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Aligning Nurse Practitioner Statutes in California

JULY 2021

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Acknowledgment

The authors would like to thank Dr. Susanne J. Phillips, DNP, RN, FNP-BC, FAANP, FAAN, for her significant contribution to this publication.

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DESIGN BY DANA KAY HERRICK

Executive Summary

California legislation (Assembly Bill 890, or AB 890) enacted in September 2020 authorizes certain nurse practitioners to practice without physician supervision and standardized procedures.[1] Implementation of this statute holds significant promise to expand access to high-quality care, particularly for underserved places and populations. The Board of Registered Nursing (BRN) is tasked with appointing a Nurse Practitioner Advisory Committee, reviewing current nursing regulations, and promulgating regulations and guidelines to implement AB 890.[2] To meet the access to care needs in California, it is essential that the BRN complete this work with expediency since nurse practitioners cannot practice without physician supervision before the BRN work is completed. To realize the intent of AB 890 and provide maximum benefit to Californians, action is also required to align existing, related statutes, including provisions of California's Education, Health and Safety, and Labor Codes. This report offers an analysis of existing statutes that, without review and action, may inhibit full realization of the promise of AB 890.

Introduction and Background

In 2020, California enacted legislation (Assembly Bill 890) to expand the practice authority for nurse practitioners (NPs). This legislation holds promise to increase access to primary care and other services by allowing NPs to offer care within a defined scope of practice without physician supervision requirements. With this statute, California joins 28 other states that previously expanded NPs' scope of practice.

The law promotes NPs as important providers of health care for underserved and vulnerable populations, particularly in rural areas with limited access to primary care services. AB 890 creates two new categories of nurse practitioners allowed to practice without physician supervision, as detailed in Appendix A. For ease of nomenclature, these two categories are often referred to as "103 NPs" and "104 NPs" to correspond to the respective statutory sections defining each under Business and Professions Code (BPC) §§ 2837.103 and 2837.104. Currently, nurse practitioners are authorized to practice via standardized procedures developed by the NP, supervising physician, and health care organization pursuant to BPC § 2725(c), BPC § 2836.1, and Title 16 of the California Code of Regulations (CCR) §§ 1470–1474. Additionally, the standardized procedure must define physician supervision requirements. (See Cal. Code Regs. tit. 16, § 1474(b)(7)). Simultaneously, AB 890 defines eligibility requirements for NPs to practice without physician supervision, including certification from a nationally accredited certifying entity and completion of postgraduate transition-to-practice (TTP) requirements in California.[3] AB 890 also requires the Board of Registered Nursing to appoint a Nurse Practitioner Advisory Committee, review current nursing regulations, and promulgate regulations and guidelines to implement AB 890.

The passage of AB 890 represents an important step to meet the pressing health care needs in the state by expanding the independent practice of nurse practitioners. The legislation also elevates the need to reexamine intersecting statutes, regulations, payer policies, clinical agency operations, interprofessional team structures, health care finance, and employment relationships and align them to fully realize the goals and intent of AB 890.

This report examines existing statutes and regulations that could be updated to align with AB 890. The report uses three priority policy issues — increasing access to care, especially in underserved communities of color; managing the opioid crisis; and caring for vulnerable older adults — to illustrate how statutory and regulatory alignment could enhance the state's capacity to meet community health care needs. Solutions to these policy issues are multifactorial. However, research points to expanded NP practice as one meaningful solution. States that removed physician supervision of NPs experienced a growth in the number of routine checkups, increased access for rural and vulnerable populations, decreases in emergency department use, and reductions in health care costs.[4] Evidence indicates that NP services ensure quality of care for chronic illnesses and improvement in functional status for patients in long-term care facilities.[5] Also, access to

treatment for opioid use disorder increased in states where there was no physician oversight of NPs compared with states that required NP supervision.[6]

Methodology

Research for this report included a review of the California laws related to NP practice that could be updated to be in greater alignment with AB 890. NP experts in practice, administration, education, and policy were queried about statutes that codify NP practice in California. Subsequently, the research team conducted a search of California code sections via the California Legislative Information website (leginfo.legislature.ca.gov) and Westlaw or LexisNexis using the search terms "nurse practitioner," "advanced practice registered nurse," "scope of practice," and "standardized procedures" to generate a list of statutes for analysis. For each statute, the research team identified the issue and the background of the statute, analyzed the statute's alignment with AB 890, and made recommendations regarding any misalignment with the policy enacted in AB 890 or its underlying goals.

Findings and Discussion

List of Statutes for Review and Action

The research team reviewed a comprehensive, but not exhaustive, list of California statutes that govern healing arts practitioners and identified opportunities for better alignment between existing laws and new legislation or regulatory action. Specifically, the analysis included a review of how newly authorized practice authority for NPs under AB 890 may affect and interact with sections of the Business and Professions Code (BPC) as well as other California codes, including but not limited to the following:

- Education Code (EDC)
- Evidence Code (EVID)
- Health and Safety Code (HSC)
- Insurance Code (INS)
- Labor Code (LAB)
- Probate Code (PROB)
- Unemployment Insurance Code (UIC)
- Welfare and Institutions Code (WIC)

Appendix A provides detail on these statutes and regulations.

To illustrate how existing statutes and identified areas of misalignment play out in practice, three priority health challenges confronting California are described in the next sections: access to care, the opioid crisis, and care of vulnerable adults. Aligning existing statutes to reflect the policy enacted in AB 890 has the potential to advance progress on these important issues.

