BOARD OF REGISTERED NURSING
Nursing Practice Committee
Agenda Item Summary

AGENDA ITEM: 10.1
DATE: February 11, 2016

ACTION REQUESTED: **Review and Comment on Proposed Language for Article 8 Standards of Nurse Practitioner Practice: Office of Administrative Law's Pre-notice Public Discussion**

REQUESTED BY: **Trande Phillips RN, Chair**
Nursing Practice Committee

BACKGROUND:

The Practice Committee received three (3) letters (attached)

1. October 22, 2015 letter from professor and director of the Family Nurse Practitioner Program at Western University
2. December 20, 2015 University of San Diego 5 NP student letter
3. December 20, 2015 University of San Diego 3 NP student letter

At the October 8, 2015 Nursing Practice Committee the following organization provided oral and written comments in agreement with updating Proposed Language for Article 8 Standards for Nurse Practitioner Practice: California Action Coalition, California Association for Nurse Practitioners, California Hospital Association, Association of California Nurse Leaders, and Western University of Health Science-Education Perspectives. The California Nurses Association provided written opposition, as specified, to the Proposed Language for Article 8, Standards for Nurse Practitioner Practice.

All letters have been attached to this agenda item.

The Board invites interested parties to submit information/responses regarding the Proposed Language for Article 8 Standards of Nurse Practitioner Practice language to the following Nursing Practice Committee and Board at the following meetings. (Attached)

January 14, 2016
Practice Committee
Committee Meetings will follow in sequence, approximate time 1:00 pm
Hilton Sacramento Arden West

February 11, 2016
Board Meeting
Doubletree by Hilton Sacramento

March 16, 2016
Practice Committee South

April 14, 2016
Board Meeting South

Staff requests information/responses that will be presented at the above committee/board meetings be submitted prior or at time of meeting in writing to:

Janette Wackerly RN, BSN, MBA
Board of Registered Nursing
1747 North Market Blvd., Ste. 150
Sacramento, CA 95834

NEXT STEPS: Place on Board agenda.

FISCAL IMPACT, IF ANY: None

PERSON(S) TO CONTACT: Janette Wackerly, RN, BSN, MBA
Supervising Nursing Education Consultant
916-574-7686
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Western University
OF HEALTH SCIENCES
The discipline of learning.
The art of caring.

October 22, 2015

Janette Wakerly, MBA, RN, NEC
California Board of Registered Nursing

To Ms. Wakerly,

I am writing in support of updating California's Board of Registered Nursing's regulations on APRNs to include a requirement for a National Certification examination as part of the requirement to hold out a Nurse Practitioner. As one of only three states left in the country to not require this (CA, NY, KS), it is really quite an embarrassment that our standards are not of the highest. Since most insurers, Medicare and Medicaid mandate national certification of any NP for reimbursement purposes, this is a moot point and nearly all California NPs must have this for employment purposes.

National and 47 state requirements hold NPs to the highest standards for certification, and California needs to join the ranks of those who require this as soon as possible.

I am a Family Nurse Practitioner of 29 years experience and I am the current Director of the FNP program at Western University of Health Sciences, College of Graduate Nursing and the Assistant Dean of Distance Operations. All of our students are required to take a National Certification exam (either ANCC or AANP), yet California's regulations do not support this important standard.

Please shore up this weak link in our regulatory requirements in California and make National Certification a requirement for Nurse Practitioners in California.

Thank you for your time in consideration of this important issue.

Respectfully,

Diana Lithgow PhD, RN, FNP-BC

Diana Lithgow, PhD, FNP, RN-BC
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Janette Wackerly RN, BSN, MBA
1747 North Market Blvd., Ste 150
Sacramento, CA 95834

Dear Members of the Nurse Practice Committee,

As current graduate Nurse Practitioner students and licensed practicing Registered Nurses, we are in favor to the proposed revisions and verbiage by the California BON with regard to Article 8 Standards with a few exceptions. As future California APRN-CNPs, we feel the revisions and verbiage to Article 8 will not only outline who we are as healthcare providers, but also be a reference to other healthcare disciplines to understand our level of educational preparation and credentialing, including clinical hours, and board approved core graduate courses. It will also assist the public in understanding what our role is and how we would like to be addressed with regard to our advance practice degree. The addressing of Nurse Practitioner as an APRN-CNP will aid in the ability to provide uniformity between Certified Nurse Practitioners practicing in California and other states. Just as important, it will outline facts regarding our background as active licensed Registered Nurses, which may provide for easier comparisons of an APRN-CNP, to a Physician Assistant (P.A.), or Physician.

Our position again is mainly in agreement with the proposed modifications designated in Article 8 or Title 16 of the California Code of Regulations. As you are aware, the initial regulations for Nurse Practitioners were adopted between 1979 and 1985. Therefore, we feel that these proposed changes are a long time coming. The need for this revision is a must in order to remain current as a healthcare provider and practitioner, in light of all the demographic and socio-economic changes our nation faces.

A- Our consonance

-We agree on removal of "holding out" that was noted in the previous CA Board of Nursing (BON) outline for Nurse Practitioner (NP) practice.

-We also agree with the proposed changes to be made to the letters of RN, NP to APRN-CNP, in order to become more consistent with the national APRN Consensus Model. Along with these new letterings, we believe the board should address the Certified Nurse Practitioner as APRN- CNP, instead of Nurse Practitioner (NP) or Advanced Practice Nurse (APN) in the subsequent text in order to clarify the language with a consistent vocabulary.

-In addition, we agree with the addition of Advanced Pathophysiology, Advanced Health Assessment and Advanced Pharmacology as core courses required in the education of APRN Nurse Practitioners.

-We also agree that a national certification as well as completion of a graduate level degree should be a requirement for APRN-CNPs to practice in the state of California. Certification has never been a requirement in the past, but we believe it should be, to help make our profession uniform throughout the nation. Thus, Nurse Practitioners currently practicing without a graduate degree or certification, should be given a reasonable time frame in order to accomplish these goals.

B- Our Resonance

We perceive the work done in Article 8 as remarkable. Yet, we believe further rectifications should be added to the proposed changes in Article 8 of Title 16. We will identify such modifications by only copying statements to which we propose modifications and we will submit our proposed changes with underline and ~~strikethrough~~.

1480. Definitions

We believe a clear definition of APRN should be included in 1480 to reflect the objective of congruency prominent in the Consensus Model. In fact this definition should stand as the first one.
Definition of the APRN according to the Consensus Model:

> An Advanced Practice Registered Nurse (APRN) means a nurse with advanced nursing training or education at a graduate level that includes practice beyond the scope of practice of the basic Registered Nurse license, nationally certified, and ready to fulfill four specific nursing roles: Certified Nurse Practitioner (CNP),
> Certified Nurse Midwife (CNM), Certified Registered Nurse Anesthetist (CRNA),
> Clinical Nurse Specialist (CNS).

As a result, nurse practitioner students from accredited educational programs complying with the Consensus Model should be referred to as APRN-NP students, in line with the APRN definition. This will single them out of the various educational programs leading to different levels of education and/or levels of clinical experience, and will thus prepare such students for the title of APRN-CNP towards which they currently are working.

(j) "Advanced practice registered nursing core" means the essential broad-based curriculum required for all ~~nurse practitioners~~ APRN-NP students in the areas of advanced health assessment, advanced pathophysiology, and advanced pharmacology (lines 32-34).

(p) "National Board Certification" means current certification as an ~~advanced nurse practitioner in a role and~~ APRN licensed to fulfill the role of CNP with population focus through testing accredited by the national commission on certifying agencies or the American Board of Nursing Specialties, as approved by the board (lines 52-54).

(q) "Nurse ~~p~~Practitioner ~~p~~Program ~~d~~Director" means the individual responsible for administration, implementation, and evaluation of the ~~n~~Nurse ~~p~~Practitioner ~~p~~Program and the achievement of the program objectives in collaboration with program faculty (lines 55-57).

(r) "Non-California based ~~graduate~~ ~~n~~Nurse ~~p~~Practitioner ~~p~~Programs" means an academic program accredited by a nursing organization recognized by the United States Department of Education or the Council of Higher Education accreditation that offers a graduate degree or graduate level certificate to qualified students and does not have a physical location in California (lines 58-61).

1481. Categories of Certified Nurse Practitioners

(b) A ~~r~~Registered ~~n~~Nurse who has been certified by the board as a Certified ~~n~~Nurse ~~p~~Practitioner may be known as an ~~advanced practice nurse~~ Advanced Practice Registered Nurse (APRN) and may place the letters APRN-CNP after his/her name or in combination with other letters or words that identify the population focus (lines 79-81).

1484. Nurse Practitioner Education

The program of study preparing a ~~e~~Certified ~~n~~Nurse ~~p~~Practitioner shall (line 180)
(A) A ~~college or~~ university that prepares ~~n~~Nurse ~~p~~Practitioners at the ~~m~~Master's degree or ~~higher~~ doctorate degree is accredited by a nursing organization that is recognized by the United States Department of Education or the Council of Higher Education Accreditation that offers a graduate degree or graduate level certificate to qualified students (lines 198-202)

(B) prepares graduates to be eligible for national certification as a ~~an advanced~~ Certified ~~n~~Nurse ~~p~~Practitioner in a population focus through testing accredited by the National Commission of Certifying Agencies or the American Board of Nursing Specialties, as approved by the board (lines 204-207).

Have a Master's degree or ~~higher~~ Doctoral degree in ~~n~~Nursing; (lines 235-236)

Have at least two years of clinical experience as ~~an nurse practitioner~~ a Certified Nurse Practitioner within the last five (5) years and consistent with the teaching responsibilities; (lines 237-238)

(C) Have had one academic year's experience within the last five (5) years, as an instructor in a school of professional nursing, or in a program preparing ~~nurse practitioners~~ APRNs (lines 253-254)

(D) Be certified by the board as ~~an advanced nurse practitioner~~ an APRN Certified Nurse Practitioner and nationally certified as ~~advanced nurse practitioner~~ APRN-CNP in one or more population foci; (lines 255-256)

(1) The program shall include all theoretical and clinical instruction necessary for the graduate to provide acute and /or primary health care in one or more population foci (lines 280-282).

(A)The ~~nurse practitioner~~ APRN core courses (advanced health assessment, advanced pharmacology, and advanced pathophysiology) are completed prior to or concurrent with commencing clinical coursework (lines 297-298).

(D) The majority of the supervised direct patient care precepted clinical experiences shall be under the supervision of the ~~certified nurse practitioner~~ Certified Nurse Practitioner (lines 303-304).

1485. Scope of Practice

The ~~nurse practitioner~~ APRN Certified Nurse Practitioner shall function within the scope of practice as specified in the Nursing Practice Act and as it applies to all ~~registered nurses~~ APRNs. (lines 369-371).

Opposite thoughts would include questions on how to name Nurse Practitioners who worked in clinical settings before the creation of the Joint Dialogue Group? Another question would be where do they fit in the interdisciplinary team, knowing that their levels of education vary, and that their clinical expertise, although probably extensive, is difficult to predict?

The Consensus Model proposes clauses to grandfather such Nurse Practitioners, to encourage furthering their education when needed, and to press on by taking the national certification exam. These steps will make Advanced Practice Registered Nurses' education, clinical work, scope of practice, and privileges congruent from state to state. In turn, this uniformity will allow a predictable level of foundational knowledge which will grant the APRNs an ease in publicizing their roles, since these roles will be perceived as specific and unambiguous. Overtime, with repetition of the same information, APRNs will become familiar to the general population. Also, this homogeneity and consistency of the APRNs' roles throughout the country could afford open doors to add to their expected knowledge, thanks to specializations done in a structural way, and hence expand their scope of practice in an irrefutable way.

These proposed and important changes will assist the public and other healthcare providers understanding of the background and qualifications of an APRN-CNP, including level of education and clinical experience. A sufficient level of understand of who the APRN-CNPs are will lead the population to an increased general level of trust and comfort in receiving health care through an APRN-CNP. Trust is much needed nowadays for quality of care, therapeutic milieu, patient-centered care and increased compliance. These proposed modifications must happen promptly to establish APRN-CNPs as trusted healthcare providers as early as possible in the population in general, but also in diverse communities, especially the underserved, who struggle with health care access, critical up-to-date information, and education. These modifications will help clearly define the APRN to the general public, which will foster proper health care delivery to our aging population and to millions of individuals newly receiving access to health care, thanks to the implementation of our health care reforms.

Sincerely,

Belinda Akakpo Maxwell, RN, BSN
Georgeana Browning, RN, BSN
Leslie Hermoso RN, CCRN, BSN
Joseph F. Burkard, DNSc, CRNA, Associate Professor, AACN Health Policy Fellow
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HAHN SCHOOL OF NURSING AND HEALTH SCIENCE

Dec 20, 2015

Janette Wackerly, RN, BSN, MBA
1747 North Market Blvd., Ste 150
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Dear California Board of Registered Nursing:

We are contacting you in response to your request for constituent feedback for the **Adoption and Revision 1480-1486 in Article 8 of Title 16 of the California Code of Regulations.** We are currently nurse practitioner students at the University of San Diego who feel it is important for the BRN to receive and consider feedback from nurses practicing under the current regulations to help in the efforts for the final hearing in January 2016. As nurses we look to the Code of Regulations to establish policies of conduct to be followed by every nursing student, nurse, and educational institution. In addition, these regulations are shared with other entities, such as The Medical Board of California to demonstrate the rigor of policies under which nurses are educated, deemed competent, and currently practice. In reviewing Article 8 we found the regulations to be lacking critical verbiage to clearly articulate the definition of an advanced practice registered nurse, the education they receive, and the process in which their credentials are analyzed. Omission of clear explanations of definitions, categories, nurse practitioner use of title, and standards of education could result in the value of our profession not being fully acknowledged. We submit these recommendations with a sense of urgency to update these regulations so that all advanced practice nurses can be held to high standards and the value of our profession can be realized.

One key reason Article 8 must be updated is that the current regulations were written and adopted between 1979 and 1985. These regulations have not been updated to keep up with the advances in nursing education and are shamefully outdated. This document must clearly articulate who, what, where, when, and why for education and evaluation of credentialing of advanced practice nursing, with no room for interpretation. Through this Code of Regulations it should describe the process upon which an advance practice nurse must go through to obtain their role in society. The Code of Regulations should also serve as a framework to which the public can hold the individual clinician and profession accountable. Article 8 is serving no purpose if it does not clearly articulate current education and credentialing requirements for advanced practice registered nurses. We urge the BRN to review the Code of Regulations every five years at a minimum, and to make necessary revisions.

As part of this submission we have included several proposed changes to Article 8. The anticipated benefits of the changes we are proposing are to establish clear pathways in which advanced practice registered nurses can obtain competency and the rigor to which these competencies will be upheld. As nurse practitioner students we are grateful for the opportunity to provide feedback and for our voice to be heard. Please continue the efforts to bring Article 8 into alignment with today's practice environment.

Proposed Changes to 1480-1486 in Article 8 of Title 16 of the California Code of Regulations:

- 2 (a) "Nurse Practitioner" means a registered nurse who possesses advanced education, training, preparation and skills in physical diagnosis, psycho-social assessment, health management, preventive care and management of health-illness needs in primary health care, who has been trained in a program conforming to board standards as specified in section 1484.

- 14 (C) "Clinically Competent" means the individual possesses and exercises the communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and the community being served.

- 18 (e) "Acute Care" means the restorative care provided by the certified nurse practitioner to patients with rapidly changing, unstable, chronic, complex acute and critical conditions in a variety of clinical practice settings. As well as providing care for acute and critical illnesses.

- 26 (h) "Advanced pharmacology course" means integration the advanced knowledge of pharmacotherapeutics, pharmacoeconomics, pharmacokinetics, pharmacodynamic, substance abuse, prescriptive authority, state regulations, authority and collaboration content across the life span used in the treatment of selected health conditions commonly encountered by the advanced practice nurse.

- 43 M – "Direct Supervision" means the clinical preceptor or the faculty member physically present at the practice site where the patient/client is located. The clinical preceptor and/or faculty member retains the responsibility for developing, and implementing the curriculum, policies, and practices for a nurse practitioner program.

  Clinical preceptor should be educated before-hand with making new policies in order to be able to cover all required practices, policies, etc. Also – recommended to reinforce method of using liability waivers for the faculty member/clinical preceptor and practicing student.

- **Revise item (a) to state:**
  (a) "Certified Nurse Practitioner" means an Advanced Practice Registered Nurse (APRN) who is currently holds a valid license in California as Registered Nurse (RN) who has current authorization by the Board to engage in advanced practice nursing activities. APRN practice activities include, but are not limited to: advanced assessment, diagnosis, treatment, referrals, consultations, and other modalities for individuals, groups or communities across the lifespan for health promotion or health maintenance and for those who are experiencing acute or chronic disease, illness, trauma or other life-altering event in which rehabilitative, and/or palliative interventions are necessary. APRN practice is defined to include only those activities within the APRN's authorized clinical category, scope of practice competencies, and accepted standards of Advanced Nursing practice.

- **Add:**
  "Valid License" means a current license to practice nursing in California properly issued to a nurse by the Board on the basis of truthful information related to the qualifications for licensure as a Registered Nurse (RN), which License is current.

  "Board" means the Board of Registration in Nursing.

- **Revise item (p) to state**:
  "National Board Certification" means the registered nurse is currently certified as an advanced practice nurse by a board recognized certifying organization.

- **Add:** "Board Recognized Certifying Organization" means a certifying organization for APRN practice that: (a) is national in the scope of its credentialing
- (b) establishes and maintains conditions for writing the certification examination that are consistent with acceptable national standards
- (c) establishes and maintains educational requirements that are consistent with the requirements of the APRN clinical category of practice
- (d) establishes and maintains standard methodologies that are national in scope such as incumbent job analysis studies
- (e) designs and administers a certification examination that represents entry-level practice in the APRN clinical category and that represents the knowledge, skills and abilities essential for the delivery of safe and effective advanced practice nursing care
- (f) uses and periodically reviews examination items for content validity, cultural bias and correct scoring using an established mechanism
- (g) is psychometrically sound, legally defensible, and which meets nationally recognized standards for accreditation standards for certification programs.
- (h) specifies certification maintenance requirements (e.g., continuing education, practice, examination, etc.) which ensure continued competency measures.
- (i) establishes conflict resolution principles and rules which it follows

- **Revise "Section 1483. Evaluation of Credentials" to state:**
  Certified Nurse Practitioner (CNP).

To be eligible for initial Board authorization to practice as a CNP an applicant must provide proof satisfactory to the Board of the following:
1. Valid California RN licensure in good standing;
2. Good moral character as required as established by Board policy;
3. Compliance with the following academic requirements:
a. Graduation from a graduate degree program designed to prepare the graduate for practice as a CNP that is approved by a national accrediting organization for academic programs acceptable to the Board; and
b. Successful completion of, at minimum, core content at the graduate level in advanced physical assessment, advanced pathophysiology and advanced pharmacology.
4. Current CNP certification granted by Board recognized certifying organization; and
5. Payment of the required fees as established by the Executive Office of Administration and Finance

- In section **1484 Nurse Practitioner Education**
  Replace Lines 222-259 with:

Faculty qualifications:

(a) Administrator. The program administrator shall:
1. Hold a current California Registered Nurse license in good standing;
2. Possess an earned Master's degree in nursing or an earned entry level doctorate in nursing;
3. Possess a minimum of five years full-time nursing experience, or its equivalent, within the last eight years, with at least three years experience in nursing education; and
4. Maintain expertise appropriate to administrative responsibilities.

(b) Instructor. Faculty teaching either the theoretical or clinical component of a nursing course shall:
1. Hold a current California Registered Nurse license in good standing;
2. Possess an earned baccalaureate degree in nursing or an earned Master's degree in nursing for appointment to the faculty of a Practical Nursing program;
3. Possess an earned Master's degree in nursing, or possess an earned doctorate in nursing, for appointment to the faculty of a Registered Nursing program;
4. Possess a minimum of two years full-time experience in nursing, or its equivalent, within the last five years and evidence of clinical competence in the area of clinical instruction; and
5. Maintain expertise appropriate to teaching responsibilities

Also in section1484. Nurse Practitioner Education, edit the following to:
-268 (4) Clinical preceptor functions and responsibilities shall be clearly documented in a written agreement between the agency, the preceptor, and the nurse practitioner program including the clinical preceptor's role to teach, supervise and evaluate students in the nurse practitioner program, which will be included in the Nurse Practitioner program's Student handbook.

-273 (B) Clinical preceptors shall be evaluated by the program faculty annually.

-303(D) The majority of the supervised direct patient care precepted clinical experiences shall be under the supervision of the certified nurse practitioner or MD.

