HealthImpact

Optimizing health through nursing

Value of Nursing Project: Phase I

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Glossary of Terms

Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA) or colloquially Obamacare, is a United States federal statute signed into law by President Barack Obama on March 23, 2010. The aim of the Act is a health care law aimed at improving the health care system of the United States by widening health coverage to more Americans, as well as protecting existing health insurance policy holders.

Accountable Care Organization

An accountable care organization (ACO) is a healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. A group of coordinated health care providers forms an ACO, which then provides care to a group of patients.

Care Delivery Model

The Affordable Care Act has been a catalyst for developing new health care delivery and payment systems that will improve outcomes, decrease cost, and restructure reimbursements.

Patient Centered Medical Homes (PCMH) and Accountable Care Organizations (ACO) are two of the new models that are being tested across the country. The Centers for Medicare and Medicaid Services (CMS) are also awarding "innovation grants" to health care organizations, academic institutions and not for profits who are testing other models of care and reimbursement.

Return on Investment

In business, the purpose of the "return on investment" (ROI) metric is to measure, per period, rates of return on money invested in an economic entity in order to decide whether or not to undertake an investment. It is also used as indicator to compare different project investments within a project portfolio.

Scope of Practice

The Scope of Practice describes the procedures, actions, and processes that a healthcare practitioner is permitted to undertake in keeping with the terms of their professional

license. The scope of practice is limited to that which the law allows for specific education and experience, and specific demonstrated competency. Each jurisdiction has laws, licensing bodies, and regulations that describe requirements for education and training, and define scope of practice.

Value Based Purchasing

Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.

Background

California was the first state to embrace the Affordable Care Act (ACA) and its coverage provisions, including the establishment of Covered California – the state's health benefit exchange. California is a national leader in the implementation of the ACA, but it has not been without challenges related to health care costs and quality improvement efforts. The cost of health care continues to grow, "National health spending reached $2.8 trillion in 2012 and is projected to increase to $5.0 trillion by 2022. The projection period (2013 to 2022) reflects a growth assumption of 6.0% per year, about two percentage points higher than recent growth rates." In the California Health Care Almanac, it was noted, based on 2012 data, "Even with the slow growth in national health spending in recent years, the US continued to spend a greater percentage of its wealth on health care more than any other industrialized nation. In 2012, the US spent an average of $8,915 per person on health care, reaching a total of $2.8 trillion." Health care spending's share of the economy in 2012 remained stable at 17.2%, while health care spending consumed 42% of federal revenues and 6% of household income. (California Health Care Foundation, 2014)

In California, approximately $280 billion was spent on health care at the start of the decade and could grow to more than $570 billion by 2020. This acceleration in the state health care expenditure growth rate will be driven by the combined impact of ACA implementation, an aging and more medically complex patient population, and delivery system transformation that supports and incentivizes care coordination among providers, interprofessional teams, and services to deliver cost-efficient, effective, high quality health care.

The population now receiving this valuable commodity of health care has a historical pattern that is episodic in nature and utilizes inappropriate resources to access care. This of course is due in part to previous lack of coverage and lack of access to care, and health care habits that will need to be addressed in order to reduce the burden of care, born by impacted emergency departments across California. In the Statistical Brief #174 it was noted that, "ED utilization reflects the greater health needs of the surrounding community and may provide the only readily available care for individuals who cannot obtain care elsewhere. Many ED visits are "resource sensitive" and potentially preventable, meaning that access to high-quality, community-based health care can prevent the need for a portion of ED visits. (Weiss, 2014)

The most versatile non-physician provider in the health care team is the registered nurse who has the knowledge, creativity and expertise to impact health care by decreasing costs, improving quality and providing greater access to health care services. The delivery of new models of care will be further driven by new roles assumed within and leading the interprofessional care teams by registered nurses. In 2012, the California Hospital Association (CHA) published a document titled *Transforming for Tomorrow* to assist hospitals and health systems to prepare for delivery system changes associated with health care reform. The following year, the California Institute for Nursing and Health Care (CINHC) published a white paper titled *The Nurse Role Exploration Project: The Affordable Care Act and New Roles for Nurses* to identify and prioritize new roles for RNs in this changing environment. These works led to generative dialog which resulted in development of a tool to assist nurse leaders across California in preparing nurses for these future roles. The RN Role Transformation Tool© predicts which new roles will be necessary for various types of hospitals, how important each role will be

given the hospital's strategic goals, as well as offering examples of how each role could be applied in practice. (California Hospital Association, 2012) (Berg J. G., 2013) (Berg J. G., October 2014)

Currently, the models of care utilized and under development are primarily physician and physician extender based models. These models limit access because they are dependent on providers that are currently in short supply. To enhance access, we propose expanded team models that include registered nurses working to the full extent of their education and training in multiple settings across the continuum. Because the registered nurse (RN) utilizes nursing diagnoses to treat a person's response to their health and illness, RN's are uniquely positioned to provide person-centric care across the continuum of acute and primary care settings. Donna E. Shalala, Ph.D., chair of the Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine (IOM) stated, "This report is really about the future of health care in our country. It points out that nurses are going to have a critical role in that future especially in producing safe, quality care and coverage for all patients in our health care system." (Committee on the Robert Wood Johnson Foundation, 2011) The report generated four key messages, two of which are important to this project, "Nurses should practice to the full extent of their education and training and Nurses should be full partners, with physicians and other health professionals, in redesigning health care in the United States." Along with the four key messages eight recommendations were made. The following recommendations are important to this work, Recommendation #1: Remove scope of practice barriers, #2 Expand opportunities for nurses to lead and diffuse collaborative improvement

efforts and #7 Prepare and enable nurses to lead change to advance health. (American Association of the Colleges of Nursing, 2015)

It is important to note that there are more than four times as many RNs in the United States as physicians. Registered Nurses deliver an extended array of health care services, including primary and preventive care by advanced, independent nurse practitioners in such clinical areas as pediatrics, family health, women's health, and gerontological care. Nursing's scope also includes care by clinical nurse specialists, certified nurse-midwives and nurse anesthetists, as well as care in cardiac, oncology, neonatal, neurological, and obstetric/gynecological nursing and other advanced clinical specialties. Nurses comprise the largest single component of hospital staff, are the primary providers of hospital based care, and deliver most of the nation's long-term care. Currently 62.2 percent of all employed Registered Nurses work in the acute care setting. (American Association of the Colleges of Nursing, 2015) As the landscape of health care and reimbursement changes to a model that embraces prevention and population health the registered nurse is well positioned to provide an integral role in improving care rendered to a new generation of insured patients.

Historically, the health care financial payment model includes nursing care bundled in the general bed charges billed for acute hospital services. Within a hospital, nursing care measured by Nursing Hours per Patient Day, and associated charges for nursing care, are generated and bundled via a room charge which includes the physical space in which care is provided and other non-physician services. The physician currently bills for services, and insurers, led by the standards set by the Centers for Medicare and Medicaid Services, have promoted this fee for service payment methodology by establishing specific physician billing

codes. However, health care reform is shifting the profitability fee for service model toward performance based reimbursement, accentuating health outcomes that matter to the patient relative to the cost. Two components exist within the equation for value, quality and cost. In other words, value equals outcomes divided by cost, or Value=Outcome/Cost. In the new performance based model, different from the volume based financial model, where nursing costs were hidden, the quantitative value of the RN will be instrumental in defining their individual impact on health care outcomes. Defining the value impact that an RN has on improving health outcomes is an important component in defining new roles in health care and developing team delivery models that include and promote the unique scope of practice and competencies of the registered nurse.

To support the case in defining the work of an RN and place a monetary value on the primary care role that an RN is uniquely suited to provide, supporting evidence is presented. Much literature has been generated showing the cost and quality effectiveness of the RN within various care settings. The following research helps to support this proposition, as shared in Nursing World, "the adequacy of nursing staffing and proportion of registered nurses is inversely related to the death rate of acute medical patients within 30 days of hospital admission (Tourangeau, et al, 2005). Increasing RN staffing could reduce costs and improve patient care by reducing unnecessary deaths and reducing days in the hospital (Stone, et al, 2007)...patients hospitalized for heart attacks, congestive heart failure and pneumonia…are more likely to receive high quality care in hospitals with higher registered nurse staffing ratios (Landon, 2006). Higher fall rates were associated with fewer nursing hours per patient day and a lower percentage of registered nurses…(Dunton, et. al., 2004)… can accurately differentiate

pressure ulcers from other ulcerous wounds in web-based photographs, reliably stage pressure ulcers, and reliably identify community versus nosocomial pressure ulcers (Hart, et al, 2006). A 10% increase in the number of patients assigned to a nurse leads to a 28% increase in adverse events such as infections, medication errors, and other injuries (Weisman, 2007). Understaffing of registered nurses in hospital intensive care units increases the risk of serious infections for patients; specifically, pneumonia (Hugonnet, et al, 2007). According to The Joint Commission (2005), "quantifying the effect that nurses and nursing interventions have on the quality of care processes, and on patient outcomes, has become increasingly important to support evidence-based staffing plans, understand the impact of nursing shortages and optimize care outcomes." (Gallagher, 2010) The Value of Nursing project continued the natural progression of the transformative work accomplished by the California Hospital Association and HealthImpact (formerly known as CINHC), by applying the RN Transformation Tool© with the new role definitions to create a business and quality case for implementation of a new model of care utilizing registered nurses as key providers. The new roles defined within the HealthImpact (CINHC) Nurse Role Exploration Project are Care Coordinator, Faculty Team Leader, Informatics Specialist, Nurse/Family Cooperative Facilitator and Primary Care Partner. Within the RN Role Transformation Tool© a transformation grid was developed helping to identify the level of importance of each new role to each of the five types of hospital destinations. Working with a group of nursing leaders from academic and practice settings across California, a clear and concise definition of the value of the RN has been developed defining key talking points to increase awareness and support change within the health care industry and the general population. Developing a clear understanding of the nursing profession related to value based

purchasing and health outcomes will bring about greater opportunity for collaboration and creativity amongst health care professionals.

Value of Nursing Project Overview

This Value of Nursing project was generated from previous work completed by HealthImpact (Formerly CINHC) and The California Hospital Association. This innovative journey has convened nursing thought leaders from both academic and practice settings from across the country including co-Leaders, BJ Bartleson, Vice President, Nursing & Clinical Services California Hospital Association and Stephanie Decker, National Nursing Policy Consultant, National Patient Care Services, Kaiser Permanente. The project has generated interest from nursing coalitions across the nation who would like to collaborate. Three focused workgroups were developed around the key components.

The first key component is the creation of a consistent definition of the value of nursing that can be shared both within healthcare and with the general population. The reason this work is important, is that without a clear understanding of the scope and capabilities of a registered nurse linked to value based outcomes, the development of creative models of care in which the registered nurse may/may not be fully utilized to enhance accessibility, will be limited. The team is working to develop key talking points, sharing the definition of value based nursing in relevant messages to targeted audiences. These messages will be adapted to the setting in which they are used to enhance relevance and application to desired outcomes.

The second key component is developing a business case for the utilization of the RN. Within this body of work, a return on investment calculator will be developed which can be used by healthcare leaders to exhibit the financial benefit gained when utilizing a registered nurse in specific roles and programs. This calculator takes into account the benefits of nursing

sensitive indicators that are not historically considered when producing financial analysis in various healthcare settings. Examples of these benefits are: reduction of hospital acquired infections, reduction of hospital re-admissions, reduction of emergency department utilization, reduction of hospital admissions, reduction in mortality rate and improvement of various health indicators such as Hemoglobin A1C, controlled blood pressure, lower cholesterol, amongst many others. A significant body of work exists that supports that appropriate RN utilization improves patient outcomes. Defining the business case will create a greater understanding amongst those in decision making positions regarding the allocation of resources; that the investment in positioning RN's in specific roles can result in lower overall costs of health and be of financial benefit.

The last key component is the development of a licensing certification competency crosswalk for the interprofessional team. Within healthcare, many professions provide various roles within the health care delivery system. Each of these professional roles carry a specific scope of practice and these roles are not always well understood or well-coordinated, particularly in terms of capability and outcome driven measures. Developing a crosswalk that can describe each professional's role in the provision of care as well as the associated costs, will help leaders decide how best to allocate resources. The crosswalk will include which profession is competent to provide specific care and services, under what circumstances and in what settings. Each type of care provider displayed within the crosswalk will indicate unique competencies, education and training. Based upon this crosswalk, team models will be recommended applicable to various levels, settings, and types of care. The crosswalk will guide and support those responsible for resource allocation to articulate the case for utilization of the

appropriate level of professional in a specific circumstance. It will highlight the effective scope and breadth of care capability of the RN, as further evidence of the scope of practice, breadth of services, and flexibility that an RN brings to the health care table.

To our knowledge there has not been a comprehensive look at these key components across the California landscape or with other states we have networked with. Developing these three components will help educate the body of healthcare professionals about the RN scope of practice and capability to meet the goal of creatively influencing, supporting, and providing new models of care that enhance value. This project meets the call of the, Initiative on the Future of Nursing, at the Institute of Medicine (IOM) "Nurses should practice to the full extent of their education and training and Nurses should be full partners, with physicians and other health professionals, in redesigning health care in the United States." (Committee on the Robert Woods Johnson Foundation, 2011) California can lead the way in establishing the case for the effective utilization of RN's across all health care settings, including ambulatory care, community health centers, outpatient care, and primary care office settings.

Defining the Registered Nurses Role in Healthcare – Key Talking Points

The development of Key Talking Points describing the role of the Registered Nurse (RN) has been identified as an important strategy in furthering the understanding of the value that the RN has to the provision of healthcare. Professional colleagues, the press and, by extension, the public need to gain a better understanding of the scope and abilities of nurses, creating greater comprehension of the nursing profession's significant and unique contributions to health care.

In finding a way to share the definition and important messages about the RN, it was determined that creating visual messaging would be the strategy of choice. The team created a series of power points designed to communicate the value of nursing to healthcare professionals as well as the general public. Using the nursing process as a foundation, the team designed a message about the value of the RN to healthcare in terms of a public model and a professional model. In order to describe ways in which the RN can lead health care to greater levels of performance and add improved access and quality of care, messages have been developed sharing the nursing process in the context of future RN roles within health care with a focus on community health.

