CNO Advisory Committee Meeting

Meeting Book

Wednesday, January 17, 2018

California Hospital Association

1215 K Street, Ste 800

Sacramento, CA, 95814

Conference Call Option:

800-882-3610 passcode: 7795222#

Meeting Book - CNO Advisory Committee Meeting

10:00 I. CALL TO ORDER/INTRODUCTIONS
BURNES BOLTON

A. Introductions

B. Committee Roster — Page 4

C. Committee Guidelines — Page 9

D. 2018 Committee Meeting Schedule — Page 13

II. MINUTES
BURNES BOLTON

A. October 3, 2017 Meeting Minutes — Page 14

III. OLD BUSINESS
BURNES BOLTON

A. Value of Nursing & Nursing Diagnosis Survey Results — Page 18
Berg

B. CDPH Update — Page 19
Rogers

IV. NEW BUSINESS
BURNES BOLTON

A. Clinical Displacement/Alliance — Page 21
McFarland

B. 2016 RN Survey Results — Page 23
Berg

C. NHSN Antibiotic Use Module — Page 31
Rogers

D. Nursing Community Coalition — Page 32
Bartleson

E. Dialysis Unit Staffing Ratios — Page 37
Rogers

F. CHPAC

12:00 V. LUNCH

12:30 VI. LEGISLATIVE AND REGULATORY UPDATE

A. Federal Regulatory Overview — Page 53
Keefe

B. Nurse Practitioner - Full Practice Authority Legislation, California Action Coalition — Page 56
Bartleson/Berg

C. State Legislation
Rogers

Page 58

D. 2017 Report on Legislation

VII. ROUNDTABLE DISCUSSION

A. Roundtable Discussion

Page 59

B. Flu Update
Rogers

C. Tubing Connectors
Rogers

VIII. INFORMATION

A. New HRSA NEPQR Grant Announced

Page 60

B. Workplace Violence Prevention

C. Future of Nursing - Campaign for Action

Page 62

2:00

IX. ADJOURNMENT
BURNES BOLTON

A. Next Meeting - Wednesday, April 25, 2018

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

CNO Advisory Committee

2018 Member Roster

CHAIRS

Linda Burnes Bolton, DrPH, RN, FAAN
Chief Nursing Officer
Cedars-Sinai Medical Center
8700 Beverly Blvd.
Los Angeles, CA 90048-1865
(310) 423-5191
Linda.burnes-bolton@cshs.org
Admin: Nichele Hopson
Nichele.hopson@cshs.org

Anna J. Kiger, DNP, DSc, MBA, RN, NEA-BC
Chief Nurse Officer
Sutter Health
Office of Patient Experience
2200 River Plaza Dr.
Sacramento, CA 95833
(916) 286-6843
kigeraj@sutterhealth.org

MEMBERS

Margarita Baggett, MSN, RN
Chief Clinical Officer
UC San Diego Health
9300 Campus Point Drive-7984
La Jolla, CA 92037-7984
858-249-5537
mbaggett@ucsd.edu
Admin: Marcia Jackson
mgjackson@ucsd.edu

Gloria Bancarz
Vice President/Chief Nursing Officer
Adventist Health
2100 Douglas Blvd.
Roseville, CA 95661-3898
(916) 781-4690
Gloria.bancarz@ah.org

Donna Brackley
Senior Vice President, Patient Care Services
John Muir Medical Center – Concord
2540 East Street
Concord, CA 94520-1960
(925) 674-2530
Donna.brackley@johnmuirhealth.com

Theresa Brodrick, RN, PhD
Regional Chief Nursing Executive
VP Clinical Integration
Kaiser Permanente
1950 Franklin Street, 20th Fl
Oakland, CA 94612
(510) 987-4502
Theresa.m.brodrick@kp.org
Admin: Yin Tham
Yin.p.tham@kp.org

Jennifer Castaldo, MSHA, BSN, RN, NEA-BC
Vice President and Chief Nursing Officer
Henry Mayo Newhall Hospital
23845 McBean Parkway
Valencia, CA 91355
(661) 200-1027
castaldojr@henrymayo.com
Admin: Kasey Lee
leeka@henrymayo.com

Tim L. Clark, BSN, MBA
Regional Chief Nursing Officer Division I
Prime Healthcare Management
3300 Guasti Road
Ontario, CA 91761
(909) 687-3590
ticlark@primehealthcare.com

Michael Collins
Chief Clinical Officer
Vibra Hospital of Sacramento
330 Montrose Drive
Folsom, CA 95630-2720
(916) 351-8854
mcollins@vhsacramento.com

Jerome Dayao, MSN, RN, NEA-BC, CPHQ, HACP, CCRN, PCCN
Chief Nursing Officer
Arrowhead Regional Medical Center
400 North Pepper Ave.
Colton, CA 92324
(909) 580-6180
Jerome.dayao@armc.sbcounty.gov

Pilar De La Cruz-Reyes, MSN, RN
Former Chief Nurse Executive
Fresno Heart Hospital
Vice President
Health Education Alliance
1625 E. Shaw Ave., Suite 146
Fresno, CA 93710
pdelacruz@csufresno.edu
ralip151@hughes.net

Sue Fairley, MSN/MHA, RN, CENP
Chief Nursing Officer
Barton Health
2170 South Avenue
South Lake Tahoe, CA 96150-7008
(530) 543-5568
sfairley@bartonhealth.org

Annette Greenwood, BSN, MHA, RNC
Senior Vice President/Chief Nursing Officer
Riverside Community Hospital
4445 Magnolia Avenue
Riverside, CA 92501
(951) 788-3430
Annette.greenwood@hcahealthcare.com

Karen Grimley, PhD, MBA, RN, FACHE
UCLA Health Chief Nursing Officer
Assistant Dean UCLA School of Nursing
757 Westwood Plaza
Los Angeles, CA 90095-8358
(310) 267-9304 – office
(714) 305-3988 - cell
kgrimley@mednet.ucla.edu

Beverly Haden-Pugh
Senior Vice President, Clinical Operations/Chief Nursing Officer
Valley Children's Healthcare
9300 Valley Childrens Place
Madera, CA 93636-8761
(559) 353-6609
Bhayden-pugh@valleychildrens.org

Susan Herman, DNP, MSN, RN, NEA-BC, CENP
Chief Nursing Officer and Vice President Patient Care Services
Adventist Health Bakersfield
418 Spirea St.
Bakersfield, CA 93314 (home address)
(650) 575-0536
Hermansb01@ah.org
Admin: Joe Alaniz
Alanizja01@ah.org

Linda J. Knodel, MHA, MSN, NE-BC, CPHQ, FACHE, FAAN
Senior Vice President/Chief Nurse Executive
Kaiser Permanente
National Patient Care Services
One Kaiser Plaza
Oakland,CA 94612
(510) 409-9529
Linda.j.knodel@kp.org
Admin: Jason Rhodes
Jason.rhodes@kp.org

Toby Marsh
Chief Patient Care Services Officer
UC Davis Medical Center
2315 Stockton Blvd.
Sacramento, CA 95817-2282
(916) 734-2470
tkmarsh@ucdavis.edu
Admin: Cathy Montes
cmmontes@ucdavis.edu

Terry Peña, MS-HCA, BSN, RN
Chief Operating Officer, Chief Nursing Officer
San Bernardino Mountains Community Hospital District
PO Box 70
Lake Arrowhead, CA 92352
(909) 436-3070
Terry.pena@mchcares.com

Connie Rowe
Vice President, Patient Care Services
Enloe Medical Center – Esplanade Campus
1531 Esplanade
Chico, CA 95926-3386
(530) 332-7369
Connie.rowe@enloe.org

Katie Skelton, RN, MBA, NEA-BC
VP Patient Care Services/ Chief Nursing Officer
St. Joseph Hospital, Orange
1100 West Stewart Drive
Orange, CA 92868-3891
(714) 744-8898
Katie.skelton@stjoe.org

Lauren Spilsbury, RN, MSN
CNO/Vice President, Patient Care Services
Redlands Community Hospital
350 Terracina Blvd.
Redlands, CA 92373-4897
(909) 335-5513
las@redlandshospital.org

Sylvain Trepanier, DNP, RN, CENP, FAAN
Chief Clinical Executive
Providence St. Joseph Health
Southern California Region
20555 Earl Street
Torrance, CA 90503
(310) 793-8076
Sylvain.trepanier@providence.org
Admin: Lisa Schwartz
Lisa.schwartz@profidence.org

Pam Wells, MSN, MSA, RN, NEA-BC
Chief Nursing Officer and Vice President, Patient Care Services
Sharp Memorial Hospital, Sharp Healthcare
7901 Frost Street
San Diego, CA 92123
(858) 939-3523
Pam.wells@sharp.com

Page West, RN, MPA, MHA, HACP
Senior Vice President/Chief Nursing Officer
Dignity Health
185 Berry Street, Suite 300
San Francisco, CA 94107-1773
(415) 438-5668
Page.west@dignityhealth.org
Admin: Victoria Lovatio
Victoria.Lovato@dignityhealth.org

EX OFFICIO

Judee Berg, MS, RN, FACHE
(Ex Officio)
Chief Executive Officer
HealthImpact
663 13th Street, Suite 300
Oakland, CA 94612
(510) 832-8400
judee@healthimpact.org
Admin: Laura Ford
laura@healthimpact.org

Mary Bittner, DNP, MPA, RN, CENP
(Ex Officio)
Vice President, Clinical Development
Caravan Health
PO Box 1330
Nevada City, CA 95959
(530) 588-3846
mbittner@caravanhealth.com

Anita Girard, DNP, RN, CNL, CPHQ, NEA-BC
(Ex Officio)
Vice President
American Nurses Association/California
1121 L Street, Suite 406
Sacramento, CA 95814
(408) 396-0162
vicepresident@anacalifornia.org

Marketa Houskova, MAIA, BA, RN
(Ex Officio)
Executive Director
American Nurses Association – California
1121 L Street, Suite 406
Sacramento, CA 95814
(916) 346-4590
Marketa@anacalifornia.org

Pat McFarland, MSN, RN, FAAN
(Ex Officio)
Chief Executive Officer
Association of California Nurse Leaders
2520 Venture Oaks Way
Suite 210
Sacramento, CA 95833
(916) 779-6949
patrica@acnl.org
Admin: Wendy Smolich
Wendy@acnl.org

Joseph Morris, PhD, MSN, RN
(Ex Officio)
Executive Officer
California Board of Registered Nursing
Department of Consumer Affairs
1747 N. Market Blvd., Ste 150
Sacramento, CA 95834-1924
(916) 574-7603
Joseph.morris@dca.ca.gov
Admin: Eloisa Zinzun
Eloisa.zinzun@dca.ca.gov

Heather Young, PhD, RN, FAAN
(Ex Officio)
Founding Dean and Professor
Betty Irene Moore School of Nursing
Dignity Health Dean's Chair in Nursing Leadership
Associate Vice Chancellor for Nursing,
UC Davis Health
2570 48th St., Suite 2400
Sacramento, CA 95817
(916) 734-4745
hmyoung@ucdavis.edu
Admin: Liz deVictoria
ecdevictoria@ucdavis.edu

REGIONAL ASSOCIATION REPRESENTATIVES

Jenna Fischer
Vice President, Quality and Patient Safety
Hospital Council
1215 K Street, Suite 700
Sacramento, CA 95814
(925) 746-5106
jfischer@hospitalcouncil.org

Teri Hollingsworth
Vice President, Association and HR Services
Hospital Association of Southern California
515 South Figueroa, Ste. 1300
Los Angeles, CA 90071
(213) 538-0763
thollingsworth@hasc.org

Judith Yates
Senior Vice President
Hospital Association of San Diego & Imperial Counties
5575 Ruffin Rd., Suite 225
San Diego, CA 92123
(858) 614-1557
jyates@hasdic.org
Admin: Silka Benic
sbenic@hasdic.org

CHA STAFF

BJ Bartleson, RN, NEA-BC
Vice President, Nursing & Clinical Services
California Hospital Association
1215 K Street, Suite 800
Sacramento, CA 95814
(916) 552-7537
bjbartleson@calhospital.org

Debby Rogers, RN, MS, FAEN
Vice President, Clinical Performance and Transformation
California Hospital Association
1215 K Street, Suite 800
Sacramento, CA 95814
(916) 552-7575
drogers@calhospital.org

Barb Roth
Administrative Assistant California Hospital Association
1215 K Street, Suite 800
Sacramento, CA 95814
(916) 552-7616
broth@calhospital.org

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

GUIDELINES FOR THE
CALIFORNIA HOSPITAL ASSOCIATION
CNO ADVISORY COMMITTEE

I. NAME

The name of this committee shall be the CNO Advisory Committee

II. MISSION

The mission of the CNO Advisory Committee is to advise CHA on key policy and advocacy issues specific to hospital and health system nurse executive practice.

III. PURPOSE

The purpose of the CNO Advisory Committee is to provide support for member hospitals and to solicit input for CHA advocacy on key issues.

The committee will provide a forum to:

1. Provide advice and expert analysis on issues of importance.
2. Cooperate with CHA on programs and activities and to support the positions and services of CHA.
3. Make recommendations related to state and federal legislation and regulations related to hospital and health system nursing and clinical services.
4. Conduct other activities approved by the CHA Board of Trustees.

IV. COMMITTEE

The Committee (the "Committee") shall consist of no more than 25 voting members representative of the types, location, and size of CHA institutional members.

A. MEMBERSHIP

1. Membership on the Committee shall be based upon institutional membership in CHA.
2. Committee members shall consist of various representatives from large hospital systems, public institutions, private facilities, free-standing facilities, small and rural facilities, university/teaching facilities and specialty facilities.
3. Non-hospital members will be considered ex-officio members including faculty, consumers and other members of the health professions who are beneficiaries of nursing practice and can only be appointed to the committee at the discretion of the CHA staff.
4. Committee members are appointed by CHA staff.
5. Committee members shall serve three-year terms staggered in a fair and equitable manner as determined by the nominating committee and accepted by the Committee.

Members are limited to two consecutive terms. There must be at least a one-year interval before being eligible for another term.

B. MEMBER RESPONSIBILITIES

1. Accept their appointment with an interest and willingness to serve.
2. Mark their calendars with the advance notice of meetings for the year and make every reasonable effort to keep those dates and times open for the meeting.
3. Attend every meeting possible.
4. Be prepared by reviewing any discussion material provided in advance of the meeting.
5. Contribute to the discussion and consider the subject matter for the benefit of the association as a whole, not just an individual member.
6. Respond to requests for input and feedback on business and issues before the Committee.
7. Disseminate information to committees and to member organizations as appropriate.

C. COMMITTEE MEETINGS

1. Meetings of the Committee shall be held quarterly in person. Additional conference call or web-based meetings may be scheduled as indicated.
2. To maintain continuity substitution of members is not normally allowed.
3. Three consecutive unexcused absences by a Committee member will initiate a review by the Chair and CHA staff for determination of the Committee member's continued service on the Committee.
4. Special meetings may be scheduled by the Chair, majority vote or CHA staff.

D. VOTING

1. Voting rights shall be limited to members of the Committee, and each member present shall have one vote. Voting by proxy is not acceptable.
2. All matters requiring a vote of the Committee must be passed by a majority of a quorum of the Committee members present at a duly called meeting or telephone conference call.

E. QUORUM

Except as set forth herein, a quorum shall consist of a majority of members present/participating or not less than eight.

F. MINUTES

Minutes of the Committee shall be recorded at each meeting, disseminated to the membership, and approved as disseminated or as corrected at the next meeting of the Committee.

V. OFFICERS

The officers of the Committee shall be the Committee Chair, Vice Chair, Immediate Past Chair and CHA staff.

The Chair shall be appointed by CHA staff for a two-year term. Should a Chair vacate his/her position prior to the end of the term, CHA staff will appoint a replacement to complete the remainder of the term.