Thank you for your consideration in this matter,

Zaida Zuniga, RN, BSN, NP Student
Sadie Kane, RN, BSN, NP Student
Anapatricia Najera-Higareda, RN, BSN, NP Student
Diana Borrego, RN BSN, NP Student
Kim Tran, RN, BSN, NP Student

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CALIFORNIA ACTION COALITION
Advancing Health In California

October 8, 2015

Janette Wackerly, MBA, BSN, RN
Nursing Education Consultant
Board of Registered Nursing

Dear Ms. Wackerly,

The California Action Coalition applauds the efforts of the Board and staff in amending the outdated nurse practitioner regulations. We have submitted proposed language changes previously, however, given the new format and additional proposed langauge, we are submitting a new document for the Board's review and consideration.

Following review of the latest draft presented by the Nursing Education Consultant APRN Workgroup (4 OAL Proposal Forma 1480-1486 2015 06 09 2015 07 31 Numbered), we have a request for the following amendments with rationale:

1. **Section 1480 Definitions**
    a. The California Action Coalition supports amendments of this section as drafted with the request for the following changes as specified below:
        i. **Line 43** (m) "Direct Supervision of Students" means ~~the~~ a clinical preceptor or faculty member is physically present at the practice site where the patient/client is located. The clinical preceptor and/or faculty member retains the responsibility for patient care while overseeing the student.
        Rationale: The CAC believes we should specify who must be directly supervised to avoid confusion.
        ii. **Line 52** (p) "National Board Certification" means current certification as a~~n~~ ~~advanced~~ certified nurse practitioner in a role and population focus through testing accredited by the national commission on certifying agencies or the American Board of Nursing Specialties, as approved by the board.
        Rationale: In an effort to standardize terminology, we do not want confusion to occur among "advanced nurse practitioner" and "certified nurse practitioner"

2. **Section 1481 Categories of Nurse Practitioners**
    a. The California Action Coalition supports amendments of this section as drafted with the request for the following changes as specified below:
        i. **Line 78** (6) Psychiatric-Mental Health (across the lifespan)
        Rationale: Maintain consistency with accepted national title
        ii. **Line 79** (b) A registered nurse who has been certified by the board as a nurse practitioner may be known as an advanced practice registered nurse and may place the letters APRN-CNP after his/her name or in combination with other letters or words that identify the population focus.

Rationale: To maintain consistency with legal titling and to avoid confusion.

3. **1482 Requirements for ~~Holding Out As a~~ Certification as a Certified Nurse Practitioner**
   a. The California Action Coalition supports amendments of this section as drafted with the request for the following changes as specified below:
      i. **Lines 89-98 & Lines 102-108**: The California Action Coalition supports the recommended changes as printed.
      ii. **Lines 99-101** (3) The California Action Coalition does not support this statement and recommends deletion.
      Rationale: This regulatory amendment would potentially authorize physician assistants and physicians to be certified as nurse practitioners in this state; however, individuals without a MS in Nursing or Doctoral degree in nursing would not be authorized to sit for a national nurse practitioner certification examination and therefore could not be credentialed as a nurse practitioner. The CAC understands the disconnect between B&P Code Sections 2836 (a) and 2835.5 (d)(1-3); however, given the prevailing and most recent legislative update to Section 2835.5, this could be easily rectified in board-sponsored or supported clean-up legislation.

4. **1483 Evaluation of Credentials**
   a. The California Action Coalition supports amendments of this section as drafted.

5. **1483.1 Requirements for Nurse Practitioner Education Programs based in California**
   a. The California Action Coalition supports amendments of this section as drafted.

6. **1483.2 Requirements for Reporting Nurse Practitioner Program Changes.**
   a. The California Action Coalition supports amendments of this section as drafted.

7. **Section 1484 ~~Standards of~~ Nurse Practitioner Education:**
   a. The California Action Coalition supports amendments of this section as drafted with the request for the following changes as specified below:
      i. **Lines 203 – 207** (B) A general acute care hospital licensed pursuant to Chapter 2 (Section 1250) of Division 2 of the Health and Safety Code, which has an organized outpatient department. Prepare graduates to be eligible for national certification as a~~n advanced~~ nurse practitioner in a population focus through testing accredited by the National Commission on Certifying Agencies or the American Board of Nursing Specialties, as approved by the board.
      Rationale: Maintain consistency with titling.
      ii. **Line 237** (c) Have at least two years of clinical experience as an nurse practitioner, CNM, CNS, or CRNA within the last five (5) years and consistent with the teaching responsibilities;
      Rationale: CNMs and CNSs have valuable knowledge and skills to share with NP students and may be qualified to teach clinical courses where appropriate to their education and expertise, such as women's health and mental health. CRNAs have valuable knowledge and skills to share with NP students and may be qualified to teach clinical courses where appropriate to their education and

expertise in acute care NP programs. Given the tremendous shortage in qualified nursing faculty, we would like to avoid limiting nursing faculty with appropriate training, experience, and expertise.

iii. **Lines 242-244** (7) Interdisciplinary faculty who teach non-clinical nurse practitioner nursing courses such as but not limited to, pharmacology, pathophysiology, and physical assessment, shall have an active, valid California license issued by appropriate licensing agency and an advanced graduate degree in the appropriate content areas taught.
Rationale: We want to avoid limiting interdisciplinary faculty where their education, skills, and expertise provide a rich learning experience.

iv. **Lines 285-288** (3) Training for practice in an area of specialization shall be broad enough, not only to detect and control presenting symptoms, but to minimize the potential for disease progression. The curriculum shall provide broad educational preparation including a graduate core; advanced practice registered nursing ~~nurse practitioner~~ core, the nurse practitioner core role competencies, and the competencies specific to the population focus/foci.
Rationale: Consistent use of regulatory definitions as defined above.

v. **Lines 296-297** (A) The advanced practice registered nursing ~~nurse practitioner~~ core courses (advanced health assessment, advanced pharmacology, and advanced pathophysiology) are completed prior to or concurrent with commencing clinical course work.
Rationale: Consistent use of regulatory definitions as defined above.

vi. **Lines 302-303** (D) The majority of the supervised direct patient care precepted clinical experiences shall be under the supervision of the certified nurse practitioner.
Concerns: Where it is ideal for the majority of supervised direct patient care precepted clinical experiences should be under the supervision of a CNP, this may not be feasible in rural and underserved areas where provider availability is limited. Consider revising.

vii. **Lines 316-318** (7) (8) The program may be full-time or part-time and shall be comprised of not less than thirty (30) semester units, (forty-five (45) quarter units), but must be congruent and consistent with national standards for graduate and nurse practitioner education, which shall include theory and supervised clinical practice.
Concerns: Consider the added text. This minimum total program requirement was established prior to a required standard of academic preparation. Academic institutions should weigh in on whether current criterion is too low based on accreditation standards for NP programs and should provide recommendations a careful focus on competency standards. It is clear that current California criterion for minimum clinical practicum hours (540) meets and exceeds the national standard (500).

8. **1486 Requirements for Clinical Practice Experience for Nurse Practitioner Students Enrolled in Out of State Nurse Practitioner Programs.**
   a. The California Action Coalition supports amendments of this section as drafted.

9. **Grandfathering language to be added:**
    a. The California Action Coalition requests careful review of proposed language and discussion with stakeholders to ensure grandfathering language is added to appropriate sections. This will ensure the new regulatory requirements do not disenfranchise currently licensed/certified nurse practitioners or education programs.

We applaud the BRN's efforts to bring NP standards and regulations into alignment with today's practice environment and the California Action Coalition, with vast expertise in NP practice and education, continue to partner in this effort.

Respectfully submitted

Susanne J. Phillips, DNP, RN, FNP-BC
Co-Lead, Workgroup #1: Removing Practice Barriers
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Garrett Chan, Ph.D, RN, ACNP-BC, CNS, FAAN
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CALIFORNIA ACTION COALITION
Advancing Health In California

October 8, 2015

Janette Wackerly, RN, MBA
Nursing Education Consultant
Board of Registered Nursing

Dear Ms. Wackerly,

Below you will find our testimony presented October 8, 2015 during the Nursing Practice Committee Meeting in Santa Ana, CA. The CAC would like to thank the members of the Board and the Board Staff for their interest in amending outdated regulations pertaining to NP education.

Good afternoon Chair Phillips, members of the Nursing Practice Committee. I am Dr. Susanne Phillips, a Clinical Professor and a family nurse practitioner at UC Irvine, where I have been a nurse educator for nearly 20 years.

I am here today on behalf of the California Action Coalition, as the Co-Lead for Recommendation #1, to remove all barriers to full practice authority for California's nurses. The California Action Coalition supports the BRN's work to update the 35-year-old nurse practitioner regulations pertaining to definitions and categories of NPs, "Holding-Out" as a NP, evaluation of credentials, as well as the standard of NP education. As a nurse practitioner and nurse educator in the UC System approaching 20 years, as well as a former member & President of this Board, I have seen first-hand the importance of updated regulatory guidance in defining the practice of, credentialing, and training our registered nurses (RNs) and advanced practice registered nurses (APRNs). In an effort to support the movement toward full practice authority for all nurses in the State of California, it is imperative that our regulations reflect accepted national standards and mandate uniform comprehensive, high quality training.

We have done good work over the years by moving NP education to academic institutions. All NP education in California is now completed at the Master's degree or higher level as a result of legislation sponsored by Assemblyman Todd Spitzer (AB 2226) signed in 2004, amending Business & Professions Code Section 2835.5, mandating that NPs enter into practice with a minimum of a Master's degree in nursing. Unfortunately, other related nurse practice act statutes such as Business & Professions Code Section 2836 (a), added in 1977, were not deleted or amended following that legislation. This is unfortunate; however, I can attest, having been closely involved with the legislation at the time, it was simply an oversight, not a meaningful omission. We now have an opportunity to "clean-up" this issue, given the standard of academic preparation for all nurse practitioners. During several Nursing Practice Committee Meetings, board members have also questioned the need for national certification as a requirement for NPs to enter into practice in California, stating that because it was not included in the 2004 Spitzer legislation, the legislature did not want that standard here in California. I refute that idea, as I personally drafted the language in AB 2226 (Spitzer) and although national certification language was included in early drafts, it was removed due to political opposition, not as a

matter of policy opposition by the author, sponsor, or the legislative body at large. In fact, there was considerable discussion of placing that language in a future bill.

It is both a professional and regulatory responsibility to ensure our nurse practitioners are educated in institutions held to the highest, most up-to-date standards of patient safety and quality, as well as held to minimum competency standards as new graduates. Not only have we seen an evolution of NP practice settings, but state and federal payers have mandated through regulation, advanced education and national certification. For instance, to be credentialed and reimbursed as a recognized independent provider for both Medi-Cal and Medicare, a NP must have graduated from a nationally-accredited Master's- or Doctoral-degree program and be nationally certified in one of the recognized NP population specialties. This supports alignment of NP education regulations with Medi-Cal (Title 22) and Medicare regulations.

California licenses & certifies over 20,000 active nurse practitioners; the largest numbers of NPs in the country are actively practicing in our state and the vast majorities are working in small private and community-based practices. In fact, the largest individual employers of NPs in the state, Kaiser and the UC system, employ less than 20%. Those systems provide an infrastructure of support for nurse practitioners as their practice evolves; however, most NPs in our state do not practice in those settings; they are working in small practices, side-by-side with physician partners, and we have a social and ethical responsibility to ensure they are universally prepared to deliver high quality care. The CAC understands that there are sensitive issues surrounding compact language. We are not in a position to take a stand on that issue and our support of this process has to do with ensuring California's regulatory standards meet or exceed national standards. Current language is far below the national benchmark.

We applaud the BRN's efforts to bring the NP education regulations into alignment with today's practice environment and the California Action Coalition, with vast expertise in NP education, continue to partner in this effort.

Respectfully submitted

Susanne J. Phillips, DNP, RN, FNP-BC
Co-Lead, Workgroup #1: Removing Practice Barriers
California Action Coalition
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POWER IN PRACTICE

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October 8, 2015
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Louise R. Bailey, MEd, RN, Executive Officer
Janette Wackerly, RN, MBA, Nursing Education Consultant
Ms. Trande Phillips, RN, Board Member and Chair, Nursing Practice Committee

Re: Support Adopted Revisions of Proposed Language for Article 8 Standards of Nurse Practitioner Practice

Dear California Board of Registered Nursing:

On behalf of the California Association for Nurse Practitioners (CANP) we greatly appreciate the work of the California Board of Registered Nursing in their review and consideration to adopt revisions to **Proposed Language for Article 8, Section 1480 – 1484, Standards of Nurse Practitioner Practice, Title 16 of the California Code of Regulations,** and applaud your efforts to modernize and update language that reflects current nurse practitioner (NP) practice. CANP is the only professional NP organization that represents and advocates for more than 18,000 practicing NPs statewide on policy and practice issues. We strongly believe an educated and competent NP workforce, reflected in certifying standards, will ensure that the health care needs of the population are safely met. With the addition of millions of newly insured Californians entering the health care system under the Patient Protection and Affordable Care Act (PPACA), NPs play a critical and necessary role in serving the present and future health care needs in this effort.

Over 205, 000 NPs practice nationwide that contribute to the health care system. Many of the revisions as identified outline requirements in licensure, accreditation, certification, and education that have been adopted by several states with others proposing legislation and rules change to move closer to compliance. This alignment offers benefit to consumers, employers, NP educational programs, legislators, regulators, and present and future NPs, providing a clear understanding of their role, preparation, training, and scope of practice, and upholds public protection and accountability to the standards for practice.

As previously noted, Article 8 *Standards for Nurse Practitioner* regulations were primarily adopted between 1979 – 1985. However, the 1979 – 1985 context and content in Article 8 Standards of Nurse Practitioner are no longer relevant in the areas of Definitions, Categories, Holding Out as NP, Evaluation of Credentials, and Standards of Education. Following review of the latest draft presented by the Nursing Education Consultant APRN Workgroup, we concur

with the request for "amendments with rationale" and the recommended changes, deletions and additions, as thoughtfully detailed in the document. CANP agrees that the amendments here provide clarity in definitions, categories, NP use of title, and Standards of Education that reflect the practice of nurse practitioners today.

We remain confident that the CA-BRN is amenable to revisiting antiquated regulations of the past, update regulations that reflect current practice, and as always, offer our assistance to the board during this ongoing endeavor.

The revisions to sections 1480 –1486 in Article 8 of Title 16 of the California Code of Regulations is a forward step in California and will ensure educational standards and competence for the future practice of NPs, providing uniformity in the regulations.

We appreciate your consideration of our comments and thank the board for their continued work on this important area of our APRN practice.

Respectfully,

Donna Emanuele, RN, MN, CNS, DNP, FNP-BC, FAANP
President, CANP

CALIFORNIA
HOSPITAL
ASSOCIATION

Providing Leadership in Health Policy and Advocacy

October 8, 2015

Janette Wackerly, RN,BSN, MBA
California Board of Registered Nursing
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1747 North Market Blvd., Suite 150
Sacramento, CA 95834

BY ELECTRONIC CORRESPONDENCE

RE: PRE-NOTICE PUBLIC DISCUSSION FOR CALIFORNIA CODE OF REGULATIONS, TITLE 16, ARTICLE 8, SECTIONS 1480-1486, STANDARDS FOR NURSE PRACTITIONERS PROPOSED REGULATIONS

Dear Ms. Wackerly:

The California Hospital Association (CHA), the largest professional hospital trade association in the nation, is the statewide leader representing the interests of hospitals and health systems in California with the legislature, the administration and regulatory agencies. CHA's vision is an optimally healthy society, where every Californian has equitable access to affordable, safe and high-quality health care. On behalf of its more than 400 member hospitals and health systems, CHA respectfully offers the following comments for consideration for the "pre-notice public discussion" period prior to the opening of the formal rulemaking process for Title 16, Article 8, Standards for Nurse Practitioners.

Advanced practice registered nurses (APRN), including their ability to practice to the full extent of their education and training, are key in the state's ability to improve access to care and promote delivery system transformation. More than 2.7 million additional California state residents who have enrolled in Medi-Cal since its expansion do not have access to services that could be provided by APRNs. It is imperative that nurse practitioners are well educated and competent to provide care, and that their professional competencies and state mandated regulations reflect contemporary practice.

Present standards for nurse practitioner regulations were adopted between 1979 and1985. Much of Article 8 is no longer relevant, and in need of updates to definitions, categories, nurse practitioner use of title and standards of education. The Board of Registered Nursing (BRN) Nurse Practice Committee (NPC), comprised of board staff, has proposed changes reflective of current APRN practice based on foundational work of the *2008 National Council of State Board's of Nursing (NCSB) Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education*, a pivotal document that provides guidance for all states to adopt uniformity in the regulation of APRN roles. In 2008, awareness of the important role the APRNs play in improving access to high-quality, cost effective care grew nationally. However, the lack of common definitions regarding APRN roles, increasing numbers of nursing specializations and

debates on appropriate credentials and scope of practice, along with lack of uniformity in educational and state regulations, have limited patients' access to APRN care. The APRN consensus model document addresses these issues, and has been used both nationally and by the NPC as a springboard for necessary changes to California's outdated APRN regulations.

CHA supports raising APRN certifying standards to include the NPC's recommendations, such as certification and examination by an accredited certifying organization as outlined in suggested revision of Section 1482 Requirements for Certification as a Certified Nurse Practitioner, consistent with the APRN consensus model. This requirement currently applies to nurse anesthetists in California but not APRNs, making California one of only four states that does not require passage of a national certification exam for an APRN to enter into practice. This certification ensures that APRNs have the minimum level of knowledge needed to provide quality care to the public.

CHA strongly endorses this certification process to not only ensure competency, but also to help streamline the credentialing process so that APRNs can enter the workforce more quickly. Only nationally-certified APRNs are qualified to bill for Medicare services. Medi-Cal allows nationally certified APRNs to bill for certain services. This certification would allow APRNs to provide critical health care services in medically underserved areas of our state.

In addition to the APRN consensus model, the NPC based its proposed changes to the regulations on qualified organizational standards such as those from the National Organization for Nurse Practitioner Faculties and the National Task Force — the same standards used by accreditors reviewing nurse practitioner programs across the country. In the interest of being consistent and current with national accrediting standards, CHA strongly supports the changes suggested throughout the proposed regulations.

Significant health care changes drive the need to improve access to care through modernization of the regulations guiding professional practice. CHA firmly believes that the NPC-proposed changes are in the best interests of Californians, and encourages the California Board of Registered Nursing to fully endorse these changes through the formal rulemaking process.

CHA appreciates the opportunity to comment on proposed changes to Title 16, Article 8, Standards for Nurse Practitioners. If you have any questions or require additional input, please do not hesitate to contact me at bjbartleson@calhospital.org or (916) 552-7537.

/s/

BJ Bartleson, RN, MS, NEA-BS
Vice President, Nursing and Clinical Services

cc: Louise Bailey,Med, RN, Executive Officer, BRN
Michael Jackson, MSN,RN,CEN, MICN,President, BRN

BJB:rf

Association of California Nurse Leaders

A professional nursing organization that develops nurse leaders, advances professional practice, influences health policy and promotes quality and patient safety.

October 5, 2015

Janette Wackerly, BSN, MBA, RN,
Supervising Education Consultant
Board of Registered Nursing
1747 North Market Boulevard, Suite 150
Sacramento, CA 95834

Regarding: Support of proposed adoption and revision of 1480-1486 in Article 8 of Title 16 of the California Code of Regulations

Dear Mrs. Wackerly,

The Association of California Nurse Leaders (ACNL) is the voice for nursing leadership in our state representing nurse leaders in service and academia. Our membership is in **support** of the proposed revisions to Sections 1480-1486 in Article 8 of Title 16 of the California Code of Regulations.

ACNL is the largest state chapter of the American Organization of Nurse Executives with approximately 1400 members. ACNL's mission is to develop nurse leaders, promote professional nursing practice, influence health policy and promote quality health care and patient safety. For more than 35 years we have had an excellent working relationship with the Board of Registered Nursing (BRN) and staff. We respect the work the Board has done and continues to do to protect the public by regulating the practice of registered nurses. The proposed revisions supports the Board's mission.

An estimated five million Californians will be newly insured under health reform, and nurse practitioners (NPs) are critical in providing health care for this population. We need to ensure that nurse practitioners are well educated and competent to provide the best possible health care for our citizens.

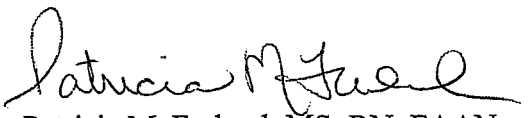
ACNL supports the additional prerequisite for national certification and examination by an accredited certifying agency as a requirement for certification as a nurse practitioner in California. The examination requirement currently applies to nurse anesthetists in California and, we are asking that the same requirement apply to nurse practitioners. California is only one of four states which currently does not require passage of a nurse practitioner certification exam to enter into practice. ACNL supports the inclusion of appropriate grandfathering language as to not disenfranchise currently practicing NPs.

The examination ensures that recent nurse practitioner graduates have the minimum level of knowledge needed to safely enter into practice, and that they are competent to provide the best possible care for California residents. ACNL believes the requirement would also help streamline credentialing processes so NPs may enter the workforce more quickly. The proposed regulation would also facilitate reimbursement through full credentialing in programs such as

Medicare, Medi-Cal, Tricare and others, so NPs may effectively provide critical health services in medically underserved areas of our state.

