Date of Hearing: June 28, 2016

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Rudy Salas, Chair
SB 323(Hernandez) – As Amended July 9, 2015

SENATE VOTE: 25-5

NOTE: This bill is being heard on reconsideration having previously failed passage in this committee on June 30, 2015 with a 4-9 vote.

SUBJECT: Nurse practitioners: scope of practice

SUMMARY: Permits Nurse Practitioners (NPs) to practice, without being supervised by a physician and surgeon, if the NP has met specified requirements including possessing liability insurance and national certification.

EXISTING LAW:

1) Establishes the Board of Registered Nursing (BRN), within the Department of Consumer Affairs (DCA), and authorizes the BRN to license, certify and regulate nurses. (Business and Professions Code (BPC) §§ 2701; 2708.1)

2) Clarifies that there are various and conflicting definitions of "nurse practitioner" and "registered nurse" (RN) that are used within California and finds the public interest is served by determining the legitimate and consistent use of the title "nurse practitioner" established by the BRN. (BPC § 2834)

3) Requires applicants for licensure as a NP to meet specified educational requirements including: (BPC § 2835.5)

    a) Holding a valid and active registered nursing license;

    b) Possessing a Master's degree in nursing, a Master's degree in a clinical field related to nursing, or a graduate degree in nursing; and,

    c) Completion of a NP program authorized by the BRN.

4) Recognizes the existence of overlapping functions between physicians and NPs and permits additional sharing of functions within organized health care systems that provide for collaboration between physicians and NPs. (BPC § 2725; Health and Safety Code (HSC) § 1250)

5) Defines "health facility" as any facility, place, or building that is organized, maintained and operated for the diagnosis, care, prevention, and treatment of physical or mental human illness including convalescence, rehabilitation, care during and after pregnancy, or for any one or more of these purposes, for which one or more persons are admitted for a 24-hour stay or longer. (HSC § 1250)

6) Authorizes a NP to do the following, pursuant to standardized procedures and protocols (SPPs) created by a physician or surgeon, or in consultation with a physician or surgeon: (BPC § 2835.7)

   a) Order durable medical equipment;

   b) Certify disability claims; and,

   c) Approve, sign, modify or add information to a plan of treatment for individuals receiving home health services.

7) Defines "furnishing" as the ordering of a drug or device in accordance with SPPs or transmitting an order of a supervising physician and surgeon. (BPC § 2836.1(h))

8) Defines "drug order" or "order" as an order for medication which is dispensed to or for an ultimate user and issued by a NP. (BPC § 2836.1(i))

9) Establishes that the furnishing and ordering of drugs or devices by NPs is done in accordance with the SPP developed by the supervising physician and surgeon, NP and the facility administrator or designee and shall be consistent with the NPs educational preparation and/or established and maintained clinical competency. (BPC § 2836.1)

10) Indicates a physician and surgeon may determine the extent of supervision necessary in the furnishing or ordering or drugs and devices. (BPC § 2836.1(g)(2))

11) Permits a NP to furnish or order Schedule II through Schedule V controlled substances and specifies that a copy of the SPP shall be provided upon request to any licensed pharmacist when there is uncertainty about the NP furnishing the order. (BPC § 2836.1(f)(1)(2); HSC §§ 11000; 11055; 11056).

12) Indicates that for Schedule II controlled substances, the SPP must address the diagnosis of the illness, injury or condition for which the controlled substance is to be furnished. (BPC § 2836.1(2))

13) Requires that a NP has completed a course in pharmacology covering the drugs or devices to be furnished or ordered. (BPC § 2836.1(g)(1))

14) States that a NP must hold an active furnishing number, register with the United States Drug Enforcement Administration and take a continuing education course in Schedule II controlled substances. (BPC § 2836.1(3))

15) Specifies that the SPP must list which NPs may furnish or order drugs or devices. (BPC § 2836.1(c)(1))

16) Requires that the physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include collaboration to create the SPP, approval of the SPP and availability of the physician and surgeon to be contacted via telephone at the time of the patient examination by the NP. (BPC § 2836.1(d))

17) Limits the physician and surgeon to supervise no more than four NPs at one time. (BPC § 2836.1(e))

18) Authorizes the BRN to issue a number to NPs who dispense drugs or devices and revoke, suspend or deny issuance of the number for incompetence or gross negligence. (BPC § 2836.2)

THIS BILL:

1) Makes Legislative findings and declarations as to the importance of NPs providing safe and accessible primary care.