The responsibilities of the Committee Chair are to:

1. Monitor staff in the execution of their responsibilities to the Committee.
2. Conduct meetings which assure an orderly flow of the discussion and a constructive use of the group's time.
3. Interpret the action of the Committee and speak for the Committee when necessary to report to the CHA Board of Trustees.

The responsibilities of the Committee Vice Chair are to:

1. Assist the Chair in the execution of his/her responsibilities to the Committee.
2. In the absence of the Chair, assume the role and responsibilities of the Chair.

VI. GENERAL PROVISIONS

A. COMMITTEE ACTIVITIES
Committee activities, including goals and objectives, shall be developed by the Committee with approval by CHA staff. Quarterly updates and progress reports shall be completed by the Committee and CHA staff. Committee staff should communicate regularly with the Committee on the activities and priorities of the Committee. The Committee may request that staff develop a general work plan which defines the goals and objectives of the Committee for the coming year.

B. SUB-COMMITTEES
Task forces or subcommittees of the Committee may be formed at the discretion of the Committee Chair and member and CHA staff for the purpose of con ducting activities specific to a special topic or goal.

C. STAFF SUPPORT
Staff leadership shall be provided by CHA with Regional Association staff leadership provided by Hospital Council, the Hospital Association of Southern California, and the Hospital Association of San Diego and Imperial Counties. The primary office and public policy development and advocacy staff of the Committee shall be located within the CHA office.

VII. AMENDMENTS

These Guidelines may be amended by a majority vote of the members of the Committee at any regular meeting of the Committee and with approval by CHA.

VIII. LEGAL LIMITATIONS

Any portion of these Guidelines which may be in conflict with any state or federal statutes or regulations shall be declared null and void as of the date of such determination.

Any portion of these Guidelines which are in conflict with the Bylaws and policies of CHA shall be considered null and void as of the date of the determination.

Information provided in meetings is not to be sold or misused.

IX. CONFIDENTIALITY FOR MEMBERS

Many items discussed are confidential in nature, and confidentiality must be maintained. All Committee communications are considered privileged and confidential, except as noted.

X. CONFLICT OF INTEREST

Any member of the Committee who shall address the Committee in other than a volunteer relationship excluding CHA staff and who shall engage with the Committee in a business activity of any nature, as a result of which such party shall profit either directly or indirectly, shall fully disclose any such financial benefit expected to CHA staff for approval prior to contracting with the Committee and shall further refrain, if a member of the Committee, from any vote in which such issue is involved.

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

August 28, 2017

TO: CNO Advisory Committee Members

FROM: BJ Bartleson, MS, RN, NEA-BC
Debby Rogers, RN, MS, FAEN

SUBJECT: 2018 Meeting Schedule

Following is the meeting schedule for 2018 CNO Advisory Committee meetings:

January 17, 2018	Sacramento
April 25, 2018	Sacramento
July 25, 2018	Sacramento
October 3, 2018	Sacramento

You will receive a save-the-date approximately one month prior to each meeting to verify your attendance/participation.

Thank you and if you have any questions, please feel free to call me directly at (916) 552-7537.

BB:br

CNO ADVISORY COMMITTEE
MEETING MINUTES
October 3, 2017 / 10:00 a.m. – 2:00 p.m.

UC Davis Health, Main Hospital
North 1, Room 1204
2315 Stockton Blvd.
Sacramento, CA

Members Present: Linda Burnes-Bolton, Pat McFarland, Michael Collins, Joseph Morris, Pam Wells, Tim Clark, Gloria Bancarz, Terry Peña, Pilar De La Cruz, Jenn Castaldo, Toby Marsh, Donna Brackley, Anna Kiger, Anita Girard, Sylvain Trepanier, Judith Yates, Judee Berg, Jenna Fischer, Mary Bittner, Sue Fairley, Lauren Spilsbury, Lani Dickinson, Katie Skelton, Julia Slininger

Members on Call: Theresa Brodrick, Jerome Dayao, Julie Morath

Members Absent: Benny Lucas, Susan Herman, Mary Ellen Doyle, Beverly Haden-Pugh, Connie Rowe, Page West, Heather Young

Guest: Betty Rambur, Marlee Gruber

CHA Staff: BJ Bartleson, Debby Rogers, Barb Roth

I. CALL TO ORDER/INTRODUCTIONS

The committee meeting was called to order by Chair at 10:00 a.m.

II. REVIEW OF PREVIOUS MEETING MINUTES

The minutes of the June 20, 2017, CHO Advisory Committee conference call were reviewed.

IT WAS MOVED, SECONDED AND CARRIED:

- *ACTION: minutes approved as submitted.*

III. GUEST SPEAKER (Betty Rambur)

Dr. Rambur presented, "Policy, Politics and People's Lives: What Health and Payment Reform Mean to You". A member of the committee posed a question on telehealth. Dr. Rambur expects it will be predominant in the future. Other primary care coordination models such as a "warm handoff in primary care," are emerging. Same day access for primary care is essential.

IV. NEWBUSINESS

A. The Value of Nursing and Nursing Diagnoses (Bartleson/Berg)

Ms. Berg presented HealthImpact's work on the value of nursing in health care reform, titled, "Value of Nursing Project, Phase I" (https://healthimpact.org/resources) The value of nursing was described using three components: 1) Defining the Registered Nurses' Role in Healthcare 2) Developing a Quantitative Business Case for Nursing Care, and 3) Developing an Interprofessional Competency Crosswalk. Ms. Berg and Ms. Bartleson focused the conversation on the first component, the definition of nursing, and how nursing practice-using

the term nursing diagnosis, is defined and described between industry and academia. Nurse informatics was mentioned as being of particular importance in ensuring the nursing process is adequately addressed in EHRs. EPIC and Cerner were the two EHRs that were identified and each have different ways to incorporate the nursing process, and it is different in every EHR. A suggestion was made to have academic curriculum committees more involved in the EHR development. Both industry and academia need to influence the EHR platform engineers to minimize the differences.

The Committee discussed the regulatory requirements for the use of the nursing process (both Title 22 and the BRN regulations). Members agreed that some CDPH surveyors were able to find the needed information in the EHR, even if the nursing process was part of an interdisciplinary team, and some were not. Some members had received deficiencies related to the nursing process, but each member agreed with the findings.

HealthImpact is performing a survey between academia and service on the use of nursing diagnosis in defining nursing practice.

- *ACTION: Ms. Berg will report on the survey findings.*

B. Nursing Span of Control (Slininger)

Ms. Slininger reported the Hospital Association of Southern California's Nursing Advisory Council created a draft white paper on nursing span of control after an intensive literature review.

Dr. Burnes-Bolton discussed research done through the Collaborative Alliance for Nursing Outcomes which identified various definitions of the manager role. Each organization can have different ways in which management roles are defined and how the management system is organized. It's not a one size fits all process. There is a need to develop leaders to address various competency levels of the roles. Perhaps to be considered for a leadership role the candidate should perform an initial assessment and complete programs through outside organizations, such as the American Organization of Nurse Executives and the Association of California Nurse Leaders. There should also be additional competency assessment, such as emotional intelligence. Dr. Burnes-Bolton emphasized the importance of a formalized emerging leader program. Ms. McFarland also talked about the importance of mentorship programs. Ms. Skelton's facility has an internal emerging nurse leader program and contribute this to their ability to easily recruit and retain nurse leaders.

- *ACTION: Information only.*

C. Hospital Quality Institute Update (Morath)

Ms. Morath reported the HQI Annual Conference is November 1-3 in Monterey, CA. Dr. Lucien Leape will be a keynote and Dr. Bev Malone will present and discuss nursing issues.

The Hospital Quality Institute is working on Hospital Consumer Assessment of Healthcare Providers and Systems measures where California is presently in the bottom quartile of national ratings One method to make improvements is to increase the response rate by 3% to boost California into a higher quartile, since the more people surveyed, theoretically improves overall scoring. Language preferences is another improvement target as language matters relative to survey performance - if English is not a person's first language, telephonic survey is better. Also use of a competent vendor to inform patients on how to use the survey even though they cannot inform patients on how to answer.

The Hospital Quality institute is advocating for voluntary sepsis reporting since this promotes flexibility and innovation versus mandated regulations. California's sepsis mortality rate is down to 16.8%.

- *ACTION: Information Only.*

V. LEGISLATION AND REGULATORY (Rogers)

A. Tubing Connectors

Ms. Rogers reported that the California Hospital Association (CHA) did a survey on tubing connectors and found 22% of respondents had fully transitioned and 66% of respondents reported they will convert in the near future. More hospitals than expected responded that they are fully compliant on epidural connectors. Committee members felt these results are what they expected.
CHA is hosting a tubing webinar on November 15, 2017. Information for registration is available on the CHA website.

- *ACTION: Information, Ms. Rogers will update members on webinar at next meeting*

B. California Department of Public Health Timelines

Ms. Rogers reported there are ongoing issues with the department's workload. Changing or adding a hospital service is the most concerning delay. The department has centralized part of the application process from the District Offices (DOs) into a Central Applications Unit. Unfortunately the workload is voluminous and they are overwhelmed and understaffed. Their goal is to put performance data on their website within a month. Sometimes the delays are with the provider because some information is missing. The department has agreed to do a webinar with CHA in December. The department will inform participants on some of the key problems. They are is also automating their system.

- *ACTION: Information, Ms. Rogers will update members on webinar at next meeting.*

C. Legislation (Rogers)

Ms. Rogers reported problems related to unrepresented patients. Existing California law allows a Skilled Nursing Facility (SNF) team in the SNF to make decisions for patients who lack capacity and do not have a conservator or surrogate. This issue went to court and the court ruled this process unconstitutional. The case is on appeal. CHA worked on a bill to address this problem, unfortunately it did move this year. Now, in the lawsuit being appealed, advocates have come out on the opposite side. If the court's ruling is not overturned, these patients will end up back at the hospital Emergency Departments for this type of care.

Medicaid potentially preventable complications – Department of HealthCare Services (DHCS) are auditing and "truing it up" the penalties. CHA requesting DHCS provide information regarding their methodology.

- *Action – Information, Ms. Rogers will update members on legislative activity next meeting.*

D. Discharge Delay

Ms. Rogers reported the CHA Case Management Committee identified a problem with discharge delays. The majority are Medi-Cal patients and/or patients with major issues such as behavioral problems or homelessness or behavioral health issues. CHA is writing a proposal for the CHA Board of Directors to fund an initiative to look into this further. Conservatorship is

also a problem in regard to this issue.

- *Action- Information and follow up by Ms. Rogers in future meetings.*

VI. ROUNDTABLE DISCUSSION

1. Ms. Bartleson provided an overview about the Emergency Care Systems Initiative and CHA and the Regional Associations mission to transform emergency services through a statewide collaborative approach. Ms. Bartleson also mentioned the CHA Behavioral Health Symposium and ED Forum, December 4-6 in Riverside. Registration information can be found on the CHA website.

   - *Action: Information only.*

2. Request for feedback regarding topics for future discussion:
   a. April – new CalOSHA legislation regarding workplace violence. Ms. Blanchard-Sager has developed a website on this topic.

      - *Action: Ms. Blanchard-Saiger will report at next committee meeting.*

   b. Expanded role of nurse practitioners

      - *Action: Ms. Bartleson will report back on the full practice authority legislation along with other NP statewide information.*

   c. Some topics are outside of the hospital setting, might we consider other care settings like home health, hospice, nurse leader for post-acute to have those CNOs join the Committee. Perhaps look to including members for the Center of Post-Acute Care on this committee.

      - *Action: Committee members will add members from other care continuum sites.*

   d. Clinical displacement.

      - *Action: Clinical displacement will be added to next meeting's agenda.*

VII. NEXT MEETING

Wednesday, January 17, 2018

VIII. ADJOURNMENT

Having no further business, the committee adjourned at 1:58 PM

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

January 17, 2018

TO: CNO Advisory Committee Members

FROM: Judee Berg, MS, RN, FACHE, CEO, HealthImpact

SUBJECT: Value of Nursing & Nursing Diagnosis Survey Results

SUMMARY

HealthImpact conducted a statewide survey in collaboration with the California Hospital Association (CHA) of pre-licensure RN programs, and CHA hospitals to explore how RN students are taught and learn nursing diagnoses, and how nurses in practice utilize them. How schools of nursing teach nursing diagnoses to students and how nurses in practice utilize them continues to arise as a central issue in understanding, communicating, and carrying out nursing's unique role and scope. The specific responsibility nurses have in assessing patient responses to health, determining specific evidence based causes, and making decisions regarding interventions to be carried out can be linked to the achievement of certain health outcomes, utilization of health care resources, and nursing's impact in reducing the future cost of health care.

Survey results will be presented at the meeting.

DISCUSSION

1. Do the results seem accurate?
2. Do you find this concerning?
3. When you have to justify nursing FTE's, how do you describe nursing's work?

ACTION REQUESTED

- *Committee discussion*

BJB/DR:br

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

January 17, 2017

TO: CNO Advisory Committee

FROM: Debby Rogers, RN, MS, FAEN
VP Clinical Performance & Transformation, California Hospital Association

SUBJECT: CDPH Licensing Issues

CENTRALIZED APPLICATIONS UNIT

In response to member hospital concerns, CHA and the California Department of Public Health (CDPH) hosted a webinar to assist hospitals in understanding the Centralized Applications Unit (CAU) applications process. The webinar was held in December, 2017 and had over 140 participants.

CDPH stated the current queue is 6 to 8+ months for an application to reach the analyst, who then reviews it and either approves it or asks for more information. CHA surveyed hospital CEOs in October 2017 and found 70% have experienced delays in getting approval for new or expanded services (n=169). This number is likely higher, because not every hospital had recently requested a new or expanded service. Once the application is deemed complete, hospitals report waiting over 4.5 months, on average, to obtain approval for the new or expanded service (including wait time for onsite survey completion).

CDPH has taken some action to alleviate the backlog. CDPH is in process of hiring 13 additional CAU staff. In December, 2017, CDPH moved general acute care hospital applications from the CAU to local district offices to complete the process (LA County hospital applications remain in the CAU queue). CDPH believe these actions will decompress the CAU and allow for timely processing of applications.

CHA continues to work collaboratively with CDPH leadership to identify solutions to improve this backlog.

STERILE COMPOUNDING REQUIREMENTS

State and federal requirements, including the California Board of Pharmacy (BoP) regulations, may require many hospitals to update their physical plant and policies/procedures to perform sterile compounding. These requirements go into effect when the United States Pharmacopeial Convention (USP) requirements take effect. BoP regulations allow for a construction waiver to delay compliance due to physical construction, alterations or improvements necessary to meet requirements. Hospitals must be compliant with both BoP and CDPH licensing requirements by the time USP becomes effective.

The BoP, OSHPD and CDPH work closely to coordinate and align regulatory requirements, construction plans and licensing requests. However, due to the complex nature of the changes and multiple agencies involved, hospitals are encouraged to:

1. Work with pharmacy and facilities personnel to perform a gap analysis and mitigate a plan to meet both federal and state requirements.
2. If your hospital has been granted a temporary waiver of the regulatory requirements, make sure that you assess CDPH licensing requirements to meet deadlines.
3. Assess construction work plan and activity with OSHPD timelines.
4. Consult CHA website at https://www.calhospital.org/sterile-compounding for further information.

Changes in the physical plant will require a CDPH application for the updated pharmacy (with sterile compounding capabilities) and likely an onsite survey. CHA is working with CDPH, OSHPD and BoP to develop a comprehensive checklist of all CDPH requirements and will distribute it once it is completed.

DISCUSSION QUESTIONS:

- Does your hospital have a waiver?
- Where is your hospital in the construction process? And what is your timeline for completion of the construction and programmatic changes?