Access to Care

One of the biggest challenges in California is ensuring access to high-quality care, particularly primary care, in all parts of the state. Many communities — from rural areas to low-income urban neighborhoods — face barriers to accessing care. In part, these barriers are driven by an inadequate supply of providers to provide high-quality, culturally inclusive care. According to the California Future Health Workforce Commission, in just 10 years, California is projected to face a shortfall of more than 4,100 primary care clinicians.[7] The commission also found that seven million Californians — with the vast majority being Latino, Black, and Native American — live in Health Professional Shortage Areas, a federal designation for counties experiencing shortfalls of primary care, dental care, or mental health care providers. AB 890 is, at its core, a health care access intervention, and while the legislation largely supports this intent, a few statutory considerations would benefit from consideration in order to advance the expansion of access to care.

In addition, although nurses may legally form nursing corporations in California pursuant to Corporations Code § 13401.5(f), NPs have historically faced

administrative and bureaucratic barriers to making these corporations financially and practically viable. Updates are needed to statutes, rules, and regulations associated with laws that define owning or operating a business or employing healing arts licensees in order to ensure that nurses may form and run corporations to provide a full range of clinical services with qualified personnel. For NPs, additional legal and practice barriers to the types of groups and corporations with which managed care entities contract may require further analysis.

Another hurdle to realizing the potential of NPs' practicing to the full extent of their education is the disconnect between AB 890's authorization of NPs' practicing without physician supervision and other laws, such as California's laws regarding managed health care plans. Known as the Knox-Keene Act of 1975, HSC § 1340 et seq. is a nearly 50-year-old set of laws designed to ensure that managed health care is regulated appropriately and that physicians' and other health professionals' decisions about patient care are not unduly affected by managed care companies. For example, HSC § 1375.9 requires that there be at least one full-time equivalent primary care physician for every 2,000 enrollees of a managed health care plan. NPs with their own primary care clinic practices may not satisfy this requirement. Permitting health plans to consider NPs when demonstrating that the plans have met network adequacy standards would be consistent with the policy enacted in AB 890. A comprehensive review of all nuances of the Knox-Keene Act will need to be conducted to evaluate any potential discrepancies or inconsistencies between AB 890 and Knox-Keene.

Opioid Crisis

California continues to experience an opioid abuse crisis and increases in opioid-related deaths. California's opioid overdose death rate in 2019 was 7.9 deaths per 100,000, up 2.3 deaths per 100,000 since 2017.[8] A recent report on buprenorphine, a treatment for opioid addiction, indicated a nearly fourfold increase in buprenorphine prescriptions in the state between 2014 and 2018.[9] The supply of chemical dependency resources — from hospitals to the workforce — does not meet the demand from individuals ready to seek treatment for substance abuse disorders. The number of chemical dependency beds decreased in California by 26.2% between 2005 and 2014, while the rate of addiction to opioids was increasing.[10]

In states or situations where physician supervision of NPs is required, the supervising physician must also be qualified to prescribe buprenorphine. When AB 890 is implemented, NPs will have full authority pursuant to BPC §§ 2837.103(c)(4) and 2837.104(a)(1) to prescribe buprenorphine and to treat individuals seeking help for opioid addiction, which will increase access options, particularly for the homeless and other vulnerable populations in California affected by substance use disorders.

Two regulations related to chemical dependency treatment that were not addressed in AB 890 concern medical staff privileges in chemical dependency hospitals and the care provider list for psychiatric and mental health services. Although AB 890 authorizes 103 NPs to serve on medical staff and hospital committees and 104 NPs to be eligible for medical staff membership, chemical dependency facilities were not specifically considered in the legislation. To align with AB 890, the California Code of Regulations could be updated to explicitly authorize NPs to serve on medical staff committees or be eligible for medical staff membership of chemical dependency recovery hospitals (Cal. Code Regs. tit. 22, § 79303) and include psychiatric mental health NPs on the list of Medi-Cal providers recognized for psychiatric and mental health services with county mental health plans (Cal. Code Regs. tit. 9, § 1810.240). These two updates would reduce discrepancies between laws and regulations, facilitating the implementation of AB 890 and thereby increasing the potential to expand chemical dependency services in California.

Care of Vulnerable Adults

Skilled nursing facilities (SNFs) and long-term care facilities have been particularly vulnerable during the COVID-19 pandemic. Long-term care facility

residents represented about 3.5% of the COVID-19 cases in 2020 but represented 64.9% of deaths due to COVID-19.[11] SNFs and long-term care facilities often care for populations with complex chronic health conditions, including hypertension, cardiac disease, diabetes, and cognitive impairment, which increase vulnerability to infections.

In 1973, the California Legislature passed the Long-Term Care, Health, Safety, and Security Act (HSC § 1417 et seq.). This law was created to ensure the quality of care in long-term health facilities by delineating minimum standards of care and by creating a licensing, inspection, and reporting system and a citation system for a wide variety of long-term care facilities. Some long-term care facilities, such as skilled nursing facilities, are regulated by both the state and the Medicare Conditions of Participation. Other long-term care facilities, such as congregant living health facilities, are regulated by the state.

Under AB 890, NPs could independently treat patients in long-term care facilities. However, existing language in the Health and Safety Code limits their contributions. Specifically, the long-term care code sections related to patient admission and treatment (HSC § 1417 et seq.) could be updated to allow NPs to practice in these facilities, improving continuity of care and eliminating gaps in care. Such changes have the potential to improve management of complex chronic health care conditions in long-term care facilities and to decrease public health costs in California over time.