The Association of California Nurse Leaders believes these regulatory updates are the next step in enhancing nurse practitioners' ability to effectively serve millions of Californians who will need health services under the Affordable Care Act (ACA). We hope the California Board of Registered Nursing will join us in supporting this important initiative on behalf of California's advanced practice nurses.

Respectfully submitted,



Patricia McFarland, MS, RN, FAAN
CEO, Association of California Nurse Leaders

cc. Louise Bailey, Med, RN, Executive Officer BRN
Michael Jackson, MSN, RN, CEN, MICN, President, BRN

Board of Registered Nursing

Karen Hanford EdD, MSN, FNP

Dean, College of Graduate Nursing

Western University of Health Sciences

October 8, 2015

Educational Perspective in Support of the New Proposed Language for APRN Regulations.

The new APRN proposed regulations is needed to assure that APRN education meets standards of quality in education and graduates are competent to practice (protect the public) in CA. APRN national certification can serve as a benchmark and measure of student competency. I am an educator with over 30 years' experience and 20 years as a Family Nurse Practitioner. I am the founding Director for Western University of Health Sciences MSN/FNP program (1997) and have served as the founding Dean for the College of Graduate Nursing for 18 years. All of our Master's and Doctoral programs are BRN approved and CCNE accredited. It is imperative for CA to advance the APRN regulations to include national certification. Program effectiveness, transparency to consumers, and prospective students is required by multiple state and national entities. These include the Council of Higher Education (CHEA), Western Assoc of Senior Colleges and Universities (WASC), professional nursing accreditation (NLN, CCNE) and the Department of Education (state and national).

Fact

CA is **one of three states** that does not require national certification to practice as an APRN. This is an embarrassment in the academic community nationally. SON in CA cannot benchmark effectiveness of our programs to our professional accrediting bodies and students who are applying to APRN programs are not informed.

Nationally transparency for outcomes of schools is the norm. Schools are required to report outcome data, graduation rates, pass scores, etc. on their website. This is being driven by the Dept. of Education and the federal government due to concerns regarding student debt. Institutions must be accountable to the communities they serve, and students must make informed decisions when selecting a school.

Having benchmark data would actually assist the BRN to monitor NP outcomes and focus efforts to underperforming schools, similar to how schools are monitored by NCLEX pass rates. The blue print for the two APRN certification exams can be viewed on the website for each entity. The exams are very rigorous.

Cost Issues – if an APRN is not certified then there are less employment opportunities as you must be nationally certified to serve populations of patients (Medicare and Medical). Billing for services provided by APRN's to these populations is limited if they are not nationally certified. This is critical as

NP's care for the most vulnerable. If clinics are not able to secure sufficient funding, then our safety net clinics will not be sustainable.

Graduates would not be able to practice out of state. Why would our standards be less than other states?

Public Safety – would only be enhanced if all APRN's were held to a standard. The BRN does not have the resources to be experts in all APRN programs. National certification can assist the BRN as does NCLEX scores.

Recently the CACN surveyed all APRN schools of nursing on whether they felt CA schools should require national certification. Ninety (90%) of all schools supported national certification for APRN's. This survey was conducted by Dr. Lucy Huckabee at CSULB.

My second comment is in regards to the proposed standards by the APRN sub-committee and I find that the new regulations to be an improvement **except:**

The one proposed regulation states the majority of preceptorship should be with NP's.

We do not have an adequate preceptor base to exclude MD's and DO's. We are moving healthcare towards a patient centered IP team and we need collaboration with all members of the healthcare team.

In addition, we need to increase the number of NP's to meet the healthcare needs of our nation.

Thank you for the time to review my public comments to the Practice Committee regarding the proposed new regulations.

Respectfully,

Karen Hanford

Karen Hanford EdD, MSN, FNP

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August 31, 2015

Trande Phillips, RN
Chairperson, Nursing Practice Committee
California Board of Registered Nursing
P.O. Box 944210
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RE: August 6, 2015 Draft Revisions to CCR, Title 16, Article 8, Sections 1480-1484 – OPPOSE

Dear Ms. Phillips,

Thank you for the opportunity to provide comments on the regulatory proposal to update the Nurse Practitioner (NP) standards (California Code of Regulations Title 16, Article 8, §§ 1480-1484), as prepared by the Nursing Education Consultants for the BRN's Nursing Practice Committee meeting on August 6, 2015. The California Nurses Association (CNA) represents over 90,000 Registered Nurses (RNs) in California, many of whom are Advanced Practice Registered Nurses (APRNs) and RNs seeking to become APRNs. As such, we have a vested interest in both current and future APRN regulations, and appreciate your consideration of our comments.

As you are aware, CNA took an oppose position to the previous version of the draft regulations as discussed at the January 8, 2014 Nursing Practice Committee meeting. Regrettably, the revisions to the previous language do not adequately address our concerns. As such, CNA maintains its opposition to the proposed regulatory changes. Our opposition is based on five key concerns: (1) the proposed regulations are inconsistent with current statutes; (2) the proposed regulations will lead to an abdication of the Board's authority and responsibility to regulate NPs and NP education programs; (3) these regulations will dramatically increase costs for NPs; (4) we are concerned that the Board lacks the authority to promulgate these regulations; and (5) the proposed regulations put California on track to adopt compact licensure, which CNA strongly opposes.

(1) The Board cannot promulgate the proposed regulations because they are inconsistent with current statutes:

Government Code § 11349.1(a)(4) prohibits an agency from promulgating regulations which contradict or are inconsistent with an existing statute. CNA is concerned that several key provisions of the proposed regulations are inconsistent with current statutes. The first such provision is the requirement for all NPs to be nationally certified in order to practice. When it was introduced, AB 2226 (Spitzer 2004) would have amended Business & Professions Code § 2835.5 to add a fourth requirement mandating that all NPs seeking initial qualification on and after January 1, 2008 *"[p]resent documentation of initial certification that he or she has been granted a nurse practitioner credential by a national certification organization*

recognized by the board." The bill was quickly amended to eliminate the requirement that NPs be credentialed by a national certification organization. After the amendment, the bill was passed by the legislature.

The fact that the legislature passed AB 2226 only after amending it to eliminate the national certification requirement strongly indicates that the legislature specifically disapproved of that language, and that the law should be interpreted to exclude that provision. This analysis of legislative history amounts to a rule of statutory interpretation, which is supported by ample California case law.[1] Given this rule of statutory interpretation, the regulations currently under consideration by the Board are in conflict with the Business & Professions Code. Thus, by requiring national certification as a condition of NP qualification, the Board may be proposing language that would violate Government Code § 11349.1(a)(4), which requires regulations to be consistent with existing statute. It is inappropriate for the Board to attempt to impose by regulatory fiat the precise requirement that was rejected by the Legislature not long ago.

CNA is also concerned that, by requiring national certification as a condition of practice, the Board is imposing a *de facto* requirement for a master's degree in nursing, which would directly conflict with existing law. The previous draft regulations presented to the Board on January 8, 2014, contained language in § 1482 *Requirements for Nurse Practitioner Certification*, which would have required NPs to have a "master's degree in nursing or a higher degree in nursing." This requirement was in direct conflict with B&P Code § 2835.5 (amended by AB 2226 in 2004), which states that, on and after January 1, 2008, an applicant for initial qualification as an NP must "possess a master's degree in nursing, *a master's degree in a clinical field related to nursing,* or a graduate degree in nursing." In our previous opposition letter, CNA argued that, because the draft required a "master's degree in nursing or a higher degree in nursing," but did not allow for "a master's degree in a clinical field related to nursing," the regulations directly conflicted with an existing statute and thus would violate the Government Code.

In the most recent discussion draft, presented to the Board on August 6, 2015, it appears that the requirement for NPs to have a master's degree in nursing has been removed from § 1482. While we appreciate these changes in their attempt to conform to the B&P Code, there are still two underlying problems that have not been resolved. First, in the latest draft regulations, § 1484 *Standards of Nurse Practitioner Education* requires NP programs to be "[a] college or university that prepares nurse practitioners at the master's degree or higher," whereas the current regulations allow for "[a]n institution of higher education that offers a baccalaureate or higher degree in nursing, medicine, or public health."

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[1] See, for example, *Prospect Medical Group Inc. v. Northridge Emergency Medical Group* (2006, 2nd Dist.) 136 Cal.App.4th 1155, 1169-70 ("[T]he Legislature's omission of a provision from the final version of a statute which was included in an earlier version 'constitutes strong evidence that the act as adopted should not be construed to incorporate the original provision.'); *People v. Goodloe* (1995, 1st Dist.) 37 Cal.App.4th 5433, 555 ("The evolution of a proposed statute after its original introduction in the Senate or Assembly can offer considerable enlightenment as to legislative intent. Generally the Legislature's retraction of a specific provision which appeared in the original version of an act supports the conclusion that the act should not be construed to include the omitted provision."); *Wilson v. City of Laguna Beach* (1992, 4th Dist.) 6 Cal.App.4th 543, 555 ("The rejection [by the Legislature] of a specific provision contained in an act as originally introduced is most persuasive that the act should not be interpreted to include what was left out."

Second, national certification companies like the American Nurses Credentialing Center (ANCC) and the National Certification Corporation (NCC) *do* require a master's, postgraduate, or doctoral degree from an NP program, and the draft regulations require national certification. Taken together, this implies that the regulations as proposed contain a *de facto* requirement for a master's degree or higher in nursing and do not allow for a master's degree in a *clinical field related to nursing*. As we stated in our previous comments, this *de facto* requirement conflicts with B&P Code § 2835.5 and lacks the flexibility that the Legislature intended when it passed AB 2226.

(2) The proposed regulations will lead to an abdication of the Board's authority and responsibility to regulate NPs and NP education programs:

CNA opposes the proposed regulations because they privatize a state responsibility and give undue authority to private, national certification corporations outside California. In the current proposal, certification by a national certification/accreditation company becomes a requirement for qualification to practice as an NP (as opposed to current regulations, in which certification is not mandatory, but is just one of several pathways to Board approval). In addition, accreditation becomes required for all NP education programs. Under the B&P Code § 2835, the Legislature gave the BRN the statutory authority to establish standards for NPs to practice in this state. By requiring NPs to be certified by national certification agencies, the Board is essentially handing over this responsibility and authority to private entities. We urge the Board to refrain from ceding power, responsibility, and authority to regulate nursing practice to a private enterprise.

In essence, this change allows national certification/accreditation corporations to dictate APRN standards to the state of California. Going forward, the BRN would have no control, input, or oversight over the contents of the certification examinations or accreditation standards. A state board cannot impose requirements on a private accrediting agency. The entities which provide national certification and accreditation, such as ANCC and NCC, do not operate with transparency and have no duty to accept input from the BRN regarding the content of their examinations, to notify the BRN when the content changes or share the nature of those changes. Furthermore, there is no way for the BRN to verify the examination's reliability in measuring competency or preparedness for current practice standards. Whether the BRN agrees with the content of these examinations and the philosophies of these accrediting agencies as they stand *today* is beside the point, because they are subject to change at any time without the insight and oversight of the Board members and staff.

The move to shift control away from the state board and towards private entities will not be limited to the advanced practice arena. If the Board allows this shift to occur, the same changes will be suggested next for other APRNs, and then for all RNs and RN programs. By ceding this authority, the BRN will become little more than a "rubber stamp" for the decisions made by private entities outside the state of California, whereas once it had genuine control over the regulation of the profession. This shift severely diminishes the Board's ability effectively to regulate the nursing profession within the state, to protect public safety, and to maintain its own high standards. The BRN retains some of the highest standards for practice in the

country; once these are replaced with a uniform national standard, the standards are likely to fall to the "lowest common denominator" seen in other states.

At the end of the day, these national credentialing and accreditation businesses are just that—businesses. The BRN has a statutorily mandated purpose, which is to protect the public. Indeed, § 2708.1 of the B&P Code mandates that protection of the public must be the Board's highest priority, and that "[w]henever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount." Private credentialing companies have no such mandate. Their overriding interest is not solely to maintain the integrity of the profession or the safety of the public, but to maximize the business interests of the corporation.

CNA contends there is an inherent conflict of interest where the company issuing credentials has a business interest in handing out more credentials, since the more people and institutions it approves, the more it can collect in certification, accreditation, and renewal fees. This is a conflict of interest that would harm both nurses and the public. CNA is also concerned that there was a conflict of interest at play in the development of these proposed regulations, since the Consensus Model for APRN Regulation, which provides the foundation for the current proposal, was developed by a workgroup which included the certification corporations themselves—business entities with a clear self-interest in requiring national certification for all NPs and accreditation for all NP programs. Indeed, more than 20% of the members of the APRN Consensus Process Work Group represented private accrediting bodies that stand to benefit financially from the implementation of this new regulation and both of the nursing accreditation bodies currently recognized by the US Department of Education had representatives on the committee that drafted the Consensus language.

Despite their nonprofit status, the national certification organizations charge very significant fees for the testing and certification services they provide (and pay their executives very handsome compensation packages). They are not organized and tax qualified as charitable or educational institutions under Internal Revenue Code (IRC) § 501(c)(3), but rather, as "business leagues" under § 501(c)(6). Reg. 1.501(c)(6)-1 defines a business league as

> *"an association of persons having a common business interest, whose purpose is to promote the common business interest and not to engage in a regular business of a kind ordinarily carried on for profit. Its activities are directed to the improvement of business conditions of one or more lines of business rather than the performance of particular services for individual persons."*

At their core and by definition, these institutions are designed to promote their own business interests, not necessarily the health, safety, or welfare of the public.

CNA recognizes that a new section has been added to the most recent draft proposal—§ 1483.1 *Requirements for Nurse Practitioner Education Programs Based in California*—in which language has been added to state that:

> *"[t]he Board shall retain its authority to monitor, regulate and change the approval status for board approved nurse practitioner programs at any time. If the Board determines the program has not provided necessary compliance evidence to meet board regulations irrespective of institutional and national nursing accreditation status and review schedules"* [sic.]

We assume that this language is attempting to maintain the authority of the Board, despite the addition of the national accreditation requirement for all NP programs. While we appreciate the inclusion of this language, we do not think it goes far enough in protecting the Board's role. By requiring all NP programs based in California to be accredited by national accreditation companies over which the Board has no input, oversight, or control, the Board is ceding too much of its statutory responsibility and authority to private companies. It is clear from the NCSBN's *Preferred Future for Prelicensure Nursing Program Approval* guide that the ultimate goal of this agenda is significantly to minimize the role of state boards in the initial and continuing approval of nursing education programs. Although the plan is not to eliminate the state boards all together, their role would be limited mostly to enforcement, while the bulk of the oversight and approval responsibilities would belong to the private accreditation companies. Again, given that the Board has a statutory mandate to protect the public, while the accreditation companies are motivated primarily by their own business interests; this is a shift that should be of grave concern to the Board members and the public alike.

(3) These regulations will dramatically increase costs for NPs, leading to a decrease in diversity in the field:

CNA objects to the national certification requirement because it will impose on NPs an unnecessary and unfounded obligation to pay additional sums of money to a private enterprise in order to practice in this state. The requirement that all NPs must be credentialed by a national accreditation agency will make it significantly more costly and cumbersome for NPs to practice in California. As an example, to be certified by ANA/ANCC, an NP must pay $395 for the certification exam and $350 every 5 years for the renewal. This added expense will likely discourage RNs from becoming NPs, inhibit upward mobility for nurses from lower economic backgrounds, and discourage diversity in the field. Additionally, these prices are subject to change at any time, and the Board will have no control over such changes. At a time when the Board is already considering raising licensure fees in order to cover its own costs, it seems especially unjust to require NPs to hand over more money to a private enterprise.

Furthermore, despite the costly nature of this requirement, there is no evidence that requiring NPs to obtain national certification will lead to any additional protection for the public. To our knowledge, there is no credible quantitative, qualitative, or even anecdotal evidence demonstrating that such "certified" practitioners are more competent than those without national certification, or that national certification of NPs is correlated in any way with enhanced patient safety or improved patient outcomes. Given that this requirement would dramatically increase the cost of obtaining education and licensure as an NP, the lack of evidence of any benefit is troubling to say the least.

(4) CNA is concerned that the Board lacks the authority to promulgate these regulations:

Government Code § 11349.1(a)(2) requires an agency to have statutory authority to adopt, amend, or repeal a regulation. Without a stature enabling it to do so, CNA strongly questions whether the Board has the authority to promulgate new regulations requiring national certification as a prerequisite to practicing as an NP. California Business and Professions Code (B&P) § 2835 confers authority on the Board to establish the "standards and qualifications" required to practice as an NP in California. However, in § 2835.5, the statute lays out three specifically enumerated requirements for initial qualification on or after January 1, 2008:

> *(1) Hold a valid and active registered nursing license issued under this chapter;*
> *(2) Possess a master's degree in nursing, a master's degree in a clinical field related to nursing, or a graduate degree in nursing; and*
> *(3) Satisfactorily complete a nurse practitioner program approved by the board.*

It is not clear whether the statute grants the Board authority to go beyond these statutory requirements by requiring national certification for all NPs.

(5) These regulations will put California on track to adopt compact licensure, which CNA strongly opposes:

The foundation for the recommended changes currently under consideration is the *Consensus Model for APRN regulation,* a document prepared by the National Council of State Boards of Nursing (NCSBN, Inc.) in conjunction with other professional organizations. CNA does not support the NCSBN's Consensus Model, in part due to its stated goal of allowing for "mutual recognition [of NPs] through compact." CNA strongly opposes compact licensure due to a multitude of concerns, which have largely been shared by the Board. Amongst other reasons, CNA is concerned that compact licensure is likely to erode disciplinary procedures, public safety, educational standards, and continued competence.

a. **Disciplinary Procedures:** The Board is empowered to discipline RNs and APRNs with licenses issued by the Board. Currently, only nurses with licenses issued by the Board are allowed to practice in California. Participating in the Compact would restrict the Board's ability to discipline or address complaints regarding RNs and APRNs practicing in California under licenses from other Compact states outside California.
b. **Public Safety:** Currently several Compact states do not require licensees to undergo criminal background checks and fingerprinting before obtaining a license. Under the Compact, nurses from those states would be allowed to practice nursing in California under licenses from their home states.
c. **Educational Standards**: Educational requirements vary widely from state to state. If California became part of the Compact, the Board would be forced to recognize licenses issued by states that
d. do not conform to California's stringent educational standards. Thus, NPs from other states may effectively be held to a lower standard than NPs from our own state.

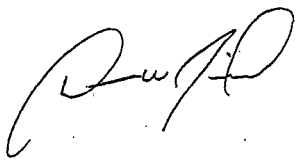
e. **Continued Competence:** Continuing education requirements also vary widely from state to state. Some states have little to no continuing education requirement for license renewal. Under Compact licensure, the nurse is only required to meet the continued competence requirements in his or her home state, not in the state where s/he practices. Thus, if California became part of the Compact, nurses who have not met California's strict standards would still be able to practice here.

As Californians are gaining broader access to our health care system through the Patient Protection and Affordable Care Act, NPs and other APRNs will continue to be key providers of primary and specialty care. For this reason, it is vitally important that the Board act deliberately and methodically in order to protect the public interest and its own role in the regulation of this profession. We hope that the board will take these concerns into consideration and vote to oppose these regulatory changes at this time.

Thank you for your time and consideration.

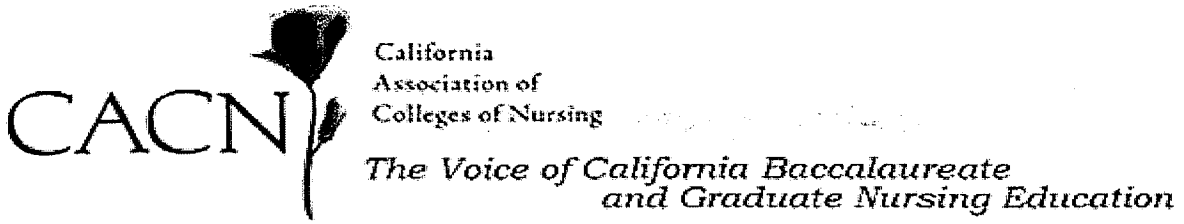
Sincerely,

CALIFORNIA NURSES ASSOCIATION/
NATIONAL NURSES UNITED



Donald W. Nielsen
Director, Government Relations

cc: Cynthia Cipres Klein, RN, Nursing Practice Committee Member, BRN
Elizabeth Woods, RN, FNP, MS, Nursing Practice Committee Member, BRN
Michael Jackson, MSN, RN, CEN, MICN, Nursing Practice Committee Member, BRN
Louise Bailey, RN, Executive Officer, BRN
Janette Wackerly, RN, MBA, Nursing Education Consultant, BRN



Janette Wackerly, BSN, MBA, RN
Supervising Education Consultant
Board of Registered Nursing
1747 North Market Boulevard, Suite 150
Sacramento, CA 95834

January 14, 2016

Regarding: Adoption and revisions of 1480-1486 in Article 8 of Title 16 of the California Code of Regulations related to Nurse Practitioners

Dear Ms. Wackerly:

It is the mission of the California Association of Colleges of Nursing (CACN) "To lead in advancing California baccalaureate and graduate nursing education." Our membership includes nurse practitioner programs that currently conform to the Board's Standards of Education for Nurse Practitioner Programs (California Code of Regulations Section 1484) and have been approved by the BRN.

