

BACKGROUND PAPER FOR THE BOARD OF REGISTERED NURSING

**Joint Sunset Review Oversight Hearing, March 10, 2026
Senate Committee on Business, Professions, and Economic Development
and Assembly Committee on Business and Professions**

IDENTIFIED ISSUES, BACKGROUND AND RECOMMENDATIONS

BRIEF OVERVIEW OF THE BOARD OF REGISTERED NURSING

History and Function of the Board of Registered Nursing (BRN or Board).

The first regulation of nursing began in 1905 when the University of California (UC) Board of Regents was granted authority by the Legislature to administer examinations, approve educational programs, issue certificates, and revoke certificates of registered nurses (RNs).

In 1913, the Legislature formed the Bureau of Registration of Nurses under the State Board of Health. The bureau was charged with administering an examination, registering qualified RNs, accrediting nursing schools, and revoking licenses of RNs found to be unsafe to practice.

The current Nursing Practice Act (Act) was not established until 1939 by AB 620 (Cronin, Chapter 807, Statutes of 1939). A few provisions in the current Act remain from the originating statutes including the requirement for the BRN offices to be in Sacramento, and the requirement for applicants to pay an application fee to name a few.

The BRN licenses and regulates close to 566,914 RNs which includes around 53,883 advanced practice registered nurses (APRNs). APRNs are RNs who have obtained advanced training and education. Each APRN profession has its own scope of practice, advanced certification requirements, and professional settings. Currently, the BRN oversees approximately 3,071 Clinical Nurse Specialists (CNSs), 45,838 Nurse Practitioners (NPs), 3,460 Certified Registered Nurse Anesthetists (CRNAs), 1,514 Certified Nurse Midwives (CNMs), 197 Psychiatric Mental Health Nurses (PMHNS) and 66,950 Certified Public Health Nurses (PHNs). The BRN also approves nursing education providers and has approved 163 prelicensure nursing programs offered throughout California at community colleges, UCs, California State Universities (CSUs) and private, for-profit and not-for-profit institutions.

License Types

- Registered Nurse (RNs): RNs are authorized to perform health care functions, including direct and indirect patient care; disease prevention and restorative measures; administration of medication and therapeutic agents; skin tests; immunizations; blood withdrawal; and patient assessment, analysis, planning, treatment implementation; and laboratory tests. The practice of nursing also includes observing signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (A) determining of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B)

implementing, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures. Standardized procedures are policies and protocols developed by a licensed health facility through collaboration among administrators and health professionals including physicians and nurses as well as policies and protocols developed through collaboration among administrators and health professionals, including physicians and nurses, by an organized health care system, which is not a health facility.

- *Clinical Nurse Specialist (CNSs)*: CNSs are RNs with advanced education who participate in expert clinical practice, education, research, consultation, and clinical leadership. BRN certification may be obtained through successful completion of a master's program in a clinical field of nursing or a clinical field related to nursing with specified coursework.
- *Nurse Practitioner (NPs)*: NPs are RNs who possess additional preparation and skills in the physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care. NP certification can be obtained through successful completion of a program that meets BRN standards or by obtaining a certification through a national organization, as well as completing an out-of-state program whose standards are equivalent to those of the BRN. An applicant for initial certification as an NP who has not been qualified or certified as an NP in California or another state must possess a master's or other graduate degree in nursing, or in a clinical field related to nursing. NPs may apply for an NP furnishing number, enabling them to write a medication order and furnish drugs to a patient. To obtain a furnishing number, the NP must take an advanced pharmacology course. Upon completion of the course and notification to the BRN, the NP then applies to the Drug Enforcement Administration (DEA) to obtain a DEA number so they can furnish schedule II medications. The BRN is required to make a list of furnishing numbers for NPs available to the Board of Pharmacy.¹

As a result of AB 890 (Wood, Chapter 265, Statutes of 2020), NPs who meet additional training requirements are authorized to practice without standardized procedures in two distinct settings: defined healthcare settings and outside of those defined settings. These NPs are often referred to as 103 NPs and 104 NPs, which is based on their respective code section numbers.

- 103 NPs: To practice without standardized procedures in a defined healthcare setting with at least one physician and surgeon, the 103 NP must have obtained a master's or doctoral degree, passed a national NP-board certification examination, hold a certification as an NP from a national certifying body recognized by the BRN, and complete a transition to practice of a minimum of three years or 4,600 hours of practice
- 104 NPs: For those NPs seeking to practice independently outside of a defined healthcare setting, the NP is required to meet all the above requirements for the 103 NP and have three years of practice as a 103 NP in good standing in addition to the transition to practice.

¹ Business and Professions Code § 2836.3(a)

- *Certified Registered Nurse Anesthetist (CRNAs)*: CRNAs are RNs who provide anesthesia services at the direction of a physician, dentist, or podiatrist. CRNA applicants must provide evidence of certification by the National Board of Certification and Recertification for Nurse Anesthetists.
- *Certified Nurse Midwife (CNMs)*: CNMs are RNs who are authorized to attend low-risk pregnancies and childbirth and provide prenatal, intrapartum, and postpartum care, including family planning care for the mother and immediate care for the newborn. CNM certification may be obtained by successful completion of a BRN-approved nurse-midwifery program or certification as a CNM by the American Midwifery Certification Board and completing an out of state program whose standards are equivalent to those of the BRN. CNMs may apply for an CNM furnishing number, enabling them to write a medication order and furnish drugs to a patient. To obtain a furnishing number, a CNM must take an advanced pharmacology course. Upon completion of the course and notification to the BRN, the CNM then applies to the DEA to obtain a DEA number so they can furnish schedule II medications. The BRN is required to maintain a list of CNMs that it has certified and make the list available to the California State Board of Pharmacy, if requested.²
- *Public Health Nurse (PHN)*. PHNs provide direct patient care and services related to maintaining the public and community's health and safety. To be eligible for certification, the applicant must hold a baccalaureate or entry-level master's degree in nursing awarded by a school accredited by a BRN-approved accrediting body and proof of supervised clinical experience. Equivalency methods are provided for individuals whose baccalaureate or entry-level master's degree in nursing is from non-approved accredited schools and for those who have a baccalaureate degree in a field other than nursing.
- *Psychiatric Mental Health Nurse (PMHN)*. The BRN maintains a list of RNs who possess a master's degree in psychiatric/mental health nursing and two years of supervised experience as a psychiatric/mental health nurse. To be eligible for the listing, RNs must complete and submit verification of the required education and experience to the BRN. The BRN also accepts American Nurses Credentialing Center certification as a CNS in psychiatric/mental health nursing. This voluntary listing enables the psychiatric/mental health nurse to receive direct insurance reimbursement for counseling services.

The current mission statement of the BRN as noted in its 2026-2030 Strategic Plan, is:

The Board of Registered Nursing protects the health, safety, and well-being of the public through the fair and consistent application of the statutes and regulations governing nursing practice and education in California.

The Board's mandate is: Protection of the public shall be the highest priority for the Board of Registered Nursing in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.³

² Business and Professions Code § 2746.51(b)(1)

³ Business and Professions Code § 2708.1

Board Membership and Committees

The Board is comprised of 9 members: five professional and four public representatives.⁴ Board members are subject to four-year terms, and no person may serve more than two consecutive terms. Two of the board members are serving in a 1-year grace period, and unless reappointed, their terms will expire on June 1, 2026. The professional membership of the BRN is required to meet the following designations:

- 2 RNs engaged primarily in direct patient care with at least five continuous years of experience, who are not engaged as an educator or administrator of a nursing education program.
- 1 APRN
- 1 RN who is an active educator or administrator of a BRN-approved nursing education program.
- 1 RN who is a nursing services administrator with at least five years of continuous service.