Further, statutes governing respite care services in intermediate care and skilled nursing facilities (HSC § 1418.1) could be updated to allow an NP who is treating a person being admitted to respite care the authority to issue advance orders for care and treatment for that person, thus providing continuity of care and better oversight of the various aspects of care for that patient while addressing gaps in care in vulnerable and underserved populations.

Adult day health care centers (ADHCs) support the health and social needs of vulnerable older adults. Many ADHCs were forced to close during the pandemic. A recent study focused on ADHCs in California and the impact of the closures found declines in physical, cognitive, and mental health users of ADHCs and increased caregiver strain.[12] Expanding mental health services in ADHCs has the potential to improve treatment management among this vulnerable, underserved population in California.

Welfare and Institutions Code § 14550(e), which governs the services and standards provided in ADHCs, lists the health care professionals permitted to provide psychiatric or psychological services: a psychiatrist, a clinical psychologist, or a psychiatric social worker. Psychiatric/mental health NPs (PMHNPs) are educated and qualified to provide psychiatric and psychological services to older adults who need individual assessments and/or group or individual treatment for persons with diagnosed mental, emotional, or behavioral problems. Amending this section of the Welfare and Institutions Code to include NPs would provide clarity to the list of qualified psychiatric/mental health providers authorized to provide care in ADHCs and could have a positive impact on access to mental health services in ADHCs.

Conclusion

In a review of the California codes, many statutes were found to be misaligned with the newly enacted AB 890. This misalignment may limit the opportunity and intent of the legislation. Concerted effort will be required through a variety of interventions, including legislation, administrative action, and change in practice and operations, to realize the full benefit of the scope of practice reform for nurse practitioners in improving access to and quality of care.

This report has focused predominantly on the inconsistencies in clinical care and practice operations described in the various California codes. Further analyses of the intersection of AB 890 with health plans, health care financing, and the business aspects of a practice are needed.

Appendix A. Aligning Existing California Statutes and Regulations with AB 890

The statutes cited in Table A1 are presented in two categories. The first category contains statutes that are inconsistent with the intent and policy of AB 890, including statutes that predate the passage of AB 890 and reflect a pre-AB 890 physician supervision of NP practice. In many cases, these laws do not expressly exclude 103 NPs and 104 NPs; rather, the laws do not include these NPs, and therefore the inconsistent statutes could be seen as restricting the practice of 103 NPs and 104 NPs even after the passage of AB 890.

Also, many of the laws in the first category already confer authority to NPs who practice under standardized procedures. AB 890 authorizes 103 NPs and 104 NPs to practice without physician supervision and without the use of standardized procedures.[13] Each of these code sections could be clarified to include reference to 103 NPs and 104 NPs to ensure that they can practice without standardized procedures, so that the intent of AB 890 is not diminished.

Table A1. Category 1: Laws That Conflict with Policy Established in AB 890

ISSUE	PRE-AB 890 CALIFORNIA STATUTE	AB 890 CALIFORNIA STATUTE
Medical assistant supervision	**BPC § 2069(a)(2)(A).** This law authorizes NPs to delegate tasks to medical assistants pursuant to standardized procedures.	103 NPs and 104 NPs may delegate tasks to medical assistants under AB 890 pursuant to BPC § 2837.103(c)(6) and BPC § 2837.104(a)(1). Pre-AB 890 statute could be updated accordingly.
Dispensing drugs to outpatients in hospitals that do not employ full-time pharmacists	**BPC § 4056(f).** This law authorizes physicians to dispense drugs to outpatient patients in rural hospitals and licensed hospitals that contain 100 beds or fewer and that do not employ a full-time pharmacist.	BPC § 2837.103(c)(4)(B) authorizes 103 NPs and 104 NPs to dispense drugs. Pre-AB 890 statute could be updated accordingly.
Furnishing nonprescription drugs and devices to NPs	**BPC § 4057(b)(1).** This law specifies the healing arts professionals to whom a person can sell or furnish specific nonprescription drugs and devices. NPs are not listed as being able to buy nonprescription drugs and devices.	103 NPs and 104 NPs are able to procure, dispense, and furnish over-the-counter, nonprescription drugs and devices pursuant to BPC § 2837.103(c)(4)(B). Pre-AB 890 statute could be updated accordingly.
Furnishing prescription drugs and devices	**BPC § 4059(a).** This law specifies the healing arts professionals to whom a person can sell or furnish prescription drugs and devices. NPs are not listed as being able to buy nonprescription drugs and devices.	103 NPs and 104 NPs are able to procure and prescribe over-the-counter, legend, and controlled substances pursuant to BPC § 2837.103(c)(4)(B). Pre-AB 890 statute could be updated accordingly.
Possessing and stocking of drugs and devices	**BPC § 4060.** This statute limits the possession of any controlled substance to NPs functioning pursuant to standardized procedures. Additionally, this section does not authorize an NP to order his or her own stock of drugs and devices.	Pursuant to BPC §§ 2837.103(c)(4) et seq., 103 NPs and 104 NPs are authorized to prescribe and procure drugs and devices. Pre-AB 890 statute could be updated accordingly.
Protection from discovery	**EVID § 1157.** The Evidence Code does not include NPs as a healing arts professional for whom proceedings or records of organized committees or peer review bodies are protected from discovery. These protections are conferred to other healing arts professionals such as, but not limited to, physicians and surgeons, psychologists, dieticians, pharmacists, and licensed clinical social workers.	With the passage of AB 890, NPs are part of BPC § 805 peer review. Therefore, the peer review proceedings and discussions for organized committees that include committees composed of NPs should be protected from discovery, and NP meeting attendees should be protected from testifying during a hearing. Pre-AB 890 statute could be updated accordingly.