2) Specifies that, in the interest of providing patients with comprehensive care and consistent with the spirit of the federal Patient Protection and Affordable Care Act, the bill is supportive of the national health care movement towards integrated and team-based health care models.

3) Authorizes a NP who holds a national certification from a national certifying body recognized by the BRN ("certified NP") to practice without the supervision of a physician if the certified NP practices in one of the following settings:

   a) A clinic;

   b) Specified health facilities, including a general acute care hospital, acute psychiatric hospital, skilled nursing facility, intermediate care facility, correctional treatment center, and hospice facility, as specified;

   c) A county medical facility;

   d) An accountable care organization;

   e) A group practice, including a professional medical corporation, another form of corporation controlled by physicians, a medical partnership, a medical foundation exempt from licensure, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services; and,

   f) A medical group, independent practice association, or any similar association.

4) Provides that, in addition to any other practice authorized in statute or regulation, a "certified NP" practicing in specified settings may do all of the following without physician supervision, unless collaboration is specified:

   a) Order durable medical equipment;

   b) Certify disability for purposes of unemployment after performance of a physical examination by the certified NP and collaboration, if necessary, with a physician;

   c) Approve, sign, modify, or add to a plan of treatment or plan of care for individuals receiving home health services or personal care services after consultation, if necessary, with the treating physician and surgeon;

   d) Assess patients, synthesize and analyze data, and apply principles of health care;

e) Manage the physical and psychosocial health status of patients;

f) Analyze multiple sources of data, identify a differential diagnosis, and select, implement, and evaluate appropriate treatment;

g) Establish a diagnosis by client history, physical examination, and other criteria, consistent with this section, for a plan of care;

h) Order, furnish, prescribe, or procure drugs or devices;

i) Delegate tasks to a medical assistant pursuant to SPPs developed by the NP and medical assistant that are within the medical assistant's scope of practice;

j) Order hospice care, as appropriate;

k) Order and interpret diagnostic procedures; and,

l) Perform additional acts that require education and training and that are recognized by the nursing profession as appropriate to be performed by a NP.

5) States that it is unlawful for a "certified NP" to refer a person for laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy or diagnostic imaging goods or services if the NP or his or her immediate family has a financial interest with the person or in the entity that receives the referral.

6) Further specifies that the BRN shall review the facts and circumstances of any conviction and take appropriate disciplinary action if the "certified NP" has committed unprofessional conduct and that the BRN may assess fines and appropriate disciplinary action including the revocation of a "certified NP's" license.

7) Specifies that a "certified NP" is subject to the peer review process where a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes or professional conduct of licentiates to make recommendations for quality improvement and education in order to do the following:

a) Determine whether a licentiate may practice or continue to practice in a health care facility, as specified; and,

b) To assess and improve the quality of care rendered in a health care facility as specified.

8) Requires the BRN to disclose 805 reports, which are the written reports filed with the BRN, as a result of an action of a peer review body, within 15 days after any of the following occur:

a) A "certified NP's" application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason;

b) A "certified NP's" membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason; or,

c) Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for accumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.

9) Indicates that if the BRN or licensing agency of another state revokes or suspends, without a stay, the license of a physician and surgeon, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.

10) Requires a "certified NP" to refer a patient to a physician or other licensed health care provider if a situation or condition of the patient is beyond the scope of the education and training of the NP.