Two of the public members and all professional members are appointed by the Governor. The Speaker of the Assembly and the Senate Committee on Rules each appoint one public member. The BRN is required to meet at least once every three months and must hold meetings in both Northern and Southern California.⁵ All BRN and BRN committee meetings are subject to the Bagley-Keene Open Meetings Act (Bagley-Keene Act).

The BRN notes that since its last sunset review in 2022, it has not had to cancel any full board meetings due to a lack of quorum. However, the BRN had to cancel 11 Intervention Evaluation Committee (IEC) meetings and one each of the Nurse Midwifery Advisory Committee and Certified Registered Nurse Anesthetist Advisory Committee meetings.

The BRN has four statutorily mandated committees: the Nurse Midwifery Advisory Committee, the Intervention Evaluation Committee, the Nurse Education and Workforce Advisory Committee, and the Nurse Practitioner Advisory Committee.⁶ Committee membership for the Nurse-Midwifery Advisory Committee, the Nurse Practitioner Advisory Committee, and the Intervention Evaluation Committee is specified in statute and each committee is required to have a physician and surgeon member. The Nurse Education and Workforce Advisory Committee is mandated to have four members who are not public members, RNs or APRNs.

The BRN, with permission from the Director of the Department of Consumer Affairs (DCA), may create additional advisory committees as needed to advise the BRN on the implementation of the (Act).⁷ The BRN has two board-established committees: the Certified Registered Nurse Anesthetist Advisory Committee and the Clinical Nurse Specialist Advisory Committee. Members of any BRN advisory committee are entitled to a \$100 per diem and specified expense reimbursement.⁸

⁴ Business and Professions Code § 2702

⁵ Business and Professions Code § 2709

⁶ Business and Professions Code §§ 2746.2, 2770.1, 2710.5, 2837.102

⁷ Business and Professions Code § 2710.5

⁸ Business and Professions Code § 103

Fiscal, Fund, and Fee Analysis

Similar to other boards and bureaus within the DCA, the BRN is considered a special fund entity and therefore does not receive any General Fund (GF) support, relying solely on fees established in statute and collected from licensing and renewal fees. Renewal fees assessed by the BRN account for 53% of BRN revenue.⁹ To increase or reduce fees within the statutory minimum and maximum levels, the BRN may adjust fees through the regulatory process. To increase fees at the statutory maximum, legislation is necessary.

All BRN-issued licenses and certificates are renewed biannually¹⁰. The BRN is required to collect an additional \$10 from each licensure renewal for the Registered Nurse Education Fund (NEF).¹¹ Monies from the NEF are used for two purposes: 1) to fund scholarships for ADN and BSN students, and 2) for a loan repayment program for practicing RNs to increase the number of trained RNs providing direct patient care in a qualified facility or area in California and for providing direct patient care in an underserved area or qualified facility throughout California. The NEF is administered by the Department of Healthcare Access and Information (HCAI). HCAI collects approximately \$2 million from the BRN for the NEF each FY.

The BRN projects total revenues for FY 2025/26 to be \$81.2 million and \$79.6 million in FY 2026/27. Total expenditures are projected to be \$67.6 million in FY 2025/26, and \$69 million in FY 2026/27, (which is \$5million over its projected budget authority in FY 2026-27). The BRN projects a healthy reserve for both FYs 2025/26 and 2026/27 with 15.5 months and 16.9 months respectively. A significant improvement from FY 2023/24 when the BRN’s reserve was 5.3 months.

The BRN has provided two GF loans within the last five FYs. In 2020/21 the BRN loaned the GF \$30 million, reportedly to assist with COVID-19 budget constraints. That loan was repaid in full in FY 2024/25. In FY 2023/24, the BRN loaned the GF \$65 million, which remains outstanding.

Table 3. Expenditures by Program Component (list dollars in thousands)

	FY 2021-22		FY 2022-23		FY 2023-24		FY 2024-25	
	Personnel Services	OE&E						
Enforcement	\$ 8,655	\$ 12,827	\$ 9,465	\$ 12,905	\$ 10,227	\$ 13,330	\$ 9,958	\$ 13,476
Examination	\$ -	\$ 109	\$ -	\$ 95	\$ -	\$ 1	\$ -	\$ 54
Licensing	\$ 6,710	\$ 1,354	\$ 7,520	\$ 1,746	\$ 8,126	\$ 1,496	\$ 7,912	\$ 1,206
Administration ¹	\$ 6,926	\$ 1,352	\$ 6,710	\$ 1,505	\$ 7,233	\$ 1,289	\$ 7,080	\$ 1,038
DCA Pro Rata	\$ -	\$ 15,256	\$ -	\$ 15,439	\$ -	\$ 16,764	\$ -	\$ 17,336
Diversion (if applicable)								
TOTALS	\$22,291	\$30,898	\$23,695	\$31,690	\$25,586	\$32,880	\$24,950	\$33,110

¹ Administration includes costs for executive staff, board, administrative support, and fiscal services.

*Revised Table 3. Provided by the BRN

Fund Condition (list dollars in thousands)						
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⁹ California Board of Registered Nursing, Sunset Review 2026 Report

¹⁰ Business and Professions Code § 2833

¹¹ Business and Professions Code § 2815.1

(Dollars in Thousands)	FY 2021-22*	FY 2022-23	FY 2023-24	FY 2024-25	FY 2025-26**	FY 2026-27**
Beginning Balance¹	\$36,193	\$56,290	\$77,484	\$27,543	\$75,766	\$89,426
Revenues and Transfers	\$77,934	\$81,182	\$77,125	\$80,073	\$81,292	\$79,575
Total Resources	\$114,127	\$137,472	\$154,609	\$107,616	\$157,058	\$169,001
Budget Authority	\$61,592	\$62,212	\$66,463	\$65,879	\$61,913	\$63,770
Expenditures²	\$58,186	\$60,410	\$62,535	\$61,850	\$67,632	\$69,044
Loans to General Fund	\$0	\$0	-\$65,000	\$0	\$0	\$0
Accrued Interest, Loans to General Fund	\$0	\$0	\$0	\$0	\$0	\$0
Loans Repaid from General Fund	\$0	\$0	\$0	\$30,000	\$0	\$0
Fund Balance	\$55,941	\$77,062	\$27,074	\$75,766	\$89,426	\$99,957
Months in Reserve	11.1	14.8	5.3	13.4	15.5	16.9

¹Actuals include prior year adjustments

²Expenditures include reimbursements and direct draws to the fund

*Includes EO transfer to GF (AB 84)

**Revised Table 2 provided by the BRN

There is no statutorily mandated reserve level for the BRN. However, if the fund reserve level exceeds 24 months at the end of any FY, the BRN is required to reduce license or other fees during the following FY.¹²

For the last four FYs, the Board has expended approximately 40% on enforcement, 0% on examinations, 16% on licensing, 15% on administration, and 29% on DCA pro rata. In the BRN's 2021 supplemental sunset report, the BRN reported that it did not expend any resources on examinations. In the BRN's recent 2026 report, the BRN reports that it expends 8% of its budget on examinations. The BRN no longer administers its own examination and instead relies on a national examination for licensure (NCLEX). However, the BRN is required to conduct an occupational analysis of the NCLEX and the national certification examination for NPs.¹³ The BRN notes that the expenditures listed for examination as provided in the 2026 Sunset Review Report was an error, and the BRN provided the updated Table 3 above, which revised examination expenditures.