These powerful messages once fully developed will be used to provide all leaders with a platform to share the message explaining the value of nursing to the provision of health care. These materials would then be utilized within the context of a media campaign sharing the value of the RN using consistent language and definition so that the messaging can be clearly understood by all.

The three sets of material have been tailored to inform our colleagues within health care and the general public about the scope and role of the RN. The third power point describes the nursing process in the context of the present and future roles in community health. These examples of future roles that the RN may play in the future will help the general public and leaders within health care to creatively see the role the RN can play in future models of care.

The fully developed materials will be the basis of a public relations campaign designed to raise the profile of the nursing profession and communicate the unique value of nursing. The public will be educated not only about the unique role of nursing, but how it is an essential component for future health care delivery.

Appendix A - *Key Talking Points-Public Version*

Appendix B - *Key Talking Points-Professional Version*

Appendix C - *Key Talking Points-New Roles*

Developing a Quantitative Business Case for Nursing Care

One identified area in which nursing leadership often struggles is that of clearly articulating how nursing has impacted the financial picture. Nurses at all levels have historically been focused on the provision of quality care and patient outcomes and have neglected the development of business acumen. It is especially important now that nursing leadership learn to articulate how the utilization of an RN impacts the financial "bottom line" for an institution. The inability of health care leaders to recognize the value that the RN brings to the various care delivery or operational models, has led to the reduction in utilization of the RN due to perceived higher salary costs associated with the RN's use. The RN brings a unique set of competencies and qualifications to the ever changing world of health care and should be seen as a very important asset to health care. The RN can create better patient outcomes, provide increased access to care and improve the patient's perception of care, all of which often results in improved financial performance for the organization.

With the implementation of the Affordable Care Act (ACA), reimbursement changes have affected all organizations and will continue to change rapidly in the foreseeable future. The health care market is seeing a shift in reimbursement reducing the use of fee-for-service reimbursement models and moving towards a value based payment structure. These rapid changes are driving organizations to creatively seek ways in which they can remain financially viable, determining the best way to meet goals, either through improving the quality of care provided, reducing the cost of providing care by reducing the total spend of the organization, as well as identifying key service lines to either be expanded or reduced based on revenue

production. Many challenges lay ahead for health care organizations and understanding under which system of payment reimbursement will occur will be crucial to helping any health care organization maintain financial viability.

Health systems determining to be responsible for the health of a defined population, such as an Accountable Care Organization (ACO), have decided to be responsible for the health care of large cohorts of patients, the cohort is assigned through contracts with payers who have the responsibility of providing coverage to large groups of covered lives. A negotiated rate is agreed upon between the payer and the health system in which coverage for each patient life is paid for annually at a fixed rate. Many payers are attempting to set rates that are similar to those of Medicare for senior populations. The health system then is responsible for providing all care for each individual covered life at a pre-determined cost. If a patient is kept healthy and uses very little medical care, the ACO may be able to earn money by spending less on care and receiving more in the annual negotiated rate for that person than expended. If a covered patient uses a large amount of care within that year and that care costs more than was negotiated, the health system will lose money. In order to maximize negotiated rates, organizations are moving as much care as possible outside of the acute care setting into ambulatory or outpatient care settings because these services are less expensive to provide. The more successful a organization is at keeping patients healthy and out of the hospital, the more likely they can operate into a positive cash position, essentially operating in “the black.”

During this period of dramatic change to health care, patients and consumers of care are becoming educated regarding what to expect from health care providers, as well as how they can become responsible for their own health and subsequent cost of care. The public has

become a better informed consumer of health care making decisions and choices about their health care policies based on their own personal values and needs. They are able to assess what level of quality that health care providers can provide and compare the costs of care across organizations and providers. Ultimately consumers are able to weigh the value, quality and cost of various health care options, basing decisions on information that is now readily available to the consumer.

As a result of the ACA, a Value Based Purchasing (VBP) model now drives all inpatient reimbursement. There are very complicated formulas associated with this reimbursement model which depend on current performance, the performance of other facilities and the organization's performance improvement as compared with previous data. VBP focuses on 4 areas of performance: Patient Outcome and Safety, Patient Experience, Process of Care and Efficiency. Each of these areas are broken down into sub-sections which identify the specific measures to be assessed. For each measure, there is a specific VBP domain weight attached that cumulatively adds up to an overall score for each healthcare organization. For the nurse leader, the main focus remains on quality itself, however it is also important to understand that these points represent the quality of the organization, which then are added up and compared to other organizations. Reimbursement is then determined based upon the organizations scores. Each organization working with their Quality and Finance Departments can determine what points have been earned and subsequently what the exact reimbursement is expected to be.

It is the nurse leader's responsibility to have an understanding of these new payment models. Nursing has a direct affect not only on the quality of care delivered to the patients in

their organizations, but to the financial health and bottom line of the organization. As a result, the nurse leader must be at the decision making table with other experts to ensure quality care and financial stewardship. This is done through ownership of the nurse sensitive indicators, Surgical Care Improvement Project measures, improving patient experience and through creativity developing new programs and new roles to enhance revenue or cost savings.

When making a change in practice or adding a new role or program, it is the nurse leader's responsibility to fully understand the goal to be achieved, as well as current limitations, available resources, costs and organizational culture. A close relationship with the Finance and Quality departments is a must in order to gain the information needed to assess current state and future outcomes. Using the formula developed in this work to understand the return on investment of any initiative requires that the organization use its own financial and quality data.

To determine the data needed, contact staff responsible for quality data to discuss the parameters and operational goals of the project to insure that you have the appropriate data for use in the formula. Share observations and the changes you are considering. It will be helpful to listen to the Quality Department staff and ask leading questions to better understand their view of the current state. Ultimately, the nurse leader should have an understanding of their quality scores and the data measured and the basic contributors to the scores. By understanding the process and the scores themselves, and by working with the Quality Department, a new goal or target for improving the measure can be set.

Collaboration with the Finance Department is also important in moving toward a successful solution. Spending time with finance staff allows the nurse leader to provide information as to how clinical needs relate to patient outcomes. It is equally important to

understand the finance perspective so as to create an understanding of potential associated consequences related to each operational decision. Ask questions regarding reimbursement based on current quality scores and ask how this might change with improved quality outcomes. Both the Finance and Quality Departments may have complicated quality/reimbursement formulas converted to simplified formats explaining how quality changes impacts overall hospital scores and thus reimbursement.

If, as a part of an improvement strategy, a position is to be added or modified, Human Resources has information regarding salaries for each associated position. The costs associated with the utilization or additions of products or equipment, can be obtained through your organization's supply chain representative.

The Return on Investment Formula

The ROI formula is divided into 4 basic factors to be addressed by the nurse leader:

1. The cost avoidance measure (or service to be added if developing new revenue)
2. The target (X) is the increase or decrease of the measure or service
3. The cost of the investment, usually the salary of the role to drive the outcome.
4. Any additional costs or savings because of the measure or service.

The formula:

ROI = (cost avoidance measure) (X) - Cost of investment - new costs or + new savings

Formula Definitions

Cost Avoidance Measure

When determining the measure or service change and looking at organization data, review *specific* data pertaining to the change to be made and not the "averages" of the

measure. For example, if a decrease in Stage 4 HAPUs is the cost avoidance target, data regarding actual cost and numbers of Stage 4 HAPUs should be reviewed, not an average of all HAPUs.

Target

The nurse leader must establish a target regarding a decrease of measure (such as decreasing falls or CLABSI infections) or increase in service (such as an increase in visits at a clinic). When creating these targets, the nurse leader should look at what metrics need to be met to receive reimbursement.

Cost of investment

Cost of investment is determined by assessing the product to be delivered and determining the best role or roles that will achieve the intended outcome. Review of the competency crosswalk will assist in this process. Often a Registered Nurse is chosen to drive practice changes because their scope of practice allows them to work both independently and overlapping into multiple other professional fields of practice. The organization chooses the best role based on their specific circumstances, review of roles available and the determination of cost savings, care redesign or revenue enhancement to be achieved.

New Costs or New Savings

While creating change, often additional costs or saving may appear during the research and must be included in the calculations. Additional costs may be ongoing new supplies or a onetime cost such as a new computer for the department. Conversely, savings may be possible by finding less expensive tools or resources that are equally or more

effective as the ones currently being using. In each of these cases, these must each be included in the calculations to represent a full cost of the project. Do not forget to explore or add any education or orientation time.

ROI Guiding Statements, Questions and Talking Points

When a nurse leader proposes a new operational or business plan to organizational leaders they must be fully prepared to discuss and defend the financial viability and associated costs as well as conveying the potential benefit to the patient in terms of care quality and outcomes. Conveying this message can be challenging. In order to assist the nurse leader when approaching these intimidating conversations we have provided several sample guiding statements, questions and talking points that will help to direct the conversation and share the story so that everyone understands the benefit.

- "I am planning to change **X** and I believe it will achieve _____ outcome.
- It is imperative we use a role that can not only assess, but can independently react to the findings of their assessment, such a registered nurse.
- By not responding to our current issue, **X** will cost us $_____ this year through extended treatments, unnecessary admissions and extended lengths of stay which lower our quality scores.
- How do you think this will affect our overall quality score and ultimately our reimbursement?
- Through this change, I expected a financial savings/gain to be $_____."

Sharing the story is important, but using the language that others understand allows the message to be heard. In this example, the nurse leader is using language to describe the

benefits financially, through a corresponding increase in quality and stressing how the nurse is the best role to drive this change.

This is the nurse leader's opportunity to show how nursing is effective in reaching important patient outcomes. Nurses have the unique ability to provide care coordination and assist patients to navigate through a confusing healthcare system. Nurses have an extraordinary ability to assess situations of patient and family health, spiritual and social needs and direct the care to the needs of the patient and family. Nurses are the only health care professional who attend to all the social determinants of health while being trusted by consumers to act in their best interest. Nurses not only respond to physical care needs of the consumers, but also decrease or prevent adverse events through their actions. Nurses also directly affect the financial health of an organization through preventative measures such as education and wellness measures which assist in keeping the community healthy and through the continuum. All of these points can and should be part of the education with decision makers.

Leading Questions and Statements

1. I understand how reimbursement is changing after the implementation of ACA.
2. In order to impact our business positively this proposal will help to ensure optimal patient care and improve the operation and thus affects our financial outcome positively.
3. I understand how to integrate professional roles in order to create positive patient outcomes.
4. This is the business plan that I am proposing to achieve _____ outcome.
5. The metrics we will be utilizing to measure the success of the changes that we have implemented are _____.

6. The expected financial gain will be_____.
7. Analysis of professional scope and roles have identified the various roles that could provide the service necessary for the project. The identified best professional role to assign to this project in order to create success is the Registered Nurse. The registered nurse has been identified based upon the scope, skills and competencies necessary for this particular project, the requirements are _____ and based upon our financial analysis utilizing the RN will create a positive financial benefit to the organization.
8. If we don't focus on this quality measure and do not implement the recommended changes, based on our current trends, we will negatively impact our reimbursement by _____.
9. After running the numbers, I project we may negatively impact our bottom line by _____. How do you think this will affect our quality score (Value Based Reimbursement) and ultimately our reimbursement margins?
10. Through this recommended change, we will decrease _____ (HAPU, CAUTI, CLABSI, etc.) which not only correlates to improved patient care, but saved $_____ by reducing care interventions, as well as improving our reimbursement by $_____ due to the increase in our quality score. (Compare score to previous scores)
11. By using a nurse in this project we meet the goals that are important to the organization; quality care and meeting our financial obligations.
12. Improving our quality performance will help build our reputation in the community and in being transparent, we will be able to improve our marketing opportunities.
13. The regulatory and surveying organizations look very closely at performance outcomes.

Concluding ROI Discussion

Health care now demands that executives and leaders not only focus on the quality aspects of care, but also on the impact to financial performance, in fact, they are inextricably linked. The ACA has demanded that organizations provide the highest quality care, while maintaining the lowest associated cost. This new value of finding ways to provide the highest

quality care while reducing cost creates new possibilities for nursing to create new roles and models of care that can help to attain higher levels of performance. It then becomes the nurse leader's role to be able to convey the message sharing how nursing is in fact a value and provides benefit to the organization by improving care, increasing access thus driving volume and reducing cost. To articulate the value of nursing the nurse leader must be able to understand financial terminology and operation, as well as understanding the various models of reimbursement. By improving the nurse leader's business acumen, the leader can inform those with decision making authority, helping to create a better understanding of the scope of practice of the RN. Creating models of care in which the full scope and practice of the RN can be utilized will in turn create greater opportunities for the organization to improve its financial status, while improving the well-being of the health care consumer.

***ROI Formula*:**

RO I = (Cost Avoidance Measure) (X) - Cost of investment - New Costs or + New Savings

X = Number of targets to achieve or incidents to avoid

Cost avoidance measure -

Note: Be specific in costs based on what you are trying to change. For example, if you are trying to affect Stage 3 pressure ulcers, use data and costs specific to your organization for Stage 3 pressure ulcers only. Do not include ALL pressure ulcer numbers and costs.

Care Practice Issue	Cost Avoidance Measure
Falls	Average cost per fall
Re-admission	Average cost per admission
CLABSI	Average cost per CLABSI
CAUTI	Average cost per CAUTI

↓ LOS	Average cost for each day

Cost of investment – Salary: What role or roles will drive intended outcome?

	Falls	Readmission	Patient Experience	CLABSI	CAUTI	↓ LOS	HAPU
RN	Yes	Yes	Yes	Yes	Yes	Yes	Yes
APN	Yes	Yes	Yes	Yes	Yes	Yes	Yes
MSW	No	No	Yes	No	No	No	No
PT/OT	Yes	No	Yes	No	No	Yes	Yes

Subtract any new costs to implement cost avoidance measure such as, education, training, resources or supplies or **add** any new savings such as cheaper supplies.

***Inpatient Examples*:**

1. Hospital Acquired Pressure Ulcer (HAPU) **–** Stage 3 acquired by 28 inpatients last fiscal year. Target to decrease by 50% = 14. A new wound care registered nurse is proposed at a salary of $94,000. In addition, re-evaluation of under-pads show that choosing one new pad will save us $5,000 annually. Another new pad under consideration and equally effective would cost us an additional $10,000 annually. Last year's loss $14,240*28 = $398,720

Using new under-pad costs additional $10,000 annually

RO I **= (**$14,240 per Stage 3 care**) (**14**) -** $94,000 - $10,000 = ***$95,360 annual savings***.

