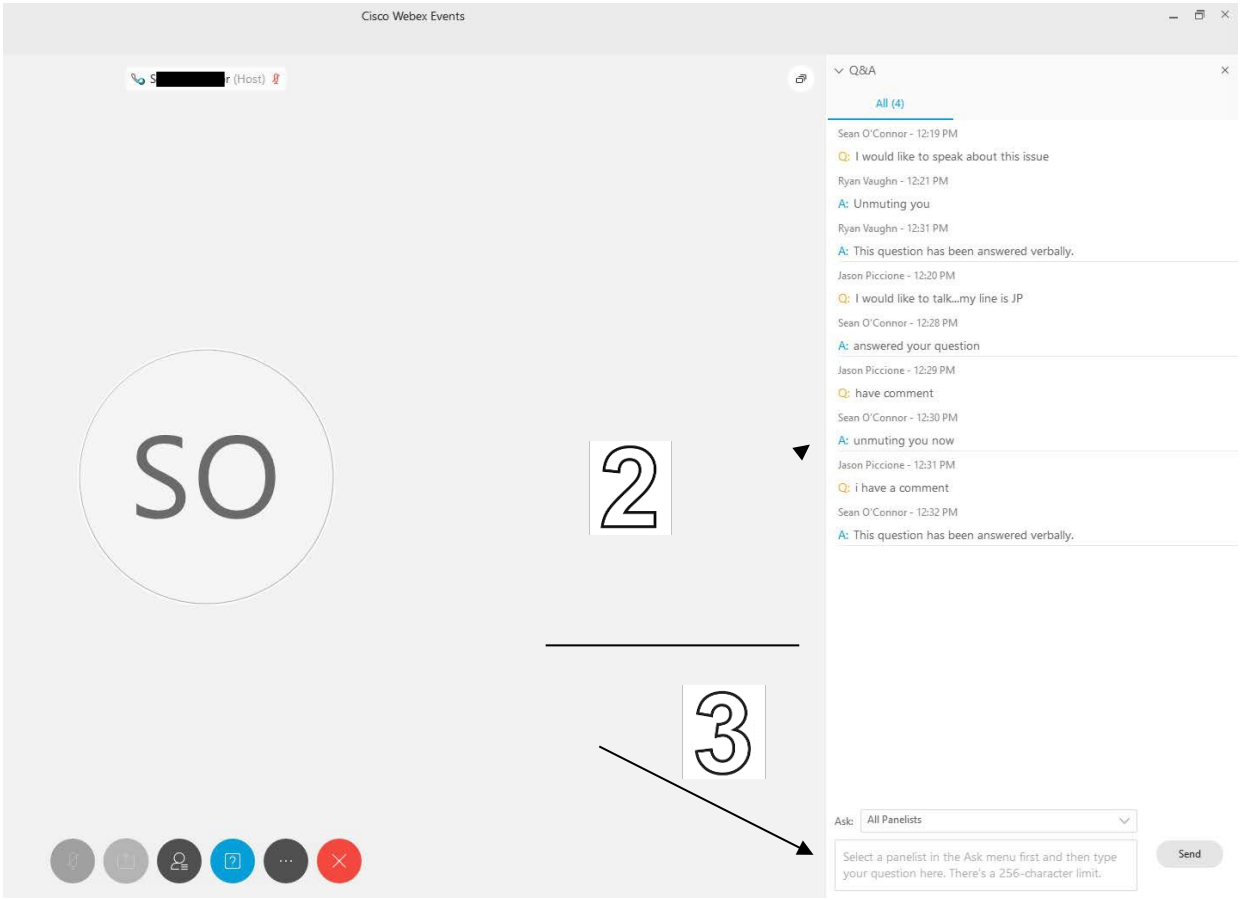
Participating During a Public Comment Period

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 3.0

Continuation of the report from the August 31, 2021 meeting from the "2837.104" subcommittee and discussion of criteria/terms delineated in BPC section 2837.104

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

AGENDA ITEM: 3.0
DATE: September 21, 2021

ACTION REQUESTED: Continuation of the report from the August 31, 2021, meeting from the "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:

During the August 31, 2021 NPAC meeting, not all members of the "2837.104" subcommittee were able to present recommendations on the criteria/terms delineated in BPC section 2837.104. This agenda item is to continue the "2837.104" subcommittee's presentation on the criteria/terms delineated in BPC section 2837.104 and allow 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:

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

Agenda Item 4.0

Update from the Department of Consumer Affairs, Office of Professional Examination Services (OPES), regarding occupational analysis mandated under BPC section 2837.105 - Informational Only

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BOARD OF REGISTERED NURSING
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AGENDA ITEM: 4.0
DATE: September 21, 2021

ACTION REQUESTED: Update from the Department of Consumer Affairs, Office of Professional Examination Services (OPES), regarding occupational analysis mandated under BPC section 2837.105 - Informational Only

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

BACKGROUND:

The OPES will provide updates on the occupational analysis (OA) pursuant to BPC Section 2837.105 and the NPAC may discuss the information presented.

RESOURCES:

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=BPC&sectionNum=2837.105.

BPC Section 2837.105:
(a)(1) The board shall request the department's Office of Professional Examination Services, or an equivalent organization, to perform an occupational analysis of nurse practitioners performing the functions specified in subdivision (c) of Section 2837.103 pursuant to that subdivision.
(2) The board, together with the Office of Professional Examination Services, shall assess the alignment of the competencies tested in the national nurse practitioner certification examination required by subparagraph (A) of paragraph (1) of subdivision (a) of Section 2837.103 with the occupational analysis performed according to paragraph (1).
(3) The occupational analysis shall be completed by January 1, 2023.
(4) If the assessment performed according to paragraph (2) identifies additional competencies necessary to perform the functions specified in subdivision (c) of Section 2837.103 pursuant to that subdivision that are not sufficiently validated by the national nurse practitioner board certification examination required by subparagraph (A) of paragraph (1) of subdivision (a) of Section 2837.103, the board shall identify and develop a supplemental exam that properly validates identified competencies.
(b) The examination process shall be regularly reviewed pursuant to Section 139.

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