11) Requires a "certified NP" to maintain professional liability insurance appropriate for the practice setting.

12) Specifies that settings where NPs practice shall not interfere with, control, or otherwise direct the professional judgment of a nurse practitioner.

FISCAL EFFECT: According to the Senate Appropriations Committee analysis, this bill will result in one-time costs, likely about $75,000, to update existing regulations. The bill may also result in minor ongoing costs for enforcement.

COMMENTS:

Purpose. This bill is sponsored by the author. According to the author, "Numerous California editorial boards have endorsed full practice authority for NPs. A 2013 *New York Times* editorial stated 'There is plenty of evidence that well-trained health workers can provide routine service that is every bit as good or even better than what patients would receive from a doctor. And because they are paid less than the doctors, they can save the patient and the healthcare system money.'

Californians deserve access to high quality primary care offered by a range of safe, efficient, and regulated providers. NPs have advanced their educational, testing, and certification programs over the past decade. They have enhanced clinical training, moved to advanced degrees, and upgraded program accreditation processes. Other states have recognized advances with NP practice acts that align with professional competence and advanced education, but California has not kept pace.

In California, we have a robust network of providers that are well-trained, evenly distributed throughout the state, and well positioned to pay particular attention to underserved areas. Deploying these professionals in a team-based delivery model where they work collaboratively with physicians will allow us to meet the demands placed on our healthcare systems created by a rapidly aging physician population and expansion of health insurance coverage."

Background. Estimates obtained from the Council on Graduate Medical Education (CGME) indicate that the number of primary care physicians actively practicing in California is far below the state's need. The distribution of these primary care physicians is also poor. In 2008, there were 69,460 actively practicing primary care physicians in California, of which only 35 percent

reported they actually practiced primary care. This equates to 63 active primary care physicians per 100,000 persons. However, according to the CGME, 60 to 80 primary care physicians are needed per 100,000 persons in order to adequately meet the needs of the population. When the same metric is applied regionally, only 16 of California's 58 counties fall within the needed supply range for primary care physicians. In other words, less than one third of Californians live in a community where they have access to adequate health care services. In addition, a 2013 study in *Health Affairs* found that the proportion of U.S. medical students choosing careers in primary care dropped from 60 percent in 1998 to approximately 25 percent in 2013. Some purport that the way to address this shortage is by expanding the role of NPs and other allied healthcare professionals to provide primary care services.

NP Education and Training. There are over 19,000 NPs licensed by the BRN. The BRN sets the educational standards for NP certification. A NP is a registered nurse (RN) who has earned a bachelors and postgraduate nursing degree such as a Master's or Doctorate degree. NPs possess advanced skill in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, 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 (Title 16 California Code of Regulations (CCR) §§ 1480(b); 1484). Examples of primary health care include: physical and mental assessment, disease prevention and restorative measures, performance of skin tests and immunization techniques, withdrawal of blood, and authority to initiate emergency procedures. Data from the Employment Developmental Department indicates that hospitals are the main employer of NPs.

NP Scope and SPPs. A NP does not have an additional scope of practice beyond the RNs scope and must rely on SPPs for authorization to perform medical functions which overlap with those conducted by a physician (16 CCR § 1485). According to the BRN, "SPPs are the legal mechanism for registered nurses, nurse practitioners to perform functions which would otherwise be considered the practice of medicine." Examples of these functions include: diagnosing mental and physical conditions, using drugs in or upon human beings, severing or penetrating the tissue of human beings,, and using other methods in the treatment of diseases, injuries, deformities or other physical or mental conditions.

SPPs must be developed collaboratively with NPs, physicians, and administration of the organized health care system where they will be utilized. Because of this interdisciplinary collaboration, there is accountability on several levels for the activities to be performed by the NP. Importantly, a NP must provide the organized health system with satisfactory evidence that the NP meets the experience, training and/or education requirements to perform the functions. If a NP undertakes a procedure without the competence to do so, such an act may constitute gross negligence and be subject to discipline by the BRN.