ACTION REQUESTED

- Discuss and advise

DR:br

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

January 17, 2018

TO: CNO Advisory Committee Members

FROM: Pat McFarland, MSN, RN, FAAN, CEO, Assocation of California Nurse Leaders

SUBJECT: Clinical Displacement/Alliance

SUMMARY

Over the past few months, the Board of Registered Nursing (BRN) and members of the Quad Council (Association of California Nurse Leaders (ACNL), California Associationof College Nursing (CACN), American Nurses Association – California (ANA\C) and California Organization of Associate Degree Nursing Program Directors (COADN)) have been discussing clinical placements for our prelicensure RN students. It has been reported to the BRN that in some areas of the state, demand for acute care clinical placements, especially in pediatrics and obstetrics, have exceeded capacity. Direct care staff are feeling the strain of continuously being in preceptor/mentor roles. Since the primary function of health care facilities is to ensure safe, high quality care for their patients, some health care leaders have voiced concern and are considering limiting the number of clinical rotations in their institutions. At the November BRN meeting, the Board moved to consider legislation to address clinical displacement. They plan to discuss this issue further at their February meeting and review potential language for legislation that may mandate facilities to accept specific programs. At this time, we have no further details about what is being considered in this proposed legislation. Collectively, professional nursing believes that this issue needs more discussion, data and alternate solutions before we move to legislation. To determine the depth and breadth of the issue, the BRN sent out a survey to all deans and directors of California's nursing schools and programs. ACNL, in collaboration with HealthImpact, CHA and CACN, have determined that a similar survey should be sent to all CNOs in the state to ensure we have complete and accurate data. To achieve this, we ask that you complete the survey when it arrives in your email. Our goal is to better understand the reach of this issue and provide the BRN with alternative solutions.

DISCUSSION

1. Are you or a designee involved in a regional consortium consisting of academia and services partners that focus on clinical placements?
2. Is your hospital enrolled in any type of electronic placement process that allocates available slots to students/schools?
3. From a statewide perspective, how do we advance educational transformation and the supply of highly educated nurses?

ACTION REQUESTED

- *Committee discussion*

BJB:br

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

January 17, 2018

TO: CNO Advisory Committee Members

FROM: Judee Berg, MS, RN, FACHE, CEO, HealthImpact

SUBJECT: 2016 California RN Survey

SUMMARY

California RN 2016 survey is the tenth survey conducted by the Board of Registered Nursing (BRN) since 1990. Surveys were mailed to 8,000 California RNs, living both within and outside California. The response rate was 53.5 % of the eligible population, producing data from 4,178 RNs. All analyses were weighted to ensure the results represent the total population of RNs with California licenses.

DISCUSSION

1. Do any of the survey data surprise you?
2. Do you track and trend your RN's employment plans?
3. Do you have a succession planning strategy?

ACTION REQUESTED

- *Committee discussion*

Attached: Registered Nurses in California
HealthImpact 2016 California BRN Survey of Registered Nurses Published

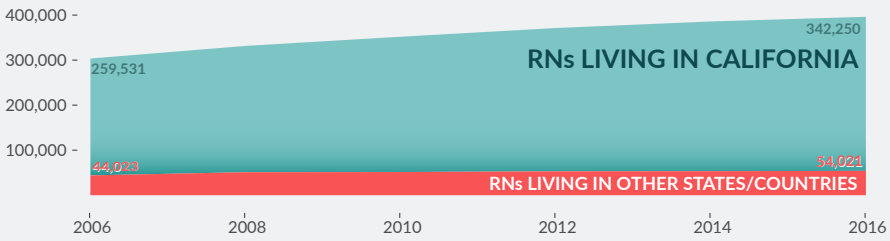
BJB:br

REGISTERED NURSES *in California*

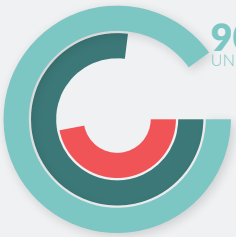
ABOUT THIS SURVEY

This study of California registered nurses (RNs) is the tenth survey conducted by the Board of Registered Nursing since 1990. In April, 2016, surveys were mailed to 8,000 RNs with California licenses living both within and outside California. The response rate was 53.5 percent of the eligible population, producing data from 4,178 RNs. All analyses were weighted to ensure the results represent the total population of RNs with California licenses.

The complete report is available at:
https://rnworkforce.ucsf.edu/publications/brn2016

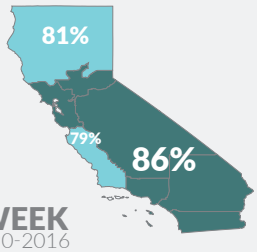


EMPLOYMENT RATES

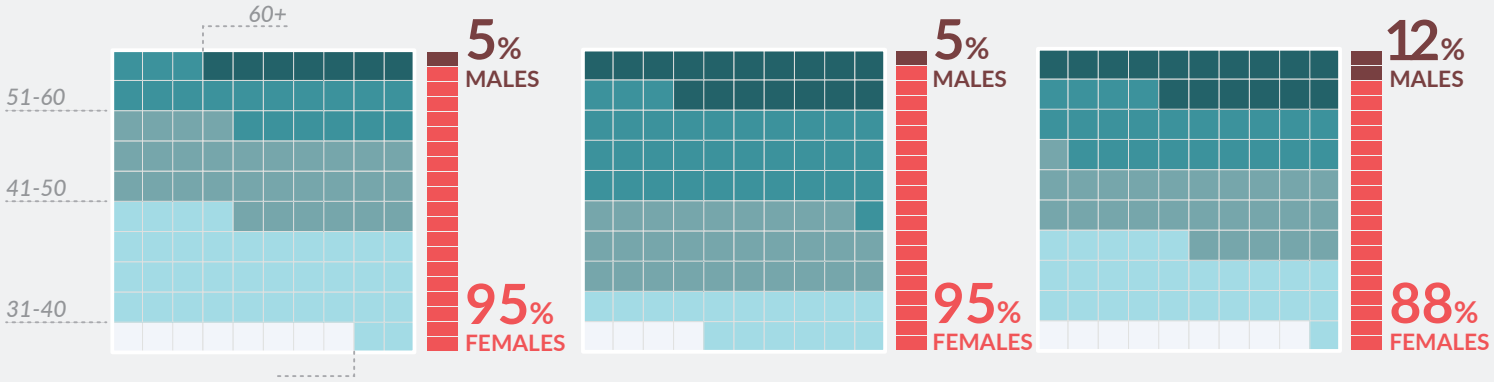


90-95% UNDER 60 YEARS
77% 60-64 YEARS
47% 65+ YEARS

36 HOURS PER WEEK
ON AVERAGE IN 1990-2016



AGE AND GENDER COMPOSITION

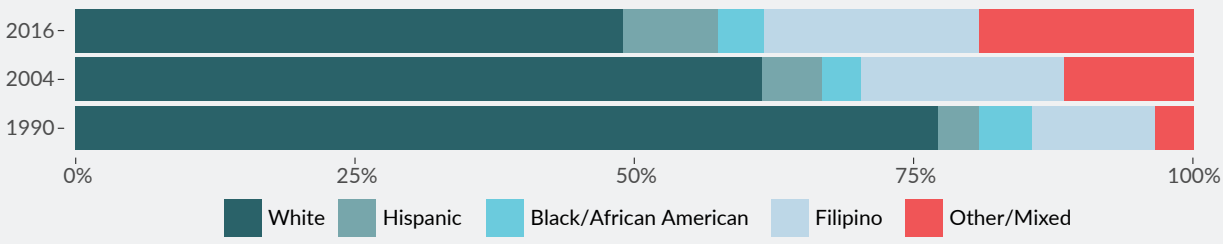


AVERAGE AGE	42.9 y
UNDER 30	8%
31-40	36%
41-50	29%
51-60	19%
60+	7%

AVERAGE AGE	47.6 y
UNDER 30	4%
31-40	16%
41-50	29%
51-60	33%
60+	17%

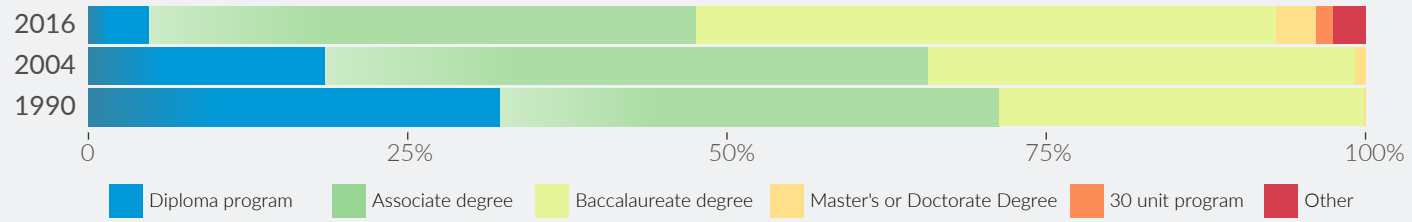
AVERAGE AGE	45 y
UNDER 30	9%
31-40	26%
41-50	26%
51-60	23%
60+	16%

RACE/ETHNICITY COMPOSITION

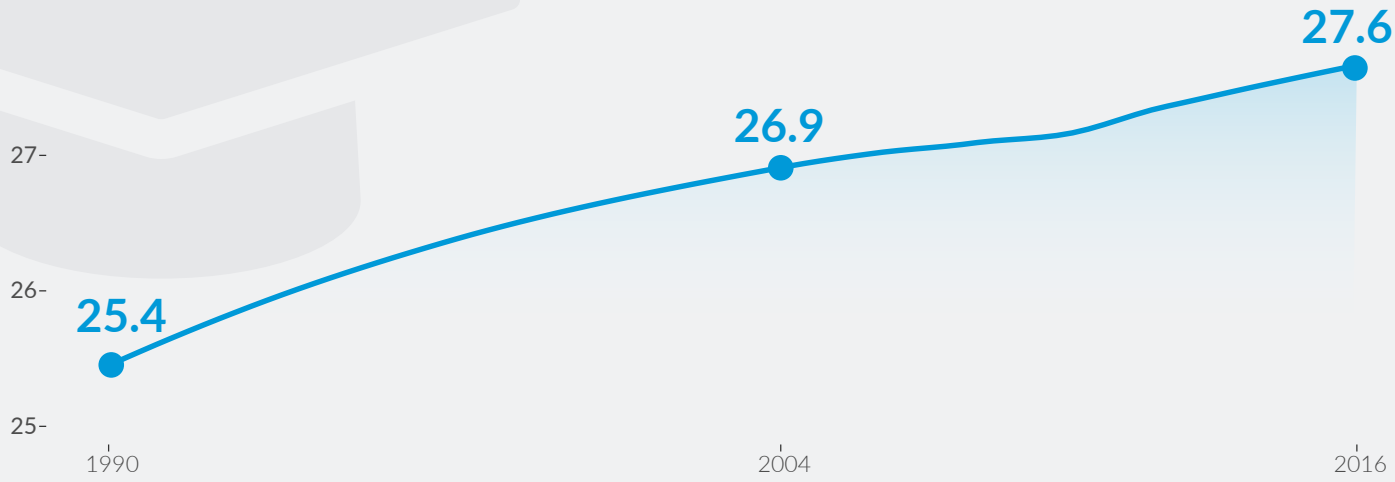


In 1990, most RNs were 31 to 40 years old. The average age of RNs has risen since then. In 2016, equal shares were 31 to 40 years old and 41 to 50 years old.

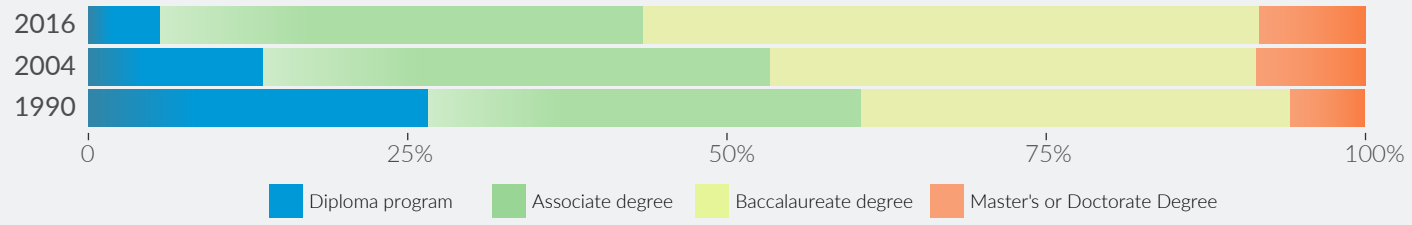
PRE-LICENSURE *EDUCATION*



AVERAGE AGE OF *GRADUATION*

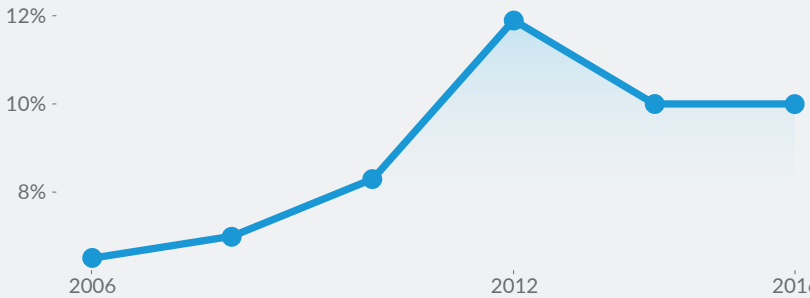


HIGHEST *NURSING DEGREE*



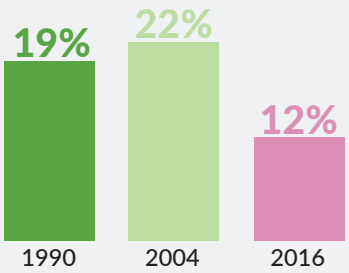
CURRENTLY ENROLLED

IN NURSING DEGREE OR CERTIFICATION PROGRAM



NURSING *JOB TITLES*

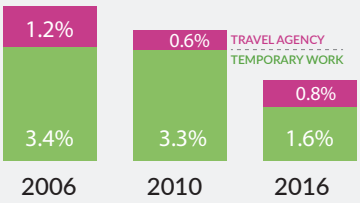
SHARE OF RNs WITH MORE THAN ONE JOB



JOB TITLE	1993	2004	2016	TREND 1993-2016
Staff Nurse/Direct patient care provider	59.5%	53.3%	51.3%	
Charge Nurse	–	–	1.9%	
Staff Nurse and Charge Nurse (both)	–	–	15.6%	
Senior management, any setting	–	–	1.8%	
Senior management, service setting	3.5%	1.7%	–	
Middle management, any setting	–	–	5.4%	
Middle management, service setting	14.5%	6.3%	–	
Front-line management	–	11.1%	2.1%	
Management/Administration, academic setting	0.2%	0.1%	–	
Clinical Nurse Specialist	3.2%	2.3%	0.5%	
Certified Registered Nurse Anesthetist	0.5%	0.4%	0.4%	
Certified Nurse Midwife	0.2%	0.2%	0.2%	
Nurse Practitioner	1.8%	3.6%	3.9%	
Educator, service setting/clinical nurse educator	2.0%	2.0%	–	
Educator, academic setting	1.3%	1.0%	–	
School Nurse	1.2%	1.9%	1.2%	
Public Health Nurse	2.2%	1.7%	1.5%	
Patient care coordinator/case manager	–	–	5.3%	
Discharge Planner	–	0.1%	–	
Case Manager	4.5%	3.9%	–	
QI/Utilization Review Nurse	–	0.7%	1.9%	
Occupational Health Nurse	–	–	0.3%	
Telenursing	–	–	1.0%	
Nurse Coordinator	–	–	–	
Consultant	0.9%	0.7%	–	
Researcher	0.8%	0.6%	0.5%	
Infection Control Nurse	–	–	0.3%	
Clinical Nurse Leader	–	–	0.3%	
Other	3.3%	8.3%	1.4%	