Table A1. Category 1: Laws That Conflict with Policy Established in AB 890, *continued*

ISSUE	PRE-AB 890 CALIFORNIA STATUTE	AB 890 CALIFORNIA STATUTE
Prescriptions	**BPC § 4040.** This law allows NPs who are functioning under standardized procedures to prescribe or order drugs and devices.	Pursuant to BPC § 2837.103(c)(4)(B), 103 NPs and 104 NPs may prescribe drugs and devices. Pre-AB 890 statute could be updated accordingly.
Manufacturer complimentary sample of drugs and devices	**BPC § 4061.** This law limits a manufacturer's sales representative in distributing complimentary samples to NPs functioning under standardized procedures.	Pursuant to BPC § 2837.103(c)(4)(B), 103 NPs and 104 NPs may procure drugs and devices. Pre-AB 890 statute could be updated accordingly.
Dispensing drugs and devices in place of practice	**BPC § 4170(a)(8).** This law permits an NP pursuant to standardized procedures to dispense drugs and devices in his or her place of practice.	Pursuant to BPC 2837.103(c)(4) et seq., 103 NPs and 104 NPs may dispense drugs and devices. Pre-AB 890 statute could be updated accordingly.
Dispensing drugs and devices by pharmacists	**BPC § 4174.** This law authorizes only pharmacists to dispense drugs and devices upon an order from an NP functioning pursuant to standardized procedures.	Pursuant to BPC 2837.103(c)(4) et seq., 103 NPs and 104 NPs may dispense drugs and devices. Pre-AB 890 statute could be updated accordingly.
Cardiac clearance for interscholastic sports	**EDC § 33479.5(c).** Students who have experienced symptoms of sudden cardiac arrest and have been removed from participation by a coach or athletic trainer need to be evaluated and cleared to return to participate in interscholastic sports with a written note from a physician and surgeon, a nurse practitioner or physician assistant practicing in accordance with standardized procedures or protocols	BPC 2837.103(c) et seq. authorizes 103 NPs and 104 NPs to evaluate and manage the care of patients. Pre-AB 890 statute could be updated accordingly.
End-of-life care counseling and options	**HSC § 442(c).** NPs are authorized to provide comprehensive information and counseling regarding legal end-of-life options when a patient is diagnosed as being terminally ill pursuant to standardized procedures.	BPC §§ 2837.103(c)(4) et seq. authorizes 103 NPs and 104 NPs to plan a therapeutic regimen that could encompass end-of-life care. Pre-AB 890 statute could be updated accordingly.
Uniform Controlled Substances Act	**HSC § 11026(a).** This law authorizes NPs functioning under standardized procedures to furnish or prescribe controlled substances.	BPC § 2837.103(c)(4)(B) authorizes 103 NPs and 104 NPs to prescribe, administer, dispense, and furnish controlled substances. Pre-AB 890 statute could be updated accordingly.
Prescription requirements	**HSC § 11150.** NPs can write or issue a prescription pursuant to standardized procedures.	BPC § 2837.103(c)(4) authorizes 103 NPs and 104 NPs to write prescriptions. Pre-AB 890 statute could be updated accordingly.
Health care service plans operations and renewal	**HSC § 1375.9(a)-(d).** This law requires a health care service plan to ensure that there is at least one full-time equivalent primary care physician for every 2,000 enrollees of the plan. After the initial 2,000 enrollees are empaneled, another 1,000 enrollees can be added for each "nonphysician medical practitioner," which is defined to include an NP performing services in collaboration with a physician.	HSC § 1375.9(a)–(d) could be amended to align with AB 890 and to ensure that 103 NPs and 104 NPs who are contracted with a health care service plan can provide care independently of a physician.

Table A1. Category 1: Laws That Conflict with Policy Established in AB 890, *continued*