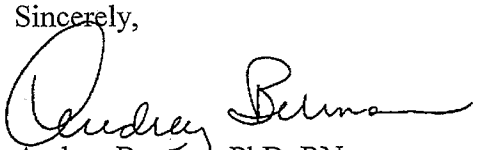
Therefore, it is critical that the executive committee of CACN provide opinion regarding the proposed revisions in the statutes describing the various aspects of nurse practitioner education and credentialing.

We have reviewed the letters sent to the BRN in the fall 2015 regarding such revisions. We find that the detailed response from the California Action Coalition (October 8, 2015 from Drs. Phillips and Chan) most closely reflects our views. In addition to those recommended revisions, we offer the following:

1. Line 233: 1484(c)(4)(a): Hold an active, <u>unencumbered/clear</u> ~~valid~~ ~~California~~ registered nurse license; [refers to faculty]
   - The term *valid* is unclear. On BreEZe, licenses are shown as *current* or *active* but can be simultaneously *on probation*. The term *valid* should be replaced with *unencumbered* or *clear*.
   - With the opportunities provided to teach using distance technology, programs may use faculty who reside outside of our state. California should be replaced with wording to indicate that faculty must be licensed but it need not be in our own state.

2. Line 237: 1484(c)(4)(c) Have at least ~~two~~ one years of clinical experience as ~~an~~ nurse practitioner, CNM, CNS, or CRNA within the last five (5) years…[refers to faculty]
   - Faculty teaching prelicensure nursing are required to have at least one year of clinical experience and this would be consistent with that requirement.
   - This change aligns with the 2012 *Criteria for Evaluation of Nurse Practitioner Programs* Criterion IV.B.3.b which requires that nurse practitioner preceptors must have one year of clinical experience.
3. Line 243: 1484(7) Interdisciplinary faculty … shall have an active, valid ~~California~~ professional license issued by appropriate licensing agency if appropriate, ….
   - We propose the deletion of California because some of these faculty may be licensed in other states, especially for online programs.
   - We propose the addition of *if appropriate* because some non-nurse faculty such as physiologists would not have any license.
4. Line 261: 1484(e)(1) A clinical preceptor shall hold active, ~~valid~~ unencumbered/clear, ~~California~~ professional license to practice his/her respective profession and demonstrate current clinical competence.
   - The term *valid* is unclear. On BreEZe, licenses are shown as *current* or *active* but can be simultaneously *on probation*. For prelicensure nursing programs, Requirements of Preceptorship (CCR section 1426.1) state the preceptor must have an "active, clear license." The term *valid* should be replaced with *unencumbered* or *clear*.
   - We propose the deletion of California because preceptors must have a license that is recognized in the state in which they work with students, which may not be in California, especially for online programs.
5. Line 274: (f) Students shall hold an active, ~~valid~~ unencumbered/clear, ~~California~~ professional registered nurse license to participate in nurse practitioner program clinical experiences.
   - The term *valid* is unclear. On BreEZe, licenses are shown as *current* or *active* but can be simultaneously *on probation*. The term *valid* should be replaced with *unencumbered* or *clear*.
   - We propose the deletion of California because the students must have a license that is recognized in the state in which they conduct their clinical experiences, which may not be California, especially for online programs.
6. Lines 303-304 (D) The majority of the supervised direct patient care precepted clinical experiences shall be under the supervision of the certified nurse practitioner or other appropriately qualified health care practitioner.
   - It may not be possible to have at least 50% of clinical supervised by a nurse practitioner particularly in some rural areas.
   - Aligns with the 2012 *Criteria for Evaluation of Nurse Practitioner Programs* Criterion IV.B.3.a that states "An interdisciplinary mix of preceptors may provide the student with the best clinical experiences to meet program objectives."

Sincerely,



Audrey Berman, PhD, RN
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510-869-6611

BOARD OF REGISTERED NURSING

Practice Committee October 8, 2015

Adoption and Revison 1480-1486 in Article 8 Standards for Nurse Practitioners

Title 16 of the California Code of Regulations

Proposed changes are designated by single underline and ~~strikeout~~.

1480. Definitions

(a) "Nurse practitioner" means ~~a~~ an advanced practice registered nurse who meets board certification requirements and ~~who~~ possesses additional advanced practice educational preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and/or acute care that meet board standards and who has been prepared in a program that ~~conforms to~~ meets the board standards. ~~as specified in Section 1484."~~

(b) ~~"Primary health care" is that which occurs when a consumer makes contact with a health care provider who assumes responsibility and accountability for the continuity of health care regardless of the presence or absence of disease.~~ "Primary care" means the comprehensive continuous care provided to patients, families and the community. Primary care focuses on basic preventative care, health promotion, disease prevention, health maintenance, patient education and the diagnoses and treatment of acute and chronic illnesses in a variety of practice settings.

(c) "Clinically competent" means ~~that one~~ the individual possesses and exercises the degree of learning, skill, care and experience ordinarily possessed and exercised by a member of the appropriate discipline in clinical practice~~.~~ of the appropriate discipline.

(d) ~~"Holding oneself out" means to use the title of nurse practitioner.~~

(e) "Acute care" means the restorative care provided by the certified nurse practitioner to patients with rapidly changing, unstable, chronic, complex acute and critical conditions in a variety of clinical practice settings.

(f) "Advanced health assessment course" means the knowledge of advanced processes of collecting and interpreting information regarding a patient's health care status. Advanced health assessment provides the basis for differential diagnoses and treatment plans.

(g) "Advanced pathophysiology course" means the foundational knowledge of physiological disruptions that accompany a wide range of alterations in health.

(h) "Advanced pharmacology course " means the integration of the advanced knowledge of pharmacology, pharmacokinetics, and pharmacodynamics content across the lifespan and prepares the certified nurse practitioner to initiate appropriate pharmacotherapeutics safely and effectively in the management of acute and chronic health conditions.

(i) "Nurse practitioner curriculum" means a curriculum that consists of the graduate core; advanced practice registered nursing core, and nurse practitioner role and population-focused courses.

(j) "Advanced practice registered nursing core" means the essential broad-based curriculum required for all nurse practitioner students in the areas of advanced health assessment, advanced pathophysiology, and advanced pharmacology.

(k) "California based nurse practitioner program" means a board approved academic program meeting nurse practitioner state certification criteria that's physically located in California. The

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program is accredited by a nursing organization recognized by the United States Department of Education or the Council of Higher Education Accreditation that offers a graduate degree or graduate level certificate to qualified students.

(l) "Clinical practice experience" means the supervised provision of direct patient care in the clinical setting that provide for the acquisition and application of advanced practice nursing knowledge, skills and competencies.

(m) "Direct supervision" means the clinical preceptor or the faculty member physically present at the practice site where the patient/client is located. The clinical preceptor and/or faculty member retains the responsibility for patient care while overseeing the student.

(n) "Lead nurse practitioner educator faculty" refers to a licensed Nurse Practitioner faculty member who is responsible for developing, and implementing the curriculum, policies and practices for a nurse practitioner program.

(o) "Major curriculum change" means a substantive change that results in a refocus of purpose and objectives ; or a substantive change in program structure or method of clinical or institutional delivery, or clinical hours and content.

(p) "National Board Certification" means current certification as an advanced nurse practitioner in a role and population focus through testing accredited by the national commission on certifying agencies or the American Board of Nursing Specialties, as approved by the board.

(q) "Nurse practitioner program director" means the individual responsible for administration, implementation, and evaluation of the nurse practitioner program and the achievement of the program objectives in collaboration with program faculty.

(r) "Non-California based ~~graduate~~ nurse practitioner programs" means an academic program accredited by a nursing organization recognized by the Unites States Department of Education or the Council of Higher Education Accreditation that offers a graduate degree or graduate level certificate to qualified students and does not have a physical location in California.

Authority cited: Sections 2715, 2725(c), 2725.5, 2835.5, 2836, 2836.1, Business and Professions Code.
References: Section 2834 and 2836.1, Business and Professions Code.

1481. Categories of Nurse Practitioners

~~A registered nurse who has met the requirements of Section 1482 for holding out as a nurse practitioner, may be known as a nurse practitioner and may place the letters "R.N., N.P." after his/her name alone or in combination with other letters or words identifying categories of specialization, including but not limited to the following: adult nurse practitioner, pediatric nurse practitioner, obstetrical-gynecological nurse practitioner, and family nurse practitioner.~~

(a) Categories of nurse practitioners shall include, but are not limited to:

(1) Family/individual across the lifespan

(2) Adult-gerontology; primary care or acute care

(3) Neonatal

(4) Pediatrics; primary care or acute care

(5) Women's health/gender-related

(6) Psychiatric/mental health

(b) A registered nurse who has been certified by the board as a nurse practitioner may be known as an advanced practice nurse and may place the letters APRN-CNP after his/her name or in combination with other letters or words that identify the population focus.

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Authority cited: Sections 2715, 2835.5, 2836, Business and Professions Code. Reference: Sections 2834 and 2836,-2836.1 and 2837, Business and Professions Code.
Note: Authority cited: Section 2715, Business and Professions Code. Reference: Sections 2834 and 2836, Business and Professions Code.

1482. Requirements for ~~Holding Out As a~~ Certification as a Certified Nurse Practitioner.
~~The requirements for holding oneself out as a nurse practitioner are:~~
(a) Active, valid, ~~licensure~~ license as a registered nurse in California; and
(b) One of the following:
(1) Successful completion of a program of study and national certification as recognized by the board and ~~which conforms that meets to board standards~~ as set forth in this article; or
(2) Certification ~~by a national or state organization whose standards are equivalent to those set forth in Section 1484;~~ in the role and population focus through testing accredited by the national commission on certifying agencies or the American Board of Nursing Specialties, as approved by the board and as set forth in this article; or
(3) A nurse who has not completed ~~a~~ an academically affiliated nurse practitioner program of study ~~which meets board standards as specified in Section 1484,~~ shall ~~be able to~~ provide~~:~~ evidence of having completed equivalent education and supervised clinical practice as set forth in this article.
~~(A) Documentation of remediation of areas of deficiency in course content and/or clinical experience, and~~
~~(B) Verification by a nurse practitioner and by a physician who meet the requirements for faculty members specified in Section 1484(c), of clinical competence in the delivery of primary health care.~~
(4) Graduates from a nurse practitioner program in a foreign country shall meet the requirements as set forth in this article. The applicant shall submit a credentials evaluation through a board approved or directed service demonstrating education equivalency to a Master's or Doctoral degree in Nursing.

Note: Authority cited: Section 2715, Business and Professions Code. Reference: Sections 2835 and 2836, Business and Professions Code.

1483. Evaluation of Credentials
An application for evaluation of a registered nurse's qualifications ~~to hold out~~ to be certified as a Certified N~~n~~urse P~~p~~ractitioner shall be filed with the board ~~on a form prescribed by the board~~ and shall be accompanied by the fee prescribed in Section 1417 and such evidence, statements or documents as therein required by the board. ~~to conform with Sections 1482 and 1484.~~
Certified Nurse Practitioner application shall include submission of the following information:

(a) Name of the graduate nurse practitioner program or post-graduate nurse practitioner program.
(b) Official transcript documentation with the date of graduation or post-graduate program completion, nurse practitioner population foci, credential conferred, and the specific courses taken to provide sufficient evidence the applicant has completed the required course work including the required number of supervised direct patient care clinical practice hours.
(c) Students who graduate from a board approved nurse practitioner program shall be considered graduates of a nationally accredited program if the program held national nursing accreditation at the time the graduates completed the program. These program graduates are eligible to apply for nurse practitioner certification with the board regardless of the program's current national nursing accreditation status.

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The board shall notify the applicant in writing that the application is complete and accepted for filing; or that the application is deficient and specify what additional information is required within 30 days from the receipt of an application. A decision on the evaluation of credentials shall be reached within 60 days from the filing of a complete application. The median, minimum, and maximum times for processing an application, from the receipt of the initial application to the final decision, shall be 42 days, 14 days, and one year, respectively, and take into account Section 1410.4 (e) which provides for abandonment of incomplete applications after one year.

Authority cited: Sections 2715 and 2718, Business and Professions Code. Reference: Sections 2815 and 2835.5, Business and Professions Code.

1483.1 Requirements for Nurse Practitioner Education Programs based in California.

(a) The nurse practitioner programs shall:

(1) Be an academic program approved by the board and is accredited by a nursing organization recognized by the United States Department of Education or the Council of Higher Education Accreditation that offers a graduate degree or graduate level certificate to qualified students.

(2) Provide the board evidence of initial accreditation within 30 days of the program receiving this information from the institutional accreditation body.

(3) Provide the board evidence of ongoing continuing nurse practitioner program accreditation within 30 days of the program receiving this information from the national nursing accreditation body.

(4) Notify the board of changes in the program's institutional and national nursing accreditation status within 30 days.

(b) The board may grant the nurse practitioner program initial and continuing approval when the board receives the required accreditation evidence from the program.

(c) The board shall retain its authority to monitor, regulate and change the approval status for board approved nurse practitioner programs at any time. If the Board determines the program has not provided necessary compliance evidence to meet board regulations irrespective of institutional and national nursing accreditation status and review schedules.

Authority cited: Section 2715, Business and Professions Code. Reference: Sections 2785, 2786, 2786.5, 2786.6, 2788, 2798, 2815 and 2835.5, Business and Professions Code.

1483.2 Requirements for Reporting Nurse Practitioner Program Changes.

(a) A board approved nurse practitioner program shall notify the board within thirty (30) days of the following changes:

(1) A change of legal name or mailing address prior to making such changes. The program shall file its legal name and current mailing address with the board at its principal office and the notice shall provide both the old and the new name and address as applicable.

(2) A fiscal condition that adversely affects students enrolled in the nursing program.

(3) Substantive changes in the organizational structure affecting the nursing program.

(b) An approved nursing program shall not make a substantive change without prior board notification. These changes include, but not limited to:

(1) Change in location;

(2) Change in ownership;

(3) Addition of a new campus or location.

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Authority cited: Section 2715, Business and Professions Code. Reference: Sections 2785, 2786, 2786.5, 2786.6, 2788, 2798, 2815 and 2835.5, Business and Professions Code.

§ 1484. ~~Standards of~~ Nurse Practitioner Education.

The program of study preparing a certified nurse practitioner shall ~~meet the following criteria~~:

(1) Be approved by the board.

(2) Be consistent with the curriculum content to support nurse practitioner core competencies as specified by National Organization of Nurse Practitioner Faculties and the Curricular Leadership Committee for the population foci as recognized by the board. ~~shall meet the following criteria:~~

(a) Purpose, Philosophy ~~and~~ Objectives, and Learning Outcomes

~~(1) have as its primary purpose the preparation of registered nurses who can provide primary health care; (2) have a clearly defined philosophy available in written form;~~

~~(3) have objectives which reflect the philosophy, stated in behavioral terms, describing the theoretical knowledge and clinical competencies of the graduate.~~

(1) The purpose for preparation of the graduate nurse practitioner providing primary care and/or acute care services to one or more of the population foci.

(2) Written program materials shall reflect the mission, philosophy, purposes, and objectives of the program and be available to all students.

(3) Learning outcomes for the nurse practitioner Program are measurable and reflect assessment and evaluation of the theoretical knowledge and clinical competencies required of the graduate.

(b) Administration and organization of the nurse practitioner program:

~~(1) Be conducted in conjunction with one of the following:~~

(A) ~~An institution of higher education that offers a baccalaureate or higher degree in nursing, medicine, or public health~~ A college or university that prepares nurse practitioners at the master's degree or higher is accredited by a nursing organization that is recognized by the United States Department of Education or the Council of Higher Education Accreditation that offers a graduate degree or graduate level certificate to qualified students

(B) ~~A general acute care hospital licensed pursuant to Chapter 2 (Section 1250) of Division 2 of the Health and Safety Code, which has an organized outpatient department.~~ Prepare graduates to be eligible for national certification as an advanced nurse practitioner in a population focus through testing accredited by the National Commission on Certifying Agencies or the American Board of Nursing Specialties, as approved by the board.

(2) (1) Have admission requirements and policies for withdrawal, dismissal and readmission clearly stated and available to the student ~~in written form~~.

(3) (2) Have written policies for clearly informing applicants of the academic status of the program.

(4) (3) Provide the graduate with official evidence indicating that he/she ~~has demonstrated clinical competence in delivering primary health care and has achieved all other objectives of the program.~~ meet the curriculum requirements in effect at the time of enrollment.

~~(5)~~ (4) ~~Maintain systematic, retrievable records of the program including philosophy, objectives, administration, faculty, curriculum, students and graduates. In case of program discontinuance, the board shall be notified of the method provided for record retrieval.~~ The nurse practitioner program shall maintain a method for retrieval of records in the event of program closure.

(5) (5) ~~Provide for program evaluation by faculty and students during and following the program and make results available for public review.~~ The nurse practitioner program shall have and implement a written total program evaluation plan for improvement.

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(6) The nurse practitioner program shall have sufficient resources to achieve the program objectives.
(c) Faculty ~~There shall be an adequate number of qualified faculty to develop and implement the program and to achieve the stated objectives.~~
(1) There shall be an adequate number of qualified faculty to develop and implement the program and to achieve the stated objectives.
~~(1)~~ (2) Each faculty person shall demonstrate current competence in the area in which he/she teaches.
(3) There shall be a lead nurse practitioner faculty educator who meets the faculty qualifications for the population focus/foci tracks and nationally certified for the population focus program track he/she serves as the lead faculty.
(4) Faculty who teach in the nurse practitioner program shall be educationally qualified and clinically competent in the same population foci as the theory and clinical areas taught. Faculty shall meet the following requirements:
(a) Hold an active, valid California registered nurse license;
(b) ~~(c)~~ ~~(3)~~ ~~Faculty in the theoretical portion of the program must include instructors who hold a Master's or higher degree in the area in which he or she teaches.~~ Have a Master's degree or higher degree in nursing;
(c) Have at least two years of clinical experience as an nurse practitioner within the last five (5) years and consistent with the teaching responsibilities;
(5) Faculty teaching in clinical courses shall maintain currency in clinical practice.
(6) Each faculty member shall assume responsibility and accountability for instruction, planning and implementing the curriculum, and evaluation of students and the program.
(7) Interdisciplinary faculty who teach non-clinical nurse practitioner nursing courses, such as pharmacology, shall have an active, valid California license issued by appropriate licensing agency and an advanced graduate degree in the appropriate content areas taught.
(d) Director
(1) ~~(c)(2))~~ ~~The director or co-director of the program shall:~~ The nurse practitioner program director is responsible and accountable for the nurse practitioner program within an accredited academic institution including those functions aligned with program and curricular design and resource acquisition and allocation and shall meet the following requirements:
(A) ~~Be a~~ Hold an active, valid California registered nurse license
(B) Have earned ~~hold~~ a master's or a doctoral ~~higher~~ degree in nursing ~~or a related health field from an accredited college or university~~;
(C) Have had one academic year's experience, within the last five (5) years, as an instructor in a school of professional nursing, or in a program preparing nurse practitioners
(D) Be certified by the board as an advanced nurse practitioner and nationally certified as advanced nurse practitioner in one or more population foci;
(E) The director shall have sufficient time dedicated for the administration of the program.
(F) The director, if he/she meets the requirements for the certified nurse practitioner role, may fulfill the lead nurse practitioner faculty educator role and responsibilities.
(e) Clinical Preceptors in the nurse practitioner program shall
(1) ~~(c) (4)~~ A clinical ~~instructor~~ preceptor shall hold active ~~licensure~~ valid, California license to practice his/her respective profession and demonstrate current clinical competence.
(2) ~~(c) (5)~~ A clinical preceptor ~~instructor~~ shall participate in teaching, supervising and evaluating students, and shall be appropriately matched with the content and skills being taught to the students.