Using new under-pad saves $5,000 annually

ROI **= (**$14,240 per Stage 3 care**) (**14**)** - $94,000 + $5,000 = ***$110,360 annual savings***

2. *Central Line Associated Blood Stream Infection (CLABSI)* **–** Between all units, 20 cases of CLABSI occurred last year.

For this facility:

Average reimbursement per case	$64,894
Average cost per case with a CLABSI	$91,733
Average loss per case	($26,839)

The CNO wants to add one Infection Prevention and Control position at an annual salary of $100,000.00 to reduce and stabilize CLABSI. The target is to reduce CLABSI by 75% or eliminate 15 cases per year.

ROI **=** **(**$26,839 loss per case of CLABSI**)** **(**15 cases**)** - $100,000 salary = $***302,585 annual savings***

Ambulatory Care Examples:

1. Readmission to the hospital **-** Last year the hospital ambulatory clinic was unable to follow up on 25 post pneumonia patients who had been admitted for pneumonia and each of whom experienced a less than 30-day post-discharge re-admission. Each hospital re-admission costs the hospital $13,000. The CNO has created a care coordinator position at an annual salary of $94,000 for the clinic to provide immunizations, follow up phone calls, patient education and care coordination for patients discharged with a pneumonia diagnosis. A new space in the clinic for this additional practitioner (new phone line and computer and office furniture, desk, file cabinet, desk chair and 2 guest chairs) will be needed at a cost of $25,000. The non-personnel costs are a one-time cost for the initial year only.

Last year's loss: $13,000*25 = $325,000

The new target is to reduce re-admissions for patients discharged with a pneumonia diagnosis by 80%.

ROI = ($13,000 loss per readmission) (20 cases) – $94,000 salary - $25,000 one-time overhead = ***$141,000 annual savings***

2. Increasing a provider – A Federally Qualified Health Center (FQHC) currently has 2 physicians and 3 Nurse Practitioners. An analysis of clinic data reveals that the clinic has noted an increase in non-urgent visits. The clinic would like to increase their ability to see urgent or same day appointments timely and increase the total number of patients seen at the clinic. The Clinic Director would like to increase the number of visits by 5 visits a day. The Director believes this can be accomplished by adding one Nurse Practitioner at an annual salary of $145,000 who will be responsible for implementing a Clinic Fast Track. This will decrease the number of non-urgent patients that must be evaluated by a physician, improving their efficiency and reducing delays in scheduled appointments. This will also help to improve the ability of the clinic to room urgent care patients timely. Unused exam rooms will be utilized to open the Fast Track and thus there is no additional equipment (exam room furnishings) costs associated with the implementation.

Reimbursement per visit -$158.85

ROI = ($158.85) ((5 visits a day*5 days a week) (50 weeks a year)) – $145,000 salary = ***$53,562***

Developing an Interprofessional Competency Crosswalk

The Interprofessional Competency Crosswalk will be used by healthcare professionals and institutions as well as academic institutions and faculty, to understand the value each profession can bring to the health care team. The crosswalk can be used to assist in determining which health care professional would be best suited to fulfill roles within various care delivery models. Helping to create an understanding amongst healthcare providers of the scope and capacity of each professional will help to insure that the right professional is available to provide the appropriate level of care for the individual at the time the service is needed. Further developing the concepts associated with the provision of interprofessional care will help to promote new and creative inspiration surrounding the development of care delivery models increasing access and improving the quality of care. The crosswalk will improve the ability of health care leaders to review scope, licensure, and cost associated with the utilization of each professional. This information is key to utilizing professionals appropriately to the fullest extent that their scope and licensure will allow. Utilizing professionals, expanding access and capacity can demonstrate evidenced based outcomes at a reduced cost, while improving access to care.

The licensing and certification crosswalk for the interprofessional team will inform the larger work helping to define the value of nursing. The value of nursing work includes the creation of, educational messaging sharing the definition of the registered nurse, as well as the development of a health care return on investment calculator. Upon completion the three deliverables will help to inform the general public about the value of the registered nurse to the care delivery team in terms that are easy to understand by those not in health care. The

crosswalk will enhance the healthcare professionals understanding of the roles each provider can play on the care delivery team by creating an “at a glance” reference from which healthcare leaders can choose participants for care delivery. They will then test the financial viability of the new care delivery model utilizing the return on investment calculator to determine the viability of the business case, assessing the value associated with the proposed model of care, given the costs and savings anticipated.

How to Use the Interprofessional Competency Crosswalk

The Interprofessional Competency Crosswalk contains the following information within the body of the spreadsheet:

- Profession/Licensure Information
- Regulatory Agency Governance
- Locations of Practice
- Summary Scope and Standards of Practice
- Average Annual Salary (CA)

This is followed by an appendix with additional information for each profession. (Appendix E)

The health care leader should review the Interprofessional Competency Crosswalk when investigating the efficiency and effectiveness of new care delivery models or changes to internal operational configurations. The leader should review the overall scope and standards of the professionals associated with the operation and determine which professional can provide the services necessary to institute the care model being considered. The leader would determine if there existed more than one professional able to provide the service. If the service can only be

provided by one professional, then the leader can move forward with clarity. If there exists more than one professional with the capability under their legal scope and standards, that can provide the service, then the health care leader should review the costs associated with each profession, as well as the level of quality and flexibility that the profession can provide to the care practice that is being considered. The *Interprofessional Competency Crosswalk* should be used as a tool informing the health care leader and their decision support team in determining all available possibilities to consider when creating care delivery models/operations.

Interprofessional Competency Crosswalk

Profession/License	Regulatory Agency	Location of Practice	Summary of Scope of Practice, Standard of Practice Services Provided	Average CA Salary
Acupuncturist	Acupuncture Board of California 916.515.5200	Skip for now		
Audiologist	Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board 916.263.2666	Skip for now		
Chiropractor	Board of Chiropractic Examiners 916.263.5355 866.543.1311	Skip for now		
Clinical Social Worker	Board of Behavioral Sciences 916.574.7830	Private Practice Hospital/clinical Setting Other agencies (county setting, community based settings, social services)		$66,000
Contact/Spectacle lens dispenser	Medical Board of California 800.633.2322	Skip for now		

Dental Hygienists	Dental Hygiene Committee of California 916.263.1978	Skip for now		
Dentist	Dental Board of California 877.729.7789 916.263.2300	Skip for now		
Educational Psychologist	Board of Behavioral Sciences 916.574.7830	Secondary		$89,000
Hearing Aid Dispensers	Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board 916.263.2666	Skip for now		
Marriage and Family Therapists	Board of Behavioral Sciences 916.574.7830			$69,000
Licensed Midwife	Medical Board of California 800.633.2322 Board of Registered Nursing 916.322.3350	"The practice settings in which the licensed midwife practices."		$110,000
Naturopathic Doctor	Naturopathic Medicine Committee 916.928.4785	Skip for now		
Occupational Therapist	Board of Occupational Therapy 916.263.2294	Both inpatient and outpatient settings		$90,000
Ophthalmologist	Medical Board of California 800.633.2322	Skip for now		
Optician	Medical Board of California 800.633.2322	Skip for now		
Optometrist	Board of Optometry 916.575.7170 / 866.585.2666	Skip for now		
Osteopathic Physician	Osteopathic Medical Board of California 916.928.8390	Skip for now		
Pharmacist	California State Board of Pharmacy 916.574.7900	Licensed Healthcare facility, home health agency, clinic		$120,000

Pharmacy technician	California State Board of Pharmacy 916.574.7900	Must work under direct supervision of pharmacist. Therefore: Licensed Healthcare facility, home health agency, clinic	"Pharmacy technician" means an individual who assists a pharmacist in a pharmacy in the performance of his or her pharmacy related duties	$40,000
Physical Therapist	Physical Therapy Board of California 916.561.8200	Both inpatient and outpatient settings		$95,000
Physician	Medical Board of California 800.633.2322 916.263.2382		The practice of medicine involves diagnosis, treatment, or correction of human conditions, ailments, diseases, injuries, or infirmities whether physical or mental, by any means, methods, devices, or instruments.	$206,000
Surgeon	Medical Board of California 800.633.2322 916.263.2382			
Physician Assistant	Physician Assistant Board 916.561.8780	All areas of medicine.		$100,000
Podiatric Physician	California Board of Podiatric Medicine 916.263.2647	Skip for now		
Psychiatrist	Medical Board of California 800.633.2322	Secondary		
Psychologist	Board of Psychology 866.503.3221 916.574.7720	Secondary		
Respiratory Therapist	Respiratory Care Board of California 866.375.0386 916.999.2190	Hospital, home health, clinics		$70,000
Speech Language Pathologist	Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board 916.263.2666			$88,000
Nursing Specific Professions				
CNA	California Department of Public Health		Unlicensed, trained/certified.	$33,000

LVN	Board of Vocational Nursing and Psychiatric Technicians			$14 - $24 Per Hour $26,880 - $46,080 Per Year
LPT	Board of Vocational Nursing and Psychiatric Technicians	Inpatient and outpatient settings		$15 - $27 Per Hour $30,720 - $51,840 Per Year
RN	Board of Registered Nursing	"In an organized health care system"		$74,000
NP	CA Board of Registered Nursing			$102,000
CRNA	Board of Registered Nursing	Both Private and Public Settings	California allows CRNAs to administer anesthesia without physician supervision.	$164,000 (Compared to $290,000 for anesthesiologist)
CNS				$76,000
Community Outreach Worker	Unlicenced, not regulated			Variable but approximately $35,000-$50,000
Medical Technician		I only see EMT and AEMT, no mention of Medical technician		
Clinical Lab Scientist	American Society for Clinical Pathology	Hospitals, diagnostic laboratory, doctor's office		$66,000
Medical Assistant	Not licensed, certified, or registered by the State of CA, regulated by the Medical Board of CA	Offices and clinics. MAs may not work for inpatient care in licensed general acute care hospitals.	Administer medication and assist with ambulation, transfers and ADLs.	$65,000
EMT	Local EMS agency, done by county. Not a statewide certification	During training, while at the scene of an emergency, during transport of the sick or injured, or during interfacility transfer	Basic Life Support + Optional Skills: Advanced first aid and OTC Medications, CPR, AED	$37,000
Paramedic	California Emergency Medical Services Authority		All EMT & AEMT skills and medications,	$44,000
Dietician	The Accreditation Council for Education in Nutrition and Dietetics (ACEND®)	hospitals, long-term care facilities, clinics, private practice, and other institutions.	Multidisciplinary Care, Individualizing a treatment plan, Accept and Transmit Verbal and Electronic Orders, Medical Laboratory Tests (Initiate orders when authorized by physician)	$57,000

Applying Competencies to New Roles and Care Delivery Models

With the expansion of health care coverage under the Affordable Care Act comes the challenge of creating timely and appropriate access to care. One of the recommended strategies to increase access to care has been to create new ways to expand the utilization of the Registered Nurse to the fullest capacity allowed under their scope and standards. Recently, a review of the shifting needs of health care revealed five important new roles the Registered Nurse can assume, helping to increase the quality of care and access to care. These new roles as identified in the *Nurse Role Exploration Project: The Affordable Care Act and New Nursing Roles* are: Care Coordinator, Faculty Team Leader, Informatics Specialist, Nurse/Family Cooperative Facilitator and Primary Care Partner. (Berg J. G., October 2014). (Berg J. G., 2013)

The five conditions with the highest re-admission rates are Mental Health associated conditions, Coronary Artery Disease, Diabetes Mellitus, Congestive Heart Failure and Re-occuring Asthma. Based upon the five identified new roles for the Registered Nurse and a review of literature showing that the health of the chronic disease population can be improved, the following examples of new Registered Nurse roles are shared to stimulate creative thought around new paradigms for care delivery.

Example #1: *(Mental Illness)*

One new role that can be used in the care of those with a chronic mental health condition is the role of *Care Coordination*. One example under care coordination would be the utilization of a *Care Transition Nurse*. The Care Transition Nurse meets with the client while they are still admitted to the hospital. The transition nurse works to create a relationship with the client during their hospitalization. The nurse provides contact information for the client so that they have direct contact to the nurse for advice, information, or just to talk about how

things are going. Once the client is discharged from the acute care setting the transition nurse follows up with the client in their home within forty-eight hours. This provides the nurse with an opportunity to evaluate the client's condition, their home circumstance and availability of resources. The transition nurse can then insure that the client has the appropriate care and social resources to stabilize their condition and improve health. The transition nurse operates under standardized protocols/procedures to assess the client and implement appropriate interventions to assist in maintaining health. This role is used in the *Transitional Care Model*, a proven nurse-led team based approach. The American Academy of Ambulatory Care Nursing (AAACN) (American Academy of Ambulatory Care Nursing - Editor Kitty M. Shulman, September - October 2015) recently developed RN *competencies for care coordination and transition management*, and an *online course* to impart these competencies, including:

- Support for self-management
- Education and engagement of patients and families
- Cross-setting communications and care transitions
- Coaching and counseling of patients and families
- Nursing process: proxy for monitoring and evaluation
- Teamwork and collaboration
- Patient-centered care planning
- Population health management

The development of this new role which is uniquely suited to the Registered Nurse is one way in which we could create a comprehensive and holistic approach to care of the mental health

patient. A reduction in re-admissions of patients suffering from mental illness would align with federal goals of improved quality at a reduced overall cost. Working with registered nurses to improve training in care coordination and transition management will be the key to meeting the needs of those suffering from mental illness.