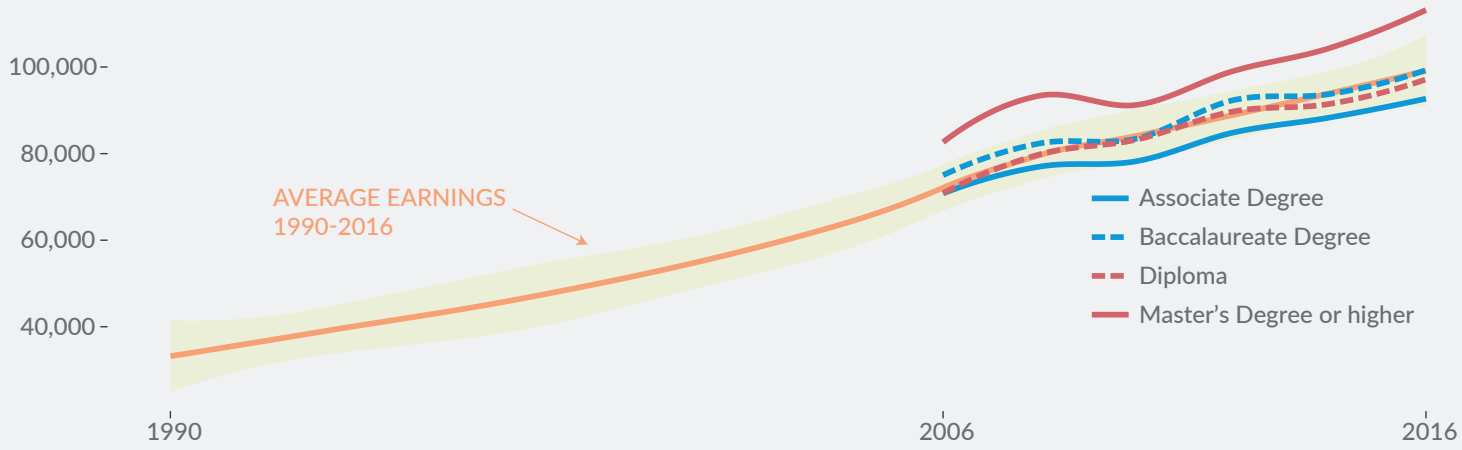
NURSING *WORK SETTING*

SHARE OF RNs IN A TEMPORARY OR TRAVELING JOB

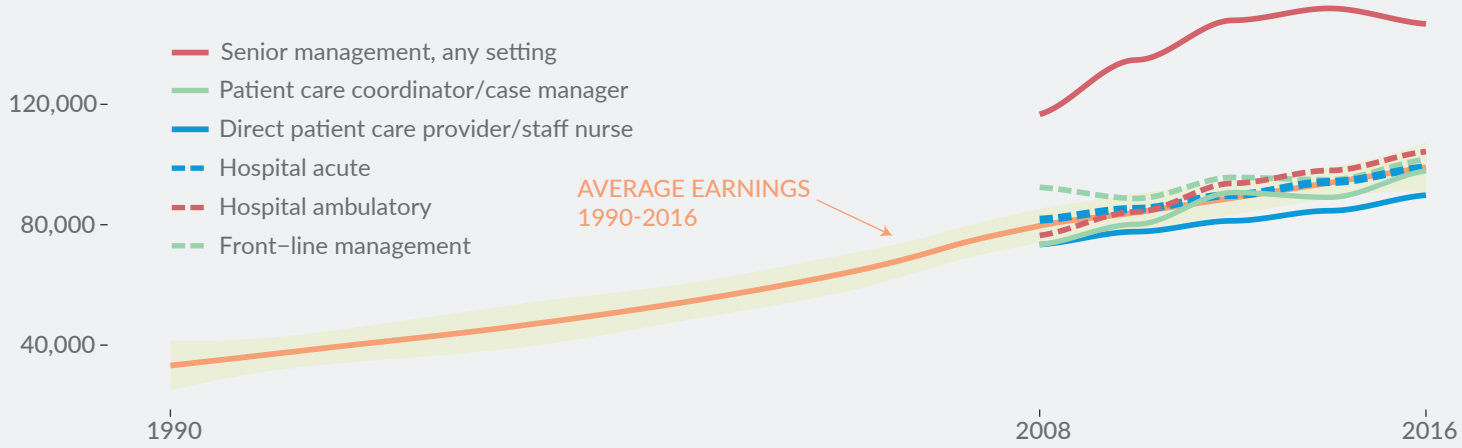


WORK SETTING	1990	2004	2016	TREND 1990-2016
Acute hospital	67.9%	60.9%	66.3%	
Hospital, inpatient or emergency	–	–	56.1%	
Hospital, nursing home unit	–	–	1.1%	
Hospital, ambulatory unit	–	–	8.1%	
Hospital, ancillary unit	–	–	0.5%	
Hospital, other department	–	–	2.1%	
Skilled nursing/extended care/ rehabilitation	5.6%	4.4%	5.1%	
Academic nursing program	1.3%	0.9%	0.9%	
Public health dept/community health agency	3.4%	2.1%	1.4%	
Home health nursing agency/service	3.8%	3.3%	3.4%	
Hospice	–	1.3%	0.3%	
Ambulatory care setting (office, surgery center)	11.8%	10.8%	8.2%	
Dialysis	–	–	1.0%	
Telenursing organization/call center	–	0.6%	0.6%	
Occupational health/employee health	1.5%	0.3%	0.4%	
School health (K-12 or college)	2.1%	2.0%	1.3%	
Mental health/drug and alcohol treatment	–	2.0%	1.6%	
Forensic setting (correctional facility, prison, jail)	–	1.1%	1.5%	
Government agency (local, state, federal)	–	2.7%	0.8%	
Case management/disease management	–	–	2.1%	
Self employed	1.1%	0.8%	0.3%	
Other	1.5%	6.9%	2.5%	

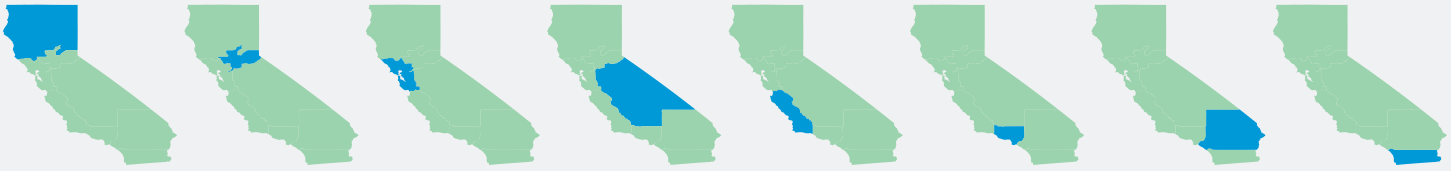
EARNINGS BY *HIGHEST EDUCATION*



EARNINGS BY *WORK SETTING*



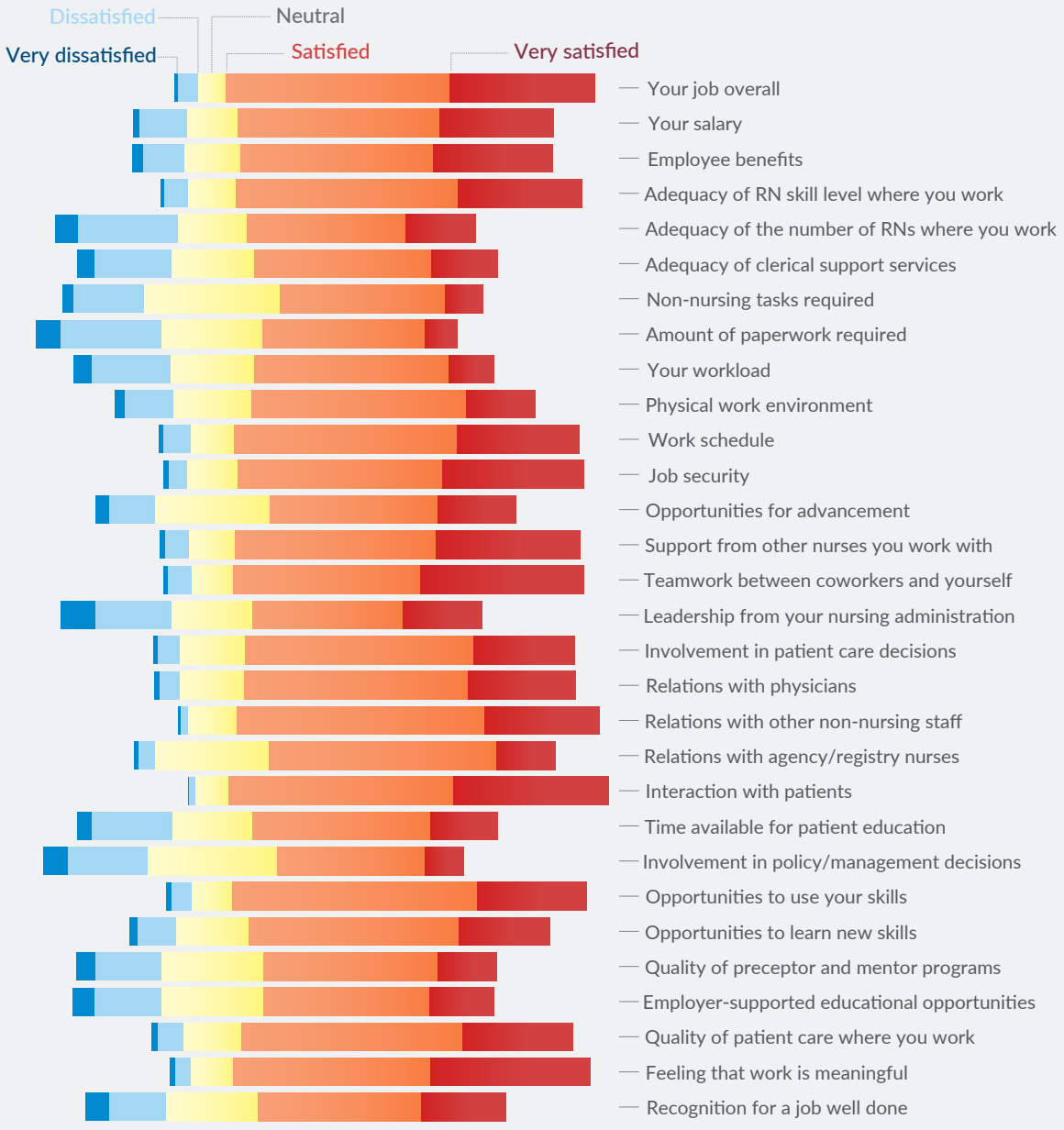
EARNINGS BY *REGION*



NORTHERN REGION		SACRAMENTO		BAY AREA		CENTRAL VALLEY		CENTRAL COAST		LOS ANGELES		INLAND EMPIRE		BORDER COUNTIES	
2006	$60,160	2006	$72,594	2006	$78,319	2006	$65,689	2006	$65,715	2006	$67,207	2006	$66,938	2006	$67,188
2010	$70,763	2010	$82,498	2010	$93,406	2010	$81,973	2010	$76,563	2010	$79,381	2010	$77,913	2010	$76,008
2012	$74,387	2012	$92,732	2012	$98,075	2012	$82,908	2012	$83,096	2012	$85,577	2012	$81,805	2012	$79,842
2014	$82,318	2014	$99,289	2014	$102,539	2014	$89,111	2014	$90,601	2014	$86,261	2014	$84,071	2014	$84,056
2016	$86,777	2016	$106,961	2016	$111,213	2016	$96,026	2016	$90,940	2016	$88,703	2016	$91,025	2016	$89,121

JOB *SATISFACTION* IN 2016

Four of the five aspects of nursing that received the highest average satisfaction ratings in 2016 were the same items receiving the highest ratings in 2014: Interactions with patients, nursing profession overall, feeling that work is meaningful, and job overall. In 2014, the five items with greatest satisfaction also included relations with non-nursing staff (ranked 7th in 2016).



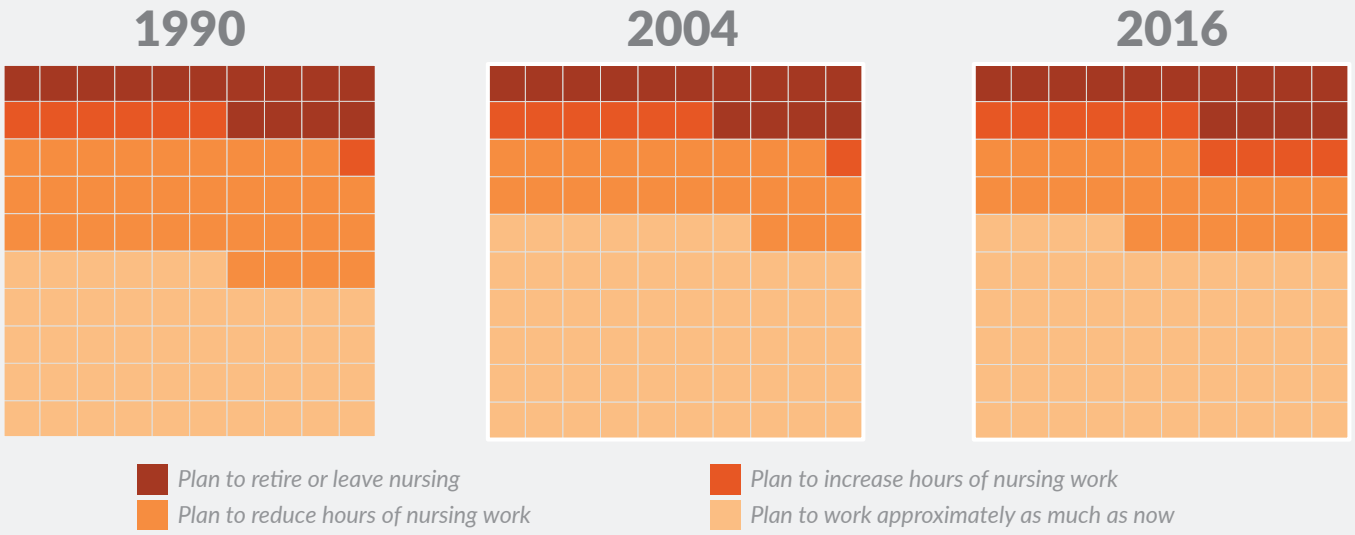
TOP 5

INTERACTION WITH PATIENTS (4.24)
NURSING PROFESSION OVERALL (4.21)
FEELING THAT WORK IS MEANINGFUL (4.16)
YOUR JOB OVERALL (4.15)
TEAMWORK (4.14)