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(3) Clinical preceptor means a health care provider qualified by education, licensure and clinical competence in assigned population focus/foci to provide direct supervision of the clinical practice experiences for a nurse practitioner student.
(4) Clinical preceptor functions and responsibilities shall be clearly documented in a written agreement between the agency, the preceptor, and the nurse practitioner program including the clinical preceptor's role to teach, supervise and evaluate students in the nurse practitioner program.
(A) Clinical preceptor is oriented to program and curriculum requirements, including responsibilities related to supervision and evaluation;
(B) Clinical preceptors shall be evaluated by the program faculty at least every two (2) years.
(f) ~~Curriculum~~ Students shall hold an active, valid registered nurse California license to participate in nurse practitioner program clinical experiences.
(g) ~~(d)~~ Nurse Practitioner Curriculum:
The nurse practitioner program curriculum shall meet the standards set forth in this Section, be congruent and consistent with national standards for graduate and nurse practitioner education, including nationally recognized core role and population focused competencies and be approved by the board.
(1) The program shall include all theoretical and clinical instruction necessary for ~~to enable~~ the graduate ~~to provide~~ ~~primary~~ health care ~~for persons for whom he/she will provide care.~~ the graduate in one or more population foci.
(2) The program shall ~~provide evaluation~~ evaluate ~~of~~ previous education and/or experience in ~~primary~~ health care for the purpose of granting credit for meeting program requirements~~.~~, when applicable.
(3) ~~Training for practice in an area of specialization shall be broad enough, not only to detect and control presenting symptoms, but to minimize the potential for disease progression.~~ The curriculum shall provide broad educational preparation including a graduate core; nurse practitioner core, the nurse practitioner core role competencies, and the competencies specific to the population focus/foci.
(4) ~~Curriculum, course content, and plans for clinical experience shall be developed through collaboration of the total faculty.~~ The program shall prepare the graduate to be eligible to sit for a specific national nurse practitioner population foci certification examination consistent with educational preparation.
(5) ~~Curriculum, course content, methods of instruction and clinical experience shall be consistent with the philosophy and objectives of the program.~~ The curriculum plan evidences appropriate course sequencing and progression, this includes, but is not limited to:
(A) The nurse practitioner core courses (advanced health assessment, advanced pharmacology, and advanced pathophysiology) are completed prior to or concurrent with commencing clinical course work.
(B) Instruction and skills practice for diagnostic and treatment procedures shall occur prior to application in the clinical setting.
(C) Concurrent theory and clinical practice courses in the population focus/foci emphasize the management of health-illness needs in primary and/or acute care.
(D) The majority of the supervised direct patient care precepted clinical experiences shall be under the supervision of the certified nurse practitioner.
(6) ~~Outlines and descriptions of all learning experiences shall be available, in writing, prior to enrollment of students in the program.~~ The program shall meet the minimum clinical hours of supervised direct patient care experiences as specified in current nurse practitioner national education standards. Additional clinical hours required for preparation in more than one population foci shall be identified and documented in the curriculum plan for each population focus/foci.

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(7) The curriculum shall include content related to California Nursing Practice Act, Business & Professions Code, Division 2, Chapter 6, Article 8, Nurse Practitioners and California Code of Regulations Title 16, Division 14, Article 7 Standardized Procedure Guidelines and Article 8 Standards for Nurse Practitioners, including, but not limited to:
(A) Section 2835.7 of Business & Professions Code Authorized standardized procedures;
(B) Section 2836.1 of Business & Professions Code Furnishing or ordering of drugs or devices by nurse practitioners.
~~(7)~~ (8) The program may be full-time or part-time and shall be comprised of not less than thirty (30) semester units, (forty-five (45) quarter units), which shall include theory and supervised clinical practice.
~~(8) The course of instruction shall be calculated according to the following formula:~~
~~(A) One (1) hour of instruction in theory each week throughout a semester or quarter equals one (1) unit.~~
~~(B) Three (3) hours of clinical practice each week throughout a semester or quarter equals one (1) unit.~~
~~(C) One (1) semester equals 16-18 weeks and one (1) quarter equals 10-12 weeks.~~
(9) The course of instruction program units and contact hours shall be calculated using the following formulas:
(A) One (1) hour of instruction in theory each week throughout a semester or quarter equals one (1) unit.
(B) Three (3) hours of clinical practice each week throughout a semester or quarter equals one (1) unit. Academic year means two semesters, each semester is 15-18 weeks; or three quarters, each quarter is 10-12 weeks.
(10) ~~(9)~~ Supervised clinical practice shall consist of two phases:
(A) Concurrent with theory, there shall be provided for the student, demonstration of and supervised practice of correlated skills in the clinical setting with patients.
(B) Following acquisition of basic theoretical knowledge prescribed by the curriculum the student shall receive supervised experience and instruction in an appropriate clinical setting.
(C) At least 12 semester units or 18 quarter units of the program shall be in clinical practice.
(11) ~~(10)~~ The duration of clinical experience and the setting shall be such that the student will receive intensive experience in performing the diagnostic and treatment procedures essential to the practice for which the student is being prepared.
(12) ~~(11)~~ The program shall have the responsibility for arranging for clinical instruction and supervision for the student.
~~(12) The curriculum shall include, but is not limited to:~~
~~(A) Normal growth and development~~
~~(B) Pathophysiology~~
~~(C) Interviewing and communication skills~~
~~(D) Eliciting, recording and maintaining a developmental health history~~
~~(E) Comprehensive physical examination~~
~~(F) Psycho-social assessment~~
~~(G) Interpretation of laboratory findings~~
~~(H) Evaluation of assessment date to define health and developmental problems~~
~~(I) Pharmacology~~
~~(J) Nutrition~~
~~(K) Disease management~~
~~(L) Principles of health maintenance~~
~~(M) Assessment of community resources~~

DRAFT

~~(N) Initiating and providing emergency treatments~~
~~(O) Nurse practitioner role development~~
~~(P) Legal implications of advanced practice~~
~~(Q) Health care delivery systems~~
~~(13) The course of instruction of a program conducted in a non-academic setting shall be equivalent to that conducted in an academic setting.~~

Authority cited: Sections 2715, 2835.5, 2835.7, 2836, 2826.1, Business and Professions Code. Reference: Sections 2835, 2835.5, 2835.7, 2836, 2836.1, 2836.2, 2836.3, 2837, Business and Professions Code.

1485. Scope of Practice
Nothing in this article shall be construed to limit the current scope of practice of the registered nurse authorized pursuant to the Business and Professions Code, Division 2, Chapter 6. The nurse practitioner shall function within the scope of practice as specified in the Nursing Practice Act and as it applies to all registered nurses.

Authority cited: Section 2715, Business and Professions Code. Reference: Sections 2834 and 2837, Business and Professions Code.

1486. Requirements for Clinical Practice Experience for Nurse Practitioner Students Enrolled in Out of State Nurse Practitioner Programs.
(a) The out-of-state nurse practitioner Program requesting clinical placements for program students in clinical practice settings in California shall:
(1) Obtain prior board authorization;
(2) Ensure students have successfully completed prerequisite courses and are enrolled in the nurse practitioner Program;
(3) Secure clinical preceptors who meet board requirements;
(4) Ensure the clinical preceptorship experiences in the program meet all board requirements and national education standards/competencies for the nurse practitioner role and population focus/foci;
(5) Demonstrate evidence the curriculum includes content related to legal aspects of California certified nurse practitioner laws and regulations.
(6) Notify the board of pertinent clinical placement changes within 30 days.
(b) The board may withdraw authorization for program clinical placements in California, at any time.

Authority cited: Section 2715, Business and Professions Code. Reference: Sections 2729, 2835, 2835.5 and 2836, Business and Professions Code.

DRAFT

BOARD OF REGISTERED NURSING
Nursing Practice Committee
Agenda Item Summary

AGENDA ITEM: 10.2
DATE: February 11, 2016

ACTION REQUESTED: **Information only: Http://coalitionccc.org/POLSTeducation or contact Coalition for Compassionate Care of California regarding Physician Orders for Life Sustaining Treatment (POLST) signed by Nurse Practitioner and Physician Assistant acting under the supervision of the physician. Revised POLST form January 1, 2016**

REQUESTED BY: Trande Phillips RN
Chair, Practice Committee

BACKGROUND:
Coalition for Compassionate Care of California provides information regarding changes to the POLST form, where to order POLST from Med-Pass, previous versions of POLST will still be honored and best practice is to use POLST 2016 form, the POLST form in other languages with translations will be available to download from California Coalition for Compassionate Care of California January 11, 2016

Healthcare professionals with questions about POLST are encouraged to connect with their local POLST Coalition, or contact Coalition for Compassionate Care of California at 1331 Garden Highway, Suite 100, Sacramento, CA 95833 or e-mail kscholl@coalitionccc.org.

NEXT STEPS: Place on Board agenda.

FISCAL IMPACT, IF ANY: **NONE**

PERSON(S) TO CONTACT: Janette Wackerly, RN, BSN, MBA
Supervising Nursing Education Consultant
(916) 574-7686

o

6 things you should be doing to prepare for the new POLST.

View this email in your browser

POLST
CALIFORNIA
PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

Are you ready for the new POLST?

Starting on Jan. 1, 2016, nurse practitioners and physician assistants – *under the supervision of a physician and within their scope of practice* – are authorized to sign POLST forms and make them actionable medical orders.

Here are 6 things you should be doing right now to prepare for the new form.

1. **Read "Changes to POLST in 2016"**—this takes *less than 1 minute!*

2. **Order the new POLST forms from** Med-Pass.

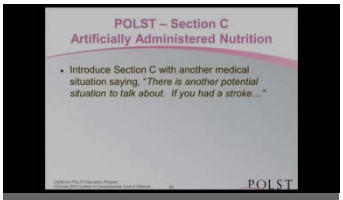
3. **Familiarize yourself with the new form:** Download a PDF copy in English.

4. **Replace old forms.**
   Previous versions of POLST will still be honored after the 2016 form goes into effect, however, it is best practice to complete a 2016 version of POLST—and void older versions of the form—when a patient's POLST is updated.

5. **Download the 2016 POLST form in other languages.** Translations will be available for download after January 11. Ask the responsible staff person to download all copies of POLST in other languages and have these forms ready for when you need them. Get copies of the forms at the bottom of www.capolst.org. Order POLST in braille by contacting us.

6. **Spread the word among your colleagues by sharing**

Download the POLST Form. Multiple languages available.



Extra Credit: Watch this recorded webinar for an in-depth look at the changes to the form. (Length: 1 hour.)

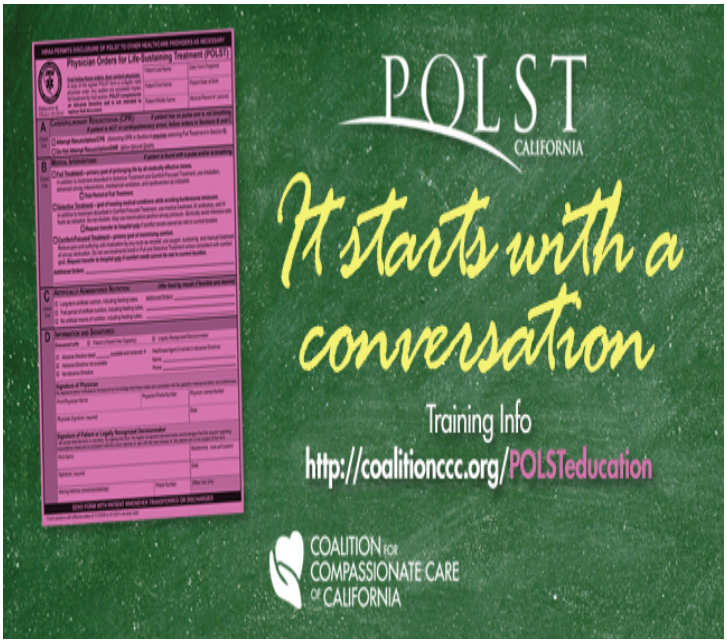
Download answers to 36 questions asked during the webinar (PDF)

Support Our Work

this email. *Thanks!*

Questions?

Healthcare professionals with questions about POLST are encouraged to connect with their local POLST Coalition, or contact the Coalition for Compassionate Care of California.



Finally! Have effective POLST conversations

POLST: It Starts with a Conversation is a two-day program designed to help healthcare providers and organizations develop the skills necessary to have quality POLST conversations. Using the standardized California POLST curriculum, the program guides participants through the POLST form and uses role-playing exercises to model the complex scenarios that arise during end-of-life care

discussions.

- **San Diego:** February 23-24, 2016
- **San Francisco:** July 14-15, 2016

Learn more...

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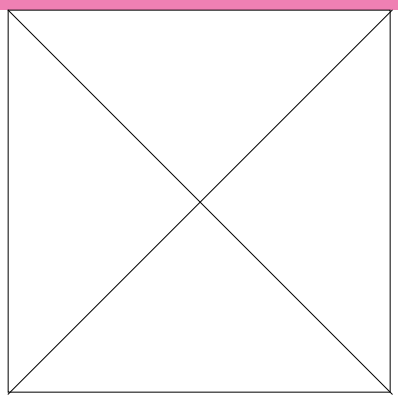

Close

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 1/1/2016)*

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document**.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — CARDIOPULMONARY RESUSCITATION (CPR): *If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

Check One

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — MEDICAL INTERVENTIONS: *If patient is found with a pulse and/or is breathing.*

Check One

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Request transfer to hospital only** if comfort needs cannot be met in current location.*

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

_____

C — ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Check One

☐ Long-term artificial nutrition, including feeding tubes.
☐ Trial period of artificial nutrition, including feeding tubes.
☐ No artificial means of nutrition, including feeding tubes.

Additional Orders: _____
_____
_____

D — INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed →
☐ Advance Directive not available
☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	**FOR REGISTRY USE ONLY**
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011 or 10/1/2014 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: M F

NP/PA's Supervising Physician	**Preparer Name** (if other than signing Physician/NP/PA)	
Name:	Name/Title:	Phone #:

Additional Contact ☐ None

Name:	Relationship to Patient:	Phone #:

Directions for Health Care Provider

Completing POLST

- **Completing a POLST form is voluntary**. California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive**. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit **www.caPOLST.org**.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

BOARD OF REGISTERED NURSING
Nursing Practice Committee
Agenda Item Summary

AGENDA ITEM: 10.3
DATE: February 11, 2016

ACTION REQUESTED: **Information Only: Emergency Medical Services Authority regulations for lay rescuer epinephrine auto-injector training certification standards**

REQUESTED BY: **Trande Phillips RN**
Chair, Nursing Practice Committee

BACKGROUND:
The Emergency Medical Services Authority announces that the *lay rescuer epinephrine auto-injector training certification standards* regulations were approved by the Office of Administrative Law on October 16, 2015 and became effective January 1, 2016.

On January 1, 2016 the EMS Authority can begin reviewing and approving training programs to provide training and certification for the administration of epinephrine auto-injectors to lay rescuers and off-duty EMS personnel.

Certification from an approved training program will allow a layperson or off-duty EMS personnel to obtain a prescription for and administer an epinephrine auto-injector for use on a person experiencing anaphylaxis, with civil liability protection, when acting in good faith and not for compensation.

EMS Authority Contact
Corrine Fishman, Program Analyst
Personnel Standards Unit
Emergency Medical Services Authority
Phone: (916) 431-3727
Fax: (916) 324-2875
e-mail: corrine.fishman@emda.ca.gov

NEXT STEPS: Place on Board agenda.

FISCAL IMPACT, IF ANY: **None**

PERSON(S) TO CONTACT: Janette Wackerly, RN, BSN, MBA
Supervising Nursing Education Consultant
(916) 574-7686

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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Louise R. Bailey, MEd, RN, Executive Officer

Emergency Medical Services Authority

Lay rescuer epinephrine auto-injector training certification standards

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Effective January 1, 2016

California Code of Regulations
Title 22. Social Security
Division 9. Prehospital Emergency Medical Services
Chapter 1.9. Lay Rescuer Epinephrine Auto-injector Training Certification Standards.

On January 1, 2016 the EMS Authority can begin reviewing and approving training programs to provide training and certification for administration of epinephrine auto-injectors to lay rescuers and off-duty EMS personnel.

Certification from an approved training program will allow a layperson or off duty EMS personnel to obtain a prescription for and administer an epinephrine auto injector for use on a person experiencing anaphylaxis, with civil liability protection, when acting in good faith and not for compensation.

Information can be obtained about the approved training program:
Emergency Medical Services Authority
Phone- 916-322-4336
Fax- 916-324-2875
Website tentatively scheduled to be up for January 1, 2016

A copy of the approved regulations is attached

California Code of Regulations
Title 22. Social Security
Division 9. Prehospital Emergency Medical Services
Chapter 1.9. Lay Rescuer Epinephrine Auto-injector Training Certification Standards

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Article 1. Definitions.

§ 100044 Anaphylaxis.

"Anaphylaxis" means a potentially life-threatening hypersensitivity or allergic reaction.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

§ 100044.1. Approved Training Program.

"Approved training program" means a training program that is approved by the EMS Authority to provide epinephrine auto-injector training.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

§ 100044.2. Authorized Health Care Provider.

"Authorized Health Care Provider" means a currently licensed health care professional who is legally authorized in California to issue a prescription for or dispense an epinephrine auto-injector to an individual who meets the requirements of Section 100046 of this Chapter.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

§ 100044.3. Authorized Training Provider.

"Authorized training provider" or "instructor" means an individual who is authorized by an approved training program to provide epinephrine auto-injector training as approved by the EMS Authority and who meets the requirements set forth in Section 100050 of this Chapter.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

§ 100044.4. Automated External Defibrillator.

"Automated external defibrillator" or "AED" means an external defibrillator capable of cardiac rhythm analysis which will charge and deliver a shock either automatically or by

user interaction after electronically detecting and assessing ventricular fibrillation or rapid ventricular tachycardia.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.5, 1797.190, 1797.196, 1797.197 and 1797.197a, Health and Safety Code and Section 1714.23, Civil Code.

§ 100044.5. Cardiopulmonary Resuscitation.
"Cardiopulmonary resuscitation" (CPR) means ensuring adequate circulation either spontaneously or by means of closed chest cardiac compression, establishing and maintaining an open airway, and ensuring adequate ventilation equivalent to current standards promulgated by the American Heart Association's (AHA) Guidelines for CPR and Emergency Cardiovascular Care (ECC) or the American Red Cross.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code; and Section 1714.23, Civil Code.

§ 100044.6. Certification of Training.
"Certification of training" means the certification card issued by the EMS Authority to an individual who satisfies the requirements outlined in Section 100046.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

§ 100044.7. Epinephrine Auto-injector.
"Epinephrine auto-injector" means a disposable drug delivery system with a spring-activated needle that is designed for emergency administration of epinephrine to provide rapid, convenient first aid for persons suffering from anaphylaxis.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a and Section 1714.23, Civil Code.

§ 100044.8. Lay Rescuer.
"Lay rescuer" means any person who has met the training standards and other requirements of this Chapter but who is not otherwise licensed or certified to use an epinephrine auto-injector on another person.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code; and Section 1714.23, Civil Code.

§ 100044.9. Prehospital Emergency Medical Care Person.
"Prehospital emergency medical care person" means any of the following: authorized registered nurse, mobile intensive care nurse, nurse practitioner, nurse midwives, clinical nurse specialist, nurse anesthetists, physician assistant, emergency medical technician, advanced emergency medical technician, paramedic, lifeguard, firefighter, peace officer, or a physician and surgeon who provides prehospital emergency medical care or rescue services.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.56, 1797.80, 1797.82, 1797.84, 1797.182, 1797.183, 1797.189, 1797.197 and 1797.197a, Health and Safety Code; and Section 1714.23, Civil Code.

§ 100044.10. Training Program Director.

"Training program director" means the person who is designated in the application as the director and who provides oversight of the approved training program as set forth in Section 100049 of this Chapter.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

Article 2. Certification Requirements.

§ 100045. Application and Scope.

(a) Upon certification by the EMS Authority as defined in Section 100044.6 a lay rescuer, or off-duty prehospital emergency medical care personnel are authorized to administer an epinephrine auto-injector to treat a person who is suffering or reasonably believed to be suffering from anaphylaxis under the following conditions:

(1) The epinephrine auto-injector is legally obtained by prescription from an authorized health care provider who may issue a prescription for an epinephrine auto-injector to a person described in this subdivision for the purpose of rendering emergency care to another person upon presentation of current and valid certification card issued by the EMS Authority, and

(2) The epinephrine auto-injector is used on an individual, with the express or implied consent of that person, to treat anaphylaxis, and

(3) The epinephrine auto-injector is stored and maintained as directed by the manufacturer's instructions for that product, and

(4) The emergency medical services system is activated as soon as practical when an epinephrine auto-injector is used.

(b) Certified persons shall make, maintain, and make available to EMSA upon request a record for five years reflecting:

(1) Dates of receipt, use and destruction of each auto-injector dispensed, and

(2) The name of any person to whom epinephrine was administered by using an auto-injector, and

(3) The circumstances and manner of disposal of any auto-injectors.

(c) The training standards prescribed by this Chapter shall apply to lay rescuers and off duty prehospital emergency medical care personnel.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code, 4119.3 of the Business and Professions Code.

§ 100046. Certification Requirements.