Example #2: *(Coronary Artery Disease)*

Several outpatient clinics are utilizing the Registered Nurse in a new way, they have established *RN-led new patient visits*. (Center for Excellence in Primary Care, August 2015) This role as a *Primary Care Partner* can help to create new avenues of access to care for those with chronic conditions, in this case Coronary Artery Disease. A Registered Nurse new visit schedule is created and a template and protocols are built into the electronic medical record. The nurse gathers a comprehensive health history, including social history, ordering pertinent laboratory work and assessing the patient's acuity. If diagnostic radiological exams are necessary, the registered nurse will contact a physician to obtain the order. The registered nurse will then determine the need to see the physician and the timing of this visit. These RN-led visits help the patient to be seen timely and to begin care regimens quickly thus reducing the severity of the condition and the need for acute care intervention. Nurse only visits at this time are reimbursed at a much lower rate than the physician visits, however the benefits of creating greater access, higher levels of patient satisfaction and reducing the care burden on the greater health care system are but a few of the benefits of this care delivery model. The Medicaid program is beginning to look for ways to incentivize this type of creative model of care delivery by providing pay for performance, recognizing organizations that are creating better outcomes while maintaining or improving the cost of care.

***Example #3**: Diabetes Mellitus*

A new role for the registered nurse within health care is the role of Informatics Specialist. The Registered Nurse can have a significant impact on the quality of care delivered to the diabetic patient without ever seeing the patient. The health informatics developer-RN will work within an organization to create and design systems to support practice and care by all team members along the entire continuum, especially for mobile devices. The RN-developer will design applications that can be used by patients and family caregivers that support self-management and allow information to be quickly and accurately transmitted to providers and care coordinators.

An example of how this work assists the care of the diabetic, is when an electronic medical record is developed to include reminders for the provider of when to order a hemoglobin A1c, diabetic retinal exams, and lipid level blood testing. Not only would the application share these reminders with the provider, but it would track the compliance of the care regimen and alert the provider when visits are missed or ordered tests remain incomplete. The RN-developer can help to institute diabetic registries within organizations so that the patient is tracked across the entire organization facilitating care consistency among different providers.

Utilizing evidenced based practice, the RN-Developer is able to model the template built within the electronic medical record to insure that the identified best practice is delivered consistently to all patients in the system. These RN-developers can help to lead best practice in both ambulatory and acute care settings, engineering out of the system inconsistent care

practices and reducing “missed” opportunities by the provider to intervene earlier and create better health.

Example #4: *(Congestive Heart Failure)*

A *Registered Nurse Navigator* is one of the roles that the RN’s are taking on helping to solve the issues associated with facilitating care for patients with chronic or acute conditions. This is a role categorized under the *Nurse/Family Cooperative Facilitator*. The RN Navigator supports patients and families in choosing the best approaches to meet individualized needs. They create assessment tools for outreach workers to use in identifying potential problems upon intake into the care facility. They connect with patients and families prior to the need for complex care to ensure preparation and best outcomes are achieved.

The RN Navigator will establish contact with a patient when the diagnosis of Congestive Heart Failure (CHF) is made, either in an acute care setting or in an ambulatory care setting. The RN will determine the needs of the patient, assessing the patient’s current physical status as well as reviewing their circumstances including where they live, their financial situation and who is available to provide support. Based upon their findings, the navigator will help to coordinate the interventions and care necessary to move the patient towards health. They will advocate on behalf of the patient with insurers, care providers, and help to explore financial assistance if necessary. One of the most important roles the navigator plays is helping to interpret what information those within the health care system are saying to the patient. The navigator creates a level of comfort and security for the patient, helping to alleviate some of the worry that accompanies the diagnosis of CHF. In turn the ability of the patient to focus strictly

on their condition with less worry creates improved outcomes and helps the patient to maintain their health.

Example #5: *Re-occurring Asthma*

Asthma continues to maintain one of the highest hospital re-admission rates across all conditions. The ability to impact the disease is hampered by a lack of consistent access to a primary care provider due to the overall shortage across the country of providers. A new model has emerged to create increased access to care in which the registered nurse is utilized to increase availability of the provider for all patients by creating what is known as a "flip" visit. (Center for Excellence in Primary Care, August 2015) The *Primary Care Partner Roles* are roles in which the registered nurse can partner with physicians to increase the number of patients seen and improve the overall quality of the care that is provided. The *Clinic Registered Nurse* can be utilized to begin a visit evaluating and assessing the patient, once gathered the patient can either be "flipped" or seen for a short visit by the provider or the provider can in full partnership with the RN complete the visit. This type of patient visit helps to increase the number of patients that are able to be seen in one day. From a financial perspective the visit will qualify as a billable visit under Medicare guidelines.

Another way in which the clinic registered nurse can be leveraged to improve patient outcomes and increase access to care is to utilize a nurse only visit in which the RN can provide assessment, education/coaching, and prevention services. For the patient with asthma, providing access to education about the condition by a professional helps to decrease acute episodes. Management of the condition is difficult for patients that have to wait for large periods of time in between provider visits. Having an RN available to meet the patients' needs

for education, assessment and coaching can make the difference for the patient. The RN can quickly determine based upon the assessment what interventions are necessary and what level of care is necessary. Keeping the patient out of the hospital and maintaining their health is the primary focus of the clinic RN.

While reimbursement for nurse only visits lags that of visits with the physician provider, Medicare is working to create ways in which creatively delivered quality care can be incentivized. Recently, new financial incentives have emerged; for example, as of January 2015, Medicare is paying *$42.60 per month* for care management of patients with two or more chronic conditions, like heart disease and diabetes. (Center for Excellence in Primary Care, August 2015)

These are but a few examples in which the utilization of the Registered Nurse can create a positive impact on both the patient and the organization. We encourage you to creatively consider the utilization of the Registered Nurse in further development of care delivery models.

References

Adams, A. (2015, August 15). *Fresh Data on ACA 411 Show Impacts of Health Reform*. Retrieved from California Health Care foundation CHCF Blog: http://www.chcf.org/articles/2015/08/fresh-data-aca-411

Aiken, L. C. (2003 Volume 200, no.12). Educational Levels of Hospital Nurses and Surgical Patient Mortality. *Journal of the American Medical Association*, 1617-1623.

Ameican Academy of Ambulatory Care Nursing. (Ocotober 2015). Joint STatemetn: The Role of the Nurse Leader in Care Coordination and Transition Management Across the Health Care Continuum. *Nursing Economics*, 281-282.

American Association of the Colleges of Nursing. (2015). *Your Nursing Career A Look At the Facts*. Retrieved from American Association of the Colleges of Nursing: http://www.aacn.nche.edu/students/your-nursing-career/facts

American Nurses Association. (2015). *Nursing: Scope and Standards of Practice.* Maryland: American Nurses Association.

Berg, J. G. (2013, September 25). *Nurse Role Exploration Project: The Affordable Care Act And New Nursing Roles*. Retrieved from HealthImpact: http://www.healthimpact.org/wp-content/uploads/2015/08/NurseRoles-1009201311.pdf

Berg, J. G. (October 2014). *Future RN workforce Strategies RN Role Transformation Tool.* Oakland: HealthImpact.

California Health Care Foundation. (2014, July). *California Health Care Almanac Healthcare Costs 101: Slow Growth Persists*. Retrieved from California Healthcare Almanac: http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20H/PDF%20HealthCareCosts14.pdf

California Hospital Association. (2012). *Transforming for Tomorrow: Strategies to Transition California Hospitals*. Retrieved from California Hospital Association: www.calhospital.org/transforming-recording-1

Center for Excellence in Primary Care. (August 2015). *RN Role Reimagined: How Empowering Registered Nurses Can Improve Primary Care.* San Francisco : California Healthcare Foundation.

Chappell, S. R. (2015). *Joint Statement: The Role of the Nurse Leader in Care Coordination and Transition Managment Across the Health Care Continuum.* American Academy of Ambulatory Care Nursing and American Organization of Nurse Executives.

CNPE Health Policy Workgroup, 2011-2012. (June 2012). The Value of Nursing Care Coordination A White Paper of the American Nurses Association. *Nursing World-ANA*, 1-24.

Committee on the Robert Wood Johnson Foundation. (2011). *The Future of Nursing Leading Change Advancing Health*. Retrieved from The Future of Nursing IOM Recommendations: http://www.thefutureofnursing.org/recommendations

Committee on the Robert Woods Johnson Foundation. (2011). *Initiative on The Future of Nursing*. Retrieved from Robert Woods Johnson - The Future of Nursing IOM Recommendations: http://thefutureofnursing.org

Department of Health And Human Services, Centers for Medicare & Medicaid Services. (2013). *CMCS Informational Bulletin.* Washington D.C.: DHHS Center for Medicare & Medicaid Services.

Forbes III, T. M. (2014). Making the Case for the Nurse as the Leader of Care Coordination. *Wiley Periodicals Volume 49*, 167-170.

Fraher, E. P. (2015). *Nursing in a Transformed Health Care System: New Roles, New Rules.* Leonard Davis Institute of Healthcare Economics.

Gallagher, R. M. (2010, April 10). *The Impact of Nursing Care on Quality*. Retrieved from Nursing World: http://www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/PatientsSafetyQuality/Research-Measurement/Nursing-and-quality.pdf

James, B. C. (2011). How Intermountain Trimmed Health Care Costs Through Robust Quality Improvement Efforts. *Heatlh Affairs Vol. 30 No. 6*, 1185-1191.

Kavanaugh, K. T.-B. (2012). Moving Healthcare Quality Forward With Nursing-Sensitive Value-Based Purchasing. *Journal of Nursing Scholarship*, 385-395.

Kind, A. J. (2012). Low-Cost Transitional Care With Nurse Managers making Mostly Phone Contact with Patients Cut Rehospitalization At A VA Hospital. *Health Affairs*, 2659-2668.

McHugh, M. K.-L. (2011). Nurses' Widespread Job dissatisfaction, Burnout and Frustration With Health Benefits Signal Problems for Patient Care. *Health Affairs*, 202-210.

McHugh, M. L. (2016). Achieving Kaiser Permanente Quality. *Healthcare Management Review*, 1-11.

Moorehead, S. J. (2004). *Nursing Outcomes Classification.* St. Louis: Mosby.

Nickitas, D. M. (2015). Understanding Health and payment Reform - Essential for the New World of Nursing; An Interview with Betty Rambur. *Nursing Economics*, 155-181.

North American Nursing Diagnosis Association. (2007). *NANDA Nursing Diagnosis.* Kaukana: Wiley-Blackwell.

Office Statewide Health Planning and Development. (2015, September 25). *Primary Care Shortage Areas*. Retrieved from Health Care Atlas OSHPD: http://www.gis.oshpd.ca.gov/atlas/topics/shortage/pcsa

Pappas, S. P.-B. (2015). Nurisng: Essential to Healthcare Value. *Nurse Leader*, 26-38.

Robert Woods Johnson Foundation prepared by Kelsey Menehan. (2011). *Measuring the Contributions of Nurses to High-Value Health Care.* Robert Woods Johnson Foundation, Program Results Special Report.

Ryrie, I. B. (2011). Tool to Assess the Cost and Benefits of Nursing Innovation. *Nursing Management*, 28-31.

SCAN Foundation, Avalere. (2014). *Achieving Positive ROI via Targeted Care Coordination Programs.* SCAN Foundation.

Stanton, M. R. (2004). Hospital Nurse Staffing and Qulaity of Care. *Agency for Healthcare Research and Quality Research in Action Issue 14*, 1-9.

Steiffel, M. N. (2012). *Innovation Series 2012: A Guide to Measuring the Triple Aim; Population Health, Experience of Care.* Cambridge: Cambridge: Institute for Healthcare Improvement.

Thungjaroenkul, P. G. (2007). The Impact of Nurse Staffing on Hospital Costs and Patient Length of Stay. *Nursing Economics*, 255-265.

Weiss, A. J. (2014, June). *Overview of Emergency Department Visits in the United States - Health care Costs and Utilization Project.* Retrieved from Agency for Healthcare Quality and Research: http://www.hcup-us.ahrq.gov

Welton, J. M. (2006). Nurse Staffing, Nursing Intensity, Staff Mix, and Direct Nursing Care costs Across Massachusetts Hospitals. *Journal of Nursing Administration*, 416-425.

Welton, J. M. (2007). Hospital Billing and Reimbursement Charging for Inpatient Nursing Care. *Journal of Nursing Administration*, 164-166.

Welton, J. M. (2008). Implication of Medicare Reimbursement Changes Related to Inpatient Nursing Care Quality. *Journal of Nursing Administration*, 181-188.

Welton, J. M. (2008). Implications of Medicare Reimbursement Changes Related to Inpatient Nursing Care Quality. *Journal of Nursing Administration*, 325-330.

Welton, J. M. (2011). Hospital Workforce Costs, Wages, Occupational Mix, and Resource Utilization. *Journal of Nursing Administration*, 309-314.

Welton, J. M. (2013). *Nursing and the Value Proposition: How Information Can Help Transform the Healthcare System.* Minnesota: University of Minnesota School of Nursing, Center for Nursing Informatics.

Welton, J. M. (2014). Business Intelligence and Nursing Administration. *Journal of Nursing Administration*, 245-246.

Welton, J. M. (2014). Massachusetts New Nurse Staffing Law. *Journal of Nursing Administration*, 553-555.

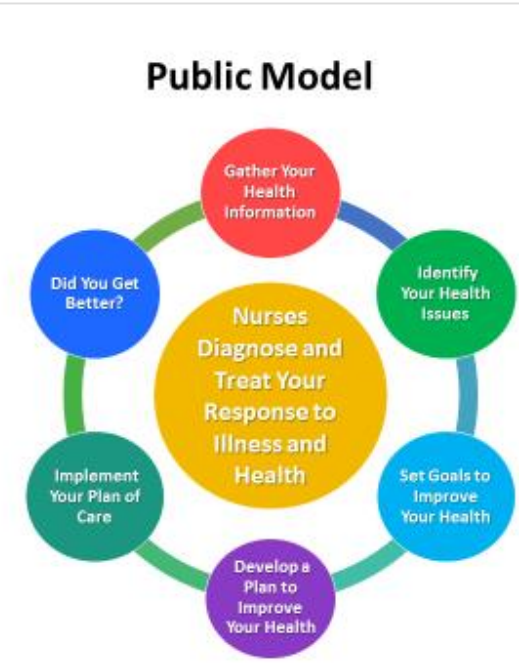
Welton, J. M. (2015). Nursing Care Value-Based Financial Models. *Nursing Economics*, 14-25.