ISSUE	PRE-AB 890 CALIFORNIA STATUTE	AB 890 CALIFORNIA STATUTE
Contracting with life and disability insurance	**INS § 10133.4.** This law allows for NPs functioning in collaboration with a physician to be primary care providers who contract with life and disability insurance for alternative rates.	Pursuant to BPC §§ 2837.104 et seq., NPs in their own primary care practices should be eligible to be recognized as primary care providers. Pre-AB 890 statute could be updated accordingly.
Long-term care facility services	**WIC § 14111(c).** This law allows NPs functioning under the supervision of a physician and surgeon and pursuant to a standardized procedure to provide health services in a long-term care facility that is reimbursed by Medicare.	NPs with their own practices pursuant to BPC §§ 2837.103 et seq. and §§ 2837.104 et seq. should be authorized to provide health care services that are delegated to the NP without a standardized procedure. Pre-AB 890 statute could be updated accordingly.
Occupational therapy and topical medications	**BPC § 2571(a).** This law permits an occupational therapist to apply topical medications prescribed by an NP pursuant to standardized procedures.	Occupational therapists should be authorized to apply topical medications prescribed by 103 NPs and 104 NPs without needing to practice under standardized procedures. Pre-AB 890 statute could be updated accordingly.
Risk factor screening for hormonal contraceptives	**BPC § 2242.2.** This law permits an NP pursuant to standardized procedures to use a self-screening tool to identify patient risk factors for the use of self-administered hormonal contraceptives by a patient and, after an appropriate prior examination, prescribe, furnish, or dispense, as applicable, self-administered hormonal contraceptives to the patient.	The law could authorize 103 NPs and 104 NPs to use self-screening tools to identify patient risk factors of self-administered hormonal contraceptives without needing to practice under standardized procedures. Pre-AB 890 statute could be updated accordingly.
Workers' compensation — medical treatment	**LAB § 3209.10 (a).** This law authorizes NPs functioning pursuant to standardized procedures to provide medical treatment in the workers' compensation insurance program.	The law could authorize 103 NPs and 104 NPs to provide medical treatment in the workers' compensation insurance program without needing to practice under standardized procedures. Pre-AB 890 statute could be updated accordingly.
Medi-Cal primary care provider case management	**WIC § 14088(c).** Within Medi-Cal managed care plans, NPs are considered to be "nonphysician medical practitioners" and may perform primary care case management in the Medi-Cal program only in collaboration with a physician and surgeon.	The law could authorize 103 NPs and 104 NPs to independently perform primary care case management in the Medi-Cal program. Pre-AB 890 statute could be updated accordingly.

The second category lists laws that are not in conflict with AB 890 but that do not reflect the intent or spirit of the policy enacted in AB 890 (see Table A2). Many of the laws in this category restrict NPs' ability to provide a full range of evidence-based clinical services, to establish and run a practice efficiently, or to complete forms related to patient care. Alignment of these statutes with the policy established in AB 890 would, therefore, facilitate the delivery of safe, high-quality, seamless patient care.

In addressing the statutes that could interfere with NP clinical practice, one solution is to adopt statutes or agency rules that authorize an NP to sign, attest, certify, stamp, verify, endorse, or provide an affidavit for any form for patient care within the NP's scope of practice.[14] These laws are generally known as "global signature" laws. A list of states with model global signature authority legislation can be found in Appendix C.

Table A2. Category 2: Statutory Changes to Facilitate Evidence-Based Patient Care and Continuity of Care

ISSUE	PRE-AB 890 CALIFORNIA STATUTE	AB 890 CALIFORNIA STATUTE
Blood transfusions	**HSC § 1645(a).** This statute restricts the determination of need for a blood transfusion to a physician and surgeon and a doctor of podiatric medicine.	Independently practicing nurse practitioners will need to order blood transfusions based on evidence-based clinical guidelines. There are many health conditions that may require a patient to need a blood transfusion. HSC 1645(a) could be amended to authorize 103 NPs and 104 NPs to provide blood transfusions.
Respiratory therapy services	**BPC §§ 3700 et seq.** "Respiratory care as a practice means a health care profession employed under the supervision of a medical director."	Current statutes allow only physicians and surgeons to order respiratory care services. NPs are educated and qualified to evaluate patients for respiratory therapy needs and will need to order respiratory care services for patients. These statutes could be amended to include 103 NPs and 104 NPs as being eligible to order respiratory care services and supervise respiratory care practitioners.
Treating sexual partners of patients diagnosed with sexually transmitted infections	**HSC § 120582 (a)–(b).** An important public health initiative in California has been surveillance and treatment of sexually transmitted infections (STIs). This care has extended to the partners of those infected. The current statute allows only physicians and surgeons to prescribe, dispense, furnish, or otherwise provide a prescription to a patient's sexual partner or partners without examination of that patient's partner or partners.	This statute could be amended to allow 103 NPs, 104 NPs, and NPs functioning under standardized procedures to prescribe, dispense, furnish, or otherwise provide a prescription to a patient's sexual partner or partners without examination of that patient's partner or partners.
Child health and disability prevention program	**HSC § 124030(g)(2)-(3).** This law allows for only family nurse practitioners and pediatric nurse practitioners to serve as a Child Health and Disability Prevention program director.	Children with childhood illnesses such as cystic fibrosis and congenital heart disease are now living longer and being cared for by others besides just family or pediatric nurse practitioners. This statute could be amended to authorize 103 NPs and 104 NPs to serve as program directors.
Intermediate care facility or developmentally disabled habilitative facility skilled nursing needs certification	**HSC § 1250(e).** This law specifies that physicians and surgeons are authorized to certify that patients in an intermediate care facility or developmentally disabled habilitative facility do not require continuous skilled nursing care.	NPs are educated and qualified to make the determination whether a patient needs continuous skilled nursing care or ongoing care in an intermediate facility. HSC § 1250(e) could be amended to specify that 103 NPs or 104 NPs acting as the primary care provider in these settings can determine the appropriate level of care for the patient.