(a) An individual who meets all of the following criteria shall be eligible for certification by the EMS Authority:
(1) Successful completion of training from an epinephrine auto-injector training program approved pursuant to Section 100047 of this Chapter, and
(2) Course completion document provided by the training program and signed by the class instructor and,
(3) Current certification in CPR and AED for infants, children and adults equivalent to the current standards of the American Red Cross and/or the AHA Guidelines for CPR and ECC and,
(4) Payment of all fees pursuant to Section 100054 of this Chapter and,
(5) Submit the State of California Epinephrine Certification Application form #1.9app (6/2015) herein incorporated by reference.
(b) Currently licensed California health care professionals including physician assistants, registered nurses, nurse practitioners, nurse midwives , clinical nurse specialists, nurse anesthetists, mobile intensive care nurses and currently licensed or certified California paramedics and advanced emergency medical technicians (AEMTs) shall be deemed to have met the requirement for training and are eligible for certification under this Chapter and may apply to the EMS Authority for a certification card using the State of California Epinephrine Certification Application form # 1.9app (6/2015).
(c) California emergency medical technicians, lifeguards, firefighters and peace officers in this state who have current documentation of successfully completed training in the administration of epinephrine by auto-injector, approved by a local EMS agency or the EMS Authority, are eligible for certification under this Chapter and may apply to the EMS Authority for a certification card using the State of California Epinephrine Certification Application form # 1.9app (6/2015).
(d) The effective date of the certification shall be the day the certification is issued by the EMS Authority.
(e) The certification card shall be valid for two (2) years from the last day of the month in which it was issued.
(f) The requirements and process for renewal of the certification are the same as that for the initial certification as described in Section 100046 (a)(1)-(5),(b) and (c).
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code.

Article 3. Training Program Requirements.

§ 100047. Procedures for Training Program Approval.

(a) Prospective training programs shall submit a written request for training program approval to the EMS Authority.
(b) The EMS Authority shall receive and review the following prior to program approval:
(1) A statement verifying that the course content meets the requirements set forth in Section 100048 of this Chapter, and
(2) An outline of course objectives, and

(3) A final written and skills competency examination, and
(4) The name and qualifications of the program director, and
(5) The training program address and phone number, and
(6) A copy of the training course curriculum including any workbooks, videos, textbooks, or handouts if used in the course, and
(7) The required fees for program review, and
(8) A copy of a course completion document to be provided to students who successfully complete training which shall contain all of the following elements:
(A) The name of the training program, and
(B) The name of the individual completing the course, and
(C) The course completion date, and
(D) A signature line for the class instructor, and
(E) Course name.
(c) All program materials and student records specified in this chapter shall be subject to periodic review, evaluation and monitoring by the EMS Authority.
(d) Any person or agency conducting a training program shall notify the EMS Authority in writing within thirty (30) calendar days of any change in program director, instructor, and change of address, phone number, and contact person.
(e) Any change to the curriculum once approved, shall be submitted for review and approval by the EMS Authority and shall include the requirements of Section 100048 Subsections (a) and (b) (1)-(12) and subsection (a)(2) of Section 100054
(f) The EMS Authority may request additional materials or documentation as a condition of course approval.
(g) The requirements and process for renewal of approval are the same as that for the initial approval.
(1) The training program shall submit an application for renewal at least sixty (60) calendar days before the expiration date of their approval in order to maintain continuous approval.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code

§ 100048. Course Content Requirements.
(a) Training in the administration of epinephrine shall result in the lay rescuer demonstrating competency in the assessment, management and administration of epinephrine to an individual suspected of having an anaphylactic reaction.
(b) The following topics and skills shall be included in the training:
(1) Common causative agents,
(2) Recognition of symptoms of anaphylaxis,
(3) Recognition of signs of anaphylaxis,
(4) Acquisition and disposal of epinephrine auto-injectors,
(5) Maintenance and quality assessment of epinephrine auto-injectors,
(6) Emergency use of an epinephrine auto-injector
(A) Indications,

(B) Contraindications,
(C) Adverse effects,
(D) Administration by auto-injector,
(E) Dosing,
(F) Drug actions,
(G) Proper storage, handling and disposal of used/or expired injectors,
(7) Consent law,
(8) Good Samaritan law,
(9) Emergency Care Plans,
(10) Activation of the EMS system by calling 9-1-1,
(11) Commonly available models of epinephrine auto-injectors,
(12) Record keeping requirement as specified in Section 100045(b).
(c) At the completion of training, the student shall successfully complete a competency based written and skills examination which shall include all the course content requirements listed in subsection (b) of this Section.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code

§ 100049. Director Requirements.
(a) Each training program shall have a program director that shall be qualified by education and experience in methods, materials, and evaluation of instruction.
(b) Duties of the program director shall include but not be limited to:
(1) Administering the training program, and
(2) Approving course content, and
(3) Approving all written examinations and the final skills examination, and
(4) Approving all instructor(s), and
(5) Assuring all aspects of the training program are in compliance with this Chapter and other related laws.
(6) Provide to the EMS Authority a list of all instructors at least every thirty (30) calendar days or,
(7) Notify the EMS Authority of any changes to the approved instructor list within fifteen (15) calendar days.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code

§ 100050. Instructor Requirements.
(a) Each instructor shall:
(1) Be authorized by an approved training program, and
(2) Be approved by the training program director as qualified to teach by education and experience in methods, materials, and evaluation of instruction, and
(3) Possess current certification in first aid, CPR and AED.
(b) Upon completion of each epinephrine auto-injector course the instructor shall provide the individual with a signed course completion document.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code

§ 100051. Notification of Program Approval.

(a) The EMS Authority shall notify the training program within twenty-one (21) working days of receiving its request that:

(1) The request has been received, and

(2) The request contains or does not contain the information requested in Section 100047 of this Chapter, and

(3) What information, if any, is missing from the request.

(b) Program approval or disapproval shall be made in writing by the EMS Authority to the applying training program within sixty (60) days of receiving all application information. The training program shall complete all modifications to an application or program required by the EMS Authority before approval can be given.

(c) The EMS Authority shall establish the effective date of training program approval in writing once the training program is reviewed and found in compliance with all program requirements. The EMS Authority shall issue a certificate of approval to the training program with the effective date and an expiration date.

(d) Program approval shall be for four (4) years from the last day of the month in which the approval is given and shall be reviewed by the EMS Authority for approval every four (4) years or sooner at the discretion of the EMS Authority.

(e) Approved training programs shall notify the EMS Authority in writing, and within thirty (30) calendar days of any change in name, address, phone number, hours of instruction, or program director.

Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code

§ 100052. Withdrawal of Program Approval.

(a) Failure to comply with any requirement for program approval, use of any unqualified teaching personnel, or noncompliance with any other applicable provision of this Chapter may result in probation, suspension, revocation, or denial of renewal of program approval by the EMS Authority.

(b) Notification of noncompliance and action to place on probation, suspend, or revoke shall be done as follows:

(1) The EMS Authority shall notify the approved training program course director in writing, by registered mail, of the provisions of this Chapter with which the training program is not in compliance.

(2) Within fifteen (15) working days of receipt of the notification of noncompliance, the approved training program shall submit in writing, by registered mail, to the EMS Authority one of the following:

(A) Evidence of compliance with this Chapter, or

(B) A plan for meeting compliance with the provisions of this Chapter within sixty (60) calendar days from the day of receipt of the notification of noncompliance.

(3) Within thirty (30) calendar days from the mailing date of the noncompliance notification the EMS Authority shall notify the approved training program in writing, by registered mail, of the decision to accept the evidence of compliance, accept the plan for meeting compliance, place on probation, suspend or revoke the training program approval.
(4) If the EMS Authority decides to suspend, revoke, or place a training program on probation the notification specified in the subsection (b) (3) of this Section shall include the beginning and ending dates of the probation or suspension and the terms and conditions for lifting of the probation or suspension or the effective date of the revocation which shall not be less than sixty (60) calendar days from the date of the EMS Authority's letter of decision to the approved training program.
Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections 1797.197 and 1797.197a, Health and Safety Code

§ 100053. Certification Card.
(a) The EMS Authority shall issue a certification card to each individual who satisfies the requirements of Section 100046
(b) The certification card shall contain all of the following:
(1) The name of the individual completing the course
(2) The course completion date
(3) Certification expiration date
(4) Certification number
(5) The title of the card shall be listed as: Epinephrine Auto-injector Certification.
(6) The signature of the certified Health and Safety Code Section 1797.197a Responder, affirming the statement: "I understand the scope of my authority and responsibilities as a trained Health and Safety Code Section 1797.197a Responder, and will possess and only employ epinephrine consistent with that Health and Safety Code Section 1797.197a training and applicable law, including activation of the Emergency Medical Services System and record keeping."
Note: Authority cited: Sections 1797.107, Health and Safety Code. Reference: Sections, 1797.197 and 1797.197a, Health and Safety Code.

Article 4. Fees.

§ 100054. Fees.
(a) Each epinephrine training program submitting a written request for program approval shall include a fee of:
(1) Five hundred ($500) dollars for approval and re-approval of a training program.
(2) Two hundred and fifty ($250) dollars for any changes in the course content or curriculum occurring outside of the renewal period.
(b) Each individual submitting an application for certification, recertification, or request for a replacement card shall include a fee of:
(1) Fifteen ($15) dollars.

1 (c) All fees are nonrefundable.
2 Note: Authority cited: Section 1797.107, Health and Safety Code. Reference: Sections
3 1797.197 and 1797.197a, Health and Safety Code
4
5
6

BOARD OF REGISTERED NURSING
Nursing Practice Committee
Agenda Item Summary

AGENDA ITEM:10.4
DATE: February 12, 2016

ACTION REQUESTED: **Information Only: RN Role Reimagined –How Empowering Registered Nurses Can Improve Primary Care by California Healthcare Foundation August 2015**

REQUESTED BY: **Trande Phillips RN**
Chair, Nursing Practice Committee

BACKGROUND:
About the Authors: The Center for Excellence in Primary Care (CEPC) is a research and policy center within the University of California, San Francisco, Department of Family and Community Medicine.
About the Foundation: The California Foundation (CHCF) is leading the way to better health care for all Californians. CHCF informs policymakers and industry leaders, invests in ideas and innovations and connects with changemakers to create a more responsive, patient-centered health care system.
Strategies for Changing the RN Role (Please read the attachment for CHCF report)

1. Provide RNs with additional training in primary care skills, so they can make more clinical decisions
2. Empower RNs to make more clinical decisions, using standardized procedures
3. Reduce the triage burden of RNs to free up time for other responsibilities
4. Include RNs on care teams, allowing them to focus on their team's patients
5. Implement RN-led new patient visits to increase patient access to care
6. Offer patients co-visits in which RN conduct most of the visit, with provider joining in a the end
7. Deploy RNs as "tactical nurses"
8. Provide patient with RN-led chronic care management visits
9. Employ RNs' skills to care manage patient with complex health care needs
10. Train some RNs to take responsibility for specialized functions
11. Schedule RNs to perform different roles on different days
12. Preserve the traditional RN role and focus on training MAs and LVNs to take one new responsibilities.

This report explores how safety-net clinics are responding to the challenge of using RNs' skills. The report focuses on community health centers and county health systems in California; two health centers outside Californian are listed.

The report identifies the American Academy of Ambulatory Care Nursing (AACN) recognizing the "evolving medical home concept reinforces the critical need for registered nurses to provide

chronic disease management, core coordination, health risk appraisal, health promotion and disease prevention services”

The report, Appendix A: Example of RN Prescription Refill Procedure by Standardized Procedure

Place on Board agenda.

NEXT STEPS:

FISCAL IMPACT, IF ANY: **None**

PERSON(S) TO CONTACT: Janette Wackerly, RN, BSN, MBA
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CALIFORNIA HEALTHCARE FOUNDATION

RN Role Reimagined:
How Empowering Registered Nurses Can Improve Primary Care

AUGUST 2015

Contents

About the Authors

The Center for Excellence in Primary Care (CEPC) is a research and policy center within the University of California, San Francisco, Department of Family and Community Medicine. CEPC identifies, develops, tests, and disseminates promising innovations in primary care to improve the patient experience, enhance population health and health equity, reduce the cost of care, and restore joy and satisfaction in the practice of primary care (cepc.ucsf.edu).

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About the Foundation

The California HealthCare Foundation (CHCF) is leading the way to better health care for all Californians, particularly those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

For more information, visit www.chcf.org.

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Demand for primary care is on the rise, and the number of primary care clinicians — including physicians, nurse practitioners, and physician assistants — is dwindling. Safety-net providers are looking to a team model of care to meet the needs of large panels of patients. In this model, responsibility for the health of the patient panel is shared among members of the team, and nonclinician team members are empowered to provide care to patients independently of clinicians.[1]

It is within this primary care transformation that the question arises: What is the role of the registered nurse (RN) in primary care? It is particularly in community health centers and county health systems — many of which employ RNs — that the RN role is being actively debated.

This report explores how safety-net clinics are responding to the challenge of using RNs' skills. The report focuses on community health centers and county health systems in California; two health centers outside California are included as highly successful models of expanding the RN role in primary care.

Background

With the current primary care provider shortage in the United States, the field of primary care is unable to deliver all the acute, chronic, and preventive care services that the community needs.

Primary care providers recognize the need for an interprofessional team to help them provide this care. Many providers who work in primary care settings with registered nurses appreciate their ability to fill in the care and communication gaps that are inevitable in a busy practice. Overburdened providers are some of the strongest advocates for expanding nursing roles in primary care. One clinic medical director affirmed, "RNs are highly skilled and can address many patients' needs independently."

Nurses are a large and dynamic workforce that can be tapped to promote patient engagement and help patients attain the skills and knowledge needed to improve their health. Untethered from the confines of fee-for-service payment systems, in the future, more and more primary care will be delivered by alternative methods such as telephone visits and electronic communication, thus improving the convenience and care experience for patients and their families. Nurses are in a unique position to build on trusting patient relationships to fill these needs as the health coaches, health educators, and chronic care managers of the future.

In this context, safety-net providers are asking, "What is the proper role of RNs in primary care?" Primary care practices face four main challenges in answering this question:

1. RNs spend much of their day triaging patients, leaving little time for expanding their role.
2. Present-day RN education programs do not focus on primary care.
3. RNs are expensive.
4. RNs do not bring in revenue.

Private primary care practices typically respond to these dilemmas by not using RNs at all.

CHALLENGE 1: Time-consuming triage needs

Due to the shortage of primary care providers, many primary care practices are unable to provide all patients with same-day access to care. This situation requires that patient requests for care be appropriately triaged. A person with RN-level clinical judgment must decide who simply needs telephone advice, who can wait for an appointment, who needs to be seen in the next day or two, and who needs to go directly to the emergency department (ED). Triage can occur by phone, at the clinic for walk-in patients, and through electronic medical record (EMR) in-box messages. Triage can occupy most of the average primary care RN's day. Many RNs report frustration with triage taking up a large proportion of their time. Because RNs are traditionally not empowered to make clinical decisions, they are often unable to address the patient's problem directly without provider referral.

CHALLENGE 2: The need for more primary care nursing education

Though RNs are highly trained, most nursing schools focus primarily on hospital and home care nursing and have not created a primary care track that arms RNs with all the knowledge and skills required to assume responsibility for primary care patients.

The US Bureau of Labor Statistics reports that in 2012, 61% of RNs were employed in hospitals, 7% in long-term care facilities, 6% in home care, 6% in government facilities such as the Veterans Health Administration, and 7% in physician offices.[2] The percentage in community health centers is not provided but makes up a small proportion of total RN jobs. Many nurses working in primary care are advanced practice nurses — in particular, nurse practitioners. Because most nursing jobs are outside the primary care sector, nursing schools have traditionally de-emphasized the teaching of primary care nursing skills.

A nurse leader of a large health system explained, "Working in outpatient settings can be challenging for nurses. Nursing schools need to adapt and teach ambulatory care nursing skills. In an inpatient setting, you have a set of routine orders and report off to the next shift. In ambulatory care, you don't have physician orders guiding your actions, and you need to decide what can wait until tomorrow."

In primary care clinics, patient populations present with hundreds of diagnoses and psychosocial issues. Some RNs, with much of their training focused in hospital medicine, lack experience with this breadth of clinical problems and do not feel comfortable in the primary care environment. One health center nurse leader explained, "Nursing schools focus on inpatient nursing and don't see primary care nursing as a specialty unto itself." Yet proposals for nursing education reform tend to emphasize advanced practice nursing rather than a primary care-oriented curriculum in undergraduate nursing programs.[3]

CHALLENGE 3: High nursing salaries

As highly educated and skilled professionals, RNs in California are expensive to hire for the under-resourced primary care sector. According to the US Bureau of Labor Statistics, the average national 2014 salary for an RN was $69,790. For California, the average salary was $98,400. Nationally, the average licensed vocational nurse/licensed practical nurse (LVN/LPN) earned $43,420 (up to $51,700 in California), and the average medical assistant (MA), $31,220 ($34,790 in California).[4] While RN salaries in California community health centers are below the average hospital salary, health centers still have to justify to their chief financial officer why hiring additional RNs, as opposed to LVNs/LPNs or MAs with lower salaries, is a sensible choice.

CHALLENGE 4: Little nursing reimbursement

Public and private insurers in the dominant fee-for-service reimbursement environment rarely pay for RNs to independently care for patients. The issue of RN reimbursement becomes crucial for the financial sustainability of primary care practices.

To address this issue, some health centers have implemented co-visits (also called "flip visits"), during which the RN takes the patient's history, may do a physical exam, orders diagnostic studies, and makes a provisional assessment and plan. A provider then enters the room and receives a brief report from the RN, who then may serve as scribe, documenting the provider's diagnosis and care plan. The RN implements the care plan, including patient education. Co-visits can often be billed as provider visits as long as the documentation complies with the payer's regulations. Some clinics also use the billing code 99211 for RN-only visits if the visits conform to this code's regulations; however, reimbursement is low under this billing code.

Despite these challenges, in the current atmosphere of growing expectations for primary care, RNs in safety-net clinics are being asked to do more than ever before. This report describes the attempts of several safety-net clinics to navigate this difficult terrain.

Methods

The Center for Excellence in Primary Care (CEPC) of the Department of Family & Community Medicine at the University of California, San Francisco, led this project. The CEPC project team, with the help of the project's funder, California HealthCare Foundation, identified community health centers, county health systems, and one integrated delivery system in California with reputations of building strong primary care teams. Clinic leaders were contacted by email and asked whether they or others had made institutional changes to the primary care RN role.

This process generated a list of 21 organizations, of which 11 reported having made changes in the RN role. In addition, the project team was aware of two health

centers outside California that leverage RN skills in innovative ways. Including these non-California clinics, a total of 13 organizations contributed to this report. (See Table 1.) The project team also identified and interviewed a few individuals who are knowledgeable about the legal scope of RN practice in California.

The CEPC team conducted hour-long phone interviews with leaders of nine primary care facilities using a standard questionnaire developed by the CEPC team. Six were with California community health centers, one with a California county health system, one with a California integrated delivery system, and one with an out-of-state community health center. The project team conducted three site visits in California, to one community health center and two county health system-affiliated clinics. During these visits, team members spoke with leaders and shadowed frontline RNs during their daily work. Prior to the initiation of this project, two of the project team members had visited a primary care center in Sweden, where the RN role had been greatly expanded. Researchers consulted notes from these previous visits for this project. In addition, the research team conducted phone interviews, using a focused questionnaire, with seven experts on the California RN scope of practice.

This report describes some of the different strategies for changing the role of the RN in the primary care setting, using examples from the California-based organizations contacted. The two out-of-state examples, which greatly expand the RN role, are described separately.

Table 1. Primary Care Sites Interviewed

	COMMUNITY HEALTH CENTER	COUNTY HEALTH SYSTEM	INTEGRATED DELIVERY SYSTEM
In California			
Coastal Health Alliance, Marin County	X		
Neighborhood Healthcare, San Diego County	X		
Northeast Valley Health Corporation, Los Angeles County	X		
Palo Alto Medical Foundation sites, Alameda County			X
Petaluma Health Center, Sonoma County	X		
San Bernardino County's Arrowhead Regional Medical Center		X	
San Francisco Department of Public Health's SF Health Network		X	
Santa Rosa Community Health Centers, Sonoma County	X		
Shasta Community Health Center, Shasta County	X		
Silver Avenue Family Health Center, SF Health Network		X	
West County Health Centers, Sonoma County	X		
Outside California			
Community Health Center, Inc., Connecticut	X		
Norrahammar Health Center in Jönköping County, Sweden			X

Strategies for Changing the RN Role

A wide variety of strategies are being used by the clinics studied to optimize the RN role in primary care, ranging from employing fewer RNs in primary care to giving RNs responsibility for a large proportion of primary care encounters. (See sidebar.)

Strategies for Enhancing the Role of RNs in Primary Care

1. Provide RNs with additional training in primary care skills, so they can make more clinical decisions.
2. Empower RNs to make more clinical decisions, using standardized procedures.
3. Reduce the triage burden on RNs to free up time for other responsibilities.
4. Include RNs on care teams, allowing them to focus on their team's patients.
5. Implement RN-led new-patient visits to increase patient access to care.
6. Offer patients co-visits in which RNs conduct most of the visit, with providers joining in at the end.
7. Deploy RNs as "tactical nurses."
8. Provide patients with RN-led chronic care management visits.
9. Employ RNs' skills to care-manage patients with complex health care needs.
10. Train some RNs to take responsibility for specialized functions.
11. Schedule RNs to perform different roles on different days.
12. Preserve the traditional RN role and focus on training MAs and LVNs to take on new responsibilities.