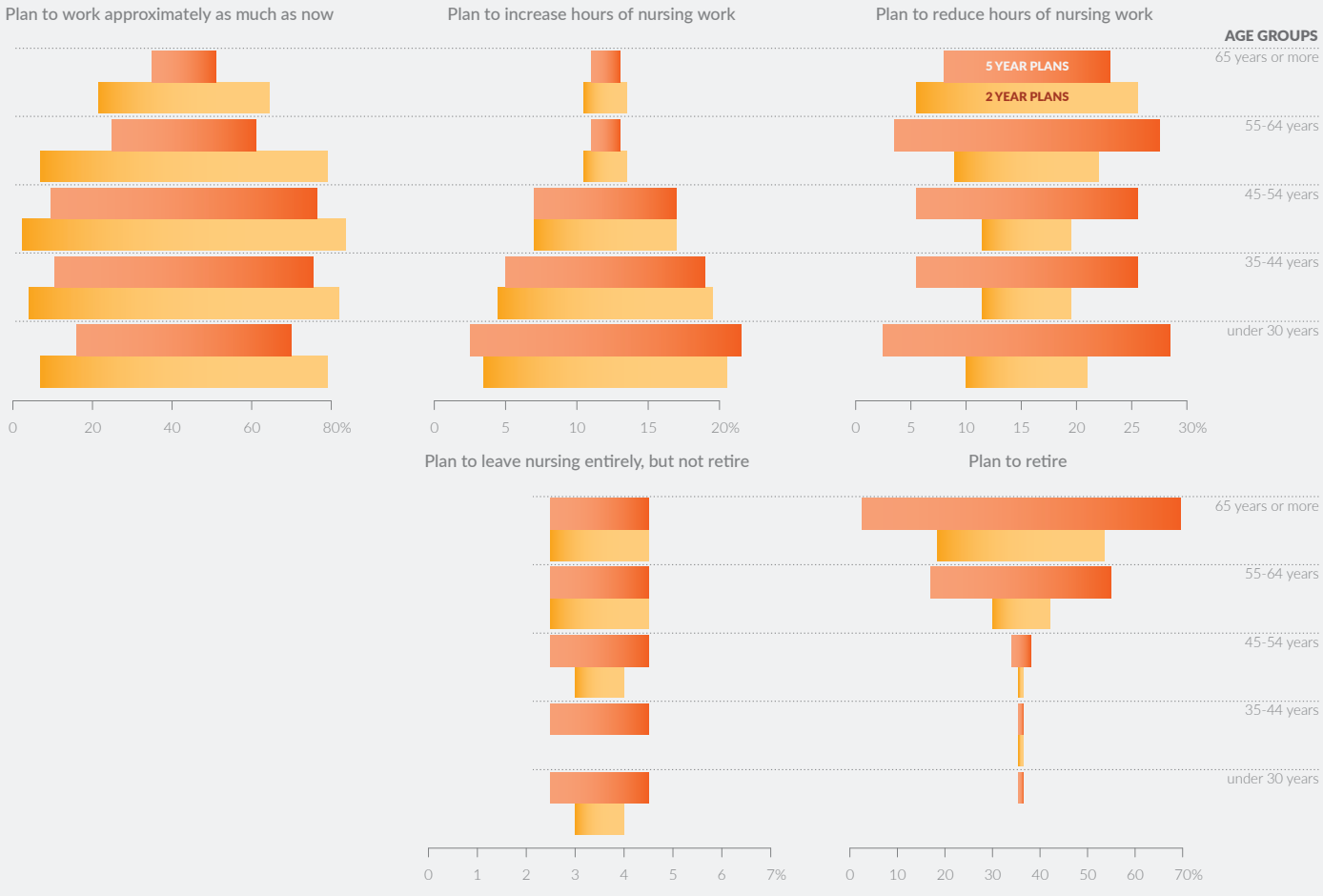
BOTTOM 5

AMOUNT OF PAPERWORK REQUIRED (3.18)
INVOLVEMENT IN POLICY AND MANAGEMENT DECISIONS (3.23)
NON-NURSING TASKS REQUIRED (3.35)
ADEQUACY OF THE NUMBER OF RN STAFF (3.37)
LEADERSHIP FROM NURSING ADMINISTRATION (3.39)

EMPLOYMENT PLANS IN *5 YEARS*



EMPLOYMENT PLANS IN *2 YEARS* AND *5 YEARS* — BY AGE GROUP (2016)



2016 California BRN Survey of Registered Nurses Published

The California Board of Registered Nursing has published the results of the 2016 Survey of Registered Nurses. The full report is available on their website, **www.rn.ca.gov**. The report highlights some of the changes occurring in the RN workforce in CA, including the following:

- 86.2% of RNs with a CA license and living in the state are employed in nursing. This percentage is up slightly from two years ago, when 83.4% were employed in nursing, and is indicative of high employment rates within the profession.
- The mean age of working RNs in CA is 45 years, as compared with 46.7 years in 2014. This indicates the RN workforce is getting younger and is close to the mean age of 44.6 years twenty years ago.
- Gender diversity is slowly creeping up with 11.9% of the workforce being male. This compares with 10.5% ten years ago.
- The racial ethnic diversity of the RN workforce continues to grow, with only 49% of RNs now identifying as White/not Hispanic (versus 62% ten years ago). Hispanic RNs now make up 8.5% of the RN workforce (versus 5.7% ten years ago), Black/African American RNs are 4.1% (versus 4.6% ten years ago), and Filipino/Asian RNs comprise 28.4% of the workforce (versus 24.3% ten years ago).
- 56.6% of currently working RNs hold a BSN-or-higher degree, as compared with 52.1% ten years ago.
- 56.1% of RNs work in hospital in-patient or emergency departments, another 11.8% work in hospital non-acute care departments, and 30.1% work in community based settings.
- 11.7% of working RNs hold more than one nursing position – the lowest percentage since 1990.
- The mean annual income for all nursing positions filled by currently working RNs residing in CA is $99,008.
- 14.5% of working RNs expect to retire or leave nursing employment in the next five years. Of those who are over 55, 47.9% plan to retire/leave nursing in the next five years (this percentage increases to 67.9% for RNs 65 years and older).

Paying attention to trends in the nursing workforce is a critical aspect of workforce planning for the future. It is gratifying to see that the RN workforce is getting younger and we can anticipate the currently employed population continuing in the workforce for longer periods of time. Conversely, the large percentage of RNs who are 55 and older planning to retire in the next five years will create a significant loss of wisdom in the workforce, and it would behoove us to develop new roles for this cohort to entice them to continue to contribute in meaningful ways. We're also noticing that a large percentage of RNs practice outside of acute care environments in CA. This is a significant shift: nursing education has traditionally depended largely on acute care settings for student clinical experience, but that may need to change in the future.

Submitted by Judee Berg, MS, RN, FACHE

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

January 17, 2017

TO: CHA CNO Advisory Committee

FROM: Debby Rogers, RN, MS, FAEN, Vice President, Clinical Performance and Transformation

SUBJECT: NHSN Antibiotic Use Module

CDPH Health Care Associated Infection Supporting NHSN AU Module

California law requires hospitals to adopt and implement an antimicrobial stewardship policy in accordance with guidelines established by the federal government and professional organizations. The CDC Core Elements of Hospital Antibiotic Stewardship Programs recommend tracking antibiotic use to identify opportunities for improvement and assess the impact of antimicrobial stewardship efforts. The Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) supports an Antibiotic Use (AU) surveillance option to provide a mechanism for hospitals to track and analyze their antibiotic use data and compare to other U.S. hospitals. Benchmarking to national risk-adjusted data has been helpful in reducing hospital-acquired infections and may play an important role in antimicrobial stewardship.

To provide support to California hospitals for meeting this mandate, the California Department of Public Health (CDPH) Healthcare-Associated Infections (HAI) Program is offering health informatics technical assistance and training to hospitals interested in implementing the NHSN AU option. To learn more about available resources, please email the HAI Program at haiprogram@cdph.ca.gov.

DR:br

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

January 17, 2018

TO: CNO Advisory Committee Members

FROM: BJ Bartleson, MS, RN, NEA-BC, Vice President, Nursing and Clinical Services

SUBJECT: Nursing Community Coalition

SUMMARY

For over a decade, the Nursing Community Coalition has been a partnership of national professional nursing associations that builds consensus and advocates on a wide spectrum of healthcare issues. Collectively, the Nursing Community is comprised of 58 national nursing organizations that represent the cross section of education, practice, research, and regulation within the profession. With over four million licensed registered nurses, advanced practice registered nurses, and nursing students, the profession embodies the drive and passion to continually improve care for patients, families, and communities across the continuum.

DISCUSSION

1. How does nursing policy and advocacy take place in California? By Whom?
2. Are all nursing issues represented?
3. How does nursing professional practice policy change in response to health care reform?
4. Would a statewide nursing community composed of nursing organizations and other community partners be beneficial?

ACTION REQUESTED

- *Committee discussion*

Attached: Nursing Community Coalition
Response to AMA's Latest Strategy that Would Reverse Access to Care

BJB:br

About Us

NURSING COMMUNITY COALITION

58 MEMBER ORGANIZATIONS

ESTABLISHED IN 2009

For over a decade, the Nursing Community Coalition has been a partnership of national professional nursing associations that builds consensus and advocates on a wide spectrum of healthcare issues. Collectively, the Nursing Community is comprised of 58 national nursing organizations that represent the cross section of education, practice, research, and regulation within the profession. With over four million licensed registered nurses, advanced practice registered nurses, and nursing students, the profession embodies the drive and passion to continually improve care for patients, families, and communities across the continuum.

The Nursing Community Coalition supports the following core principles:

- A robust and diverse nursing workforce is essential to the health of all Americans.
- Nurses are an integral part of the healthcare team, are involved in every aspect of care delivery, and are committed to the patient, their families, the community, and the nation.
- The contributions made by the practice and science of nursing are critical to the delivery of high quality, life-saving, preventive, and palliative health care across all care settings, geographic areas, and social determinants of health.
- The services RNs and APRNs provide are linked directly to the availability, cost, and quality of healthcare services.
- Affordable, accessible, high-quality health care and improved health outcomes depend upon a model of care that is patient-centered and comprehensive. This can only be achieved through the full complement of expertise gained from broad-based, inter-professional partnerships of physicians, nurses and other health professionals.
- Nursing's involvement is essential to the development of new healthcare information technology infrastructure. Nursing data are key to identifying patient outcomes and required improvements in the delivery of patient care.

Since the Start of the 115th Congress

22 LETTERS WRITTEN TO CONGRESS • 4 CONGRESSIONAL EVENTS • 13 LETTERS WRITTEN TO THE ADMINISTRATION

To review the efforts of the Nursing Community Coalition, visit: http://www.thenursingcommunity.org.

NURSING COMMUNITY COALITION

Major Policy and Legislative Highlights

SINCE JANUARY 2017

The Nursing Community Coalition has supported the following pieces of legislation during the 115th Congress:

- H.R. 959, S. 1109: Title VIII Nursing Workforce Reauthorization Act of 2017
- S. 445, H.R. 1825: Home Health Care Planning Improvement Act of 2017
- H.R. 3692: Addiction Treatment Access Improvement Act of 2017

The Nursing Community Coalition has submitted testimony to committees on the following issues during the 115th Congress:

- House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies to request $244 million for the Title VIII Nursing Workforce Development Programs and $160 million for the National Institute of Nursing Research for FY 2018.
- Senate Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies to request $244 million for the Title VIII Nursing Workforce Development Programs and $160 million for the National Institute of Nursing Research for FY 2018.

The Nursing Community Coalition has submitted comments on the following issues since the beginning of the 115th Congress:

- U.S. Department of Veterans Affairs' final rule published on December 14, 2016 (Federal Register Document Number 2016-12338, RIN 2900-AP44) regarding Advanced Practice Registered Nurses' (APRNs) clinical practice within the Veteran's Health Administration.
- U.S. Department of Health and Human Services' Draft Strategic Plan for FY 2018 to FY 2022.
- U.S. Department of Veterans Affairs' proposed rule published on October 2, 2017 that would expand telehealth services within the Veteran's Health Administration.

The Nursing Community Coalition has distributed four statements on health reform during the 115th Congress.

- January 19, 2017: Letter to Congressional Leadership on Health Reform
- January 27, 2017: Letter to Congressional Leadership Outlining Health Priorities
- February 15, 2017: Letter to HHS Secretary Tom Price on Health Reform
- June 22, 2017: Statement to Senators to Commit to America's Health

The Nursing Community Coalition has hosted events on the following topics:

- *Transforming Health and Health Care: Nursing Workforce* hosted on May 9, 2017 featured nursing experts who shared insights on how the profession is meeting the healthcare needs of the nation and preparing for future demand.
- *Transforming Health and Health Care: Nursing Research* hosted on May 11, 2017 featured nursing experts who discussed the contributions of nursing science as it relates to care across the continuum.
- *Future of Nursing: Campaign for Action* cohosted with the Robert Wood Johnson Foundation and the AARP Foundation on September 20, 2017 featured experts working to implement recommendations from the Institute of Medicine report on the future of nursing.
- *The Opioids Crisis: Nursing Practices that Save Lives* hosted on December 7, 2017 featured nursing experts who shared insights and offered solutions to the opioids epidemic facing the country.

Nursing Community Coalition Responds to the American Medical Association's Latest Strategy that Would Reverse Access to Care

November 29, 2017−The Nursing Community Coalition (NCC) is disappointed by the American Medical Association's (AMA) recent call for action that has the potential to impede access to care by qualified providers and complicates aspects of an interprofessional, team-based approach. Specifically, at AMA's recent House of Delegates Interim meeting, the association adopted an amended resolution to create a national strategy to obstruct state and national policies that would allow "non-physician" providers, including Advanced Practice Registered Nurses (APRNs), from practicing to the full extent of their education, clinical training, and certification. The coalition firmly believes in the value added to the patient, family, and community through the delivery of care from all providers practicing to the top of their licensure.

The Institute of Medicine (currently the National Academy of Medicine) calls for the removal of barriers that prevent APRNs from full practice authority in its pinnacle report *Future of Nursing: Leading Change, Advancing Health*.[1] This has served as the platform for widespread efforts to examine scope of practice policies for nearly eight years by stakeholders both within and outside of professional nursing. Additionally, the Federal Trade Commission has urged states to review laws and regulations that stifle competition in the healthcare sector, as these impose unnecessary and burdensome restrictions on APRN practice, which can negatively affect patients.[2]

The Nursing Community Coalition firmly believes we must work together to put patients first.

American Academy of Ambulatory Care Nursing
American Academy of Nursing
American Association of Colleges of Nursing
American Association of Critical-Care Nurses
American Association of Heart Failure Nurses
American Association of Neuroscience Nurses
American Association of Nurse Anesthetists
American Association of Nurse Practitioners
American College of Nurse-Midwives
American Nephrology Nurses Association
American Nurses Association

For any inquiries, please contact Dr. Suzanne Miyamoto, Executive Director of the Nursing Community Coalition at smiyamoto@aacnnursing.org.

[1] Institute of Medicine. (2010). Future of Nursing: Leading Change, Advancing Health. Retrieved from: http://www.nationalacademies.org/hmd/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx.
[2] Federal Trade Commission. (2014). Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses. Retrieved from: http://www.aacnnursing.org/Portals/42/Policy/PDF/APRN-Policy-Paper.pdf.

American Nursing Informatics Association
American Organization of Nurse Executives
American Pediatric Surgical Nurses Association
American Psychiatric Nurses Association
American Society for Pain Management Nursing
American Society of PeriAnesthesia Nurses
Association of Community Health Nursing Educators
Association of Nurses in AIDS Care
Association of Pediatric Hematology/Oncology Nurses
Association of periOperative Registered Nurses
Association of Public Health Nurses
Association of Veterans Affairs Nurse Anesthetists
Association of Women's Health, Obstetric and Neonatal Nurses
Dermatology Nurses' Association
Emergency Nurses Association
Friends of the National Institute of Nursing Research
Gerontological Advanced Practice Nurses Association
Hospice and Palliative Nurses Association
International Association of Forensic Nurses
International Society of Psychiatric-Mental Health Nurses
National Association of Clinical Nurse Specialists
National Association of Neonatal Nurse Practitioners
National Association of Neonatal Nurses
National Association of Nurse Practitioners in Women's Health
National Association of Pediatric Nurse Practitioners
National Black Nurses Association
National Council of State Boards of Nursing
National Forum of State Nursing Workforce Centers
National League for Nursing
National Nurse-Led Care Consortium
National Organization of Nurse Practitioner Faculties
Nurses Organization of Veterans Affairs
Oncology Nursing Society
Organization for Associate Degree Nursing
Pediatric Endocrinology Nursing Society
Society of Pediatric Nurses

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

January 17, 2018

TO: CNO Advisory Committee Members

FROM: Debby Rogers, MS, RN, FAEN, Vice President, Clinical Performance and Transformation

SUBJECT: Dialysis Initiative

SUMMARY

The State Legislature is deliberating two bills that address staffing, quality and financing of chronic dialysis clinics. These bills are sponsored by unions representing healthcare workers. SB 349 (Lara) would require chronic dialysis clinics to impose minimum staffing ratios that would decrease the number of patients a nurse or technician could care for. The proposal would also increase state inspections of dialysis facilities and would require a 45-minute transition time between patients. AB 251 (Bonta) would require a chronic dialysis clinic, if its direct patient care services costs, health care quality improvements costs, federal and state taxes, and facility license fees total less than 85 percent of the treatment revenue, to issue a rebate and reduction in billed amount to payers on a pro rata basis. CHA remains strongly opposed to both measures. Neither measure reached the Governor's desk in 2017, but may move in 2018.