Table A2. Category 2: Statutory Changes to Facilitate Evidence-Based Patient Care and Continuity of Care, *continued*

ISSUE	PRE-AB 890 CALIFORNIA STATUTE	AB 890 CALIFORNIA STATUTE
Congregate living health facilities — life-threatening illness	**HSC § 1250(i)(2)(B).** This statute specifies certification by physicians and surgeons that patients who need initial or ongoing care in an intermediate care facility or developmentally disabled habilitative facility need 24-hour personal care but do not need continuous skilled nursing care.	NPs are educated and qualified to make the prognosis, evaluate, and manage the care of patients with life-threatening illness. HSC § 1250(i)(2)(B) could be amended to specify that 103 NPs and 104 NPs acting as the primary care provider in these settings can determine the appropriate level of care for the patient.
Diabetes management in intermediate care facilities or developmentally disabled habilitative facility	**HSC § 1265.6(a).** Blood glucose testing in an intermediate care facility or developmentally disabled habilitative setting is permitted only if a physician orders the testing.	NPs are educated and qualified to evaluate and manage the care of patients in intermediate care facilities or developmentally disabled habilitative facilities and to determine the need for and cadence of blood glucose testing.. HSC § 1265.6(a) could be amended to allow blood glucose testing orders by 103 NPs, 104 NPs, and NPs functioning under standardized procedures.
Long-term health care facilities	**HSC § 1418.8.** Physicians and surgeons are the only authorized healing arts professionals authorized to prescribe or order a medical intervention when the patient lacks decision-making capacity.	NPs are educated and qualified to make determinations about decision-making capacity and the medical necessity of an intervention. HSC § 1418.8 could be amended to allow 103 NPs, 104 NPs, and NPs functioning under standardized procedures to prescribe or order medical interventions when the patient lacks decision-making capacity.
Death registration and certificates	**HSC § 102795, HSC § 102800, HSC § 102825, HSC § 102850(c), HSC § 102875(a)(7).** These five Health and Safety Code sections address who can complete the death registration and death certificate. HSC § 102795 states that only a physician and surgeon or physician assistant last in attendance must complete the medical and health section data and time of death. HSC § 102800 states that the medical and health section data shall be completed by a physician or coroner and the death certificate deposited within 15 hours after the death. HSC § 102825 requires the physician, or a physician assistant in the case of a death in a skilled nursing facility or long-term care facility, to state the disease or condition of death and other death certificate requirements. HSC § 102850(c) allows only a physician or physician assistant to state the cause of death. HSC § 102875(a)(7) allows only a physician or coroner to certify the death on the death certificate.	Patients who die while under the care of a 103 NP or 104 NP will need their death to be registered and a certificate to be completed. The cited code sections could be updated to ensure that NPs can complete the death registration and death certificate.
Clinical laboratory director	**BPC §§ 1209 et seq.** This law lists the definitions of who may be a laboratory director. Pursuant to BPC § 2837.103(c)(2)(B) and § 2837.104(b)(1), 103 NPs and 104 NPs may perform or interpret clinical laboratory procedures that they are permitted to perform under BPC § 1206 and under the federal Clinical Laboratory Improvement Act (CLIA). NPs who own a clinical practice will need to be authorized to be a laboratory director for waived and moderate complexity laboratory tests.	To increase available clinical and laboratory services, NPs could be authorized to be laboratory directors. BPC § 1209 could be amended to authorize 103 NPs and 104 NPs to be laboratory directors for both waived and moderate complexity laboratory tests.

Table A2. Category 2: Statutory Changes to Facilitate Evidence-Based Patient Care and Continuity of Care, *continued*

ISSUE	PRE-AB 890 CALIFORNIA STATUTE	AB 890 CALIFORNIA STATUTE
Interscholastic athletic programs — physical exams	**EDC § 494458.** This law authorizes a physician and surgeon or a physician assistant to conduct a physical exam as a condition of a student's participation in interscholastic athletic programs.	NPs are educated and qualified to conduct physical and health assessments for students. EDC § 494458 could be amended to include 103 NPs, 104 NPs, and NPs functioning pursuant to standardized procedures as authorized healing arts professionals who can conduct physical and health exams for interscholastic athletic programs.
Workers' compensation insurance — definition of authorized provider	**LAB § 3209.3.** This law defines the authorized providers used throughout the workers' compensation insurance statutes as being qualified to provide care. NPs are not listed.	This statute could be amended to authorize 103 NPs and 104 NPs to provide services to workers in the workers' compensation insurance program.
Adult day health care centers	**WIC § 14550(e).** This law requires adult day health care centers (ADHCs) to offer medical services including psychiatric services when indicated and individual or group therapy for mental and behavioral health problems. These services may be provided only by psychiatrists, clinical psychologists, or psychiatric social workers. Note that there is a shortage of mental health providers in California.	Psychiatric/mental health NPs (PMHNPs) are educated and qualified to provide psychiatric and psychological services to older adults who need individual assessments and/or group or individual treatment for persons with diagnosed mental, emotional, or behavioral problems. NPs are authorized to establish primary and differential diagnoses, create a plan of care, and initiate therapeutic regimens, and so PMHNPs could be included in this statute as authorized providers in ADHCs.

Appendix B. 103 and 104 Nurse Practitioners

Business and Professions Code (BPC) § 2837.103 NPs are eligible to practice pursuant to a defined scope of practice without standardized procedures or supervision. In order to be eligible, the NP must (1) work in one of six settings in which one or more physicians practice, and (2) satisfy specific requirements delineated in AB 890.

103 NP SETTINGS
BPC § 2837.103(A)(2)(A)–(F)

Authorized Settings and Organizations

Any of the following settings that has one or more physicians and surgeons:

- A clinic, as defined in Section 1200 of the Health and Safety Code.
- A health facility, as defined in Section 1250 of the Health and Safety Code, except for the following described under Exempted Settings.
- A facility described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.
- A medical group practice, including a professional medical corporation, as defined in Section 2406, another form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure, or another lawfully organized group of physicians and surgeons that provides health care services.
- A home health agency, as defined in Section 1727 of the Health and Safety Code.
- A hospice facility licensed pursuant to Chapter 8.5 (commencing with Section 1745) of Division 2 of the Health and Safety Code.