Cost Recovery

Current law authorizes entities within the jurisdiction of the DCA to collect certain costs associated with an enforcement action.¹⁴ The BRN reports seeking cost recovery for probationers and when licenses are subject to revocation. The BRN notes that probationers who do not fulfill the conditions of

¹² Business and Professions Code § 128.5(a)

¹³ Business and Professions Code §§ 139, 2837.105

¹⁴ Business and Professions Code § 125.3

cost recovery are subject to extended probation or licensure holds. In revocation cases, where cost recovery is ordered, but not collected, the BRN may transmit the case to the Franchise Tax Board (FTB) for collection. However, the BRN is unlikely to collect the cost recovery unless the individual with a revoked license reapplies for licensure as any cost recovery must be paid prior to license-reinstatement. Same for probationers who seek to renew a license, cost recovery conditions must be met, or they must be in an approved payment plan.

The BRN does not have statutory authority to require cost recovery for any cases involving applicants or for licensees who are board-ordered to have a mental or physical competency examination to assess for an impairment that may impact their ability to practice safely according to BPC § 820, or when a license is revoked through a default decision. In addition, the BRN does not have the statutory authority to order restitution for consumers. The BRN provided the following tables related to cost recovery; however, it is important to note that cost recovery can be ordered in one FY and not collected until a later FY.

Fiscal Year	Revocation/ Surrender	Probation	Total Amount Ordered	Collected Amount*	Uncollected**
2021/22	\$11,305	\$2,913,0976	\$2,924,402	\$1,986,368	\$938,034
2022/23	\$74,031	\$2,463,735	\$2,537,766	\$1,674,834	\$862,932
2023/24	\$4,876	\$2,788,792	\$2,793,669	\$2,066,425	\$727,244
2024/25	\$29,448	\$2,856,363	\$2,885,811	\$1,991,417	\$894,394

* Includes Public Repevals.

** Cost recovery can occur over multiple FYs.

* “Potential Cases for Recovery” are those cases in which disciplinary action has been taken based on violation of the license practice act.

Staffing Levels

The BRN has both an Executive Officer (EO) and an Assistant Executive Officer (AEO). The EO is statutorily mandated to be a current and licensed RN, appointed by the board.¹⁵ The current EO was appointed June 4, 2020, and served as the acting EO for four months prior to the formal appointment. In addition to an EO and AEO, the BRN has a chief of legislation, a chief of licensing, a chief of operations & consumer services, a chief of enforcement and utilizes the DCA deputy director of information services to aid in the oversight of the two IT Specialists and one IT Associate. In 2024, the BRN was authorized for 228 staff positions, down from 237 authorized positions in FY 2020-21.

Licensing and RN Workforce

There is a persistent concern nationally about ensuring a robust workforce of licensed RNs. The COVID-19 pandemic magnified the impact of an undersupplied and overworked RN workforce.

The BRN has consistently had one of the highest RN licensing populations in the country, followed by Texas, Florida, and New York. The BRN currently licenses and registers over 566,000 RNs and APRNs combined. The RN licensing population in California has steadily increased 13% between the years 2011 to 2025. In 2011, the BRN reported during the sunset review that it regulated

¹⁵ Business and Professions Code § 2708

approximately 380,000 RNs and in the 2026 Sunset Review Report, noted that it regulates approximately 430,000 active RN licensees that reside in-state and APRNs combined.

The BRN's licensing unit issues licenses or registrations to applicants who meet the minimum requirements of current statutes and regulations and who have not committed acts that would be grounds for denial. The BRN issues licenses and registrations to both in-state and out-of-state applicants.

The BRN reports that it has taken several steps to improve application processing efficiency, including launching the California Nursing Program Graduate Portal, partnering with the National Student Clearing house and Parchment to increase the speed of transcript processing, automating application review, and entering into a contract with a professional services firm.

Except for NP and PHN certification applications, the BRN no longer has internal performance timeframes for application processing.

For NP certification applicants, the BRN is required to notify an applicant in writing within 30 days of receipt that the application is complete and accepted for filing, or that the application is deficient and what specific information is required for the application to be considered complete. A decision on the evaluation of credentials must be reached within 60 days of the filing of a completed application. An incomplete application is deemed abandoned one year after the date of the notice of deficiency.¹⁶

For PHN certification applications, the BRN is required to notify the applicant in writing within 30 calendar days of receipt of an application and fee that the application is complete and accepted for processing or is deficient and what specific information, documentation, or fee is required to complete the application. An incomplete application is deemed abandoned one year after the date of the notice of deficiency.¹⁷

The BRN reports it is meeting the target performance requirements for NP and PHN certification applicants and is processing complete applications for NPs within 7 days and 6 days for PHNs. The processing times for 103 NPs is 35 days in FY 2024/25, down from 78 days in FY 2023/24. For RN examination applications, RN endorsement applications, CNM applications, CNS applications, CRNA applications, NP applications, and PHN applications, the BRN reports that it has reduced application processing times during the last four FYs.¹⁸

The BRN reports the following increases/decreases with respect to new applications received during the last four FYs:

- RN Examination: 19% increase
- CNM: 16% decrease
- CNM Furnishing: 17% decrease
- CNS: 17% increase
- CRNA: 1% increase

¹⁶ Title 16, California Code of Regulations, § 1483

¹⁷ Title 16, California Code of Regulations, § 1493

¹⁸ *Sunset Review 2026*, California Board of Registered Nursing, <https://www.rn.ca.gov/pdfs/forms/sunset2026.pdf>

NP: 31% increase
NP Furnishing: 39% increase
PHN: 173% increase
PMHN: 152% increase
NP 103: (*last three FYs only*): 33% decrease

As part of the licensing process, all applicants are required to submit fingerprint images to obtain criminal history background checks from the Department of Justice (DOJ) and the Federal Bureau of Investigation.

All BRN license applicants are required to submit primary source documentation, which includes educational transcripts. All new applicants must take and pass the NCLEX, which is developed and overseen by the National Council of State Boards of Nursing (NCSBN). Tests are computerized and available at Pearson-Vue testing centers. There are 27 test sites in California and examinations are administered daily by appointment. The BRN does not develop or administer any licensing, practical, or state-law examination. The NCLEX is only offered in English and French. The NCSBN conducts a triannual occupational analysis of its examination. The BRN provides NCLEX-pass rate data on its website for each approved school.

Applicants who are licensed outside of California are eligible for “licensure by endorsement” in California. To obtain licensure by endorsement, applicants must hold a license in good standing from another state that is validated through the NURSYS database, the NCSBN national database for verification of nurse licensure, discipline, and practice privileges of RNs, and APRNs licensed in participating jurisdictions. State nursing boards, including the BRN, report RN/APRN discipline to NURSYS. When applicants apply for licensure through the endorsement process, state boards of nursing can verify licensure through the NURSYS system. The BRN’s licensing unit reviews all endorsement applicants in NURSYS for any disciplinary action by another state. If action is reported, the application and all documentation are forwarded to the BRN’s enforcement division for review. For RNs licensed in California, records are reported to NURSYS. Any disciplinary actions in another state reported to NURSYS would result in a notification to the BRN. All renewal applicants are required to disclose all misdemeanor and felony convictions, as well as all disciplinary actions against any license or certificate held in California or in another state or territory. RNs are notified that failure to disclose all, or part of their convictions may be grounds for disciplinary action because failure to disclose this information is considered falsifying information.

Additionally, the BRN along with other state boards of nursing report violations through NURSYS to the National Practitioner Databank (NPBD), which is a federally administered program. The NPBD collects information and maintains reports on medical malpractice payments made on behalf of practitioners, federal and state licensure certification actions, health care-related criminal convictions and civil judgements, and adverse clinical privileges actions to name a few. BRN queries the NPBD for applicants.

Applicants for licensure by endorsement must have also passed the NCLEX (or any previously approved national examination), and provide the required fingerprint information. Licensure by endorsement does not absolve the licensed applicant from meeting California’s educational requirements which are specified in regulations. If the education is deficient, the applicant must

remediate the deficiency. The average processing time for a complete endorsement application is 40 days.