1. Provide RNs with additional training in primary care skills, so they can make more clinical decisions

Nurse training programs have traditionally focused on hospital and home care and have not concentrated on primary care.

Because Coastal Health Alliance leaders believe that nursing schools generally do not offer students sufficient training in primary care nursing, the organization has created a curriculum to train its new RN hires to make certain decisions — that are within the RN's scope of practice — independent of providers.

The organization's curriculum, led by a nurse practitioner, lasts five weeks and includes taking histories, doing physical exams, making brief case presentations to providers, solving common triage situations, and mastering clinic workflow. Clinical topics include the basics of cardiovascular disease, diabetes, common mental health issues, domestic violence, and patient education for many chronic conditions. A competency checklist for each RN includes about 100 items they are expected to master.

At Petaluma Health Center, training is considered key to the expanded RN role. New RNs participate in a one-month orientation, which includes triage management, use of various protocols, and prescription refills, among other skills. New RNs are then paired with an established RN for three to four weeks. The nurse manager has developed competency lists, which RNs use for self-evaluation, followed by a nurse manager review. Each week the nurses meet with a provider at lunchtime for follow-up training.

2. Empower RNs to make more clinical decisions, using standardized procedures

The California Board of Registered Nursing allows an expanded RN scope of practice using standardized procedures, which can empower RNs to make more independent decisions. (See page 13 for a detailed discussion of standardized procedures.)

Shasta Community Health Center has established an extensive protocol that empowers RNs and LVNs to order

medication refills. The protocol includes over 100 medications and provides guidance for standardized refills of each medication after accounting for the patient's last visit, results of laboratory tests, and other clinical considerations. Neighborhood Healthcare has a similar protocol for RNs to refill cardiovascular medications. West County Health Centers has standardized procedures for RNs to refill medications except those that are controlled or psychotropic and also has titration protocols for patients at high risk of cardiovascular events. The standardized procedures for these three clinics are written and monitored to assure compliance with the California Board of Registered Nursing requirements.

Petaluma Health Center has developed standardized procedures for medication refills, tuberculosis testing, anticoagulation management, clozapine monitoring, and chronic disease management. The standardized procedures are approved first by the center's compliance and risk manager, with final approval by the chief medical officer (CMO). Petaluma is considering a pilot program that would allow RNs to propose adjustments in certain medication doses, with providers making the final decision.

An example of a standardized procedure medication refill protocol is provided in Appendix A.

3. Reduce the triage burden on RNs to free up time for other responsibilities

Because they are rarely empowered to make independent clinical decisions, RNs are often frustrated with the many hours spent on patient triage.

In their expanded role at Shasta Community Health Center, LVNs answer some triage calls, acquire pertinent information, solve the problem if possible, and then connect the patient with an RN, thereby saving RNs time. Even with LVNs taking on some triage tasks, Shasta RNs still handle 15 to 25 triage calls each day plus walk-in triage, taking an estimated four hours of each RN's time per day. To make triage more productive, RNs at Shasta are authorized to consult a provider quickly to solve a triage issue without requiring a provider visit.

Coastal Health Alliance views acute RN visits as an extension of triage. RNs spend approximately 70% of their time doing phone triage. For walk-in triage, RNs may turn the triage encounter into an independent RN visit if the RN has the training and authority, or as a co-visit with a clinician. Approximately 80% to 90% of all triage encounters end up with a provider visit or co-visit; 10% to 20% of the time, RNs are able to address the patient's issue independently.

West County Health Centers rotate responsibility for the triage function, with each RN performing triage for the entire site two to three half-day sessions per week. On their nontriage half-days, RNs respond to EMR in-box messages from patients on their team and spend the majority of their time doing complex care management, transition care, and other care management tasks.

At Palo Alto Medical Foundation's Fremont practice, RNs rotate between triage advice, in-box management, and other duties so that RNs are not responsible for triage every day. When they are on triage duty for internal medicine (adult patients), RNs may spend a major portion of their day handling in-box messages and providing phone advice. An internal study conducted several years ago found that approximately 70% of RN triage and in-box issues at this practice required provider input, whereas 30% could be handled by RNs independently.

4. Include RNs on care teams, allowing them to focus on their team's patients

When RNs are responsible for providing care across an entire practice, they are not able to develop strong relationships with individual patients. Placing RNs on care teams allows RNs to focus only on those patients empaneled to their team. This strategy is only successful in clinics with stable teams caring for a defined panel of patients. Those working in primary care generally prefer to be well acquainted with a specific group of patients as this relationship makes the care more meaningful for health workers and increases patient trust. Research has shown that patients want to know their care team members and want the team to know them.[5] The team-based RN strategy enhances patient, provider, and RN satisfaction.

At West County Health Centers, a group of patients is empaneled to a four-member care team, including a provider, RN, MA, and front desk person. The RN-to-provider ratio is 1:1.2. With this model, the patients get to know

their team RN, and the RN develops relationships with each patient. West County's teams are similar to the team structure used throughout the Veterans Health Administration, which has been widely studied.[6]

Each RN at West County has multiple responsibilities, including addressing EMR in-box messages, which can consume several hours each day; performing chronic care visits; and managing the small number of patients on their team with complex care needs through RN visits and home visits. West County RNs also provide transitional care for patients on their team who have been hospitalized: They communicate with a transitional care RN at the hospital, conduct a home visit within 48 hours of discharge, and continue focused transition care for 30 days after discharge. RNs huddle with their teammates each day and discuss, for example, which patients may need a chronic care RN visit that day, when the RN will be away doing a home visit, or what to do about a patient on chronic opioid medications who is not adhering to the pain contract. Responsibility for triage is shared among RNs throughout the practice; each RN is responsible for two to three half-day triage sessions per week.

At Santa Rosa Community Health Centers, RNs previously took four-hour shifts each day doing triage for all patients at their site, and also had a half-day shift each week doing triage at the organization's centralized call center. The RNs did not like the triage responsibility because they were rarely empowered to make clinical decisions. In 2012, the process was changed at the Vista site so that RNs provided triage only for their own team's patients. RNs preferred this model because it meant that triage took up less of their day and they often knew the patients they were triaging. One nurse shared, "We used to hate the amount of triage; now we are much more satisfied." Clinic leaders estimated that RNs could handle about half of triage encounters without needing provider input. The RNs use a triage protocol book and can access the "doc of the day" for urgent consults if needed.

Petaluma Health Center has implemented a "teamlet model" in which a few two-person provider/MA dyads are grouped together into one larger team. The larger team includes two RNs for each of four to five teamlets. RNs are generally responsible only for patients empaneled to their team. The morning huddle begins with the entire team, followed by teamlet huddles. The RNs circulate among the teamlet huddles to plan which patients need RN visits. One of the two RNs on each team is the resource RN; the other is the team RN. The team RN is responsible for phone and walk-in triage, in-box management, telephone advice, refilling prescriptions using protocols, and responding to the needs of the team providers. Team RNs take new-patient histories and enter the information into the EMR. Team RNs have protocol books for triage and are estimated to handle 80% of triage encounters without a provider. (For ob/gyn patients, 50% of encounters require a provider visit.) Resource RNs see their own patients in 30-minute co-visits; they have about four of these visits per day.

5. Implement RN-led new-patient visits to increase patient access to care

At Shasta Community Health Center, new patients were waiting several weeks for their first appointment. The health center addressed this problem by having the call center schedule first-time patients with an RN, instead of a clinician, for their new-patient visit, which greatly reduced the patient wait time. These RN new-patient visits take 45 to 60 minutes and include building a comprehensive history in the chart, including documentation of social history, ordering pertinent laboratory work, and assessing the patient's acuity. Some patients are squeezed into a provider's schedule the same or next day; others receive later appointments. If diagnostic imaging is needed, the RN may contact a provider to order the appropriate study. A template and protocol for these visits is in the EMR. Most of the clinic's RNs conduct these visits; the RNs may be scheduled for four to five new-patient visits each day. Other RNs may be scheduled for one visit each day, during which the RN arranges for another RN to fill triage and other duties. The visits are not billed but can generate some pay-for-performance revenue.

At Silver Avenue Family Health Center, borrowing an innovation pioneered by San Francisco's Chinatown Public Health Center, some RNs do new-patient orientation clinics, with up to three visits in the morning and three in the afternoon. They can conduct these visits in English, Spanish, or Cantonese. The RNs can order labs following protocols. The visits are similar to those performed at Shasta and are also not billed.

6. Offer patients co-visits in which RNs conduct most of the visit, with providers joining in at the end

Co-visits, sometimes called "flip visits," are visits in which the RN independently handles the first portion of the patient appointment, which may involve taking the history, doing portions of the physical exam, and making a provisional assessment of the problem. The provider joins the RN and patient at the end of the visit, therefore making it billable.[7]

At Santa Rosa Community Health Centers, RNs start the visit for most new pre-natal patients and conduct 80% of the visit for well-baby care. At one site, for new patients over 60, RNs begin the visits, which are completed by the provider.

At Neighborhood Healthcare, RNs specially trained as RN panel managers are piloting flip visits with one physician for two common clinical conditions: pre-diabetes and *H. pylori*. The latter condition is treated with a complicated medication regimen, which patients often do not understand, so the RNs explain the regimen in detail. During pre-diabetes visits, RNs educate patients about their condition and coach them on making lifestyle changes. The physician comes in at the end of the visit. The clinic hopes to expand to more clinical conditions and more providers.

At Palo Alto Medical Foundation's Fremont site, some RNs engage in a type of co-visit called a "linked visit." Rather than having the RN start the visit and the provider complete it, the provider conducts the visit without the time-consuming patient education and care plan explanation, which is done by the RN immediately after the provider leaves.

Petaluma Health Center's co-visits are performed by the team's resource RN. Typical visits for the resource RN involve diabetic wound care, diabetes maintenance, blood pressure checks, new-patient visits, warfarin management, treatment of upper respiratory and urinary tract infections, and care for strep throats. Working under protocols, the nurses document each visit in the EMR and assign the visit to a co-visit provider. If the patient's primary care provider is available, that provider finishes the co-visit; if not, the "provider of the day" is typically available for co-visits. The team RN doing triage may add a co-visit to the resource RN's schedule. Because the co-visits are billed, they provide financial justification for the health center to be staffed with two RNs per team.

7. Deploy RNs as "tactical nurses"

At Petaluma Health Center, some RNs perform a role sometimes called the "tactical nurse," a concept pioneered by human resources and professional coaching firm Coleman Associates.[8] The tactical nurse develops plans with the care team during huddles each day, completes detailed histories for new patients on the schedule, conducts visits with patients who have complex care needs, performs phone and walk-in triage duties, and uses clinical judgment to anticipate what is needed on the team schedule that day. Petaluma's tactical nurses, who are referred to as team RNs, provide services only for their team's patients.

At Silver Avenue Family Health Center in San Francisco, a primary care site of the county's SF Health Network, RNs take turns assuming the tactical nurse role on different days. When working as a tactical nurse, RNs have a schedule for the day with 20-minute time slots. Nurses add new visits from the huddle and see drop-in patients. As a tactical nurse, the nurse spends about 40% of the time with walk-in triage, 40% with RN co-visits identified during the huddle, 10% addressing any clinical issues that arise, and 10% managing the EMR in-box. In-box messages can originate from the team clinicians, front desk, or other nurses. The messages include such issues as patient requests for appointments, lab and imaging results, medication changes, and provider requests to call or meet with patients. The scheduled co-visits are identified in the huddle by the patient's primary care clinician. In the co-visit, the RN takes vital signs, documents the patient's medical history, and presents the patient to the clinician. Tactical nurses can turn triage encounters into drop-in visits. The front desk has a list of clinical issues that can be scheduled for the tactical nurse to see as drop-ins or co-visits.

8. Provide patients with RN-led chronic care management visits

When RNs assist in the care of patients with chronic conditions, clinical outcomes for these patients improve compared with physician-only care.[9]

RNs at Santa Rosa Community Health Centers perform chronic care visits, mainly with diabetic patients. These visits use RNs' clinical skills and save time for providers. The visits typically last 30 to 40 minutes and include patient education, medication reconciliation, medication adherence counseling, and behavior-change goal setting. The RNs do not order labs, nor do they initiate or titrate medications. Providers are not involved in these visits, and there is no reimbursement. To increase the number of these visits, the health center reduced the amount of triage time per RN and hired more RNs.

At Shasta Community Health Center, RNs do patient education, medication reconciliation, and behavior-change counseling for patients with chronic conditions. They do not initiate medications or intensify medication doses. The visits are best performed immediately after the provider visit so that patients will not have to make an additional trip to the clinic.

At West County Health Centers, RNs conduct chronic care visits for the patients on their team. For example, RNs meet with diabetes patients about medication adherence and healthy behavior change and teach asthma patients how to use their inhalers.

Petaluma Health Center's resource RNs perform chronic care management visits with patients on their team. These visits include patient education, medication reconciliation, diet and exercise counseling, review of labs (e.g., HbA1c and low-density lipoprotein levels), diabetic foot exams, and goal setting. For patients on anticoagulation medications, RNs handle dose changes for warfarin based on evidence-based protocols in a co-visit format.

9. Employ RNs' skills to care-manage patients with complex health care needs

A number of health care organizations around the United States have initiated RN-led programs to improve the care and reduce the costs of patients with complex care needs.[10,11] These complex care management programs have become an important strategy for expanding the RN role in California's community health centers and county health systems.

Santa Rosa Community Health Centers developed an RN home visit program for patients with complex care needs. This program was partially funded by Partnership HealthPlan of California, the main insurer of the health center's Medi-Cal patients and therefore the organization that is at risk for the health care costs of these patients. The RNs are paired with a care coordinator, who may accompany the RN on the initial home visit. The care coordinator, who has minimal clinical training, assists the patients in navigating the health care and social services systems. Every day, each RN conducts about three to four home visits and three to four follow-up phone calls. The RNs co-manage the patients with the primary care physician.

At the home visits, Santa Rosa RNs can do any of the following tasks:

- Perform an overall health assessment
- Take vital signs
- Monitor oxygen saturation
- Educate patients about their condition
- Conduct medication reconciliation, education, and adherence counseling
- Assess for fall risk
- Screen for depression

RNs maintain their own schedules for the home visit program. The RNs check on the implementation of the care plan and, if necessary, contact the primary care physician from the patient's home. The home visits are not billed.

At West County Health Centers, patients with complex care needs who are high utilizers of the health care system — as identified by Partnership HealthPlan or clinic providers — are managed by their team RN. Rather than referring all such patients to a specialized complex care manager RN, all RNs have four to six patients with complex care needs who are on their team's panel. Most of these patients receive home visits from their team RN, who carries an iPad and can set up videoconferencing with the patient's provider at the home visit to allow for a conversation among the patient, RN, and provider. The initial home visit includes a lengthy assessment and formulation of a care plan.

The RN's care team discusses the plan, which the RN or another team member then carries out. The care plan might involve other staff, such as social workers,

behavioral health professionals, or patient navigators. Every six months, teams schedule a mini case conference to discuss each patient for 30 minutes. In addition, RNs may raise concerns they have with their complex care patients during any morning huddle. All RNs in the clinic receive special training on caring for patients with complex needs.

Petaluma Health Center's RN staff includes case management RNs, who have caseloads of approximately 50 patients each, and a diabetes care manager with a caseload of about 100. Case management RNs take patient histories and focused physical exams, do medication reconciliation and health education, help coordinate the patient's care with specialists, and discuss end-of-life wishes using POLST (Physician Orders for Life Sustaining Treatment) forms. The patient's provider may be asked to check in with the patient at the end of the visit. The case manager RNs generally work with the same group of patients for long periods of time.

Arrowhead Regional Medical Center initiated a complex care management program in early 2015. Four RNs, embedded in three primary care clinics, are responsible for small caseloads of high-utilizing patients with complex needs. The RNs, working closely with the patients' primary care physicians, care for their patients by phone, in scheduled nurse visits, and in physician visits attended by the RN. RNs call their patients weekly to check on their understanding of what to do if symptoms worsen (e.g., if heart failure patients gain weight), on medication adherence, and on the patients' success in meeting their behavior-change goals. One care management RN described the results of this program: "Job satisfaction has skyrocketed. Patients are so appreciative that they can call us and we are available for them."

The San Francisco Department of Public Health's SF Health Network has a Complex Care Management Program for patients at three primary care sites. At each site, the program is staffed by an RN leader and a health coach, who have access to a physician for oversight and to social workers. Patients are referred to the program if they have had three or more hospitalizations in the past year, or if their primary care physician feels that they are at risk for hospitalization. The program includes patients with diabetes, hypertension, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), asthma, chronic kidney disease, and chronic pain; many have four or five diagnoses. One-third to one-half have substance abuse or mental health issues or both. Many program participants are marginally housed; about 10% are homeless.

The complex care management RNs leading this program do not have other clinical duties and do have extensive experience in primary care. A typical caseload for an RN-health coach team is 50 patients. The teams meet weekly with the social worker and the complex care medical director. When patients are enrolled in the program, the RN and health coach do a home visit to conduct an initial assessment, create a care plan, and decide on initial goals, which are a combination of the patient's and the provider's objectives. Patients with greater acuity are scheduled for weekly encounters, mainly with the health coach, with phone or in-person visits becoming less frequent as the patient's conditions improve. Patients may have clinic appointments with the RN, who becomes move involved in the patient's care when medical issues escalate. The RNs work under patient-specific orders, not through standardized procedures. Through patient-specific orders, RNs can titrate medications such as diuretics for patients with CHF or insulin for diabetic patients.

Pre- and post-utilization data collected by the SF Health Network show a 50% reduction in hospital days one year after enrollment and a 10% reduction in ED visits. Patients reported that the team helped motivate them to change behaviors and helped them better navigate the health care system. Providers reported that the program saved them time and that they felt that their patients were receiving better care. While the program's visits and phone calls are not billed, the savings from reduced hospital days are thought to be sufficient to financially sustain the program.

10. Train some RNs to take responsibility for specialized functions

Some health centers have created specialized roles for RNs, with some RNs responsible for triage, others playing a tactical nurse role, and still others providing chronic care management.

At Petaluma Health Center, some RNs are specially trained as case manager RNs to work specifically with patients who have been admitted to or recently discharged from the hospital. Those patients with high rates

of hospital use are prioritized. The case manager RNs specialize in diabetes care, mental health care, working with homeless patients, and handling care transitions. At Santa Rosa Community Health Centers, two RNs spend 80% of their time conducting home visits for high-utilizing patients with complex care needs.

Neighborhood Healthcare created a new function, the RN panel manager, and two RNs plus the RN director of population management have been specially trained to take on this new role. RN panel managers conduct three types of RN visits: (1) routine monitoring of patients with diabetes, (2) cardiovascular risk reduction visits, and (3) flip visits with a physician. They do not perform triage or other routine back-office functions. The RN visits last 30 minutes, and the RNs keep their own schedule template. For the diabetes and cardiovascular care visits, the RN panel managers focus on medications, in addition to providing patient education and behavior-change counseling. Using medication algorithms and protocols, they enter orders in the EMR system for providers to sign and send to the pharmacy. They can independently refill about 30 medications using a detailed protocol approved by the CMO.

11. Schedule RNs to perform different roles on different days

At two Palo Alto Medical Foundation sites in Alameda County, RNs rotate between two different roles: triage and resource. The triage function includes phone triage, EMR in-box management, and phone advice for patients at the site. The resource RN handles general patient care at the site:

- Walk-in triage
- Chronic disease patient education
- Clinical procedures (e.g., catheterization, nebulizer treatments, antibiotic injections, wound care)
- Pediatric advice (e.g., newborn care, breast-feeding, toilet training)
- Inhaler teaching
- Patient counseling
- Self-management support for diet and exercise, depression, sleep hygiene
- Medication adherence counseling

This strategy of assigning different roles to RNs on different days reduces the amount of stress that is felt by primary care RNs who are traditionally multitasking throughout the day. At some sites, RNs switch roles each week.

At Silver Avenue Family Health Center, each RN dedicates one day each month to chronic disease visits. These visits are prescheduled. When working in this role, the nurse spends 90% of the time conducting patient visits and chronic care phone follow-up, with 10% of the time doing overflow walk-in triage.

12. Preserve the traditional RN role and focus on training MAs and LVNs to take on new responsibilities

It is hard for many resource-strapped safety-net clinics to hire additional RNs because RNs in California command high salaries, their work does not provide revenue for the health center, and Spanish-speaking RNs are hard to find. A strategy available to safety-net clinic leaders is to expand the roles of lower-paid care team members rather than hiring additional RNs.