The BRN and the Medical Board of California (MBC) jointly promulgated the following guidelines for SPPs: (BRN, 16 CCR § 1474; MBC, 16 CCR § 1379)

"SPPs shall include a written description of the method used in developing and approving them and any revision thereof. Each SPP shall:

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

2) Specify which SPP functions registered nurses may perform and under what circumstances.

3) State any specific requirements which are to be followed by NPs in performing particular SPP functions.

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

5) Establish a method for initial and continuing evaluation of the competence of those NPs authorized to perform SPP functions.

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

7) Specify the scope of supervision required for performance of SPP functions, for example, telephone contact with the physician.

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

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

10) Specify patient record-keeping requirements.

11) Provide for a method of periodic review of the SPP."

Nurse-Managed Health Clinics. Nurse-managed health clinics, of which many are Federally Qualified Heath Centers (FQHC) and independent non-profit clinics, are safety net clinics that provide primary care, health promotion, and disease prevention services to patients who are least likely to receive ongoing health care. Unlike other FQHC and independent non-profits, these clinics are solely operated by NPs. The Patient Protections and Affordable Care Act (ACA) defines a nurse-managed health clinic as, "…a nurse practice arrangement, managed by advanced practice nurses, that provides primary care or wellness services to underserved or vulnerable populations and that is associated with a school, college, university or department of nursing, federally qualified health center, or independent non-profit health or social services agency." (42 U.S.C. § 330A–1 (2010))

According to the National Nursing Centers Consortium, nurse-managed health clinics have doubled in their presence since 2013. To date, there are over 500 nurse-managed health clinics most of which are located in the East Coast. A small percentage of these have been chosen for funding through a federal expansion initiative. One such clinic, GLIDE Health Services, is a FQHC located in San Francisco, California and provides primary and urgent care, preventative services and psychiatric treatment to an urban population.

- Physician Supervision. In many of the nurse-managed health clinics, the physician to NP supervision relationship is quite flexible. A supervising physician may be present for a very limited amount of time to perform perfunctory tasks such as signing off on equipment orders, and reviewing and signing medical records. The physician may also elect to make himself/herself available for telephonic consult. For example, at GLIDE,

the supervising physician is physically on site 1-2 days a week to sign off on orders such as wheel chairs, walkers and commodes and review medications that have been prescribed and furnished by NPs. According to Patricia Dennehy, a NP and director of GLIDE, "Though we value our MD colleagues and consult with them for complex care issues, currently there are administrative barriers to care delivery and access that are not practical."

- Clinical Training Sites. In addition to providing care to patients, nurse-managed health clinics also play an important role in health professions education. More than 85 of the nation's leading nursing schools operate nurse-managed health clinics that serve as clinical education and practice sites for nursing students and faculty. Many, such as GLIDE, have partnerships with other academic programs and provide learning opportunities for medical, pharmacy, social work, public health, and other students.

Full Practice Authority. The American Association of Nurse Practitioners defines full practice authority as, "The collection of state practice and licensure laws that allow for nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments, including prescribe medications, under the exclusive licensure authority of the state board of nursing." Similar to the changes to statute proposed in this legislation, under full practice authority, "certified NPs" are still required to meet educational and practice requirements for licensure, maintain national certification and remain accountable to the public and the state board of nursing. Under this model, "certified NPs" would continue to consult with and refer patients to other health care providers according to the patient's needs.

Over the past 50 years, several organizations and research institutions have examined the feasibility of full practice authority for NPs. The Institute of Medicine of the National Academies of Science released a 2010 report titled, *The Future of Nursing: Leading Change, Advancing Health*, in which the IOM wrote, "Remove scope of practice barriers. [NPs] should be able to practice to the full extent of their education and training…the current conflicts between what [NPs] can do based on their education and training and what they may do according to state federal regulations must be resolved so that they are better able to provide seamless, affordable and quality care." In a 2011 report, the IOM noted that three to 14 NPs can be educated for the same cost as one physician. A report by the National Governor's Association, *The Role of Nurse Practitioners in Meeting Increased Demand for Primary Care* noted, "In light of research evidence, states might consider changing scope of practice restrictions and assuring adequate reimbursement for their services as a way of encouraging and incentivizing greater NP involvement in the provision of primary health care."