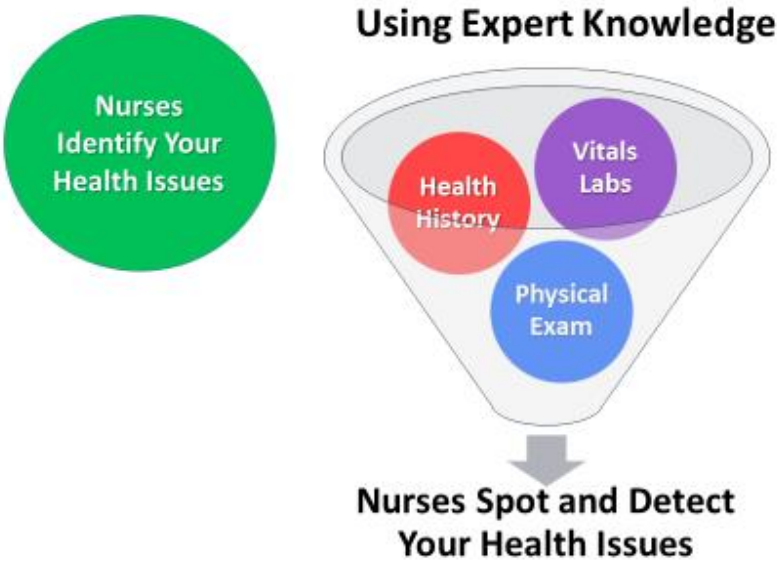
Welton, J. M.-S. (2006). Nursing Intensity Billing. *Journal of Nursing Administration*, 181-188.

Welton, J. M.-S. (2009). Estimating Nursing Intensity and Direct Cost Using the Nurse-Patient Assignment. *Journal of Nursing Administration*, 276-284.

Yakusheva, O. R. (2014). Nurse Value-Added and the Patient. *Health Services Research 49:6 Best of the 2014 Academy Health Annual Research Meeting* (pp. 1767-1784). Health Research and Educational Trust - Wiley Blackwell.

Appendix A: Key Talking Points-Public Version

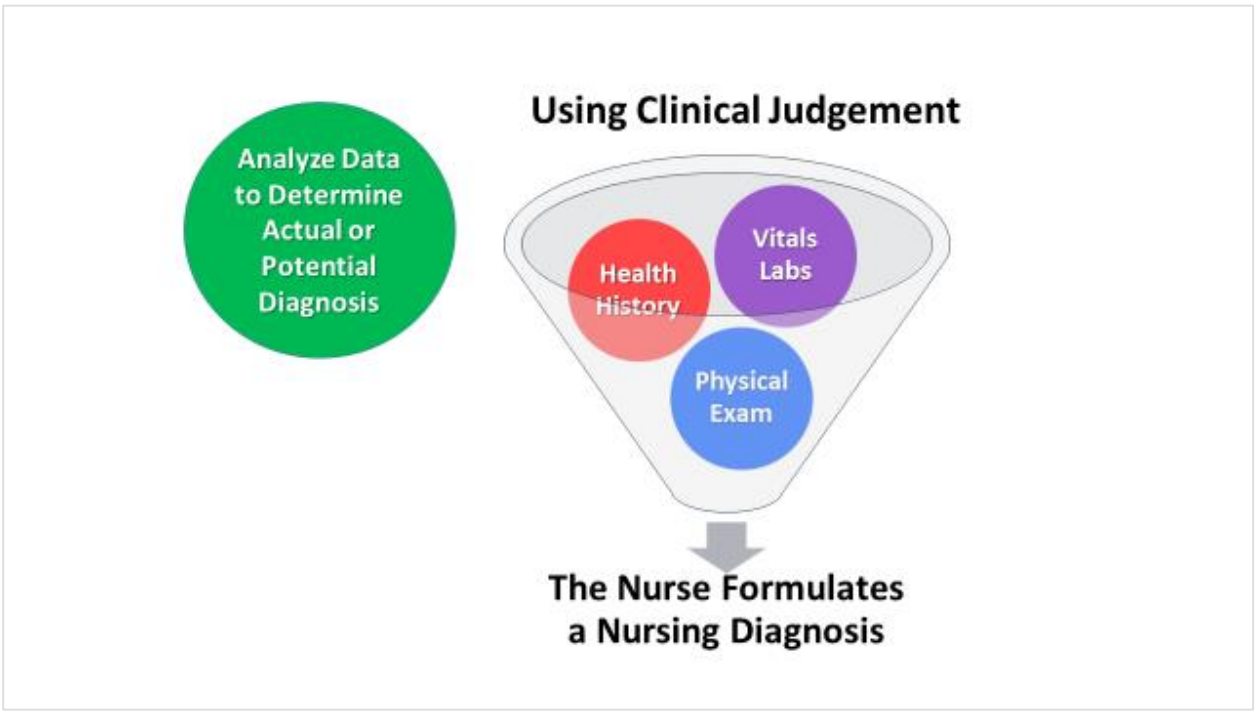




Nurses Set Goals to Improve Your Health

Nurses Develop a Plan to Improve Your Health

Appendix B: Key Talking Points-Professional Version



Nurses Identify Expected Outcomes for an Individualized HCC Care Plan

Example: Pain Control HCC Personal Actions to Control Pain

Nurses Develop a Plan to Attain Measurable HCC Outcomes

Example Plan Outcome: HCC Pain Level Reduced from 10/10 to 0/10

Nurses Implement the HCC Plan of Care

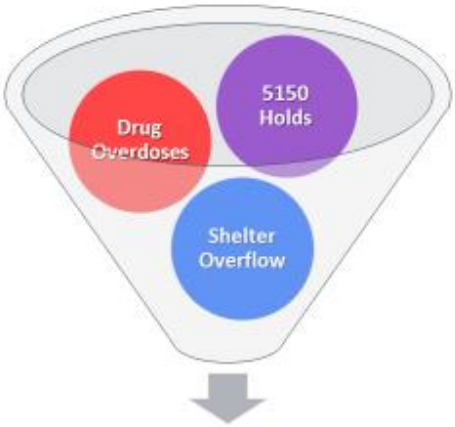
Example: Nurse Administers Pain Medication

Appendix C: Key Talking Points-Applied to New Roles

In the Future Nurses Will Not Only Assess and Treat Individuals They Will Assess and Treat the Family, the Community and Develop the Health Care Infrastructure with the Goal of Keeping People Healthy

Future RN Roles

Using Individual and Population Data



The Nurse Formulates a Nursing Diagnosis

Nurse Facilitator Develops An Individual Diagnosis

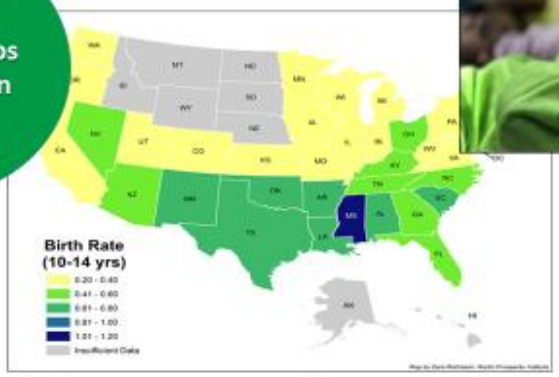
Example: HCC Admitted for Heart Failure Due to Drug Abuse

Individual Nursing Diagnosis (ND):

- **Denial**
- **Self-Care Deficit**

Community Nursing Diagnosis:

Nurse Facilitator Also Develops A Population Nursing Diagnoses



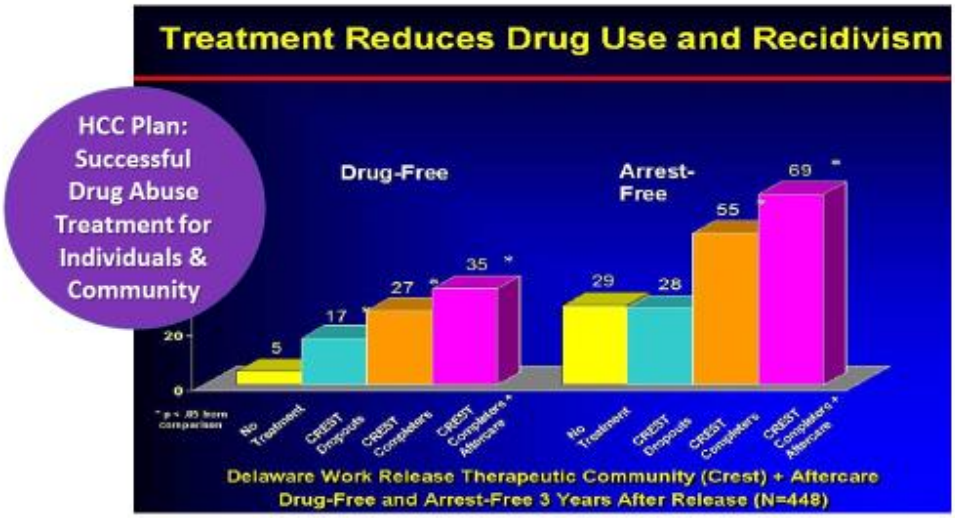
Risk of low birth rate among pregnant adolescents in the downtown area related to inadequate income and use of tobacco as evidenced by insecure housing, use of the food bank, unemployment rates, and smoking rates among pregnant teens.

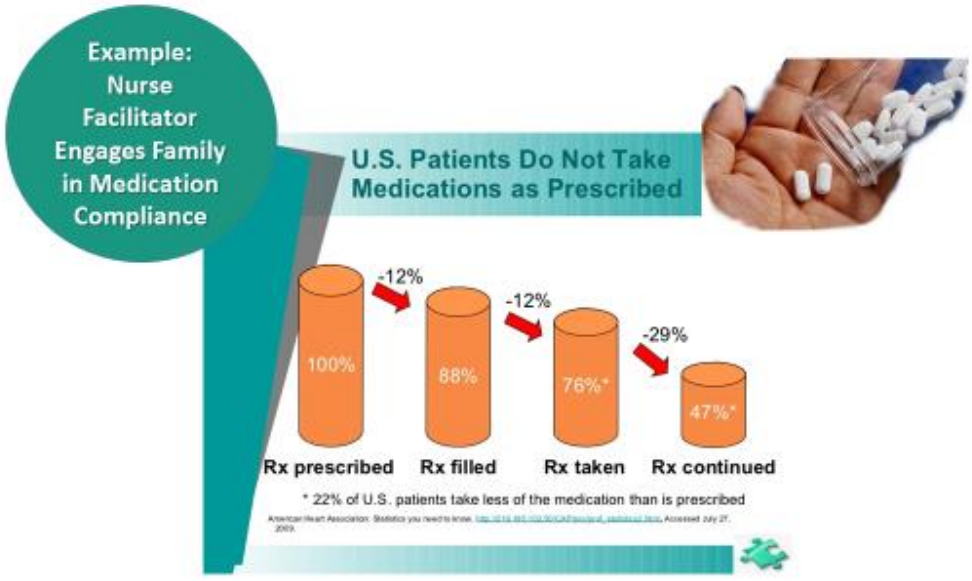
Nurses Identify Expected Outcomes For the HCC Individual and Community

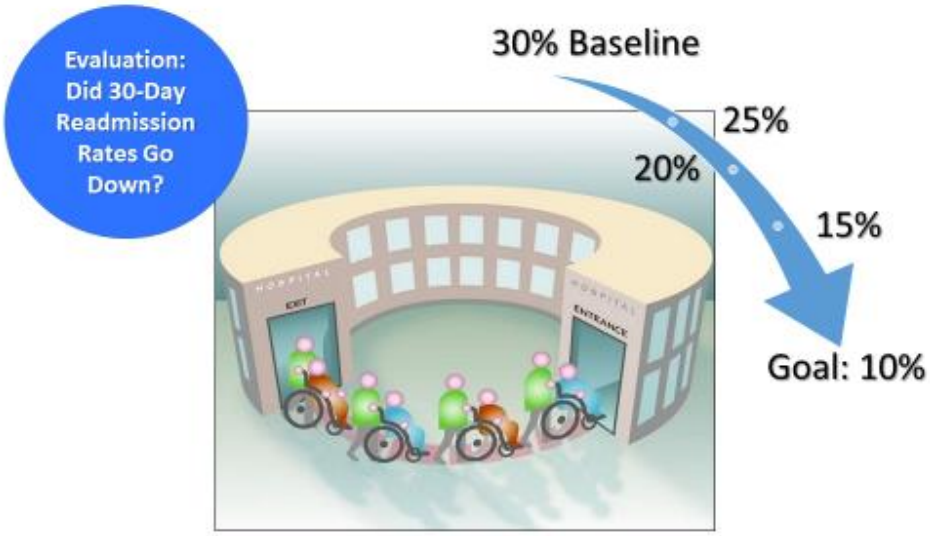
Example Individual Outcome: HCC Ceases Drug Use Though Treatment

Example HCC Community Outcome: Partnerships for Drug Abuse Treatment

Nurse Care Coordinator Develops a Plan to Attain Measurable Outcomes







Appendix D: Graphic Presentation ROI Calculator

Value Based Outcomes and Associated Nurse Driven Measures

Estimating financial returns associated with nurse driven measures and nursing sensitive indicators depends on several factors including the quantity and quality of nursing care provided, care processes, and the effectiveness of health care systems. Many value based purchasing (VBP) outcomes are endorsed by the National Quality Forum (NQF) as nursing-sensitive. The Centers for Medicare and Medicaid (CMS) incentive-based programs target specific outcomes, many of which are directly influenced by nurse sensitive indicators (National Database of Nursing Quality Indicators - NDNQI). Analysis of program elements including processes, costs, and reimbursement provides evidence of nurse driven value based performance outcomes demonstrating a return on investment (ROI).