In 2023, Operation Nightingale was a multi-state law enforcement investigation and enforcement action by the United States Department of Health and Human Services, the DOJ and the FBI that uncovered a scheme to sell fraudulent nursing diplomas and transcripts from Florida-based nursing schools to thousands of aspiring nurses across the country. These fraudulent documents were then used to qualify for the NCLEX and obtain nursing licenses in multiple states, including California. In January 2023, the United States Attorney for the Southern District of Florida, FBI, and United States Department of Health and Human Services Office of Inspector General publicly announced enforcement actions stemming from Operation Nightingale.

In response, state boards of nursing across the country, initiated reviews of licensure records and began revoking licenses obtained through fraudulent education. The BRN reports that the additional review of nursing education because of the fraudulent schools requires additional scrutiny of out-of-state licensees, those seeking advanced practice certification, or licensure in California as the BRN may need additional time to review education to ensure it was not obtained from one of the fraudulent institutions. The BRN maintains a list of the fraudulent schools on its website and encourages any employer of an RN who obtained education from a fraudulent institution to report to the BRN. The BRN reports that it will seek to revoke the license of an RN who has obtained fraudulent education.

Military Applicants

Consistent with BPC § 2786.1, if a nursing program does not have a process for granting credit for military education and experience the BRN will deny the application or revoke the school approval. Current regulations specify that California-approved nursing programs must have a process for a student to obtain credit for previous education or for other acquired knowledge in the field of nursing, including military education and experience, through equivalence, challenge examinations, or other methods of evaluation. The information must be available in published documents, such as a college catalog or student handbook, and online.¹⁹ Because of this, the BRN does not review individual requests from veterans who seek to apply veteran experience or training, as the schools make that determination of acceptable coursework and/or experience.

Moreover, the federal Servicemembers Civil Relief Act authorizes service members or their spouses who currently hold a valid license in good standing in another state to practice in California within the same profession or vocation, if they are required to relocate to California because of military orders.

School Approval

There are multiple educational pathways to become a licensed nurse in California. A certificate, an associate's degree, bachelors' degree, or an entry level master's (ELM) degree. Master's degrees are necessary for those interested in pursuing advanced practice. An RN licensee is not differentiated based on whether the applicant has a certificate, an associate degree of nursing (ADN) or a Bachelor of Nursing degree (BSN) if the program meets the licensing requirements prescribed by the BRN.

¹⁹ Title 16, California Code of Regulations, § 1430

The BRN has approved 95 ADN programs, 50 BSN programs and 15 ELM programs in California. The BRN is responsible for both initial school approval and continued approval of nursing programs. The BRN approves prelicensure nursing programs that are degree-granting institutions of higher education or affiliated with institutions of higher education, including California Community Colleges, California State Universities, and the University of California system. In addition, the BRN approves private institutions under the California Private Postsecondary Education Act subject to regulation by the Bureau for Private Postsecondary Educations (BPPE). For prelicensure programs who fall under the jurisdiction of the BPPE, the BRN must establish a MOU with the BPPE surrounding the program defining the respective authority of the BPPE to protect students and the BRN for their role of approving programs to ensure course completion is satisfactory for licensure purposes. The BRN is statutorily required to inspect all schools of nursing in California at times the BRN deems necessary.²⁰ The BRN's process for initial school approval is detailed in regulations, and requires a lengthy and comprehensive process including:

- Notice of intent from the proposed program to the BRN.
- A feasibility study detailing most aspects of the proposed program, including a description of the overall institution, including history, accreditation status, other programs. It also includes geographic area, description of program type, information on the applicant pool, description of the subject matter and support areas, including faculty and facilities, budget projections, and availability of clinical placements.
- The program applicant appoints a program director who meets the requirements in BRN-regulations.
- A Nurse Education Consultant (NEC), who is an employee of the BRN, is assigned as the BRN-liaison for the proposed program, and after a self-study, the NEC will perform a site visit of the proposed campus.
- Upon conclusion of a site visit, the NEC submits a report to the BRN as to whether the proposed program meets the BRN-requirements.
- The BRN decides to approve or deny based on the applicant's demonstration that it meets the requirements specified in regulations.²¹

The BRN is authorized to collect a fee to recoup costs for its role in nursing school/program approval.²² The fees for school approval and reapproval are as follows:

1. The fee for approval of a nursing school is set at not more than \$80,000. The current assessment is \$40,000.
2. The fee for a substantive change to an approval of a nursing school is set at not more than \$5,000. The current assessment is \$2,500. However, the BRN is prohibited from charging a fee for substantive change requests or curriculum revisions under specified circumstances and if the change is approved by its accreditor.

The BRN does not approve certification programs for the majority of APRN educational requirements except for NP education programs. Pursuant to current regulations, the program of study preparing a

²⁰ Business and Professions Code § 2788

²¹ Title 16, California Code of Regulations, § 1425(a)

²² Business and Professions Code § 2786.5

NP must be approved by the BRN and be consistent with the NP curriculum core competencies as specified by the National Organization of Nurse Practitioner Faculties in “Nurse Practitioner Role Core Competencies” (2022).²³ Other APRN programs, such as CNM programs may request a review from the BRN to ensure their programs meet the certification requirements in California pursuant to existing regulations.

Continuing Education (CE)

CE is required for licensure renewal. Licensees must complete 30 hours of CE every two years from a CE provider approved by the BRN. The BRN does not approve the content of each CE course offered, rather they approve the provider of the educational course, and review one course offered by that provider as part of the BRN’s course provider approval process. CE courses must be related to the scientific knowledge or technical skills of practical nursing or related to direct or indirect patient care. In addition, CE courses must contain a curriculum that includes the understanding of implicit bias. Self-improvement, attitude enhancers, financial gain or classes aimed at lay persons are not acceptable CE courses.²⁴

The BRN does not require certificates of completion or any supporting documentation of CE compliance from licensees at the time of licensure renewal. Renewal applicants are required to provide an attestation on the renewal application that they have met the requirements. Although BRN regulations require approved providers to issue documentation of course completion to licensees, licensees will only present the proof of coursework completion if they are subject to the BRN’s random audits of CE compliance. Failure to comply with CE requirements may result in citations and fines from the BRN. The BRN reports that it does not have cumulative statistical data for CE audits conducted during the years since the BRN’s prior sunset review. The BRN reports CE audit data only for the months of 3/01/25-10/31/25 where it was able to complete 4,645 audits. Less than two hundred of those audits were referred to enforcement. In the BRN’s 2020 sunset review report, the BRN reported that between FYs 2016/17 and 2019/20, it conducted an average of 8748 CE audits. Less than 200 of those audits each year resulted in a referral to enforcement.

The BRN is additionally required to audit CE providers at least once every five years to ensure adherence to regulatory requirements which include record keeping, changes in organizational structure, prohibition on giving students partial credit, written policies, among others. The BRN did not provide data in its Sunset Review 2026 Report on the number of CE provider audits completed in the last four FYs. In the BRN’s 2026 and 2020 sunset review reports, the BRN notes challenges conducting CE provider audits. The BRN highlights issues including staff time and resources to review all material submitted with a provider audit. The BRN reports that it continues to seek improvements in its CE provider compliance audit program and seeks a NEC to assist with the audit task and course compliance review.

Enforcement

The BRN is responsible for enforcing the Act. The purpose of enforcement is to ensure that licensees adhere to licensing and practice requirements and to protect the public from those that do not. To that

²³ <https://www.nursingworld.org/content-hub/resources/becoming-a-nurse/adn-vs-bsn/>

²⁴ Title 16, California Code of Regulations § 1484

end, the BRN is required to investigate potential violations. Cases without sufficient evidence or those that do not allege a violation are closed without further action. If the BRN finds evidence of a violation, the enforcement division may take several types of actions depending on the severity of the violation.