The Service Employees International Union – United Healthcare Workers West has filed a ballot initiative — the Kidney Dialysis Patient Protection Act — with the attorney general for the 2018 General Election. The initiative would establish minimum staffing requirements for nurses, hemodialysis technicians, social workers and registered dietitians in chronic dialysis clinics. In addition, it would create a minimum transition time between patients and limit charges to 115 percent of "reasonable treatment cost," as defined in the initiative. The initiative would also establish reporting requirements and penalties for violations. Although the initiative aims to impose these provisions on for-profit dialysis corporations, some hospitals that operate chronic dialysis clinics may also be impacted. The initiative's sponsors must collect and submit an estimated 366,000 verified signatures in April 2018 to qualify the initiative for the Nov. 6, 2018, General Election. CHA is working with a coalition of providers, led by end stage renal disease clinics, to oppose this initiative, should it qualify for the ballot.

DISCUSSION

1. Does your hospital(s) provide outpatient chronic dialysis services?
2. If so, how is that service licensed?

ACTION REQUESTED

- *Committee discussion*

Attached: Dialysis Ballot Initiative
Senate Floor Alert – AB 251 (Bonta)
Assembly Floor Alert – SB 349 (Lara)

DR:br

This initiative measure is submitted to the people in accordance with the provisions of Article II, Section 8, of the California Constitution.

This initiative measure amends and adds sections to the Health and Safety Code; therefore, existing provisions proposed to be deleted are printed in ~~strikeout~~ type and new provisions proposed to be added are printed in *italic* type to indicate that they are new.

SEC. 1. Name

This act shall be known as the "Kidney Dialysis Patient Protection Act."

SEC. 2. Findings and Purposes

A. The People make the following findings:

(1) Kidney dialysis is a process where blood is cleaned of waste and excess water, usually through a machine outside the patient's body, and then returned to the patient. If someone who needs dialysis cannot obtain or afford high quality care, toxins build up in the body, leading to death.

(2) In California, at least 66,000 Californians undergo dialysis treatment.

(3) Just two multinational, for-profit corporations operate or manage nearly three-quarters of dialysis clinics in California and treat almost 70 percent of dialysis patients in California. These two multinational corporations annually earn billions of dollars from their dialysis operations, including almost $400 million each year in California alone.

(4) Because federal law mandates private health insurance companies offer and pay for dialysis, private insurance companies have little ability to bargain with the two multinational dialysis corporations on behalf of their customers.

(5) Thus, for-profit dialysis corporations charge patients with private health insurance four times as much as they charge Medicare for the very same dialysis treatment, resulting in vast profits.

(6) In a market dominated by just two multinational corporations, California must ensure that dialysis is fairly priced and affordable.

(7) Other states have taken steps to protect these very vulnerable patients from these two multinational corporations, including by enacting common sense protections such as minimum staffing requirements.

(8) Current staffing levels in dialysis clinics in California are possibly dangerous and are inadequate to protect patient health against avoidable deaths, hospitalizations, infections, and medication errors.

(9) Efforts to enact protections for kidney dialysis patients in California have been stymied in Sacramento by the dialysis corporations, which spent over $600,000 in just the first six months of 2017 to influence the California Legislature.

B. Purposes:

(1) It is the purpose of this Act to ensure that outpatient kidney dialysis clinics provide quality and affordable patient care to people suffering from end stage renal disease.

(2) This Act is intended to be budget neutral for the State to implement and administer.

SEC. 3. Section 1226.4 is added to the Health and Safety Code, to read:

1226.4 (a) Minimum staffing requirements.

(1) A chronic dialysis clinic shall ensure that the following minimum staffing ratios are met at all times that patients are receiving, or preparing to receive, direct clinic care:

(A) At least one nurse is providing direct clinic care for every eight patients. A nurse shall only count toward this ratio during time periods the nurse has no responsibilities other than direct clinic care. A nurse manager or charge nurse shall not count toward the nurse-to-patient ratio.

(B) At least one hemodialysis technician is providing direct clinic care for every three patients. A hemodialysis technician shall only count toward this ratio during time periods the hemodialysis technician has no responsibilities other than direct clinic care. Hemodialysis technician trainees shall not count toward this ratio. Nurses counted toward the nurse-to-patient ratio shall not count toward the hemodialysis technician-to-patient ratio.

(2) A chronic dialysis clinic shall ensure that no more than 75 patients per full-time equivalent schedule are assigned at any time to any individual social worker and to any individual registered dietitian, regardless of the location where patient care is provided.

(3) The ratios described in paragraphs (1) and (2) shall constitute the minimum number of nurses, hemodialysis technicians, social workers, and registered dietitians assigned to patients. Additional nurses, hemodialysis technicians, social workers, and registered dietitians shall be assigned to the extent necessary to ensure that the patient-to-staff ratio is appropriate to the level of dialysis care given and meets the needs of patients.

(4) A chronic dialysis clinic shall ensure that the transition time between patients at a treatment station is no shorter than 45 minutes, provided that the department may by regulation set a minimum transition time other than 45 minutes if such modification is supported by changes in available clinical evidence regarding minimum transition times necessary to ensure safety and hygiene protocols in chronic dialysis clinics, including but not limited to changes in recommendations from the Centers for Disease Control and Prevention regarding standard hygiene practices.

(5) The requirements of this subdivision shall take effect on March 31, 2019.

(b) Inspections for safety and hygiene.

The department shall inspect each chronic dialysis clinic for which a license has been issued at least once per year, and shall conduct such inspections as often as necessary to ensure the existence of and compliance with adequate hygiene and sanitation protocols, compliance with this chapter, and the adequacy of the quality of care being provided.

(c) Licensing, recordkeeping, and reporting.

(1) It shall be a condition of licensure that a chronic dialysis clinic comply with this section, and the department shall not renew, transfer, or extend any license issued to a chronic dialysis clinic except upon a showing that the chronic dialysis clinic complies with the requirements of subdivision (a). The department shall not issue a license to any new chronic dialysis clinic unless that chronic dialysis clinic demonstrates the ability and intention to comply with the requirements of subdivision (a).

(2) Every chronic dialysis clinic for which a license has been issued shall maintain, and provide to the department on a form prescribed by the department, at a minimum, the following information:

(A) Actual staffing ratio and transition time data for the period covered by the submission, which shall include, at a minimum, daily totals of the total number and actual hours worked by nurses and hemodialysis technicians; the total number of patients and actual hours receiving direct clinic care; the daily average transition time for each treatment station; and, for each week, the total number of full-time equivalent social workers and registered dietitians and the total number of patients assigned to social workers and registered dietitians.

(B) Every instance, no matter how brief, during the period covered by the submission when staffing ratios or transition times did not satisfy the requirements of subdivision (a), and the reasons and circumstances therefor.

(3) The chief executive officer or administrator of the chronic dialysis clinic shall both certify under penalty of perjury that each of them is satisfied, after review, that all information submitted pursuant to paragraph (2) is accurate and complete.

(4) The chronic dialysis clinic shall periodically submit such information described in paragraph (2) to the department on a schedule and in a format prescribed by the department, provided that the clinic shall submit that information no less frequently than four times per year.

(d) Complaints and patient rights.

(1) Within 60 days of receiving a complaint from a patient, an association of patients, a family member of a patient, an employee, an association of employees, a vendor, or a contractor, of a chronic dialysis clinic that the chronic dialysis clinic has committed a violation of the requirements of this chapter, the department shall investigate the chronic dialysis clinic and, if the evidence shows a violation has occurred, the department shall impose discipline pursuant to Section 1240.1.

(2) To ensure that all health care workers of chronic dialysis clinics are entitled to whistleblower protections, Section 1278.5's protections shall apply to chronic dialysis clinics,

and to the extent of that application, references in Section 1278.5 to a health facility shall be deemed to be references to a chronic dialysis clinic, subject to paragraph (3).

(3) Notwithstanding Section 1417.2, moneys collected under paragraph (3) of subdivision (b) of Section 1278.5 from a chronic dialysis clinic shall be distributed to the department to implement and enforce laws governing chronic dialysis clinics.

(e) Protection of confidential information.

(1) The department shall redact from any writing, record, or document that is a public record within the meaning of subdivision (e) of Section 6252 of the Government Code all personal identifying or confidential information associated with any named individuals, including patients, to the extent required to prevent an unwarranted invasion of personal privacy, as that term is used in subdivision (c) of Section 6254 of the Government Code, but the department shall not withhold any such writing, record, or document in its entirety under subdivision (c) of Section 6254 of the Government Code.

(2) Information required to be submitted under subdivision (c), and complaints submitted under subdivision (d), shall not be withheld on the basis of subdivision (f) of Section 6254 of the Government Code.

(f) Definitions.

For purposes of this section:

(1) "At all times" includes times during which clinic personnel, including but not limited to nurses or hemodialysis technicians, are provided meal periods and rest or other breaks. No clinic personnel may be counted toward the required ratios during times they are taking such breaks or meal periods.

(2) "Charge nurse" means a charge nurse as described in Section 494.140(b)(3) of Title 42 of the Code of Federal Regulations as it read on December 31, 2016.

(3) "Direct clinic care" means initiating and discontinuing dialysis, monitoring patients during treatment, and administering medications, and physical presence in the immediate area where patients are dialyzed.

(4) "Full-time equivalent" means employment by a chronic dialysis clinic for 2,080 hours of work in 12 consecutive months.

(5) "Nurse" means a registered nurse licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code.

(6) "Nurse manager" means a nurse manager as described in Section 494.140(b)(1) of Title 42 of the Code of Federal Regulations as it read on December 31, 2016.

(7) "Registered dietitian" means a dietitian as described in Section 494.140(c) of Title 42 of the Code of Federal Regulations as it read on December 31, 2016.

(8) "Social worker" means a social worker as described in Section 494.140(d) of Title 42 of the Code of Federal Regulations as it read on December 31, 2016.

(9) "Hemodialysis technician" means a person who holds both of the following qualifications:

(A) The person is a patient care dialysis technician, as described in Section 494.140(e) of Title 42 of the Code of Federal Regulations as it read on December 31, 2016.

(B) The person is a Certified Hemodialysis Technician certified pursuant to Article 3.5 (commencing with Section 1247) of Chapter 3 of Division 2 of the Business and Professions Code.

(10) "Hemodialysis technician trainee" means a person who is undergoing training to become a hemodialysis technician, but who has not yet been certified as a Certified Hemodialysis Technician pursuant to Article 3.5 (commencing with Section 1247) of Chapter 3 of Division 2 of the Business and Professions Code.

(11) "Transition time" means the period of time beginning when one patient leaves a treatment station and ending when the next patient is placed in the treatment station, but does not mean the period of time after the last patient of the day leaves the treatment station.

(12) "Treatment station" means a physical location within a chronic dialysis clinic where an individual patient is dialyzed.

SEC. 4. Section 1240.1 is added to the Health and Safety Code, to read:

1240.1 (a) The director may assess an administrative penalty against a chronic dialysis clinic for a violation of this chapter. Each penalty issued pursuant to this chapter shall be classified as a major violation, an intermediate violation, or a minor violation based on the nature of the violation and the threat of harm to patients. A major violation shall be subject to an administrative penalty of up to one hundred thousand dollars ($100,000), an intermediate violation shall be subject to an administrative penalty of up to twenty thousand dollars ($20,000), and a minor violation shall be subject to an administrative penalty of up to two thousand dollars ($2,000).

(b) The department shall promulgate regulations establishing the criteria to assess an administrative penalty against a chronic dialysis clinic, which shall include, but not be limited to, consideration of all of the following:

(1) The probability and severity of the risk that the violation presents to the patient.

(2) The actual harm to patients, if any.

(3) The nature, scope, and severity of the violation.

(4) The chronic dialysis clinic's history of compliance with related state and federal statutes and regulations, including, but not limited to, the similarity in circumstances of the violation to any previous violation by the chronic dialysis clinic within a 24-month period.

(5) Factors beyond the control of the chronic dialysis clinic that restrict its ability to comply with this chapter or the rules and regulations promulgated thereunder.

(6) The demonstrated willfulness of the violation.

(7) The extent to which the chronic dialysis clinic detected the violation and took immediate action to correct the violation and to prevent that type of violation from recurring.

(c) If a chronic dialysis clinic disputes a determination by the director regarding an alleged deficiency or failure to correct a deficiency, or the reasonableness of a proposed deadline for correction of a violation or an amount of an administrative penalty, the chronic dialysis clinic may, within 10 working days, request a hearing pursuant to Section 131071. A chronic dialysis clinic shall pay all administrative penalties when all appeals have been exhausted and the department's position has been upheld.

(d) For purposes of Article 9 (commencing with Section 12650) of Chapter 6 of Part 2 of Division 3 of Title 2 of the Government Code, the information required to be provided under subdivision (c) of Section 1226.4 shall be deemed material to any claim for payment submitted by a chronic dialysis clinic within twelve months of the submission of information.

SEC. 5. Section 1240.2 is added to the Health and Safety Code, to read:

1240.2. (a) Subject to subdivision (d), prior to the effective date of regulations adopted to implement Section 1240.1, if a chronic dialysis clinic receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an administrative penalty of up to one hundred thousand dollars ($100,000). In determining the amount of the penalty, the department shall consider the severity and duration of the immediate jeopardy and the extent to which the conduct causing the immediate jeopardy could have been avoided.

(b) If a licensee disputes a determination by the department regarding an alleged deficiency or the alleged failure to correct a deficiency, or regarding the reasonableness of the proposed deadline for correction or the amount of the penalty, the licensee may, within 10 days, request an administrative hearing pursuant to Section 131071. Penalties shall be paid when appeals have been exhausted and if the department's position has been upheld.

(c) For purposes of this section "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to one or more patients.

(d) This section shall only apply to incidents occurring on or after January 1, 2018, except that this section shall only apply to violations of subdivision (a) of Section 1226.4 occurring on or after March 31, 2019.

(e) Notwithstanding Section 11 of the act that added this section, new regulations are not required or authorized for implementation of this section.

(f) This section shall become inoperative on the effective date of regulations promulgated by the department pursuant to Section 1240.1.

SEC. 6. Section 1226.7 is added to the Health and Safety Code, to read:

1226.7 (a) Reasonable limits on charges for patient care by chronic dialysis clinics; rebates and refunds for amounts charged in excess of fair treatment cost.

(1) For purposes of this section, the fair treatment payment amount shall be an amount equal to 115 percent of the sum of the reasonable treatment cost and the pro rata health care quality improvement cost.

(2) For each fiscal year starting on or after January 1, 2019, a chronic dialysis clinic shall annually issue a rebate to a payer (other than Medicare or any other federal, state, county, city, or other local government payer) for any amount paid in excess of the fair treatment payment amount, and reduce and reissue invoices to a payer for any amount billed, but not yet paid, in excess of the fair treatment payment amount, as follows:

(A) The chronic dialysis clinic shall issue the rebate or reduction in billed amount no later than 210 days after the end of the fiscal year to which the rebate or reduction relates.

(B) Where a rebate must be paid or an amount billed but not yet paid must be reduced pursuant to this section, and more than one payer is responsible, the clinic shall divide and distribute the total required rebate or reduction in billed amounts among the payers consistent with the payers' relative obligations to pay for the treatment.

(C) For each fiscal year starting on or after January 1, 2020, any rebate issued to a payer shall be issued together with interest thereon at the rate of interest specified in subdivision (b) of Section 3289 of the Civil Code, which shall accrue from the date of payment by the payer.