PROGRAM: _____ (define hospital unit, specialty service, clinic, population as applicable)

NURSING SERVICES

Structure and

process elements

Structure Elements
- Nursing Supply
- Skill mix
- Educ or Cert
- Roles

Process Elements
- Assessment methods
- Plan of care
- Interventions

PROGRAM OUTCOMES (identify nursing sensitive indicators and forecasted savings or revenue)

Acute, Chronic, Long Term, Preventive (as applicable to program)

_____

_____

_____

_____

_____

Cost savings or revenue enhancement

$_____

PLAN OR CHANGE (determine new structure, roles, or processes elements)

_____

_____

_____

_____

_____

Deduct (-) new cost or add (+) new savings

$_____

Cost $ _____

R

Program Impact $ _____ (net gain or loss)

Appendix E: Interprofessional Team Members

Role: Dietician
Regulatory Body: The Accreditation Council for Education in Nutrition and Dietetics (ACEND®)
Education Requirements:
Average CA Salary: $57,000
Location of Practice: hospitals, long-term care facilities, clinics, private practice, and other institutions.
Scope of Practice: RDN Scope of Practice in California State Law, 2015 CA Business and Professions Code 2585-2586.8 Medical Nutrition Therapy Upon referral by a health care provider authorized to prescribe dietary treatments, the RDN may perform medical nutrition therapy (MNT) for individuals or groups of patients in licensed institutional facilities or in private office settings. Referral: The referral must include: • Client/patient's diagnosis • Objective of dietary treatment • Signature of the referring health care provider in a licensed health facility, the requirement for a referral is satisfied if a diet order or the above information is included in the patient's medical record. A facility's approved nutrition screening policy and procedure also suffices in place of a referral. MNT includes: • Conducting nutritional and dietary assessments • Providing nutritional and dietary counseling • Developing and recommending nutritional and dietary treatments, including therapeutic diets/

They create nutritional programs based on the health needs of patients or residents and counsel patients on how to lead a healthier lifestyle.

Role: Paramedic
Regulatory Body: California Emergency Medical Services Authority
Education Requirements: Course work, contact hours and licensure exam
Average CA Salary: $44,000
Location of Practice:
Scope of Practice: Basic Life Support + Optional Skills (such as medication administration) that vary by county
Patient Assessment, Advanced first aid and OTC Medications with LEMSA approval, Transportation of ill & injured persons, Use of adjunctive breathing aids, administration of oxygen, Automated external defibrillator, Cardiopulmonary resuscitation, Use of tourniquets and hemostatic dressings for bleeding control, Pulse oximetry, Humidifiers, Continuous positive airway pressure, Laryngoscope, Endotracheal (ET) intubation (adults, oral), Valsalva's Maneuver, Needle thoracostomy & cricothyroidotomy, Naso/orogastric tube, insertion/suction, Monitor thoracostomy tubes, Monitor/adjust potassium (< 40 mEq/L) IV lines, Utilization & monitoring of electrocardiographic devices, Administer 25 medications, BPAP (Bi-level positive airway pressure)/PEEP (Positive end-expiratory pressure)

Role: Emergency Medical Technician
Regulatory Body: California Emergency Medical Services Authority
Education Requirements: EMT Course + Contact Hours and Certification Exam
Average CA Salary: $37,000
Location of Practice: During training, while at the scene of an emergency, during transport of the sick or injured, or during interfacility transfer, a certified EMT or supervised EMT student is authorized to do any skills in scope of practice
Scope of Practice: Basic Life Support + Optional Skills (such as medication administration) that vary by county
Patient Assessment, Advanced first aid and OTC Medications with LEMSA approval, Transportation of ill & injured persons, Use of adjunctive breathing aids, administration of oxygen, Automated external defibrillator, Cardiopulmonary resuscitation, Use of tourniquets and hemostatic dressings for bleeding control, Pulse oximetry, Humidifiers, Continuous positive airway pressure.

Role: Medical Assistant
Regulatory Body: not licensed, certified, or registered by the State of California, regulated by the Medical Board of CA
Education Requirements: EMT Course + Contact Hours and Certification Exam
Average CA Salary: $65,000
Location of Practice: Offices and clinics. MAs may not work for inpatient care in licensed general acute care hospitals.
Scope of Practice: Administer medication only by intradermal, subcutaneous, or intramuscular injections (including flu and pneumonia shots); Administer medication orally, sublingually, topically, vaginally or rectally, or by providing a single dose to a patient for immediate self-administration; Administer by inhalation if medications are patient-specific and have been or will be routinely and repetitively administered by patient; Perform venipuncture or skin puncture (including 'finger sticks") for the purposes of withdrawing blood; Perform skin tests; Measure and describe skin test reaction and make a record in the patient's chart; Perform electrocardiogram, electroencephalogram, or plethysomography (except full body) Fit prescription lenses or use any optical device in connection with ocular exercises, visual training, vision training or orthoptics according to B&P §§ 2544, 3042. Apply and remove bandages and dressings; Apply orthopedic appliances such as knee immobilizers, envelope slings, orthotics; Remove cases, splints and other external devices; Obtain impressions for orthotics, padding and custom molded shoes; Select and adjust crutches for patients; Instruct patient in proper use of crutches; Remove sutures or staples from superficial incisions or lacerations; Perform ear lavage; Collect by non-invasive techniques (including nasal smears and throat swabs), and preserve specimens (including urine, sputum, semen, stool) for testing; Assist patients in ambulation and transfers; Prepare patients for and assist MD, DPM, PA or RN in exams or procedures including positioning, draping, shaving, disinfecting treatment site, prepare patients for gait analysis testing; As authorized by MD or DPM, provide patient information and instructions; Collect and record patient data including height, weight, temperature, pulse, respiration rate and blood pressure, and basic information about presenting and previous conditions; Perform simple laboratory and screening tests customarily performed in a medical

office; Cut the nails of otherwise healthy patients; Perform other basic technical supportive services.
Reference: http://futurehealth.ucsf.edu/LinkClick.aspx?fileticket=SfdfTM3DUfU%3d&tabid=161

Role: Clinical Lab Scientist
Regulatory Body: American Society for Clinical Pathology
Education Requirements:
Average CA Salary: $66,000
Location of Practice: Hospitals, diagnostic laboratory, doctor's office
Scope of Practice: Quality clinical laboratory testing is evidenced by: performing the correct test, on the right person, at the right time, producing accurate test results, with the best outcome, in the most cost-effective manner. This is accomplished by ensuring that appropriate clinical laboratory tests are ordered. Procuring clinical laboratory test samples in an efficient, timely manner. Producing accurate clinical laboratory test results. Correlating and interpreting clinical laboratory test data. Disseminating clinical laboratory test information to clinicians and patients in a timely manner. Evaluating the outcome of clinical laboratory testing for each individual patient and the entire healthcare system. Utilizing qualified medical laboratory personnel. Assessing, designing, evaluating and implementing new clinical laboratory test methods. Evaluating the appropriateness of existing and new clinical laboratory methods for clinical utility, cost-effectiveness and cost-benefit analysis. Developing, implementing, and reporting results of clinical laboratory research. Designing and implementing cost-effective delivery models for clinical laboratories, including their services and personnel. Developing and implementing a comprehensive Quality Management System to include: Quality control and assurance of clinical laboratory testing services; Competency assessment of personnel; Integration with other aspects of the healthcare delivery system for ensuring appropriate utilization of clinical laboratory testing services; Continuous process improvement activities to effectively utilize human resources.

Designing, implementing and evaluating academic curricula for the education of new medical laboratory professionals. Designing, implementing and evaluating academic curricula for advanced education of medical laboratory professionals. Designing, implementing and evaluating continued education activities and career growth opportunities for medical laboratory professionals. Promoting awareness and understanding of the use of the clinical laboratory.

Reference: http://www.ascls.org/position-papers/186-scope-of-practice/148-scope-of-practice)

Role: Community Health Worker
Regulatory Body: Unlicensed, Unregulated
Education Requirements: Unspecified
Average CA Salary: $35,000-50,000
Location of Practice: City and county government, Outpatient Care Centers, Offices of Physicians, General Medical and Surgical Hospitals, Other Individual and Family Services, All

Other Miscellaneous Ambulatory Health Care Services, Outpatient Mental Health and Substance Abuse Centers
Scope of Practice: Community Health Workers are frontline public health professionals who perform a variety of activities from helping individuals navigate complicated health care systems to providing informal counseling and social support. As trusted members of the communities they serve, they are in a unique position to bridge gaps between underserved populations and health or social systems.
Reference: http://www.coeccc.net/documents/CHW_Research_Brief_CA_2011.pdf)

Role: Clinical Nurse Specialist
Regulatory Body:
Education Requirements:
Average CA Salary: $76,000
Location of Practice:
Scope of Practice: Clinical nurse specialists (CNSs) are registered nurses, who have graduate level nursing preparation at the master's or doctoral level as a CNS. They are clinical experts in evidence-based nursing practice within a specialty area, treating and managing the health concerns of patients and populations. The CNS specialty may be focused on individuals, populations, settings, type of care, type of problem, or diagnostic systems subspecialty. CNSs practice autonomously and integrate knowledge of disease and medical treatments into assessment, diagnosis, and treatment of patients' illnesses. These nurses design, implement, and evaluate both patient-specific and population-based programs of care. CNSs provide leadership in advancing the practice of nursing to achieve quality and cost effective patient outcomes as well as provide leadership of multidisciplinary groups in designing and implementing innovative alternative solutions that address system problems and/or patient care issues. In many jurisdictions, CNSs as direct care providers, perform comprehensive health assessments, develop differential diagnoses, and may have prescriptive authority. Prescriptive authority allows them to provide pharmacologic and nonpharmacologic treatments and order diagnostic and laboratory tests in addressing and managing specialty health problems of patients and populations. CNSs serve as patient advocates, consultants, and researchers in various settings.

These clinicians are experts in evidence-based nursing and practice in a range of specialty areas, such as oncology, pediatrics, geriatrics, psychiatric/mental health, adult health, acute/critical care, and community health among others. In addition to direct patient care, CNSs also engage in teaching, mentoring, consulting, research, management and systems improvement. Able to adapt their practice across settings, these clinicians greatly influence outcomes by providing expert consultation to all care providers and by implementing improvements in health care delivery systems.

Role: Certified Registered Nurse Anesthesiologist
Regulatory Body: Board of Registered Nursing
Education Requirements: BSN Required as prerequisite, Master or Doctorate + Certification Exam

Average CA Salary: $164,000
Location of Practice: CRNAs practice in a variety of settings in the private and public sectors and in the U.S. military, including traditional hospital operating rooms, ambulatory surgery centers, pain clinics, and physicians' offices. They practice on a solo basis, in groups and collaboratively. Some CRNAs have independent contracting arrangements with physicians or hospitals.
Scope of Practice: 1. Performing and documenting a pre-anesthesia assessment and evaluation of the patient, including requesting consultations and diagnostic studies; selecting, obtaining, ordering and administering pre-anesthetic medications and fluids; and obtaining informed consent for anesthesia. 2. Developing and implementing an anesthetic plan. 3. Initiating the anesthetic technique that may include general, regional or local anesthesia with or without sedation. 4. Performing and managing regional anesthetic techniques including, but not limited to, subarachnoid, epidural and caudal blocks; plexus, major and peripheral nerve blocks; intravenous regional anesthesia; transtracheal, topical and local infiltration blocks; intracapsular, intercostal and ocular blocks; and use of nerve stimulator devices and ultrasound that aid in the placement of the block. 2 5. Selecting, ordering, applying and inserting appropriate non-invasive and invasive monitoring modalities for continuous evaluation of the patient's physical status. 6. Selecting, obtaining and administering anesthetics, adjuvant and accessory drugs and fluids necessary to manage the anesthetics. 7. Selecting and ordering adjuvant and accessory medications, fluids, laboratory testing and other modes of analysis to evaluate patient status and promote well-being. 8. Managing a patient's airway and pulmonary status using current practice modalities including fiberoptic intubation and mechanical support. 9. Facilitating emergence and recovery from anesthesia by selecting, obtaining, ordering and administering medications, fluids and ventilator support. 10.Discharging the patient from a post-anesthesia care area, outpatient surgery section of a facility or from an ambulatory surgery center and providing post-anesthesia follow-up evaluation and care. 11.Implementing acute and chronic pain management modalities. 12.Responding to emergency situations by providing airway management, administration of emergency fluids and drugs, and using basic or advanced cardiac life support techniques. California allows CRNAs to administer anesthesia without physician supervision.

Role: Nurse Practitioner
Regulatory Body: Board of Registered Nursing
Education Requirements: Master Degree or Doctorate + Certification Exam
Average CA Salary: $102,000
Location of Practice:
Scope of Practice: The NP does not have an additional scope of practice beyond the usual RN scope and must rely on standardized procedures for authorization to perform overlapping medical functions (CCR Section 1485). Section 2725 of the Nursing Practice Act (NPA) provides authority for nursing functions that are also essential to providing primary health care which do not require standardized procedures. Examples include physical and mental assessment, disease prevention and restorative measures, performance of skin tests and immunization techniques, and withdrawal of blood, as well as authority to initiate emergency procedures.

The nurse practitioner (NP) is a registered nurse who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, who has been prepared in a program that conforms to Board standards as specified in California Code of Regulations, CCR, 1484 Standards of Education. Primary Health Care Primary health care is defined as, 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 CCR 1480 (b). This means that, in some cases, the NP will be the only health professional to see the patient and, in the process, will employ a combination of nursing and medical functions approved by standardized procedures.

Role: Registered Nurse
Regulatory Body: Board of Registered Nursing
Education Requirements: Bachelor of Science in Nursing or Associate Degree + Exam Passage
Average CA Salary: $76,000
Location of Practice: "In an organized healthcare setting."
Scope of Practice: Independent – services which enhance health by assessing, monitoring, detecting, diagnosing, and treating the human response. Those interventions that can be performed by nursing independently.

Interdependent – services which enhance health by assessing, monitoring, detecting, and preventing complications associated with certain health situations or treatment plans. Those services which can be shared with other professions through delegation.

The following aspects of the nursing process shall be performed only by registered nurses: 1) performance of a comprehensive assessment; 2) validation of the assessment data; 3) formulation of the nursing diagnosis for the individual client; 4) identification of goals derived from nursing diagnosis; 5) determination of the nursing plan of care, including appropriate nursing interventions derived from the nursing diagnosis; and 6) evaluation of the effectiveness of the nursing care provided. The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all of the following:

(1) Direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures.

(2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code.

(3) The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries.

(4) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (A) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.