For minor violations that do not rise to the level of formal discipline, the BRN may send a notice of warning letter or issue a citation, which may include a fine up to a maximum of \$5,000 or an order of abatement. For more significant violations, it may seek formal disciplinary actions against a license, including probation, suspension, or revocation. The BRN can initiate formal disciplinary action by referring the matter to the Office of the Attorney General (AG) to prepare a case for prosecution in an administrative proceeding. For violations that also involve criminal conduct, the BRN can also refer the case to law enforcement.

Disciplinary cases continue to take a significant amount of time to close (approximately 23 months). The BRN notes that these prolonged timeframes remain stable since the last sunset review, however case aging continues to be a challenge for the BRN with respect to disciplinary outcomes.

Examples of violations that do not typically subject the individual to formal discipline include CE violations (not producing the required completion documentation); failure to comply with change of address requirements; first time violations; or other criminal convictions that are not severe, as specified.

Like other licensing boards, the BRN relies on complaints and other information submitted by consumers, licensees, employers, relevant organizations, and governmental entities, including arrest and conviction notices from law enforcement. BRN enforcement staff may also open a case based on internal information reviewed by staff and notice of out-of-state discipline. During the past four FYs, the BRN has received on average 5,678 complaints. Most complaints received by the BRN are generated internally. The public and governmental agencies provide the next highest number of complaints to the BRN. The BRN reports less than 10 complaint cases received annually are closed without referral to an investigation. Most complaints received by the BRN result in an investigation.

The BRN follows DCA's *Complaint Prioritization and Referral Guidelines* which outline priority assignment by complaint type and severity.²⁵

RNs must report known or observed instances of child abuse or neglect, or elder abuse to the appropriate authorities as specified in both the Penal Code and the Welfare and Institutions Code. This mandate applies to those situations that occur in the RN's professional capacity or within the scope of employment and apply to the behavior of others.

Unfortunately, unlike several other healing arts boards under the jurisdiction of the DCA including the BVNPT, the BRN is not an automatic recipient of mandatory reporting by other entities, including employers. The BRN attempted to obtain legislative authority to receive mandated reports, but this has not been successful. However, the BRN both refers to and receives complaints from other allied health boards within DCA, the California Department of Social Services, the Department of Healthcare Services, the California Department of Public Health, other governmental agencies when applicable, and the public. The BRN reports disciplinary actions to NCSBN which, among other actions, transmits

²⁵ https://www.dca.ca.gov/enforcement/case_referral_guidelines_healing_arts.pdf

the final decision to other states in which the RN holds a license as well as to required federal agencies and databanks.

Mandatory reporting requirements under BPC § 805 are only required for 103 NPs and 104 NPs (independently practicing NPs). “805 peer review” requires peer review bodies (i.e. hospital staff), to report specified information about licensees directly to the BRN, such as denying or restricting a NP's privileges for disciplinary reasons, and for NP resignations during investigations. An 805 Report must be filed when a licensee faces denial, revocation, restriction, resignation, or suspension of staff privileges, membership, or employment for medical disciplinary reasons. This includes denials of applications, revocations, restrictions lasting 30 days or more within 12 months, resignations or withdrawals during an investigation, and summary suspensions exceeding 14 days.

Insurers providing professional liability insurance are required to report to the BRN any settlement or arbitration award over \$10,000 for damages for death or personal injury caused by the licensee’s negligence, error, or omission in practice.²⁶ Reports must be sent within 30 days after the written settlement agreement has been reduced to writing and signed by all parties or within 30 days after service of the arbitration award on the parties. The BRN provided the table below which captures the settlement data.

Fiscal Year	\$0 - \$10,000	\$10,001 – \$100,000	\$100,001 – \$500,000	>\$500,001	Overall FY Average
FY 2021/22	8	18	23	13	\$755,759
FY 2022/23	10	7	19	10	\$357,598
FY 2023/24	7	27	36	12	\$636,052
FY 2024/25	12	27	25	21	\$765,391

Under BPC § 125.3, all DCA boards have the authority to recover costs from licensees related to enforcement activities except for the Medical Board of California. All enforcement cases referred to the AG resulting in the filing of an accusation have the potential for a cost recovery order. If the case goes to an administrative hearing, an Administrative Law Judge may award cost recovery.

The BRN may reduce or eliminate, but not increase, the cost recovery amount awarded. The full amount of the cost recovery ordered is not required to be repaid until three months prior to the end of the ordered probation term, which may spread the cost recovery over the course of multiple FYs. In matters that result in revocation, a former licensee may petition for reinstatement of their license. Generally, if reinstatement is granted, all penalties and outstanding costs from any prior disciplinary matter must be paid in full before the reinstatement of the license. One significant barrier to collecting funds is the inability to collect penalties before the reinstatement of the license. For example, if a former licensee never applies for reinstatement, the BRN is unable to collect prior costs and penalties. In some cases, the actions of a licensee may be so egregious that licensure reinstatement is highly unlikely; therefore, the revoked license holder will have no incentive to pay the order. As a result, there is a significant percentage of cost recovery that will never become available to collect.

²⁶ BPC § 801(e)

The BRN provided the first table below in the 2026 Sunset Review Report which details the amount of cost recovery ordered vs collected. The second table was provided in the BRN’s 2020 Sunset Review Report. According to the totals in the tables, the BRN has been able to increase its collection of cost recovery; however, it is unclear what is leading to an increase in collection amounts. While the BRN does recover some enforcement costs, enforcement costs account for 34% of the BRN’s annual expenditure. Cost recovery is only 2% of the BRN’s revenue.

Fiscal Year	Revocation/ Surrender	Probation	Total Amount Ordered	Collected Amount*	Uncollected**
2021/22	\$11,305	\$2,913,0976	\$2,924,402	\$1,986,368	\$938,034
2022/23	\$74,031	\$2,463,735	\$2,537,766	\$1,674,834	\$862,932
2023/24	\$4,876	\$2,788,792	\$2,793,669	\$2,066,425	\$727,244
2024/25	\$29,448	\$2,856,363	\$2,885,811	\$1,991,417	\$894,394

* Includes Public Reprovals.

** Cost recovery can occur over multiple FYs.

*** Table 1

Fiscal Year	Revocation	Surrender	Probation	Total Amount Ordered	Collected Amount*	Uncollected**
2016/17	\$11,336	\$239,251	\$1,674,017	\$1,924,604	\$778,000	\$1,146,604
2017/18	\$32,210	\$299,958	\$1,592,005	\$1,924,172	\$500,000	\$1,424,172
2018/19	\$4,780	\$82,315	\$1,768,900	\$1,855,995	\$507,000	\$1,348,995
2019/20	\$0	\$0	\$2,119,543	\$2,119,543	\$901,000	\$1,218,543

* Includes Public Reprovals.

** Cost recovery can occur over multiple FYs.

***Table 2

Consumer Awareness and Education

The BRN provides important consumer information on its website including licensee information, board meeting archives and calendars, consumer publications, listing of approved nursing programs, past studies and publications including previous sunset review reports, NCLEX pass rates, approved CE providers, application requirements, information about filing complaints, processing timeframes among others.

Although not required, the BRN posts accusations and disciplinary actions which include information on suspensions and revocations of licenses issued by the BRN and other related enforcement actions consistent with the requirements specified in BPC § 27.

PRIOR SUNSET REVIEW: CHANGES AND IMPROVEMENTS

The BRN was last reviewed by the Legislature through sunset review oversight in 2022. During the previous sunset review, 38 issues were raised in the staff background paper. In January 2026, the BRN submitted its required sunset report to the Committees. In this report, the BRN described actions it has taken since its prior review to address the recommendations made. For more information about the BRN or to review the 2026 Sunset Review Report, information is available at <https://www.rn.ca.gov/>. The following are some of the more important programmatic and operational changes, enhancements and other important policy decisions or regulatory changes made. For those which were not addressed, and which may still be of concern to the Committees, they are addressed and more fully discussed under “Current Sunset Review Issues.”