(3) For each fiscal year starting on or after January 1, 2019, a chronic dialysis clinic shall maintain and provide to the department, on a form and schedule prescribed by the department, a report of all rebates and reductions it issued under paragraph (2), including a description of each instance during the period covered by the submission when the rebate or reduction required under paragraph (2) was not timely issued in full, and the reasons and circumstances therefor. The chief executive officer or administrator of the chronic dialysis clinic shall certify under penalty of perjury that he or she is satisfied, after review, that all information submitted to the department under this paragraph is accurate and complete.

(4) In the event a chronic dialysis clinic is required to issue a rebate or reduction in amount billed under this section, no later than 210 days after the end of its fiscal year the chronic dialysis clinic shall pay a penalty to the department in an amount equal to five percent of the total required rebate or reduction, provided that the penalty shall not exceed one hundred thousand dollars ($100,000). Penalties collected pursuant to this paragraph shall be used by the department to implement and enforce laws governing chronic dialysis clinics.

(5) If a chronic dialysis clinic or governing entity disputes a determination by the department to assess a penalty, or the amount of an administrative penalty, the chronic dialysis clinic or governing entity may, within 10 working days, request a hearing pursuant to Section 131071. A chronic dialysis clinic or governing entity shall pay all administrative penalties when all appeals have been exhausted and the department's position has been upheld.

(6) If a chronic dialysis clinic proves in any court action that application of this section to the chronic dialysis clinic will, in any particular fiscal year, violate due process or effect a taking of private property requiring just compensation under the Constitution of this State or the Constitution of the United States, the subdivision or subdivisions at issue shall apply to the chronic dialysis clinic, except that as to the fiscal year in question the number "115" whenever it appears in the subdivision or subdivisions at issue shall be replaced by the lowest possible whole number such that application of the subdivision or subdivisions to the chronic dialysis clinic will not violate due process or effect a taking of private property requiring just compensation. In any civil action, the burden shall be on the chronic dialysis clinic to propose a replacement number and to prove that replacing "115" with any whole number lower than the proposed replacement number would, for the fiscal year in question, violate due process or effect a taking of private property requiring just compensation.

(b) Compliance reporting by chronic dialysis clinics.

(1) For each fiscal year starting on or after January 1, 2019, a chronic dialysis clinic's governing entity shall maintain and submit to the department a report concerning the following information for all of the chronic dialysis clinics the governing entity owns or operates in California—

(A) the number of treatments performed;

(B) direct patient care services costs;

(C) the reasonable treatment cost;

(D) health care quality improvement costs;

(E) the pro rata health care quality improvement cost;

(F) the fair treatment payment amount;

(G) for each treatment—

(i) the name and location of the chronic dialysis clinic providing the treatment;

(ii) a unique identifier for the patient that does not reveal the name or identity of the patient;

(iii) each payer, and the total amount billed to and received from each payer; and

(iv) the amount, if any, by which the total amount identified under subparagraph (iii) exceeds the fair treatment payment amount.

(2) The information required to be maintained and the report required to be submitted by this subdivision shall each be independently audited by a certified public accountant in accordance with the standards of the Accounting Standards Board of the American Institute of Certified Public Accountants, and shall include the opinion of that certified public accountant as to whether the information contained in the report fully and accurately describes, in accordance with generally accepted accounting principles in the United States, the information required to be reported under paragraph (1).

(3) The governing entity shall annually submit the report required by this subdivision to the department on a schedule, in a format, and on a form prescribed by the department, provided that the chronic dialysis clinic shall submit the information no later than 150 days after the end of its fiscal year. The chief executive officer or other principal officer of the governing entity shall certify under penalty of perjury that he or she is satisfied, after review, that the report submitted to the department under paragraph (1) is accurate and complete.

(4) In the event the department determines that a chronic dialysis clinic or governing entity failed to maintain the information or timely submit a report required under paragraph (1) of this subdivision or paragraph (3) of subdivision (a), or that the amounts or percentages reported by the chronic dialysis clinic or governing entity under paragraph (1) of this subdivision were inaccurate or incomplete, or that any failure by a chronic dialysis clinic to timely issue in full a rebate or reduction required by subdivision (a) was not substantially justified, the department shall assess a penalty against the chronic dialysis clinic or governing entity not to exceed one hundred thousand dollars ($100,000). Penalties collected pursuant to this paragraph shall be used by the department to implement and enforce laws governing chronic dialysis clinics.

(c) Definitions.

For purposes of this section:

(1) "Administrator" means the administrator as that term is used in Section 494.180(a) of Title 42 of the Code of Federal Regulations as it read on December 31, 2016.

(2) "Chief executive officer" means the chief executive officer as that term is used in Section 494.180(a) of Title 42 of the Code of Federal Regulations as it read on December 31, 2016.

(3) "Direct patient care services costs" means those costs directly associated with operating a chronic dialysis clinic in California and providing care to patients in California. Direct patient care services costs shall include, regardless of the location where each patient undergoes dialysis, only (i) salaries, wages, and benefits of non-managerial chronic dialysis clinic staff, including all clinic personnel who furnish direct care to dialysis patients, regardless of whether the salaries, wages, or benefits are paid directly by the chronic dialysis clinic or indirectly through an arrangement with an affiliated or unaffiliated third party, including but not limited to a governing entity, an independent staffing agency, a physician group, or a joint venture between a chronic dialysis clinic and a physician group; (ii) staff training and development; (iii) pharmaceuticals and medical supplies; (iv) facility costs, including rent, maintenance, and utilities; (v) laboratory testing; and (vi) depreciation and amortization of buildings, leasehold

improvements, patient supplies, equipment, and information systems. For purposes of this paragraph, "non-managerial chronic dialysis clinic staff" includes all clinic personnel who furnish direct care to dialysis patients, including nurses, technicians and trainees, social workers, registered dietitians, and non-managerial administrative staff, but excludes managerial staff such as facility administrators and medical directors. Categories of direct patient care services costs may be further prescribed by the department through regulation.

(4) "Governing entity" means a person, firm, association, partnership, corporation, or other entity that owns or operates a chronic dialysis clinic for which a license has been issued, without respect to whether the person or entity itself directly holds that license.

(5) "Health care quality improvement costs" means costs, other than direct patient care services costs, that a chronic dialysis clinic or governing entity has actually expended for goods or services in California that are required to maintain, access or exchange electronic health information, to support health information technologies, to train non-managerial personnel engaged in direct patient care, and to provide patient-centered education and counseling. Additional costs may be identified by the department through regulation, provided that such costs are actually spent on services offered at the chronic dialysis clinic to chronic dialysis patients and are spent on activities that are designed to improve health quality and to increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.

(6) "Payer" means the person or persons who paid or are financially responsible for payments for a treatment provided to a particular patient, and may include the patient or other individuals, primary insurers, secondary insurers, and other entities, including Medicare and any other federal, state, county, city, or other local government payer.

(7) "Pro rata health care quality improvement cost" means the total health care quality improvement costs paid by a governing entity or its chronic dialysis clinics in a fiscal year, divided by the total number of treatments provided by chronic dialysis clinics owned or operated by that governing entity in the same fiscal year.

(8) "Reasonable treatment cost" means the average cost for a treatment, which shall be calculated by dividing the direct patient care services costs incurred by a governing entity or its chronic dialysis clinics in a fiscal year, by the total number of treatments performed by chronic dialysis clinics owned or operated by that governing entity in California in the same fiscal year.

(9) "Treatment" means each instance when the chronic dialysis clinic provides services to a patient.

SEC. 7. Section 1226.8 is added to the Health and Safety Code, to read:

1226.8 (a) A chronic dialysis clinic shall not discriminate with respect to offering or providing care, and shall not refuse to offer or provide care, to patients on the basis of the payer for

treatment provided to a patient, including but not limited to on the basis that the payer is a patient, private payer or insurer, Medi-Cal, Medicaid, or Medicare.

(b) A chronic dialysis clinic shall not terminate, abridge, modify, or fail to perform under any agreement to provide services to patients covered by Medi-Cal, Medicaid, or Medicare on the basis of requirements imposed by this chapter.

SEC. 8. Section 1266.3 is added to the Health and Safety Code, to read:

1266.3. It is the intent of the People that California taxpayers not be financially responsible for implementation and enforcement of the Kidney Dialysis Patient Protection Act. In order to effectuate that intent, when calculating, assessing, and collecting fees imposed on chronic dialysis clinics pursuant to Section 1266, the department shall take into account all costs associated with implementing and enforcing Sections 1226.4, 1226.7, 1226.8, 1240.1, or 1240.2.

SEC. 9. Section 1228 of the Health and Safety Code is amended to read:

1228. (a) Except as provided in subdivision (c), every clinic for which a license or special permit has been issued shall be periodically inspected. ~~The~~ *Except as provided in Section 1226.4, the* frequency of inspections shall depend upon the type and complexity of the clinic or special service to be inspected. Inspections shall be conducted no less often than once every three years and as often as necessary to ensure the quality of care being provided.

(b) (1) During inspections, representatives of the department shall offer any advice and assistance to the clinic as they deem appropriate. The department may contract with local health departments for the assumption of any of the department's responsibilities under this chapter. In exercising this authority, the local health department shall conform to the requirements of this chapter and to the rules, regulations, and standards of the department.

(2) The department shall reimburse local health departments for services performed pursuant to this section, and these payments shall not exceed actual cost. Reports of each inspection shall be prepared by the representative conducting it upon forms prepared and furnished by the department and filed with the department.

(c) This section shall not apply to any of the following:

(1) A rural health clinic.

(2) A primary care clinic accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Accreditation Association for Ambulatory Health Care (AAAHC), or any other accrediting organization recognized by the department.

(3) An ambulatory surgical center.

(4) ~~An end stage renal disease facility.~~

~~(5)~~

A comprehensive outpatient rehabilitation facility that is certified to participate either in the Medicare program under Title XVIII (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act, or the medicaid program under Title XIX (42 U.S.C. Sec. 1396 et seq.) of the federal Social Security Act, or both.

(d) Notwithstanding paragraph (2) of subdivision (c), the department shall retain the authority to inspect a primary care clinic pursuant to Section 1227, or as necessary to ensure the quality of care being provided.

SEC. 10. Nothing in this act is intended to affect health facilities licensed pursuant to subdivision (a), (b), or (f) of Section 1250 of the Health and Safety Code.

SEC. 11. The State Department of Public Health shall issue regulations necessary to implement this act no later than 180 days following its effective date.

SEC. 12. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

SENATE FLOOR ALERT

September 7, 2017

TO: The Honorable Members of the California State Senate

FROM: Kathryn Scott, Legislative Advocate

SUBJECT: AB 251 (Bonta) – OPPOSE

The California Hospital Association (CHA) — representing more than 400 hospitals and health systems and 97 percent of patient beds in the state — is writing today in opposition to AB 251 (Bonta). As amended on June 29, 2017, AB 251 would require a chronic dialysis clinic, if its direct patient care services costs, health care quality improvements costs, federal and state taxes, and facility license fees total less than 85 percent of the treatment revenue, to issue a rebate and reduction in billed amount to payers on a pro rata basis.

Most secondary and tertiary level acute care hospitals provide dialysis services (e.g., diabetes and end-stage renal disease) for their inpatients and a small handful have outpatient clinics. The mandate to monitor and evaluate revenue streams and specified costs that are distinct and attributable to the hospital based outpatient dialysis clinics would be onerous and administratively burdensome to the hospitals. Furthermore, the additional resources required to allocate the associated costs and revenue would increase the overall costs to the delivery system, which may limit access to hospital based dialysis clinics.

Finally, it would be extremely difficult to legislate how any hospital dialysis clinic's revenues collected above costs, be distributed in the form of rebates to private insurance payers but not Medicare or Medi-Cal or local government payer. That requirement in and of itself, will prove to be difficult and subject to audit by the state since it may require that dollars received from the Federal, state or local government be differentiated from the private insurance carriers to meet the 85 percent threshold.

There are numerous concerns related to the implementation of this legislation. Our systems of healthcare are moving toward a whole person model. As described, carving out a single service to determine costs attributed to the provision of care would be burdensome and costly to the healthcare system, at large, and would not improve care for the patient.

For these reasons, CHA urges you to vote NO on AB 251.

September 1, 2017

Assembly Floor Alert

TO: California State Assembly

SUBJECT: SB 349 (Lara) – OPPOSE

The California Hospital Association (CHA) — representing more than 400 hospitals and health systems and 97 percent of patient beds in the state, the Association of California Healthcare Districts, the California Children's Hospital Association, the District Hospital Leadership Forum, Providence Health & Services, St. Joseph Health, Scripps, and the United Hospital Association are writing today in opposition to SB 349 (Lara). Hospitals are committed to ensuring that patients receive the right care in the right place at the right time. This bill would undermine this goal for dialysis patients.

Currently, most dialysis procedures are performed in out-patient clinics. Hospitals are, however, keenly interested in this bill because of the unintended consequences. If this bill is enacted, dialysis services at the clinics will be reduced for the reasons articulated in DaVita's letter of opposition. With fewer appointments available, patients will not receive timely treatment and are more likely to end up in the emergency department with complications that could have been prevented with timely treatment.

Moreover, hospitals have direct experience with staffing ratios. Numerous studies have found that there is no conclusive evidence that staffing ratios improve quality of care while there is substantial evidence that they increase costs. Because the reimbursement rate for dialysis services is very low, the increased cost will further restrict access to this vital service.

For these reasons, CHA and the above named association and providers, respectfully requests your "NO" vote on SB 349.

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

January 17, 2018

TO: Chief Nursing Officer Advisory Committee

FROM: Alyssa Keefe, Vice President Federal Regulatory Affairs

SUBJECT: Federal Regulatory Update

Unified Agenda of Regulatory and Deregulatory Actions
In late December, the Office of Management and Budget Office of Regulatory Affairs released the Trump Administration's Unified Agenda of Regulatory and Deregulatory Actions reports on the actions administrative agencies plan to issue in the near and long term. This agenda gives a broad outline of what we may expect to see in 2018 from the Centers for Medicare & Medicaid Services (CMS) and other federal agencies.

A number of CHA priorities continue to be part of the administration's agenda, but the timing of release of any of these initiatives remains unclear. We anticipate significant policy changes in all the Medicare fiscal and calendar year payment rules, including further action on Medicare Disproportionate Share Hospital (DSH) policy and the use of Worksheet S-10, continued application of the site neutral policies as well as continued changes in all of the post–acute payment systems as required by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) as well as other legislation. Also noted in this agenda are plans for continued updates to the Medicare Conditions of Participation, a proposed rule related to regulatory provisions that promote program efficiency, transparency and burden reduction as well as a proposed rule aimed at streamlining and more efficiently administering the Medicaid and CHIP managed care programs.

Listed on the agenda, and of concern to CHA, are revisions to the 340B program ceiling prices and a final rule on Medicaid DSH allotment reductions. The narrative of the agenda notes:

> *In the coming fiscal year, HHS plans to consider a number of regulatory and deregulatory actions intended to make its processes more flexible, efficient, and transparent. In order to fully realize the potential of these efforts, HHS recognizes the need for a collaborative rulemaking process where the concerns of stakeholders are appropriately considered. By working with its community partners to understand the challenges that they face under HHS's current regulatory structures and where there are opportunities for improvement, the Department hopes to modernize and streamline its regulations to better serve the needs of the American people.*

CHA continues to make communication with CMS staff at both the central and regional offices a top priority. While this agenda details the planned release of planned proposed and final rules,

absent from this plan is the volume of subregulatory guidance we are seeing from CMS and other agencies including the Food & Drug Administration (FDA) and Health Resources & Services Administration (HRSA). In particular, CMS recently released new guidance on ligature risk, texting of patient information, surveying conditions of certification revisions for rural health centers and is poised to release updated guidance on shared and co-located services later this year. CHA's positive relationship with CMS Region 9 and Central Office Survey and Certification staff continues to keep CHA at the forefront of these issues, providing input as requested and addressing member specific issues that arise.