References: http://www.rn.ca.gov/pdfs/regulations/npr-b-03.pdf, http://nursing.uclahealth.org/workfiles/orientation/BRN-UnlicensedAssistivePersonnel.pdf

Role: Licensed Psychiatric Technician
Regulatory Body: Board of Vocational Nursing and Psychiatric Technicians
Education Requirements: Passage of Psychiatric Technician Program + Exam Passage
Average CA Salary: $
Location of Practice: State Hospitals, Day Treatment Centers, Developmental Centers, Correctional Facilities, Psychiatric Hospitals & Clinics, Psychiatric Technician Programs, Geropsychiatric Centers, Residential Care Facilities, Vocational Training Centers
Scope of Practice: An entry-level health care provider who is responsible for care of mentally disordered and developmentally disabled clients. A psychiatric technician practices under the direction of a physician, psychologist, rehabilitation therapist, social worker, registered nurse or other professional personnel. The licensee is not an independent practitioner. Activities of Daily Living.
Basic Nursing Care, Medications, Treatment Plan Development and Implementation, Individual & Group Therapy, Behavioral Management.
Reference: http://www.bvnpt.ca.gov/licensing/psychiatric_technician.shtml

Role: Licensed Vocational Nurse
Regulatory Body: Board of Vocational Nursing and Psychiatric Technicians
Education Requirements: Associate Degree + Passage of NCLEX-PN Exam. 1,530 Total Hours: Theory - *576 Hours; Clinical - 954 Hours, Pharmacology - 54 Hours
Average CA Salary: $26,000-46,000
Location of Practice: Acute Medical/Surgical Hospitals, Convalescent Hospitals (Long Term Care, Skilled Nursing), Home Care Agencies, Outpatient Clinics, Doctor's Offices, Ambulatory Surgery Centers, Dialysis Centers, Blood Banks, Psychiatric Hospitals, Correctional Facilities, Vocational Nursing Programs, Private duty patient care may be performed in any setting, including, but not limited to, acute care, long term care, or the patient's home.

Scope of Practice: The licensed vocational nurse performs services requiring technical and manual skills which include the following: (a) Uses and practices basic assessment (data collection), participates in planning, executes interventions in accordance with the care plan or

treatment plan, and contributes to evaluation of individualized interventions related to the care plan or treatment plan. (b) Provides direct patient/client care by which the licensee: (1) Performs basic nursing services as defined in subdivision (a); (2) Administers medications; (3) Applies communication skills for the purpose of patient/client care and education; and (4) Contributes to the development and implementation of a teaching plan related to self-care for the patient/client. A licensed vocational nurse when directed by a physician and surgeon may do all of the following: (a) Administer medications by hypodermic injection. (b) Withdraw blood from a patient, if prior thereto such nurse has been instructed by a physician and surgeon and has demonstrated competence to such physician and surgeon in the proper procedure to be employed when withdrawing blood, or has satisfactorily completed a prescribed course of instruction approved by the board, or has demonstrated competence to the satisfaction of the board. (c) Start and superimpose intravenous fluids if all of the following additional conditions exist: (1) The nurse has satisfactorily completed a prescribed course of instruction approved by the board or has demonstrated competence to the satisfaction of the board. (2) The procedure is performed in an organized health care system in accordance with the written standardized procedures adopted by the organized health care system as formulated by a committee which includes representatives of the medical, nursing, and administrative staffs. "Organized health care system," as used in this section, includes facilities licensed pursuant to Section 1250 of the Health and Safety Code, clinics, home health agencies, physicians' offices, and public or community health services. Standardized procedures so adopted will be reproduced in writing and made available to total medical and nursing staffs. A licensed vocational nurse, acting under the direction of a physician may perform: (1) tuberculin skin tests, coccidioidin skin tests, and histoplasmin skin tests, providing such administration is within the course of a tuberculosis control program, and (2) immunization techniques, providing such administration is upon standing orders of a supervising physician, or pursuant to written guidelines adopted by a hospital or medical group with whom the supervising physician is associated. (b) The supervising physician under whose direction the licensed vocational nurse.

Reference: http://www.bvnpt.ca.gov/pdf/vnregs.pdf, http://www.bvnpt.ca.gov/licensing/licensed_vocational_nurses.shtml

Role: Certified Nurse Assistant
Regulatory Body: California Department of Public Health
Education Requirements: High School Diploma
Average CA Salary: $33,000
Location of Practice:
Scope of Practice: Tasks which are judged by the direct care RN to not require the professional judgment of an RN may be assigned. Such assigned tasks shall meet all the following conditions: a) be considered routine care for this patient b) pose little potential hazard for the patient c) involve little or no modification from one client-care situation to another; d) be performed with a predictable outcome e) not inherently involve ongoing assessments, interpretations, or decision-making which could not be logically separated from the procedure itself.

Reference: http://nursing.uclahealth.org/workfiles/orientation/BRN-UnlicensedAssistivePersonnel.pdf

Role: Speech Language Pathologist
Regulatory Body: Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board 916.263.2666
Education Requirements:
Average CA Salary: $ 88,000
Location of Practice:
Scope of Practice: The practice of speech-language pathology means all of the following: (1) The application of principles, methods, instrumental procedures, and noninstrumental procedures for measurement, testing, screening, evaluation, identification, prediction, and counseling related to the development and disorders of speech, voice, language, or swallowing. (2) The application of principles and methods for preventing, planning, directing, conducting, and supervising programs for habilitating, rehabilitating, ameliorating, managing, or modifying disorders of speech, voice, language, or swallowing in individuals or groups of individuals. (3) Conducting hearing screenings. (4) Performing suctioning in connection with the scope of practice described in paragraphs (1) and (2), after compliance with a medical facility's training protocols on suctioning procedures. (e) (1) Instrumental procedures referred to in subdivision (d) are the use of rigid and flexible endoscopes to observe the pharyngeal and laryngeal areas of the throat in order to observe, collect data, and measure the parameters of communication and swallowing as well as to guide communication and swallowing assessment and therapy.
Reference: http://www.leginfo.ca.gov/cgi-bin/displaycode?section=bpc&group=02001-03000&file=2530-2530.6

Role: Respiratory Therapist
Regulatory Body: Respiratory Care Board of California 866-375-0386, 916-999-2190
Education Requirements:
Average CA Salary: $70,000
Location of Practice:
Scope of Practice: § 3702. Practice of respiratory care; Components; "Respiratory care protocols" Respiratory care as a practice means a health care profession employed under the supervision of a medical director in the therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities which affect the pulmonary system and associated aspects of cardiopulmonary and other systems functions, and includes all of the following: (a) Direct and indirect pulmonary care services that are safe, aseptic, preventive, and restorative to the patient. (b) Direct and indirect respiratory care services, including but not limited to, the administration of pharmacological and diagnostic and therapeutic agents related to respiratory care procedures necessary to implement a treatment, disease prevention, pulmonary rehabilitative or diagnostic regimen prescribed by a physician and surgeon. (c) Observation and monitoring of signs and symptoms, general behavior, general physical response to respiratory care treatment and diagnostic testing and (1) determination of whether such signs, symptoms, reactions, behavior or general response exhibits abnormal characteristics; (2) implementation based on observed abnormalities of

appropriate reporting or referral or respiratory care protocols, or changes in treatment regimen, pursuant to a prescription by a physician and surgeon or the initiation of emergency procedures. (d) The diagnostic and therapeutic use of any of the following, in accordance with the prescription of a physician and surgeon: administration of medical gases, exclusive of general anesthesia; aerosols; humidification; environmental control systems and baromedical therapy; pharmacologic agents related to respiratory care procedures; mechanical or physiological ventilatory support; bronchopulmonary hygiene; cardiopulmonary resuscitation; maintenance of the natural airways; insertion without cutting tissues and maintenance of artificial airways; diagnostic and testing techniques required for implementation of respiratory care protocols; collection of specimens of blood; collection of specimens from the respiratory tract; analysis of blood gases and respiratory secretions. (e) The transcription and implementation of the written and verbal orders of a physician and surgeon pertaining to the practice of respiratory care.
Reference: http://www.rcb.ca.gov/forms_pubs/rcp_scope_of_practice.pdf

Role: Physician Assistant
Regulatory Body: Physician Assistant Board 916.561.8780
Education Requirements:
Average CA Salary: $100,000
Location of Practice: All areas of medicine: They practice in family medicine, internal medicine, emergency medicine, pediatrics, obstetrics and gynecology, surgery, orthopedics, psychiatry as well as many other areas.
Scope of Practice: 1399.541. Medical Services Performable. Because physician assistant practice is directed by a supervising physician, and a physician assistant acts as an agent for that physician, the orders given and tasks performed by a physician assistant shall be considered the same as if they had been given and performed by the supervising physician. Unless otherwise specified in these regulations or in the delegation or protocols, these orders may be initiated without the prior patient specific order of the supervising physician. In any setting, including for example, any licensed health facility, out-patient settings, patients' residences, Physician Assistant Regulations 28 residential facilities, and hospices, as applicable, a physician assistant may, pursuant to a delegation and protocols where present: (a) Take a patient history; perform a physical examination and make an assessment and diagnosis therefrom; initiate, review and revise treatment and therapy plans including plans for those services described in Section 1399.541(b) through Section 1399.541(i) inclusive; and record and present pertinent data in a manner meaningful to the physician. (b) Order or transmit an order for x-ray, other studies, therapeutic diets, physical therapy, occupational therapy, respiratory therapy, and nursing services. (c) Order, transmit an order for, perform, or assist in the performance of laboratory procedures, screening procedures and therapeutic procedures. (d) Recognize and evaluate situations which call for immediate attention of a physician and institute, when necessary, treatment procedures essential for the life of the patient. (e) Instruct and counsel patients regarding matters pertaining to their physical and mental health. Counseling may include topics such as medications, diets, social habits, family planning, normal growth and development, aging, and understanding of and long-term management of their diseases. (f) Initiate arrangements for admissions, complete forms and charts pertinent to the patient's medical

record, and provide services to patients requiring continuing care, including patients at home. (g) Initiate and facilitate the referral of patients to the appropriate health facilities, agencies, and resources of the community. (h) Administer or provide medication to a patient, or issue or transmit drug orders orally or in writing in accordance with the provisions of subdivisions (a)-(f), inclusive, of Section 3502.1 of the Code. (i) (1) Perform surgical procedures without the personal presence of the supervising physician which are customarily performed under local anesthesia. Prior to delegating any such surgical procedures, the supervising physician shall review documentation which indicates that the physician assistant is trained to perform the surgical procedures. All other surgical procedures requiring other forms of anesthesia may be performed by a physician assistant only in the personal presence of an approved supervising physician. (2) A physician assistant may also act as first or second assistant in surgery under the supervision of an approved supervising physician.
Reference: http://www.pac.ca.gov/about_us/lawsregs/law-booklet.pdf

Role: Physician
Regulatory Body: Medical Board of California 800-633-2322, 916-263-2382
Education Requirements:
Average CA Salary: $206,000
Location of Practice:
Scope of Practice: The practice of medicine involves diagnosis, treatment, or correction of human conditions, ailments, diseases, injuries, or infirmities whether physical or mental, by any means, methods, devices, or instruments.

Role: Physical Therapist
Regulatory Body: Physical Therapy Board of California
Education Requirements:
Average CA Salary: $95,000
Location of Practice: hospital, private physical therapy offices, rehabilitation centers, community health centers, nursing homes, home health agencies, corporate or industrial health centers, sports facilities, research institutions, schools, pediatric centers, and colleges and universities.
Scope of Practice: Physical therapy, which is limited to the care and services provided by or under the direction and supervision of a physical therapist, includes: 1) examining (history, system review and tests and measures) individuals with impairment, functional limitation, and disability or other health-related conditions in order to determine a diagnosis, prognosis, and intervention; tests and measures may include the following: • aerobic capacity/endurance • anthropometric characteristics • arousal, attention, and cognition • assistive and adaptive devices • circulation (arterial, venous, lymphatic) • cranial and peripheral nerve integrity • environmental, home, and work (job/school/play) barriers • ergonomics and body mechanics • gait, locomotion, and balance • integumentary integrity • joint integrity and mobility • motor function (motor control and motor learning) • muscle performance (including strength, power, and endurance) • neuromotor development and sensory integration • orthotic, protective, and supportive devices • pain • posture • prosthetic requirements • range of motion (including muscle length) • reflex integrity • self-care and home management (including activities of daily

living and instrumental activities of daily living) • sensory integrity • ventilation, and respiration/gas exchange • work (job/school/play), community, leisure integration or reintegration (including instrumental activities of daily living) 2) alleviating impairment and functional limitation by designing, implementing, and modifying therapeutic interventions that include, but are not limited to: • coordination, communication and documentation • patient/client-related instruction • therapeutic exercise • functional training in self-care and home management (including activities of daily living and instrumental activities of daily living) • functional training in work (job/school/play) and community and leisure integration or reintegration activities (including instrumental activities of daily living, work hardening, and work conditioning) • manual therapy techniques (including mobilization/manipulation) • prescription, application, and, as appropriate, fabrication of devices and equipment (assistive, adaptive, orthotic, protective, supportive, and prosthetic) • airway clearance techniques • integumentary repair and protection techniques • electrotherapeutic modalities • physical agents and mechanical modalities • dry needling 3) preventing injury, impairment, functional limitation, and disability, including the promotion and maintenance of health, wellness, fitness, and quality of life in all age populations 4) engaging in consultation, education, and research.