- BRN took steps to streamline application review processes.
- Provisions of SB 1451 (Ashby, Chapter 481, Statutes of 2024), which revised and clarified the licensing and requirements to obtain recognition as a 103 or 104 NP, have been implemented.
- The 2021-2025 Strategic Plan was updated to include “diversity, equity, inclusion, and belonging” into the Board’s mission and values.
- Two new committees were established (Certified Nurse Specialist Advisory Committee & Certified Nurse Anesthetist Advisory Committee) in order to better support and address the needs of those specialized advanced nursing professions.
- NECs now meet biweekly.
- Regulations were updated to remove the requirement that a defined percentage of clinical hours be in direct patient care to instead establish a minimum hour requirement.

CURRENT SUNSET REVIEW ISSUES

The following are unresolved issues pertaining to the BRN or areas of concern that should be considered, along with background information for each issue. There are also recommendations Committee staff have made regarding issues or areas that may need to be addressed, and issues raised by the BRN in its 2026 Sunset Review Report. The BRN and other interested parties have been provided with this Background Paper and the BRN will respond to the issues presented and the recommendations of staff.

ADMINISTRATIVE ISSUES

ISSUE #1: (EXECUTIVE OFFICER) Is it necessary for the BRN executive officer to be a licensed nurse?

Background: BPC § 107 permits each board to appoint a person exempt from civil service to be designated as an EO. The EO serves as the chief executive of the organization and manages board matters. The Act requires the BRN to appoint an EO to perform duties delegated by the board and specifies that the EO must be a licensed RN. The BRN is the only licensing board under the DCA that is required to select an EO that is actively licensed as an RN. The authorization in the Act for the Board to exist is set to sunset on January 1, 2027. If the provision in the Act were to sunset, the BRN would likely rely on the permissive authority in BPC § 107 to appoint the EO; however, that section does not require an EO to be a licensee of their respective board. Because the EO is tasked with the overall management of the organization, most boards do not limit the selection of an EO by their status as a licensee.

Staff Recommendation: *The BRN should discuss the distinctions between the administration of the BRN and the other healing arts boards that necessitate the requirement of an RN executive officer.*

ISSUE #2: (GEOGRAPHIC LOCATION REQUIREMENTS FOR MEETINGS) Should the statutory requirement for the BRN to meet in Northern and Southern California be removed due to virtual attendance and participation opportunities for stakeholders?

Background: The BRN is required to meet at least once every three months in both Northern and Southern California.²⁷ The mandate for the BRN to meet once every three months has been in statute since inception of the board. However, the requirement to meet in specific regions of the state was added in 2012, SB 122, (Price, Chapter 789, Statutes of 2012). In the mid-2000s, regulatory board meetings were conducted in-person, with limited web access or availability. Requiring board meetings to be available in different regions of the state was likely to ensure that a diverse representative of stakeholders would be able to attend and participate.

The COVID-19 pandemic changed the course of business for many regulatory meetings. What was once reserved for in-person only affairs, meetings were quickly transitioned from in-person to online and remote to ensure social distancing, respect stay-at-home orders, and protect populations at risk.

²⁷ Business and Professions Code § 2709

Although the pandemic has waned, the unintended benefit of remote regulatory meetings (increased participation from all regions of California) has been a positive impact on the publics' access to meeting participation. In-person meetings require flights and hotel accommodation, which may be costly for the BRN. Remote meetings may increase efficiency, provide cost savings, and add flexibility for regulators and stakeholders.

According to the BRN, while in-person meetings have since resumed, the level of in-person participation has not returned to pre-pandemic levels. In several instances, only two to three individuals attended in person, while over one hundred participants joined remotely via WebEx (the current platform utilized by the BRN for remote meetings). This is because most of the BRN's public participation comes from working professionals (licensees, nurse educators, consumers, etc.) who are more likely to monitor the meeting while fulfilling their professional responsibilities, making remote attendance the most accessible and practical means.

The BRN reports that meetings outside of Sacramento cost approximately \$38,000 per meeting for travel, lodging, and hotel contracts (normally for rooms to host the meetings). Eliminating the traveling requirement for meetings may reduce BRN expenditures.

Staff Recommendation: *The BRN should advise the Committees of any potential fiscal and/or administrative savings by moving to remote meetings and should note whether this could limit public participation and public access to the BRN's important work.*

ISSUE #3: (BREEZE SYSTEM) Is the current IT infrastructure sufficient to handle the BRN's needs? Are the BRN's resources being used wisely on the system? What role should the DCA play in assisting the BRN to meet its IT needs efficiently?

Background: The BRN transitioned to the BreEZe system in 2013. The "BreEZe" project was designed to provide DCA boards, bureaus, and committees with a new enterprise-wide enforcement and licensing system. The updated BreEZe system was engineered to replace outdated legacy systems and multiple "work around" systems with an integrated solution based on updated technology. According to the DCA at the time, "BreEZe is intended to provide applicant tracking, licensing, renewals, enforcement, monitoring, cashiering, and data management capabilities. In addition, BreEZe is web-enabled and designed to allow licensees to complete and submit applications, renewals, and the necessary fees through the internet when fully operational. The public also will be able to file complaints, access complaint status, and check licensee information, when the program is fully operational." While the BreEZe program was initially budgeted at \$24 million, the costs grew to \$96 million.

Unfortunately, throughout the lifecycle of the BreEZe project there remain numerous challenges and problems with the planning, implementation and execution of the system upgrade. During previous sunset review oversight hearings, Committee staff routinely questioned Boards, Bureaus and the DCA about inefficiencies, costs, and delays of the BreEZe project implementation. The Joint Legislative Audit Committee requested the state auditor conduct an audit of the BreEZe IT project. The final audit report released in February 2015, noted the following, "This report concludes that the BreEZe project has been plagued with performance problems, significant delays, and escalating costs, which based on a January 2015 estimate were \$96 million—more than triple the original cost estimate—for

implementation of a system at only half of the regulatory entities originally planned for BreEZe. As of that date, only 10 regulatory entities had transitioned to BreEZe, eight more intend to transition to it in March 2016, and it is unknown whether or when the remaining 19 will transition to the system.”²⁸

The BRN was among the first of the boards and bureaus to transition to BreEZe. The BRN reported in the 2020 Sunset Review Report that it has contributed \$28,571,946 in BreEZe costs through FY 2019/2020. More recently, the BRN has expended \$7,899,000 toward the BreEZe system between FYs 2021/22-2024/25.²⁹ As noted in a 2015 state auditor report, “Our information technology (IT) expert believes that the sheer volume of the changes BRN requested suggest that Consumer Affairs may not have adequately planned the system.”