Despite these arguments, some physician groups, including the American Medical Association (AMA) assert that granting full practice authority for NPs may put patients' health at risk. They cite the difference in educational attainment noting that physicians are required to complete four years of medical school plus three years of residency compared to the four years of nursing school and two years of graduate school required for NPs. The President of the AMA, Dr. Robert M. Wah, was quoted in a 2015 *New York Times* article, "[…nurses practicing independently] would further compartmentalize and fragment health care [which should be] collaborative with the physician at the head of the team."

Financial Implications. Over the past 40 years, there have been a number of studies on the cost-effectiveness of NP practice. Results overwhelmingly show NPs provide equivalent or improved

medical care at a lower cost than their physician counterparts. After insurance reform in Massachusetts, the state demonstrated that they could gain a cost savings of $4.2 to $8.4 billion, over a 10 year period, from the increased use of NPs (Eibner, E. et al. 2009, *Controlling Health Care Spending in Massachusetts: An Analysis of Options*. RAND Health).

Though the ACA encourages the creation of nurse-managed practices, by requiring insurers to pay NPs the same rates paid to physicians for identical services rendered, Medicare will not provide equal reimbursement. Presently, Medicare pays NPs 85% of the physician rate for the same services. The Medicare Payment Advisory Commission, the federal agency that advises Congress on Medicare issues, found that there was no analytical foundation for this difference. Despite this fact, revising payment methodology would require Congress to change the Medicare law. A report by the IOM titled "The Future of Nursing, Leading Change, Advancing Health," recommended that the Medicare program be expanded to include coverage of advanced practice registered nurse services just as physician services are covered. The report also recommended that Medicaid reimbursement rates for primary care physicians be extended to advanced practice registered nurses providing similar primary care services.

Additionally, health insurance plans have significant discretion to determine what services they cover and which providers they recognize. Not all plans cover NPs. Further, many managed care plans require enrollees to designate a primary care provider but do not always recognize NPs. In fact, a 2009 survey conducted by the National Nursing Centers Consortium found that nearly half of the major managed care organizations did not credential NPs as primary care providers (www.healthaffairs.org/healthpolicybriefs/brief.php). If NPs were granted full practice authority, efforts may need to be undertaken in order for NPs to be recognized as primary care providers by insurance companies.

Other States. Many other states have recognized the ability for NPs to play a more efficient role in the delivery of health care services and have updated their practice acts to align with NPs training and education. For example, at least 20 states have adopted full practice authority for NPs. The AMA contends that many of the NPs that practice independently in these states do not deliver care to underserved areas.

Prior Related Legislation. SB 323 (Hernandez) of 2015, would have permitted a NP to practice independently after a period of physician supervision if the NP has national certification and liability insurance, and authorizes the NP to perform various other specified tasks related to the practice of nursing without protocols. *NOTE: This bill failed passage in the Assembly Committee on Business and Professions and was granted reconsideration. This bill is scheduled to be heard before this committee today.*

SB 491 (Hernandez) of 2013, would have permitted a NP to practice independently after a period of physician supervision if the NP has national certification and liability insurance, and authorizes the NP to perform various other specified tasks related to the practice of nursing without protocols. *NOTE: This bill was held in the Assembly Appropriations Committee.*

POLICY ISSUES:

1) **Patient Protections.** If granted full practice authority, per the provisions of this bill, "certified NPs" would be required to adhere to a number of patient protection requirements – similar to the requirements for physicians who practice independently. Specifically, this bill would require that a "certified NP," 1) carry malpractice insurance, 2) adhere to the anti-

kickback and referral laws, and 3) be subject to the same 805 reporting requirements that physicians are subject to. However, unlike physicians who are subject to the corporate practice of medicine bar, the NPs would not be subject to this provision.