Physical therapy means the art and science of physical or corrective rehabilitation or of physical or corrective treatment of any bodily or mental condition of any person by the use of the physical, chemical, and other properties of heat, light, water, electricity, sound, massage, and active, passive, and resistive exercise, and shall include physical therapy evaluation, treatment planning, instruction and consultative services. The practice of physical therapy includes the promotion and maintenance of physical fitness to enhance the bodily movement related health and wellness of individuals through the use of physical therapy interventions. The use of roentgen rays and radioactive materials, for diagnostic and therapeutic purposes, and the use of electricity for surgical purposes, including cauterization, are not authorized under the term “physical therapy” as used in this chapter, and a license issued pursuant to this chapter does not authorize the diagnosis of disease

Role: Pharmacy Technician
Regulatory Body: CA Board of Pharmacy
Education Requirements:
Average CA Salary: $40,000
Location of Practice: Must work under a pharmacist, wherever a pharmacist practices
Scope of Practice: (a) A pharmacy technician may perform packaging, manipulative, repetitive, or other nondiscretionary tasks, only while assisting, and while under the direct supervision and control of a pharmacist. The pharmacist shall be responsible for the duties performed under his or her supervision by a technician. (b) This section does not authorize the performance of any tasks specified in subdivision (a) by a pharmacy technician without a pharmacist on duty. (c) This section does not authorize a pharmacy technician to perform any act requiring the exercise of professional judgment by a pharmacist. (d) The board shall adopt regulations to specify tasks pursuant to subdivision (a) that a pharmacy technician may perform under the supervision of a pharmacist. Any pharmacy that employs a pharmacy technician shall do so in conformity with the regulations adopted by the board. (e) No person shall act as a pharmacy technician without first being licensed by the board as a pharmacy technician. (f) (1) A pharmacy with only one

pharmacist shall have no more than one pharmacy technician performing the tasks specified in subdivision (a). The ratio of pharmacy technicians performing the tasks specified in subdivision (a) to any additional pharmacist shall not exceed 2:1, except that this ratio shall not apply to personnel performing clerical functions pursuant to Section 4116 or 4117. This ratio is applicable to all practice settings, except for an inpatient of a licensed health facility, a patient of a licensed home health agency, as specified in paragraph (2), an inmate of a correctional facility of the Department of Corrections and Rehabilitation, and for a person receiving treatment in a facility operated by the State Department of State Hospitals, the State Department of Developmental Services, or the Department of Veterans Affairs. (2) The board may adopt regulations establishing the ratio of pharmacy technicians performing the tasks specified in subdivision (a) to pharmacists applicable to the filling of prescriptions of an inpatient of a licensed health facility and for a patient of a licensed home health agency. Any ratio established by the board pursuant to this subdivision shall allow, at a minimum, at least one pharmacy technician for a single pharmacist in a pharmacy and two pharmacy technicians for each additional pharmacist, except that this ratio shall not apply to personnel performing clerical functions pursuant to Section 4116 or 4117. (3) A pharmacist scheduled to supervise a second pharmacy technician may refuse to supervise a second pharmacy technician if the pharmacist determines, in the exercise of his or her professional judgment, that permitting the second pharmacy technician to be on duty would interfere with the effective performance of the pharmacist's responsibilities under this chapter. A 54 pharmacist assigned to supervise a second pharmacy technician shall notify the pharmacist in charge in writing of his or her determination, specifying the circumstances of concern with respect to the pharmacy or the pharmacy technician that have led to the determination, within a reasonable period, but not to exceed 24 hours, after the posting of the relevant schedule. No entity employing a pharmacist may discharge, discipline, or otherwise discriminate against any pharmacist in the terms and conditions of employment for exercising or attempting to exercise in good faith the right established pursuant to this paragraph. (g) Notwithstanding subdivisions (a) and (b), the board shall by regulation establish conditions to permit the temporary absence of a pharmacist for breaks and lunch periods pursuant to Section 512 of the Labor Code and the orders of the Industrial Welfare Commission without closing the pharmacy. During these temporary absences, a pharmacy technician may, at the discretion of the pharmacist, remain in the pharmacy but may only perform nondiscretionary tasks. The pharmacist shall be responsible for a pharmacy technician and shall review any task performed by a pharmacy technician during the pharmacist's temporary absence. Nothing in this subdivision shall be construed to authorize a pharmacist to supervise pharmacy technicians in greater ratios than those described in subdivision (f). (h) The pharmacist on duty shall be directly responsible for the conduct of a pharmacy technician supervised by that pharmacist. (i) In a health care facility licensed under subdivision (a) of Section 1250 of the Health and Safety Code, a pharmacy technician's duties may include any of the following: (1) Packaging emergency supplies for use in the health care facility and the hospital's emergency medical system or as authorized under Section 4119. (2) Sealing emergency containers for use in the health care facility. (3) Performing monthly checks of the drug supplies stored throughout the health care facility. Irregularities shall be reported within 24 hours to the pharmacist in charge and the director or chief executive officer of the health care facility in accordance with the health care facility's policies and procedures.

Role: Pharmacist
Regulatory Body: CA Board of Pharmacy
Education Requirements:
Average CA Salary: $120,000
Location of Practice:
Scope of Practice: 4051. Conduct Limited to Pharmacist; Conduct Authorized by Pharmacist (a) Except as otherwise provided in this chapter, it is unlawful for any person to manufacture, compound, furnish, sell, or dispense a dangerous drug or dangerous device, or to dispense or compound a prescription pursuant to Section 4040 of a prescriber unless he or she is a pharmacist under this chapter. (b) Notwithstanding any other law, a pharmacist may authorize the initiation of a prescription, pursuant to Section 4052.1, 4052.2, 4052.3, or 4052.6, and otherwise provide clinical advice, services, information, or patient consultation, as set forth in this chapter, if all of the following conditions are met: (1) The clinical advice, services, information, or patient consultation is provided to a health care professional or to a patient. (2) The pharmacist has access to prescription, patient profile, or other relevant medical information for purposes of patient and clinical consultation and advice. (3) Access to the information described in paragraph (2) is secure from unauthorized access and use.

Pharmacy practice is a dynamic, patient-oriented health service that applies a scientific body of knowledge to improve and promote patient health by means of appropriate drug use, drug related therapy, and communication for clinical and consultative purposes. Pharmacy practice is continually evolving to include more sophisticated and comprehensive patient care activities. (c) The Legislature further declares that pharmacists are health care providers who have the authority to provide health care services.
Reference: (http://www.pharmacy.ca.gov/laws_regs/lawbook.pdf)

Role: Occupational Therapist
Regulatory Body: Board of Occupational Therapy
Education Requirements:
Average CA Salary: $90,000
Location of Practice: • Institutional settings (inpatient; e.g., acute care, rehabilitation facilities, psychiatric hospitals, community and specialty-focused hospitals, nursing facilities, prisons), • Outpatient settings (e.g., hospitals, clinics, medical and therapy offices), • Home and community settings (e.g., residences, group homes, assisted living, schools, early intervention centers, day care centers, industry and business, hospice, sheltered workshops, transitional-living facilities, wellness and fitness centers, community mental health facilities), and • Research facilities.
Scope of Practice: A. Evaluation of factors affecting activities of daily living (ADLs), instrumental activities of daily living (IADLs), rest and sleep, education, work, play, leisure, and social participation, including 1. Client factors, including body functions (e.g., neuromuscular, sensory, visual, perceptual, cognitive) and body structures (e.g., cardiovascular, digestive, integumentary, genitourinary systems) 2. Habits, routines, roles, and rituals 3. Physical and social environments and cultural, personal, temporal, and virtual contexts and activity demands that affect performance 2 4. Performance skills, including motor, process, and social interaction

skills B. Approaches to identify and select interventions, such as 1. Establishment, remediation, or restoration of a skill or ability that has not yet developed or is impaired 2. Compensation, modification, or adaptation of activity or environment to enhance performance 3. Maintenance and enhancement of capabilities without which performance in everyday life activities would decline 4. Health promotion and wellness to enable or enhance performance in everyday life activities 5. Prevention of barriers to performance. C. Interventions and procedures to promote or enhance safety and performance in ADLs, IADLs, rest and sleep, education, work, play, leisure, and social participation, for example, 1. Occupations and activities a. Completing morning dressing and hygiene routine using adaptive devices b. Playing on a playground with children and adults c. Engaging in driver rehabilitation and community mobility program d. Managing feeding, eating, and swallowing to enable eating and feeding performance. 2. Preparatory methods and tasks a. Exercises, including tasks and methods to increase motion, strength, and endurance for occupational participation b. Assessment, design, fabrication, application, fitting, and training in assistive technology and adaptive devices c. Design and fabrication of splints and orthotic devices and training in the use of prosthetic devices d. Modification of environments (e.g., home, work, school, community) and adaptation of processes, including the application of ergonomic principles e. Application of physical agent modalities and use of a range of specific therapeutic procedures (e.g., wound care management; techniques to enhance sensory, perceptual, and cognitive processing; manual therapy techniques) to enhance performance skills f. Assessment, recommendation, and training in techniques to enhance functional mobility, including wheelchair management g. Explore and identify effective tools for regulating nervous system arousal levels in order to participate in therapy and/or in valued daily activities. 3. Education and training a. Training in self-care, self-management, home management, and community or work reintegration b. Education and training of individuals, including family members, caregivers, and others. 4. Advocacy a. Efforts directed toward promoting occupational justice and empowering clients to seek and obtain resources to fully participate in their daily life occupations. 5. Group interventions 3 a. Facilitate learning and skill acquisition through the dynamics of group or social interaction across the life span. 6. Care coordination, case management, and transition services 7. Consultative services to groups, programs, organizations, or communities.

Within their domain of practice, occupational therapists and occupational therapy assistants consider the repertoire of occupations in which the client engages, the performance skills and patterns the client uses, the contexts and environments influencing engagement, the features and demands of the activity, and the client's body functions and structures. Occupational therapists and occupational therapy assistants use their knowledge and skills to help clients conduct or resume daily life activities that support function and health throughout the life span. Participation in activities and occupations that are meaningful to the client involves emotional, psychosocial, cognitive, and physical aspects of performance. Participation in meaningful activities and occupations enhances health, well-being, and life satisfaction.
Reference: (https://www.aota.org/-/media/Corporate/Files/AboutAOTA/OfficialDocs/Position/Scope-of-Practice-edited-2014.PDF)

Role: Licensed Midwife
Regulatory Body: Medical Board of CA and the Board of Registered Nursing

Education Requirements:
Average CA Salary: $110,000
Location of Practice:
Scope of Practice: The Legislature granted the CNM an independent scope of practice. CNMs practice in collaboration and consultation with physicians as indicated. The degree of collaboration in this team approach depends upon the medical needs of the individual woman or infant and the practice setting. All complications shall be referred to a physician immediately and the CNM provides emergency care until physician assistance can be obtained. By law, nurse-midwifery care requires the supervision of a licensed physician and surgeon, but supervision does not require physical presence of the physician. CNMs are not authorized to practice medicine and surgery. For practices and procedures that overlap the practice of nurse-midwifery into medicine, standardized procedures must be developed and approved by the three entities of the CNM, physician and practice setting administration.

Episiotomies, STD treatment for pt and partner (without seeing partner), furnishing devices and drugs (including controlled substances), dispensing medications, signing birth certificates, informing patient of positive and negative aspects of blood transfusions, supervision of medical assistants, medical examination of school bus drivers.

(a) The certificate to practice nurse-midwifery authorizes the holder, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn. (b) As used in this chapter, the practice of nurse-midwifery constitutes the furthering or undertaking by any certified person, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal. All complications shall be referred to a physician immediately. The practice of nurse-midwifery does not include the assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any version. (c) As used in this article, "supervision" shall not be construed to require the physical presence of the supervising physician. (d) A certified nurse-midwife is not authorized to practice medicine and surgery by the provisions of this chapter. (e) Any regulations promulgated by a state department that affect the scope of practice of a certified nurse-midwife shall be developed in consultation with the board.
Reference: http://www.mbc.ca.gov/Licensees/Midwives/Midwives_Practice_Act.aspx

Role: Marriage and Family Therapist
Regulatory Body: Board of Behavioral Sciences
Education Requirements:
Average CA Salary: $69,000
Location of Practice:
Scope of Practice: Section: 4980.02. PRACTICE OF MARRIAGE, FAMILY, AND CHILD COUNSELING; APPLICATION OF PRINCIPLES AND METHODS: For the purposes of this chapter, the practice of marriage and family therapy shall mean that service performed with individuals, couples, or groups wherein interpersonal relationships are examined for the purpose of

achieving more adequate, satisfying, and productive marriage and family adjustments. This practice includes relationship and premarriage counseling.

The application of marriage and family therapy principles and methods includes, but is not limited to, the use of applied psychotherapeutic techniques, to enable individuals to mature and grow within marriage and the family, the provision of explanations and interpretations of the psychosexual and psychosocial aspects of relationships, and the use, application, and integration of the coursework and training

Role: Educational Psychologist
Regulatory Body: Board of Behavioral Sciences
Education Requirements:
Average CA Salary: $89,000
Location of Practice:
Scope of Practice: Section 4989.14: Scope of Practice

The practice of educational psychology is the performance of any of the following professional functions pertaining to academic learning processes or the education system or both:

(a) Educational evaluation.

(b) Diagnosis of psychological disorders related to academic learning processes.

(c) Administration of diagnostic tests related to academic learning processes including tests of academic ability, learning patterns, achievement, motivation, and personality factors.

(d) Interpretation of diagnostic tests related to academic learning processes including tests of academic ability, learning patterns, achievement, motivation, and personality factors.

(e) Providing psychological counseling for individuals, groups, and families.

(f) Consultation with other educators and parents on issues of social development and behavioral and academic difficulties.

(g) Conducting psychoeducational assessments for the purposes of identifying special needs.

(h) Developing treatment programs and strategies to address problems of adjustment.

(i) Coordinating intervention strategies for management of individual crises.

Role: Clinical Social Worker
Regulatory Body:
Education Requirements: -Get your MSW from an accredited college or university
-Register with the BBS as an Associate Clinical Social Worker (ASW)
-Gain your supervised post-masters work experience
-Complete any required additional coursework
-Apply for LCSW Examination Eligibility

-Pass the LCSW Standard Written Examination
-Pass the LCSW Written Clinical Vignette Examination
-Get your official clinical social worker license

Average CA Salary: $66,000
Location of Practice:
Scope of Practice: Section: 4996.9. CLINICAL SOCIAL WORK AND PSYCHOTHERAPY DEFINED

The practice of clinical social work is defined as a service in which a special knowledge of social resources, human capabilities, and the part that unconscious motivation plays in determining behavior, is directed at helping people to achieve more adequate, satisfying, and productive social adjustments. The application of social work principles and methods includes, but is not restricted to, counseling and using applied psychotherapy of a nonmedical nature with individuals, families, or groups; providing information and referral services; providing or arranging for the provision of social services; explaining or interpreting the psychosocial aspects in the situations of individuals, families, or groups; helping communities to organize, to provide, or to improve social or health services; or doing research related to social work.

Psychotherapy, within the meaning of this chapter, is the use of psychosocial methods within a professional relationship, to assist the person or persons to achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, to modify internal and external conditions which affect individuals, groups, or communities in respect to behavior, emotions, and thinking, in respect to their intrapersonal and interpersonal processes.

Appendix F: Acknowledgements

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