That same issue remains for the BRN today. The BRN routinely seeks technological improvements and system upgrades to increase efficiency. The BRN cited several updates to its IT infrastructure in its 2026 Sunset Review Report, including:

- Collaborating with DCA and an information technology vendor to create a secure California Nursing Program Graduate Portal for Board-approved prelicensure programs. Using the new portal, a Program Director can query a report of all applicants for initial licensure by examination, verify completion of educational requirements, and electronically transmit graduation data directly to the BRN. Once submitted, the verified information uploads into BreEZe, issues exam eligibility, and automatically sends authorization to test to Pearson VUE. This innovation eliminates the need for individual transcripts, enabling graduates to schedule the NCLEX sooner and improving the likelihood of a first-time pass.
- Expanding the portal to include NP and NM programs so Program Directors can electronically upload NP and/or NM education data, which flows directly into an applicant’s BreEZe licensing application. This automation shortens processing times and reduces data-entry errors. During the same month the Board introduced online submission and payment for APRN certification verification and international license-verification requests, providing a secure, 24-hour self-service option. To further improve document management, the BRN executed a contract with the National Student Clearinghouse, enhancing the electronic transmission and receipt of academic transcripts.
- Gaining an automatic closure function in BreEZe for applications missing required fees, eliminating manual follow-up and maintaining a cleaner database.
- NP/NP Furnishing and NM/NM Furnishing combined applications no longer required a separate furnishing license fee, reducing initial application costs by \$400 per applicant.
- Releasing the Nursing Faculty, Nursing Director and Assistant Director applications in BreEZe; this change shifted the approval of faculty from being tied to the prelicensure academic institution to instead being tied to the individual licensee, allowing approved faculty to transfer between schools more freely. Also, the new Clinical Facility Authorization (CFA) database

²⁸ Report 2014-116, *California Department of Consumer Affairs' BreEZe System: Inadequate Planning and Oversight Led to Implementation at Far Fewer Regulatory Entities at a Significantly Higher Cost*, retrieved 02/04/26

<https://information.auditor.ca.gov/pdfs/reports/2014-116.pdf>

²⁹ *Sunset Review 2026*, <https://www.rn.ca.gov/pdfs/forms/sunset2026.pdf>

allows for streamlined approval and reporting functions. The rollout of the new BreEZe applications and the CFA meet basic operational needs; however, several usability issues have been identified, and improvements are currently underway to improve performance and user experience.

While improvements and updates to the BreEZe system are necessary and help the BRN achieve efficiencies in administrative processes, updates to the BreEZe system cost fiscal resources and time. The BreEZe system is shared amongst 18 other boards and bureaus, which also relies on system specific updates that are necessary for their regulatory oversight. Requested changes are often tailored to each board or bureaus' specific needs. Because BreEZe is a shared IT system, the DCA Office of Information Systems (OIS) is the central IT infrastructure for the DCA and manages the BreEZe IT system. As such, BRN staff cannot make updates to the BreEZe system when needed.

The general change request process is as follows: The BRN requests a change to the OIS. If the change is one that impacts multiple boards and bureaus, the BreEZe Information Analysts (BIO) will determine what updates are most important and timely for implementation and will review the requests. Boards and Bureaus need to identify those change requests that are high priority. Legislative mandates take priority. Update requests to the BreEZe system are also referred to as ticket changes and can take longer than six months to process. System updates may have to wait for two to three cycles before improvements, or the ticket changes are made. Because BreEZe is a shared IT system, those 18 boards and bureaus utilizing the same system are constantly competing for updates or changes to help their programs operate more efficiently, and make any required changes based on legislation or other updates to the law. The update process can be both time-consuming and costly for these entities, including the BRN.

Staff Recommendation: *The BRN should advise the Committees about the most significant challenges with current IT operations. The BRN should advise the Committees on any improvements to IT system updates which may assist in swifter upgrades to BreEZe.*

ISSUE #4: (BAGLEY-KEENE ACT EXEMPTION FOR IEC MEETINGS) IEC handles sensitive topics, mostly in closed-session and also struggles to meet due to quorum issues. BRN believes exempting this entity from Bagley-Keene may resolve various issues.

Background: The BRN has four statutorily mandated committees: the Nurse Midwifery Advisory Committee, the Intervention Evaluation Committee (IEC), the Nurse Education and Workforce Advisory Committee, and the Nurse Practitioner Advisory Committee. As committees operating under the jurisdiction of the BRN, these committee meetings are subject to the requirements of the Bagley-Keene Act. "It is the public policy of this state that public agencies exist to aid in the conduct of the people's business and the proceedings of public agencies be conducted openly so that the public may remain informed."³⁰

In the BRN's 2026 Sunset Review Report, the BRN requested that meetings of the IEC be exempt from the provisions of the Bagley-Keene Act. The BRN oversees an Intervention Program (IP), which is a voluntary alternative to traditional discipline for RNs whose practice might be impaired due to

³⁰ Government Code § 11120

substance use disorder and/or mental illness. Through the IP, the BRN can provide a framework for rehabilitation for RNs with the goal to safely return them to practice. In FY 2024/25, 33 RNs enrolled in the IP and six were previous participants who had successfully completed in the past and have returned. To determine who is eligible for the program, the BRN utilizes the IECs.

The IECs are to evaluate and make recommendations to the BRN about whether an RN should be admitted to the IP, recommend rehabilitation, approve treatment options to include treatment, monitoring, and supervision. IECs also receive and review information related to participants in the IP and help determine whether the RN can safely return to practice. Existing law specifies the requirements for the participants of the IECs and permits the BRN to establish as many IECs as necessary.³¹ IECs must have five members including three RNs, one physician with expertise in the field of, chemical dependency or psychiatric nursing and a public member with knowledge in the field of chemical dependency or mental illness. Board members are prohibited from being appointed to IEC. The various IECs meet throughout the state and are subject to the requirements of Bagley-Keene Act as committees under the jurisdiction of the BRN.

In the BRN's 2026 Sunset Review Report, it reported that over the last four FYs, 11 IEC meetings had to be cancelled due to a lack of quorum. The BRN notes that "IECs are required to meet at least four times annually, operational demands have increased the frequency. In 2026, the IECs are scheduled to meet six times a year, totaling 54 meetings statewide over the course of the year. As most IEC members are practicing healthcare professionals, securing in-person quorums has become increasingly difficult, particularly given the high frequency of meetings. Allowing remote meeting participation would significantly alleviate this challenge." The BRN notes that IEC meetings cost approximately \$3,500 per each IEC meeting for staff and committee member travel and lodging.

The BRN also reports challenges of meeting the requirements of the Bagley-Keene Act, especially as much of the work of the IECs permits the committee to meet in closed session. Essentially, the IECs open in public session, then transition to close session to conduct the work of the IEC. According to the BRN, "Due to the confidential nature of the Intervention Program, the majority of IEC meeting content must occur in closed session. There are a few standing agenda items, such as roll call, approval of minutes, and general updates, that are addressed in open session which is typically within the first 30 minutes of the meeting. The remaining 7-8 hours of substantive work occur in closed session where members of the public cannot attend or participate, resulting in minimal and infrequent public participation." Further, the BRN believes that exempting IEC meetings from the provisions of the Bagley-Keene Act and allowing remote participation would help address any issue with meeting quorum and would reduce staff administrative time and costs to host IEC meetings. According to the BRN, "Removing administrative barriers would allow Board staff and IEC members to be more flexible and responsive to the evolving needs of participants by allowing them to appear before the IECs quickly and on a more frequent basis as they progress through the program."

The Bagley-Keene Act generally requires all state boards and commissions to publicly notice their meetings, prepare agendas, accept public testimony and conduct their meetings in public unless specifically authorized under the Bagley-Keene Act to meet in closed session. The public meeting requirement applies to board and subcommittee meetings alike. A meeting is considered a "gathering" of a majority of the board or a majority of a committee of three or more people where board business

³¹ Business and Professions Code § 2770.2

will be discussed. This includes telephone and email communications. The Legislative findings and declarations in establishing the Bagley-Keene Act note, “*In enacting this article the Legislature finds and declares that it is the intent of the law that actions of state agencies be taken openly and that their deliberation be conducted openly.*” Further, as noted in a guidance document prepared by the California AG on compliance with the Bagley-Keene Act, it cites the following:

California’s Constitution gives people the right to access information about public business. (Cal. Const., art. I, § 3, subd. (b)(1).) For that reason, the meetings of public bodies must be open to public scrutiny. (Id.) To advance this policy, the Legislature enacted the Bagley Keene Open Meeting Act (Bagley-Keene Act, or Act), intending that actions of state agencies be taken openly and that agency deliberation be conducted openly. (Gov. Code, § 11120; see Gov. Code, §§ 11120-11133.) 1 The Bagley-Keene Act protects the public’s opportunity not only to observe, but also to participate in, the decision-making process of state bodies.