Exempted Settings

NPs will still need to practice under standardized procedures in these settings. A correctional treatment center, as defined in paragraph (1) of subdivision (j) of Section 1250 of the Health and Safety Code.

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

103 NP REQUIREMENTS

REQUIREMENT	BPC SECTION
The NP has passed a national NP board certification examination.	2837.103(a)(1)(A)
If applicable, the NP must pass a supplemental examination developed by the Department of Consumer Affairs Office of Professional Examination Services (OPES).	2837.103(a)(1)(A) and 2837.105(a)(1)–(4)
The NP holds a certification as an NP from a national certifying body accredited by the National Commission for Certifying Agencies or the American Board of Nursing Specialties and recognized by the BRN.	2837.103(a)(1)(B)
The NP provides documentation that the NP education was consistent with already existing BRN regulations in BPC § 2836.	2837.103(a)(1)(C)
The NP has completed a transition to practice (TTP) in California of a minimum of three full-time equivalent years of practice or 4,600 hours.	2837.103(a)(1)(D)

Business and Professions Code (BPC) § 2837. 104 NPs are eligible to practice independently pursuant to a defined scope of practice without standardized procedures in settings outside those listed in BPC § 2837.103(a)(2)(A)–(F) if they meet the criteria in the following table. The Board of Registered Nursing (BRN) will issue a separate NP certificate once the NP completes all of the 104 NP requirements and submits an application to the BRN. With the certification, NPs can open up their own practices and businesses pursuant to already existing laws and structures such as, but not limited to, a nursing corporation.

104 NP REQUIREMENTS	
REQUIREMENT	BPC SECTION
The 104 NP must meet all of the same requirements as the 103 NPs: ► National certification ► OPES exam, if applicable ► BRN-approved NP education ► TTP	2837.104(b)
Holds a valid and active registered nurse license and a master's degree in nursing or other clinical field related to nursing or a doctoral degree in nursing.	2837.104(b)(1)(B)
The NP has practiced as an NP in good standing for at least three years, not inclusive of the TTP. The BRN may, at its discretion, lower this requirement for an NP who holds a doctorate of nursing practice (DNP) based on practice experience gained in the course of doctoral education.	2837.104(b)(1)(C)

Appendix C. States with Global Signature Laws

STATE/JURISDICTION CITATION	TEXT OF LAW
Alabama Ala. Code § 34-21-93.1	(a) When any law or rule requires a signature, certification, stamp, verification, affidavit, or endorsement by a physician, the document shall be deemed to authorize a signature, certification, stamp, verification, affidavit, or endorsement by a certified registered nurse practitioner or certified nurse midwife for the items listed in this section. The authority in this section for a certified registered nurse practitioner and a certified nurse midwife shall be subject to an active collaboration agreement. This section applies to all of the following: [a long list of defined actions, including but not limited to certifying disability for parking placards, signing death certificates, and so on]
Arkansas Ark. Code § 17-80-120	(a) When a provision of law or rule requires a signature, certification, stamp, verification, affidavit, or endorsement by a physician, the requirement may be fulfilled by an advanced practice registered nurse or a physician assistant in any of the following circumstances: (1) Certification of disability for patients to receive disabled parking permits or placards from the Office of Motor Vehicle; or (2) Signature for: (A) Sports physicals to authorize student athletes to participate in athletic activities; (B) Physicals for bus drivers; (C) Forms relating to do-not-resuscitate orders; (D) Forms excusing a potential jury member due to an illness; (E) Death certificates; (F) Workers' compensation forms; (G) Forms relating to absenteeism for employment or school purposes; or (H) Authorizations for durable medical equipment.
DC D.C. Law 22-60, § 2, 65 D.C. Reg. 5	Section 604 of the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6–99; D.C. Official Code § 3–1206.04), is amended as follows: . . . (c) A new paragraph (5) is added to read as follows: "(5) Sign, certify, stamp, or endorse all documents that require a signature by a physician, in place of a physician, provided it is within the scope of their authorized practice."
Hawaii Haw. Rev. Stat. § 457-8.8	Notwithstanding any other law to the contrary, advanced practice registered nurses shall be authorized to sign, certify, or endorse all documents relating to health care within their scope of practice provided for their patients, including workers' compensation verification documents, verification and evaluation forms of the department of human services and department of education, verification and authorization forms of the department of health, and physical examination forms; provided that nothing in this section shall be construed to expand the scope of practice of advanced practice registered nurses.
Idaho Idaho Code § 54-1420	When a provision of law or rule requires the signature, certification, stamp, verification, affidavit, or endorsement of a physician, that requirement may be fulfilled by an advanced practice registered nurse (APRN), including a certified nurse practitioner, certified nurse midwife, certified registered nurse anesthetist, or clinical nurse specialist. This section shall not be construed to expand the scope of practice of an APRN.
Maine Me. Rev. Stat. tit. 32, § 2205-B(5)	Global signature authority of a certified nurse practitioner or certified nurse midwife. When a provision of law or rule requires a signature, certification, stamp, verification, affidavit or endorsement by a physician, that requirement may be fulfilled by a certified nurse practitioner or a certified nurse midwife. This subsection may not be construed to expand the scope of practice of a certified nurse practitioner or a certified nurse midwife.
Massachusetts Mass. Gen. Laws ch. 112, § 801	When a law or rule requires a signature, certification, stamp, verification, affidavit or endorsement by a physician, when relating to physical or mental health, that requirement may be fulfilled by a nurse practitioner practicing under section 80B. Nothing in this section shall be construed to expand the scope of practice of nurse practitioners. This section shall not be construed to preclude the development of mutually agreed upon guidelines between the nurse practitioner and supervising physician under section 80E.
Rhode Island R.I. Gen. Laws § 5-34-42	Whenever any provision of the general or public law or regulation requires a signature, certification, stamp, verification, affidavit, or endorsement by a physician, it shall be deemed to include a signature, certification, stamp, verification, affidavit, or endorsement by a certified registered nurse practitioner; provided, however, that nothing in this section shall be construed to expand the scope of practice of nurse practitioners.
Vermont Vt. Stat. Ann. tit. 26, § 1616	Whenever any provision of Vermont statute or rule or any form provided to any person in this state requires a signature, certification, stamp, verification, affidavit, or other endorsement by a physician, such statute, rule, or form shall be deemed to include a signature, certification, stamp, verification, affidavit, or other endorsement by an advanced practice registered nurse (APRN) licensed pursuant to this chapter and certified as a nurse practitioner or a nurse midwife; provided, however, that nothing in this section shall be construed to expand the scope of practice of APRNs.