California law prohibits lay individuals, organizations and corporations from practicing medicine. This prohibition applies to lay entities and prohibits them from hiring or employing physicians or other health care practitioners from interfering with a physician or other health care practitioner's practice of medicine. It also prohibits most lay individuals, organizations and corporations from engaging in the business of providing health care services indirectly by contracting with health care professionals to render such services. This prohibition is designed to protect the public from possible abuses stemming from the commercial exploitation of the practice of medicine (California Physician's Legal Handbook, *Corporate Practice of Medicine Bar*, January, 2015).

According to a 2007 California Research Bureau report titled "The Corporate Practice of Medicine Doctrine," the employment status of physicians in California is applied inconsistently by the application of the doctrine as physicians are exempt from the doctrine if they work in specific settings including: professional medical corporations, local hospital districts, county hospitals, teaching hospitals, non-profit clinics and non-profit corporations.

Opponents of this bill argue that because the duties of "certified NPs" are similar to those of a physician and surgeon, "certified NPs" should be subject to the same corporate practice of medicine bar. Proponents of the measure indicate that nurse anesthetists practice independently and without being subject to the corporate practice of medicine bar. They also note that in the other four states that have a corporate practice of medicine bar and permit NPs to practice without supervision, the NPs are not subject to the corporate practice of medicine bar.

2) **Clinical Experience.** This bill does not require a NP to obtain a certain amount of clinical experience, after becoming a NP, in order to apply to the BRN to become a "certified NP." However, several other health professions require additional clinical experience in order to receive specialty certification.

AMENDMENTS:

1) Based on policy issue number 1), pertaining to the corporate practice of medicine bar, the author should amend this measure to include the following language to ensure that the same protections are in place for the practice of "certified NPs." This should include the same exemptions from the corporate practice of medicine bar that apply to the practice of physicians and surgeons in certain settings. As such, the following language should be added to Section 2837 of the bill:

   An entity described in subdivision (a) shall not interfere with, control, or otherwise direct the professional judgment of a nurse practitioner functioning pursuant to this section in a manner prohibited by Section 2400 or any other law. *Corporations and other artificial legal entities shall have no professional rights, privileges, or powers under this section, except as provided in Sections 2400, 2401, 2402, and 2403.*

2) Based on policy issue number 2), pertaining to additional clinical experience, the author should amend the bill to require a "certified NP" to complete 3 years of post-graduate

clinical practice, under the supervision of a physician and surgeon, before applying to the BRN to become a "certified NP."

REGISTERED SUPPORT:

AARP
Alliance of Catholic Health Care
Association of California Healthcare Districts
Bay Area Council
California Association for Health Services at Home
California Association of Nurse Anesthetists
California Association for Nurse Practitioners
California Association of Public Hospitals and Health Systems
California Children's Hospital Association
California Health Advocates
California Hospital Association
California Naturopathic Doctors Association
California Optometric Association
Cedars Sinai Medical Center
Mental Health America
Planned Parenthood Advocacy Project Los Angeles County
Planned Parenthood Affiliates of California
Planned Parenthood Mar Monte
Private Essential Access Community Hospitals
Providence Health & Services Southern California
SEIU California
St. Joseph Hoag Health
Stanford Health Care
Stanford Health Care- ValleyCare
University of California
1 individual

REGISTERED OPPOSITION:

American College of Cardiology, California Chapter
American College of Emergency Physicians, California Chapter
California Academy of Eye Physicians and Surgeons (unless amended)
California Academy of Family Physicians (unless amended)
California Medical Association
California Psychiatric Association
California Society of Plastic Surgeons
Medical Board of California
Osteopathic Physicians and Surgeons of California
Union of American Physicians and Dentists
Over 400 individuals

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