Northeast Valley Health Corporation, a highly regarded community health center in Los Angeles County, has low RN-to-provider ratios at all sites; at one site there is only one RN for 20 providers. Northeast Valley RNs focus almost exclusively on triage duties that require an RN-level of clinical judgment, while MAs, LVNs, and bachelor's degree-level health educators are taking on expanded roles. MAs do panel management for the patients cared for by a provider-MA teamlet. LVNs and health educators receive extensive training as care coordinators, and they meet with chronic disease patients to provide patient education, self-management support, and patient navigation assistance. In this way, Northeast Valley saves itself the cost of paying for expensive, unreimbursed RNs and also does not face the problem of freeing RNs from triage duties to perform other functions, because many of those other functions are taken care of by the MAs and care coordinators.

For similar financial reasons, some Palo Alto Medical Foundation sites have few RNs on staff and are starting to replace RNs who leave with LVNs and MAs.

California Law on RN Standardized Procedures

The Board of Registered Nursing and the Medical Board of California have jointly promulgated guidelines for the development of standardized procedures for nursing practice that allow for the expansion of RN functions.

These guidelines have become California law: Title 16, California Code of Regulations; Division 14, Board of Registered Nursing; Article 7, Standardized Procedure Guidelines; Section 1474.[12]

1474. Standardized Procedure Guidelines
Following are the standardized procedure guidelines jointly promulgated by the Medical Board of California and by the Board of Registered Nursing:

(a) Standardized procedures shall include a written description of the method used in developing and approving them and any revision thereof.

(b) Each standardized procedure shall:

(1) Be in writing, dated and signed by the organized health care system personnel authorized to approve it.

(2) Specify which standardized procedure functions registered nurses may perform and under what circumstances.

(3) State any specific requirements which are to be followed by registered nurses in performing particular standardized procedure functions.

(4) Specify any experience, training, and/or education requirements for performance of standardized procedure functions.

(5) Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform standardized procedure functions.

(6) Provide for a method of maintaining a written record of those persons authorized to perform standardized procedure functions.

(7) Specify the scope of supervision required for performance of standardized procedure functions, for example, immediate supervision by a physician.

(8) Set forth any specialized circumstances under which the registered nurse is to immediately communicate with a patient's physician concerning the patient's condition.

(9) State the limitations on settings, if any, in which standardized procedure functions may be performed.

(10) Specify patient record keeping requirements.

(11) Provide for a method of periodic review of the standardized procedures.

The Medical Board of California, which governs physician practice in the state, has issued a formal written statement about nursing scope of practice: "Registered nursing practice is recognized as having overlapping functions with physicians. The RN scope of practice permits additional sharing of functions in the organized health care system that provides for collaboration between physicians and registered nurses. Standardized procedures include policies and protocols developed in collaboration with physicians, nurses, and administrators of facilities."[13]

Some organized health systems, including community health centers, following these 11 requirements have written standardized procedures to allow RNs to work to the top of their license.

For example, one California health system has developed standardized procedures for nurses to handle prescription refills. The procedures were created by an oversight committee and are reviewed monthly, and RNs are trained and annually tested for competency. After checking that a requested refill fulfills the protocol requirements and ordering any needed laboratory studies, RNs send the refill orders to the pharmacy. In addition, under standardized procedures, RNs can order routine health maintenance services such as immunizations and chronic disease labs. For medication titration, RNs are required to have a provider review and sign the order.

Two Visionary Practices

Two primary care clinics examined for this paper, Community Health Center, Inc., in Connecticut and Norrahammar Health Center in Jönköping County, Sweden, have pioneered expansions of the RN role that go well beyond the role changes implemented by the California clinics described in this report. These examples demonstrate that primary care practices are capable of transformational changes, and that RNs can be empowered to add considerable capacity to meet the nation's growing demand for primary care.

Community Health Center, Inc. (CHCI)

CHCI is a federally qualified health center caring for 130,000 patients in 13 sites throughout Connecticut. CHCI has a primary care provider-to-RN ratio of between 2:1 and 3:1, with the goal being 2:1. Over the past few years, CHCI has implemented independent RN visits, with over 30 RNs providing almost 25,000 RN visits from October 2013 to October 2014.

Teamwork

All RNs are members of a care team, or pod, composed of two primary care providers, two MAs, one RN, and usually a behavioral health provider. Each RN is responsible for nursing support of two specific panels of patients, approximately 2,000 patients. Pods are spatially co-located to facilitate minute-to-minute team communication. RNs participate in the 10-minute morning team huddle. As part of their responsibilities, RNs enroll patients with complex care needs in care management. A tailored nursing care management plan details problems, self-management goals, clinical targets, progress toward goals, and interprofessional collaboration in the care of that patient, particularly with behavioral health but also with external organizations. The chief nurse officer monitors the number of patients actively enrolled in care management to limit each nurse's caseload to a reasonable size.

Independent RN Visits

An observational study of 10 CHCI RNs in eight sites found that 18% of RN time was spent conducting nursing visits independent of a provider, while another 10% of RN time was spent speaking with patients by phone. The independent visits addressed a wide variety of clinical issues[14]:

- Anticoagulation management
- Tuberculin skin test administration and interpretation
- Diabetes retinopathy screening using a retinal camera
- Hypertension medication adjustment
- Pregnancy testing and counseling
- Smoking cessation
- Screening and administering treatment for sexually transmitted diseases

CHCI RNs do acute and chronic care visits under standing orders and delegated order sets. Standing orders are condition- or complaint-based and are designed to cover most patients presenting with certain conditions or complaints. Delegated orders are patient-specific, written by the primary care provider for that patient only. Each nurse is expected to conduct five independent visits per day; some RNs do up to 10. These one-on-one, face-to-face visits are scheduled for 20 or 40 minutes, depending on the clinical problem being addressed, and the patients are placed in the nursing schedule. The CHCI RNs report that they like doing these independent visits and feel that they are engaged in patient care that fully uses their skills.

Like California's standardized procedures, the standing orders used at CHCI are written and approved by the CHCI Medical Quality Improvement Committee and signed by the chair of that committee, the CMO. After a standing order for nursing is approved, all RNs are trained and assessed by nurse managers. Detailed protocols and EMR templates are created for each standing order. The standing orders include:

- Uncomplicated urinary tract infections (UTIs)
- Vulvovaginal candidiasis
- Emergency contraception
- Pregnancy testing
- Comprehensive diabetes management
- Basal insulin titration
- Telemedicine-based diabetic retinopathy assessment with pupil dilation
- Emergency situations (e.g., naloxone for opioid reversal)

- Maintenance of long-acting antipsychotic medications
- Direct observation treatment for latent tuberculosis infection
- Tobacco cessation, including provision of medications
- Spirometry
- Immunizations

Provider-directed delegated orders include RN follow-up for blood pressure titration, follow-up after antidepressant initiation, wound care, and chronic pain support. (See sidebar for an example of a delegated order.)

Typical independent visits that CHCI RNs provide are chronic care visits for patients with diabetes, hypertension, asthma, or COPD. In these visits, RNs do patient education, medication reconciliation and adherence counseling, patient goal setting, and behavior-change counseling.

PCP-Delegated Nursing Order: An Example

The PCP (primary care provider) completed a visit for a patient with hypertension (HTN), in which they started a new blood pressure medication, hydrochlorothiazide (HCTZ) 12.5 mg once a day, with systolic blood pressure (SBP) target around 140 mm Hg based on the patient profile. The PCP requested that the patient return in one week for a nursing visit to follow up blood pressure and documented these follow-up orders in the EMR:

- If SBP >180, conduct full HTN screening visit, order metabolic panel and EKG [electrocardiogram], increase HCTZ to 25 mg daily, and add benazepril 5 mg daily. Return in one week with PCP.
- If SBP between 160 to 179, increase HCTZ to 25 mg daily. Return in one week with RN and check metabolic panel at that time.
- If SBP between 140 to 159, repeat in one week and send results to PCP.

In this example, the nurse can manage the medications because the provider, in advance of the nursing visit, through delegated orders, provided explicit instructions.

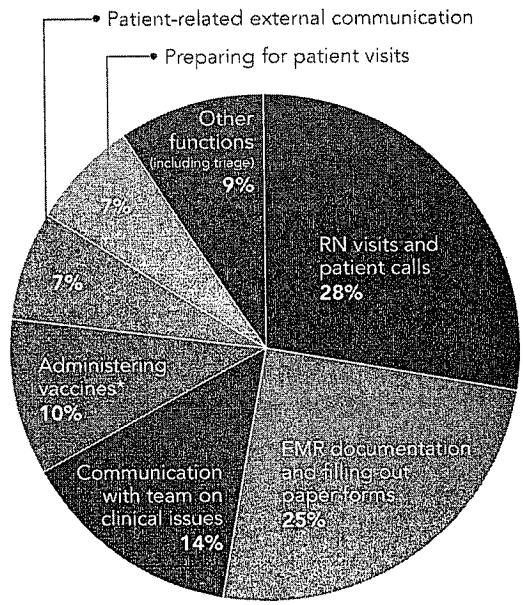
While RNs at CHCI are empowered to conduct independent visits, they always have the option of consulting with a provider for additional guidance. RNs reported that they feel greatly empowered and supported to perform at the top of their clinical expertise.

Reduced Triage Burden

CHCI has reduced the triage burden on RNs by successfully ensuring that their patients have timely access to care. Most patients can get provider appointments "today, tomorrow, or the next day." Even with such good access to care, some patient triage is still necessary.

CHCI has dramatically reduced the triage responsibility for most RNs by having two full-time nurses dedicated solely to triage. To complement the full-time triage nurses, other RNs rotate through triage less than once a week. Triage nurses address about 70% of triage calls without a provider visit. An observational study found that RNs spent about 10% of their time on patient phone calls and that only some of those calls were triage calls.[15] For most RNs at CHCI, triage takes up a small amount of their time. (See Figure 1.)

Figure 1. How RN Time Is Spent at CHCI



*May be completed by MAs in California, but not in Connecticut, where this falls only in the scope of practice of the nurse or the provider.

Source: Anderson DR, St. Hilaire D, Flinter M. "Primary Care Nursing Role and Care Coordination: An Observational Study of Nursing Work in a Community Health Center." *Online J Issues Nurs.* 2012;17(2):3.

Medications

If appropriate under standing orders, CHCI nurses initiate medications for acute issues such as UTIs and candidal vulvovaginitis. They may call in or fax these medications to the pharmacy but cannot do electronic prescribing. Under delegated orders from providers, they can increase blood pressure medication doses in RN blood pressure follow-up visits if the blood pressure has not come down to the goal set by the provider. In these cases, the provider does not need to sign the RN's medication order because the provider's specific order was documented in advance.

CHCI has transformed the nursing function. RNs at CHCI conduct a significant number of independent visits for acute and chronic clinical issues, including initiating and changing medications under standing and delegated orders. According to one CHCI nursing leader, "RNs wanted to be more involved with patients and elevated from the triage role. RNs sharing in the care was designed to reduce clinician burnout, improve the efficiency and satisfaction of the care team, and [provide] more satisfaction for the patients."

Norrahammar Health Center

Norrahammar is one of over 10 ambulatory health centers run by the Jönköping County's health system in Sweden. Sweden has created separate health systems for each county, and Jönköping's system in the southern part of Sweden has been recognized as one of the finest health systems in the world, with excellent clinical outcomes, high patient satisfaction, and low costs.[16] Norrahammar is a town of 9,000 people located eight miles from the county seat, the city of Jönköping. In 2006, the health center employed four family doctors and 12 nurses, with a total of 35 employees.

Most visits at Norrahammar Health Center are nurse visits. Physicians focus their time on the most complicated patients. When patients call the health center, a highly trained nurse, rather than a nonclinical receptionist, answers the phone. Each day, two to three of these triage nurses answer about 100 calls. Using protocol books and their own experience, they give phone advice or schedule patients with a nurse, midwife, physician, or physical therapist at the health center.

Patients with a sore throat, earache, or dysuria, or those needing a follow-up visit for diabetes, hypertension, asthma, or COPD, would see a nurse, unless their history reveals a more complicated story requiring a physician visit. Patients with a psychosocial problem see a behavioral health provider. Pregnancy checkups, contraception issues, and Pap smears are handled by a nurse-midwife, and pediatric care is mostly handled by nurses. Patients with musculoskeletal problems go directly to a physical therapist and are referred to physicians only if worrisome symptoms or physical findings are found.

In 2006, of the approximately 800 face-to-face visits provided each week, 59% were nurse visits, 24% physician visits, 13% physical therapy visits, and 4% behavioral health visits. Seventeen percent of nurse visits resulted in a full physician visit or a brief conversation with a physician for advice. Prior to the introduction of nurse visits in 2000, 56% of physician visits were for minor complaints and 36% for major illnesses; in 2004, 31% of physician visits were for minor diagnoses and 66% for major illnesses. Some of the Norrahammar nurses have specialized training in diabetes, asthma/COPD, heart failure, and acute patient complaints.

Because Jönköping County pays its health centers with a lump-sum global budget, there is no visit-based reimbursement. This payment design allows Norrahammar to offer visits with nurses and other nonphysician providers without financial concerns.

Norrahammar demonstrates how a high-performing health system can dramatically elevate the role of nurses in primary care.

Discussion

The RN role in primary care is coming full circle. Years ago, RNs in some communities were the primary care providers. In the first few decades of the twentieth century, some rural areas and inner cities created community-based health systems entirely run by RNs — for example, the Frontier Nursing Service in Appalachia, with RNs providing all primary care. Yet the urban and rural nurse-run models of care waned during the middle years of the century. With the advances in medical knowledge and technology, hospitals evolved from places where patients died to places where patients got better. Primary care and community-based nursing declined in prestige as hospitals became the center of activity for nursing education and practice.[17] To this day, the majority

of RNs — 61% in 2012 — work in hospitals.[18] Because RNs have been largely defined as hospital nurses, nursing education has focused primarily on hospital care.

Primary care nursing is now experiencing a revival. Health policy and nursing thought leaders are recognizing that fewer patients are being admitted to hospitals and more are being cared for in ambulatory settings, especially primary care. Moreover, primary care has a growing need for skilled professionals, and the over-2.5 million RNs make up the largest pool of skilled health professionals in the United States.

The Institute of Medicine report on the future of nursing affirms that "Nurses are being called upon to fill primary care roles and to help patients manage chronic illnesses, thereby preventing acute care episodes and disease progression."[19]

The American Academy of Ambulatory Care Nursing (AAACN) recognizes that "The evolving medical home concept reinforces the critical need for registered nurses to provide chronic disease management, care coordination, health risk appraisal, health promotion, and disease prevention services."[20] The AAACN is advocating for ambulatory RN residency programs to enhance RN primary care skills. In its 2014 white paper, the AAACN acknowledged: "Misconceptions and myths related to ambulatory nursing practice abound. Many experienced nurses and non-nurses think that ambulatory practice is less taxing than acute [hospital] care and a place where nurses go to retire. There are false impressions that paint the ambulatory nurse as less knowledgeable or skilled then the acute care nurse."[21] Moreover, "Residency programs for new or transitioning RNs are rarely carried out in ambulatory care."[22] The AAACN also noted: "There is often confusion about scope of practice and lack of clear understanding about the appropriate utilization of registered nurses and other health care personnel."[23]

While academic nursing leaders understand the need for reform of nursing education and RN scope of practice, it is likely that the main impetus for a rebirth of primary care nursing will come from primary care practices themselves. In particular, safety-net clinics — because they hire many RNs — have become a crucible of innovation in transforming the RN primary care role.

There is now significant literature describing these innovations in primary care settings across North America:

- Observations in three primary care networks in Canada[24]
- Phone interviews with 16 practices from across the US[25]
- A review of the Patient Aligned Care Teams in the Veterans Health Administration[26]
- Site visits with 30 high-performing primary care practices conducted by the Learning from Effective Ambulatory Practices (LEAP) project[27]

Conclusion

New trends in primary care nursing are addressing the main challenges to primary care nursing. Two of these challenges are related: RNs spending much of their time in triage, and the weakness of RN primary care training. If nursing schools elevate primary care competencies in their curricula or if RN primary care residencies take hold, then RNs will have the skills to solve the majority of triage encounters they currently refer to physicians. The combination of the evolution of scope-of-practice standardized procedure regulations and greater RN primary care skills and knowledge will expand the ability of primary care RNs to deliver a broader range of services and shift from the predominant role of triage that currently exists.

The other challenges described in this report are also linked: the relatively high California RN salaries, and low or absent reimbursement for RN patient visits. Currently, California is exploring a model of capitation for community health centers instead of provider visit-based fees. If this new payment model gains momentum, safety-net clinics could expand independent RN visits and could make compelling arguments for hiring and retaining RNs. RN salaries would be justified by their ability to add substantial primary care capacity.

Society is asking primary care to do more for patients; yet the numbers of primary care providers are falling while their burnout rates are rising.[28] Empowering and expanding the role of registered nurses, the largest pool of skilled health care professionals in the country, provides the perfect formula for the survival and transformation of primary care. Conditions are ripening for the rebirth of registered nurses in primary care.

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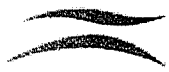
Appendix A: Example of RN Prescription Refill Standardized Procedure

Clinical Protocol: Nurse Prescription Refill Procedure
Page 1 of 2. Protocol = 2 pages; medication list = 6 pages



NEIGHBORHOOD HEALTHCARE

Effective date: 12/2012	Policy & Procedure #CSM.107
Revision date: 11/2014	
Last reviewed: Clinical QM committee	
Functional area(s):	

Document owner, title: Jim Schultz, MD

Keywords: refills, prescription, medication, RN, eCW

POLICY: It is the policy of Neighborhood Healthcare to allow qualified RNs to refill designated medications according to clinical protocol.

I. PROCEDURE:

A. Functions the RN may perform:

1. Medication refills using fax, phone or ePrescribing through eCW of those medications listed in the attached table according to the criteria defined for medication refills within this policy.
2. Substitutions within classification after confirming equivalent dosage with the patient's provider. Ensuring that the medication is on the formulary for the patient's insurance.
3. Order lab work listed under "Lab Requirement" in chart below for a prescribed medication.

B. Circumstances under which RN may perform function:

1. Setting – All Neighborhood Healthcare clinic sites.
2. Supervision – the RN may operate independently within the constraints and criteria of this policy.
3. Patient Conditions – Diagnosis of diabetes and/or hypertension and/or high cholesterol.
4. Other –
   a) The RN must always consider the immediate risk to the patient of an abrupt cessation of medication.
   b) Clinical correlation of the patient's condition, other medications prescribed, lab work and other factors which may influence care must be considered in a decision to refill or not refill a particular medication.
   c) If refill criteria for lab and clinical considerations are met but patient needs appointment, have patient scheduled for an appointment and refill medication one time.
   d) No early refills will be given under this protocol.
   e) Narcotics/controlled substances may not be refilled by the RN and will be assigned to the clinician. Prior to assigning, the RN will research information the clinician needs to make the decision about refilling, such as most recent visit for the problem and whether a toxicology screen has been performed within the last 12 months.

C. Definitions:

1. Early Refill – a refill of a medication more than 5 working days earlier than its expiration date.
2. Refill Period – the time frame to refill a medication; this calculation should take into account the date of the last visit or lab work in determining the one-year period. Example: date of refill request 5/06, with last visit date 7/05; refill medication for two months.

D. Database – Nursing Practice

1. Subjective information will include, but is not limited to:
   a) Relevant health history reported by the patient or documented in the medical record
   b) Patient reports of possible side effects
2. Objective information will include, but is not limited to:
   a) Lab reports
   b) Documentation of prescriptions in the medical record
   c) Patient visit history at Neighborhood Healthcare
   d) Appointments schedule for future visits
   e) Court requirements for children who are receiving medications under the auspices of JV220 (ward of the court)

E. Diagnosis
1. The medical diagnosis may be any chronic medical condition or disease

F. Plan
1. Treatment – refills of chronic and over-the-counter medications for period of up to one year if all criteria are met.
2. Patient condition requiring consultation – varies according to medication; see "Clinical Considerations" in chart below.
3. Education – if applicable to a particular medication
4. Follow-up – will be handled through the normal clinic process for medication management and not necessarily within the confines of this protocol.

G. Record keeping
1. All patient care, changes in medications or lab work, verbal or telephone communications with the clinician or patient/family, patient/family education and other relevant information shall be documented in the medical record.

II. REQUIREMENTS FOR REGISTERED NURSE:

A. Education/Licensure – the RN must have a California RN license and be in good standing with the Board of Registered Nursing [BRN].

B. Training –
1. The RN must have been trained by an RN staff member or provider experienced in medication refills according to Neighborhood Healthcare protocol.
2. The RN must be fully trained in use of eCW.

C. Experience – A minimum of one year's experience (full-time or 2080 hours) as an RN is required.

D. Initial Evaluation – the competence of the RN will be assessed by the provider preceptor training him/her in medication refills.

E. Ongoing Evaluation – the Rx refill process will be audited at least annually by the Quality Improvement Department.

III. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Method – the procedure shall be developed using the most current references available from the BRN and the American Academy of Family Practice.

B. Review schedule – the procedure shall be assessed the first year at 3 and 6 months after implementation, and annually thereafter.

The protocol includes a list of over 40 medications with visit and lab requirements and specific clinical considerations.