Endnotes

1. Assembly Bill 890, "Nurse Practitioners: Scope of Practice: Practice Without Standardized Procedures," California Legislative Information, September 30, 2020.
2. Assembly Bill 890. The relevant legislative language is as follows: "The bill would authorize a nurse practitioner who meets certain education, experience, and certification requirements to perform, in certain settings or organizations, specified functions without standardized procedures, including ordering, performing, and interpreting diagnostic procedures, certifying disability, and prescribing, administering, dispensing, and furnishing controlled substances. The bill, beginning January 1, 2023, would also authorize a nurse practitioner to perform those functions without standardized procedures outside of specified settings or organizations in accordance with specified conditions and requirements if the nurse practitioner holds an active certification issued by the board. The bill would require the board to issue that certification to a nurse practitioner who meets additional specified education and experience requirements, and would authorize the board to charge a fee for the cost of issuing the certificate."
3. The postgraduate transition-to-practice requirement in California is a minimum of three full-time equivalent years or 4,600 hours. BPC § 2837.103(a)(1)(D).
4. P. I. Buerhaus et al., "Practice Characteristics of Primary Care Nurse Practitioners and Physicians," *Nursing Outlook* 63, no. 2 (March/April 2015): 144–53; M. A. Davis et al., "Supply of Healthcare Providers in Relation to County Socioeconomic and Health Status," *Journal of General Internal Medicine* 33, no. 4 (2018): 412–14; *Impact of State Scope of Practice Laws and Other Factors on the Practice and Supply of Primary Care Nurse Practitioners*, US Department of Health and Human Services, November 2015; M. A. Fraser and C. Melillo, "Expanding the Scope of Practice of APRNs: A Systematic Review of the Cost Analyses Used," *Nursing Economics* 36, no. 1 (2018): 23–28; M. Weinberg and P. Kallerman, *Full Practice Authority for Nurse Practitioners Increases Access and Controls Cost* (PDF), Bay Area Council Economic Institute, 2014.
5. F. Donald et al., "A Systematic Review of the Effectiveness of Advanced Practice Nurses in Long-Term Care," *Journal of Advanced Nursing* 69, no. 10 (2013), 2148–61; S. Kaasalainen et al., "The Effectiveness of a Nurse Practitioner-Led Pain Management Team in Long-Term Care: A Mixed Methods Study," *International Journal of Nursing Studies* 62 (October 2016): 156–67.
6. J. Spetz et al., "Nurse Practitioner and Physician Assistant Waivers to Prescribe Buprenorphine and State Scope of Practice Restrictions," *JAMA* 321, no. 14, (2019): 1407–8.
7. *Executive Summary: Final Report of the California Future Health Workforce Commission* (PDF), California Future Health Workforce Commission, February 2019.
8. "Opioid Overdose Death Rates and All Drug Overdose Death Rates Per 100,000 Population (Age-Adjusted)," Kaiser Family Foundation, 2019.
9. H. B. Rowan, "Use of Buprenorphine to Treat Opioid Addiction Proliferates in California," California Healthline, May 23, 2019.
10. J. L. Chow, M. J. Niedzwiecki, and R. Y. Hsia, "Trends in the Supply of California's Emergency Departments and Inpatient Services, 2005–2014: A Retrospective Analysis," *BMJ* Open 7, no. 5 (May 2018): e014721.
11. "COVID-19 Nursing Home Data," Centers for Medicare & Medicaid Services, accessed May 3, 2021.
12. T. Sandarangani et al., "'Advocating Every Single Day' so as Not to Be Forgotten: Factors Supporting Resiliency in Adult Day Service Centers Amidst COVID-19-Related Closures," *Journal of Gerontological Social Work* 64, no. 3 (January 2021), 291–302.
13. Several California statutes granted NPs authority to perform functions pursuant to "standardized procedures" as defined in BPC § 2725(c) and the California Code of Regulations (CCR) title 16, §§ 1470–1474.
14. "Issues at a Glance: Signature Authority," American Association of Nurse Practitioners, accessed June 28, 2021.