CHA continues to remain engaged on these and other items of interest to the membership. Our areas of focus for this first quarter include, but are not limited to, continued advocacy with FDA in an effort to bring about policy actions to address the recent drug shortages, preparation for the release of the fiscal year Medicare payment rules in April, including analysis of the Worksheet S-10 data and its implications for Medicare DSH policy, continued focus on the challenges hospitals face in obtaining timely durable medical equipment in competitive bidding areas resulting in delayed discharge and continuing to advocate for policies that reduce regulatory and administrative burdens for hospitals and post-acute care providers. Looking ahead, we continue to remain engaged with the Center for Medicare & Medicaid Innovation as the framework for this administration's work around advanced payment models, including the recently released Bundled Payments for Care Improvement Advanced program, that meets the requirements of Medicare Access and CHIP Reauthorization Act of 2015 continues to unfold.

As the timing of some of these rules and guidance becomes clear, CHA will provide updates through member forums, *CHA News* and will soon release the CHA 2018 regulatory calendar for member use.

Key highlights of recent CMS actions are listed below.

Measures Application Partnership
CMS released its list of measures under consideration for future use in federal quality reporting programs. CHA attended the National Quality Forum (NQF) Measures Application Partnership meetings in December where the measures were reviewed. CHA submitted comments on the draft recommendations to NQF.

5 Star Ratings
On December 21, 2017, CMS released the revised hospital 5 star ratings on its *Hospital Compare* site. In response to stakeholder and expert input, CMS revised their methodology for hospital 5 star ratings, which CHA supported. CHA is pleased that CMS implemented many of these recommendations and took steps to share this information with stakeholders prior to the release of the ratings. CMS also reported FY 2018 Hospital-Acquired Condition Reduction Program information for each hospital on *Hospital Compare*. CHA DataSuite released hospital-specific reports for three CMS Medicare inpatient quality programs including the HAC Reduction Program from federal fiscal years 2016-18.

Quality Matrix
CHA released an updated version of its Federal Quality Measures Matrix based on policies finalized in the federal fiscal year and calendar year 2018 Medicare payment regulations. The document provides a table showing measures that are duplicated across federal reporting programs, as well as tabs for individual federal programs related to inpatient quality reporting, outpatient quality reporting, value-based purchasing, readmissions reduction, hospital-acquired condition penalty, meaningful use, inpatient psychiatric facility quality reporting, prospective payment system-exempt cancer hospital quality reporting, ambulatory surgical center quality reporting and accountable care organizations.

Request for Information on Clinical Laboratory Improvement Admendments Updates
CMS issued a request for information on updating personnel requirements, testing standards, and industry fee structures under the clinical laboratory improvement amendments (CLIA). Among the personnel requirements listed, CMS seeks comment on if it should codify in regulations the current guidance that a bachelor's degree in nursing is considered equivalent to a bachelor's degree in biological sciences for the purposes of educational requirements for moderate and high complexity testing personnel under CLIA.

CMS notes the CLIA regulations have not been meaningfully updated since 1992, and the topics listed in the request for information are areas that the Centers for Disease Control and Prevention, State Agency surveyors and other stakeholders have identified as concepts that should be updated to better reflect current knowledge and changes in the academic context, as well as advancements in laboratory testing. CMS notes it intends to consider public responses to the request for information when it drafts proposals to update the existing regulations in the future. Comments on the request for information are due March 12.

Electronic Health Records Incentive Program – QualityNet
As of Jan. 2, providers must use the QualityNet Secure Portal for calendar year 2017 attestation under the Electronic Health Records Incentive Program. This change also applies to future reporting periods in an effort to streamline the attestation process. Medicaid-eligible hospitals should contact their state Medicaid agencies for specific information on how to attest. Dually eligible hospitals and critical access hospitals will register and attest for Medicare on the QualityNet portal and update and submit registration information in the Registration and Attestation System.

Please contact me at (202) 488-4688 or akeefe@calhospital.org with any questions.

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

January 17, 2018

TO: CNO Advisory Committee Members

FROM: BJ Bartleson, MS, RN, NEA-BC, Vice President, Nursing and Clinical Services
Judee Berg, MS, RN, FACHE, CEO, HealthImpact

SUBJECT: Nurse Practitioner – Full Practice Authority Legislation, California Action Coalition

SUMMARY

The California Action Coalition is one of 51 action coalitions across the nation focused on ensuring that all Americans have access to care, with nurses contributing to the full extent of their capabilities. The action coalitions are coordinated through the Center to Champion Nursing in America, an initiative of AARP, the AARP Foundation and the Robert Wood Johnson Foundation. Mary Dickow is the California Action Coalition director and the work is housed at HealthImpact.

Removing scope of practice barriers has been a priority for the coalitions across the nation, and California. California has had several unsuccessful legislative attempts in the past several years, and continues to face major opposition from organized medicine. Per the latest Future of Nursing Update, "Assessing Progress on the Institute of Medicine Report, the Future of Nursing", coalitions should build common ground around scope of practice and other issues in policy and practice. They recommend that the campaign should broaden its coalition to include more diverse stakeholders, work with other health professional groups, policy makers, and the community to build common ground around removing scope of practice restrictions, increasing interprofessional collaboration, and addressing other issues to improve health care practice.

Last year, there were three bills that originated as full practice authority bills and one bill, AB 1612 (Burke), that would allow full practice authority for Certified Nurse Midwives, is left to be decided upon in the upcoming 2018 session. A more onerous bill, SB 457 (Bates) would prohibit physicians and midwives from attending certain births in a licensed alternative birth center (ABC) or at home, and put onerous procedures in place for those out-of-hospital births that would still legally be allowed. It would also require duplicative physical exams, extensive screening, additional handouts to be given to patients, and voluminous data reporting by health care providers — including complicated medical reports for a hospital to complete for each patient who attempted a planned ABC or home birth but was transferred to a hospital. Overall, this bill would prevent licensed midwives and certified nurse midwives from practicing to the full extent of their education, licensure/certification and experience.

DISCUSSION

1. How are nurse practitioners (NP) used in your facilities?
2. What are your thoughts relative to NP full practice authority and how it affects future care delivery in your organization?
3. Are there opportunities for a nursing community to broaden the stakeholder coalition?
4. Are nurses or NPs used as team leaders in interprofessional care models in your system?

ACTION REQUESTED

- *Committee discussion*

BJB:br

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

January 17, 2018

TO: CNO Advisory Committee Members

FROM: Debby Rogers, RN, MS, FAEN, Vice President, Clinical Performance and Transformation

SUBJECT: State Legislation

SUMMARY

The State Legislature returns from break on January 3, 2018. Bill introduction will begin in January and a few bills will be heard in policy committees. The vast majority of new bills will be introduced the week of February 12th, as the deadline for bill introduction is February 16th. Policy committees begin their work in late March and April.

Linked in BoardEffect is the CHA's 2017 *Report on Legislation.*

The Governor must submit the 2018-2019 budget by January 10th and CHA will provide a high level overview at the meeting.

ACTION REQUESTED

- *Committee discussion*

DISCUSSION

DR:br

CALIFORNIA HOSPITAL ASSOCIATION

Providing Leadership in Health Policy and Advocacy

January 17, 2018

TO: CHA CNO Advisory Committee

FROM: BJ Bartleson, MS, RN, NEA-BC, Vice President, Nursing and Clinical Services
Debby Rogers, RN, MS, FAEN, Vice President, Clinical Performance and Transformation

SUBJECT: Roundtable Discussion

SUMMARY

Issues and Comments of Interest to the Committee
Please share emerging issues related to nursing to allow the Committee to identify if there are common policy concerns.

Identify Agenda Items for Next Meeting
Please use this opportunity to provide input regarding suggested items for next meeting's agenda, April 25, 2018.

ACTION REQUESTED

- *Committee discussion*

DISCUSSION

BJB/DR:br

New HRSA Nurse Education, Practice, Quality & Retention Grant: An Exciting Opportunity for Partnership

Dear CNOs, Deans, and Colleagues:

The Health Resources and Services Administration (HRSA) is currently accepting applications from accredited schools and healthcare facilities for funding through the Nurse Education, Practice, Quality and Retention - Registered Nurses in Primary Care Training Program (HRSA-18-012).

According to HRSA, the purpose of this four-year training program is to recruit and train nursing students and current RNs to practice to the full scope of their licenses in community-based primary care teams to increase access to care, with an emphasis on chronic disease prevention and control, including mental health and substance use conditions. The program aims to achieve a sustainable primary care nursing workforce equipped with the competencies necessary to address pressing national public health issues, even the distribution of the nursing workforce, improve access to care and improve population health outcomes by strengthening the capacity for basic nurse education and practice, and addressing national nursing needs under three priority areas: education, practice and retention.

Applicants submitting an application must meet certain criteria:

- Establish or expand academic-practice partnerships to train nursing students and support current RNs in non-institutional settings such as community-based primary care, in accordance with the linkage/partnership requirements.
- HRSA encourages partnerships with other non-institutional settings, including state or local health departments, Veterans Affairs medical facilities, Area Health Education Centers, AIDS Education and Training Centers, and Public Health Training Centers
- Identify a full-time partnership liaison as a formal facilitator between academia and clinical partners.

HealthImpact is interested in working with accredited schools of nursing and healthcare facilities applying for this funding opportunity, and serving in the liaison role as formal facilitator between academic and clinical partners. As the state's designated nursing workforce center, HealthImpact has been a leader in promoting and strengthening the capacity and capability of nurses in emerging roles to meet evolving healthcare needs in California. Our scope of work includes preparing a White Paper on New Nursing Roles and development of a Nursing Education Plan for California, each highlighting the need for and strategic priority of preparing the nursing workforce in new ways to achieve future health outcomes. HealthImpact's scope of program work and strategic and change initiatives have consistently provided leadership among diverse stakeholders engaged in developing and supporting academic practice partnerships to address strategic workforce priorities.

The purpose and intent of this HRSA funding opportunity is directly aligned with California's nursing workforce needs. HealthImpact is eager to contribute to the development of programs that aim to recruit and train nursing students and current RNs to practice to the full scope of their license in community-based primary care teams. We invite schools of nursing and healthcare facilities pursuing this funding opportunity to contact us to explore how HealthImpact could contribute to this important work.

HRSA Grant Announcement - http://files.constantcontact.com/9732e768001/874cdc89-3208-4e3b-a35c-92718bdec960.pdf

HRSA Information Webinar Slides - http://files.constantcontact.com/9732e768001/2a0cd46b-be02-49b6-8584-323208bac5e4.pdf

Best regards,

Judith G. Berg, MS, RN, FACHE
Chief Executive Officer, HealthImpact
Immediate Past President, National Forum of State Nursing Workforce Centers

P 510.832.8400
judee@healthimpact.org

FUTURE OF NURSING™
Campaign for Action
AT THE CENTER TO CHAMPION NURSING IN AMERICA

Robert Wood Johnson Foundation
AARP Foundation

Campaign Update

December 12, 2017

Send shout-outs, story ideas, and webinar information to Aidan McCallion at amccallion@aarp.org.

The *Campaign Update* is on vacation until January 9.
We wish you happy and healthy holidays.

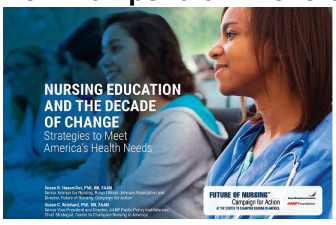
Shout-Out

Alfano Named New York Academy of Medicine Fellow
Congratulations to Lucia Alfano, RN, MA, who has joined the ranks of prestigious New York Academy of Medicine Fellows. Alfano, a *Campaign* Outreach Advocate for a Culture of Health, or COACH, was elected by her peers from the medical and health professions for this honor. Congratulations Lucia!

Campaign News and Features

a

New Compendium Covers Decade of Change in Nursing Education



Nursing education has seen tremendous change in 10 years, thanks in large part to the Academic Progression in Nursing (APIN) program, the State Implementation Program (SIP), and the Center to Champion Nursing in America, all funded by RWJF. CCNA is also an initiative of AARP Foundation and AARP. A new compendium from the *Campaign for Action* reports on the collaborations fueling the transformation, as well as strategies to continue the work.
Read more.

All Nurses Are Beautiful; This One Won Contests
Even at 18, Lisa Eichelberger, PhD, RN, had high aspirations: She wanted to teach nursing. That's why one adviser shooed her out of the diploma program and toward a bachelor's degree. A profile of Eichelberger on the *Campaign* blog shows that along the way, the Georgia Action Coalition co-leader squeezed in (and won) beauty pageants.

Read the profile.

Episcopal Health Foundation Funds Focus on Prevention
In *Health Affairs* , Episcopal Health Foundation's vice president for impact writes about its Community Centered Health Homes (CCHH) approach, which "not only acknowledges that community conditions outside the clinic walls affect patient outcomes, but also actively participates in improving those conditions." The Texas-based organization funds 13 clinics in the state.

Read the story.

Schools Chosen for Future of Nursing Scholars Program

The Robert Wood Johnson Foundation and four other funders will give grants to 31 schools of nursing to support as many as 58 nurses pursuing PhDs. The Future of Nursing Scholars Program provides scholarship financing and guidance, support that helps expand the number of nurses with PhDs. This is the program's fifth year.

Read which schools were selected.

New from *Charting Nursing's Future*

Medicare Project Shows That Funding Education Pays Off
Investing Medicare funds in the clinical training of advanced practice registered nurses pays off, says Linda Aiken, PhD, FAAN, FRCN. In an interview, the renowned researcher and University of Pennsylvania professor explains why the Graduate Nurse Education Demonstration Project is good for America's health.

Read more.

The demonstration project at a glance.

Funding, Tools, and Other Opportunities

RWJF Seeks Solutions for Social Isolation
The Robert Wood Johnson Foundation is looking for ideas that address social isolation and promote healthy social connections. This call for proposals is open to organizations from all fields to surface solutions that can be adapted in the United States. Deadline: December 21 at 3 p.m. ET.

Read more.

Recruit, Train Students for Community-Based Primary Care
The Health Resources and Services Administration is soliciting proposals from schools of nursing and health care facilities for a training program for nursing students and registered nurses to practice in community-based primary care teams with an emphasis on chronic disease prevention and control. The program aims to train nurses to address pressing national public health issues. Deadline: January 29.

Read more.

Apply To Be Part of the Eighth Class of Macy Faculty Scholars
Promising educational innovators in medicine and nursing are invited to apply for the Macy Foundation's Faculty Scholars program. Scholars will implement new educational innovations at their home institutions and participate in career development activities that prepare them for leadership roles. Informational webinar: December 14. Deadline: February 14, 2018.

Learn more.

Nurses' Health Study 3 Seeks Volunteers
The Nurses' Health Studies, the largest, longest-running investigations of women's health, has since 1976 relied on nurse participants to study a number of health factors. The third such study seeks 100,000 nurses or nurse students, ages 19 to 52, to participate in a web-based study of health issues related to lifestyle, fertility/pregnancy, environment, and nursing exposures.

Apply.

Meetings and Webinars

Meetings open to all unless otherwise noted.
Follow links for details about fees and registration.

(Rescheduled) Native American Nurses leading a Culture of Health (webinar)
Center to Champion Nursing in America. January 18, 2-3 p.m. ET.

Culture of Health and Nursing Education Learning Collaborative
(teleconference)
Center to Champion Nursing in America. January 31, 2:30-3:30 p.m. ET.
Read notes from the previous calls.

Stay in Touch: Join the *Campaign's* Listserv and Receive Our Mailings

The *Campaign*'s listserv allows collaboration among Action Coalition members, *Campaign* stakeholders, supporters, and others interested in our work. To join, visit the *Campaign Update*.

To receive the *Campaign Update,* e-alerts, or webinar invitations, register here.