The Bagley-Keene Act authorizes public bodies to meet in a closed session which is not accessible or available for public participation under special circumstances which are specified in the law. Some of the more common reasons for closed session meetings include discussions on personnel matters, pending litigation, licensing examinations, administrative adjudications, real estate negotiations, agency security, and audits. Closed sessions must comply with certain general procedures. Closed sessions may be held only during a regular or special meeting, not during an emergency meeting. (Gov. Code, § 11128.) The meeting agenda must show that the state body will hold a closed session, must identify generally the topic of the closed session, and must cite the statutory authority for the closed session.

Staff Recommendation: *The BRN should explain to the Committees why meetings of the IEC should be exempt from public access and advise the Committees on potential administrative efficiencies or cost reductions associated with an exemption from Bagley-Keene Act requirements. Is the BRN aware of any other regulatory body that is exempt from the requirements of the Bagley-Keene Act?*

ISSUE #5: (\$10 SURCHARGE ON ALL RN LICENSE RENEWALS) RN license renewal applications include a designated amount of money to fund a scholarship and loan repayment program for nurses who work in medically underserved areas. What is the status of the program?

Background: In 1988, (SB 1267, Chapter 252, Statutes of 1988), created the Registered Nurse Education Program (Ed program) within the Health Professions Education Foundation housed at the California Office of Statewide Health Planning and Development, which is now the Department of Health Care Access and Information (HCAI). SB 1267 required \$5 from every RN renewal application designated for the Ed program. That amount was increased to \$10 in 2004. SB 1267 initially included a sunset clause for the program, but in 2000, SB 308 (Escutia, Chapter 149, Statutes of 1999) eliminated the sunset date thereby extending the program in perpetuity.

According to a statement provided on HCAI’s website, “HCAI administers the Bachelor of Science in Nursing Scholarship Program (BSNSP) funded through a \$10 surcharge for renewal and licensure fees

of Registered Nurses (RN) in California”. The \$10 surcharge collected is statutorily specified as the renewal fee only.³² The education scholarship and loan repayment programs are available to eligible applicants in exchange for completing a two to four-year service obligation in direct patient care in a medically underserved area of California. This is not a voluntary charge for renewal of licenses; licensees are required to contribute.

HCAI administers the program, determines eligibility and participation requirements, and selects the recipients based on criteria developed through its program.

Between July 2022 and December 2025, the BRN has provided around \$8 million to the NEF. According to information from HCAI, a little over \$5 million has been expended between FYs 2023-2025 to the Associate Degree Nurse Scholarship Program, the Bachelor of Science Nursing Loan Repayment Program, the Bachelor of Science Nurse Scholarship Program, and the LVN-to ADN Scholarship Program. Additional resources for the ADN and the BSN scholarship program are provided through funding from the County Medical Services Program Loan Repayment Program.

The BRN notes that it last received an update during a board meeting from the HCAI in 2023. While the goal of the NEF is laudable, stakeholders including board members and the BRN’s licensing population may benefit from standard reporting requirements and accountability measures to provide greater transparency about the program including the amount dispersed, the number of benefactors, the number of applicants who are turned away and additional monies that contribute to supporting these programs. While HCAI does provide some data on its website, it includes multiple loan repayment programs that are not affiliated with the ED program, and the data is not always current related to program expenditures. It would likely be more helpful if this information were available on the BRN’s website and includes annual accounting metrics, including the amount reserved for administrative costs at HCAI.

Staff Recommendation: *The BRN should advise the Committees on what data it obtains from HCAI and if there is a mechanism to have annual updates or information that can also be available on the BRN’s website.*

FISCAL, FUND, AND FEE ISSUES

ISSUE #6: (INTERVENTION PROGRAM STPEND FUNDED THROUGH LICENSING FEES) BRN suggests providing a stipend to RNs diverted from the disciplinary process if they face substance use disorder or other issues and participate in a Board-administered program. How does this proposal benefit patients and the public?

Background: To help RNs facing substance use disorder mental health struggles, the BRN’s IP was created in 1985 as an alternative to disciplinary action for those RNs whose practice may be impaired due to chemical dependency or mental illness. The IP requires evaluation, treatment, monitoring, and support towards recovery for licensees. The legislative intent for establishing the IP, as specified in current law, charges the BRN to seek ways and means to identify and rehabilitate RNs whose

³² Business and Professions Code § 2815.1

competency may be impaired due to substance use disorder or mental health issues, rehabilitate those nurses, and return them to practice in a manner that does not endanger public health and safety.³³

Current law requires the creation of IECs, which both review requests for entry into the IP and monitor those RNs in the program. The BRN is mandated to establish criteria for the acceptance, denial, or termination of RNs in the IP. There are two ways in which RNs can volunteer for the IP: self-referral not due to disciplinary action or self-referral in-lieu of disciplinary action. Self-referral occurs when an RN directly contacts the program for assistance. This may occur outside of any investigatory or enforcement related process undertaken by the BRN. Self-referral could also occur at the request of an RN under investigation by the BRN's IP. Complaints may come from coworkers, employers, government agencies or a concerned consumer. In addition, the BRN can initiate a complaint.

Participation in the voluntary IP allows RNs to avoid disciplinary action from the BRN as they address the issues that may have led to enforcement. IP eligibility requirements specify that a participant must be licensed and reside in California, be mentally ill or have abused alcohol and/or drugs, voluntarily request admission to the program, agree to undergo reasonable medical and/or psychiatric evaluations, cooperate by providing such medical information, disclosure authorizations and releases of liability as may be requested by the IEC, and not have prior discipline by the BRN for substance abuse or mental illness, or have previously been terminated from the IP or any other IP for non-compliance³⁴. A participant in the IP may be terminated for failure to comply with the requirements of the IP and may be subject to disciplinary action if the program manager determines that the RN presents a threat to the public or their own health and safety.

The BRN has established criteria for denying a request to participate in the IP which include: not meeting the requirements specified above, information is received by the board which, after investigation, indicates that the applicant may have violated a provision of the laws governing the practice of nursing, the applicant is diverting controlled substances for sale or the IEC determines the applicant will not substantially benefit from participation in the program or that the applicant's participation in the program creates too great a risk to the public health, safety or welfare.

If an RN is mandated by the courts to attend an outside IP, that will not absolve the RN from the BRN's disciplinary action if a violation of the act occurs; however, participation in the IP will eliminate the BRN's disciplinary action for those who participate and complete the program.

IP participation is confidential, the BRN does not provide a list of RNs who are in the IP, nor does the BRN designate any license status on BreZE. RNs in the IP are prohibited from practicing as an RN during the onset of the program, however, once an IEC deems that the RN is safe to return to practice, the RN may resume duties as specified by the IEC. The minimum timeframe for participation in the IP is 30 days. BRN says that because the RN is not permitted or may have limitations to their work as an RN during involvement in the IP, they may face financial strains. The BRN notes that participation in the IP is typically between three-five years.

The cost to licensees who participate varies by each participant. IP participants are required to fund part of their participation including initial co-pays, paying for support group fees, drug testing, and administrative fees. RNs in the IP at the beginning are not permitted to practice as RNs but may hold

³³ Business and Professions Code § 2770

³⁴ Title 16, California Code of Regulations, § 1447

other employment opportunities. RNs may seek financial assistance through state agencies including Covered California (to assist with the cost of treatment) or the Employment Development Department. In addition, once an RN completes certain requirements outlined in the Uniform Standards while participating in the IP, there may be workplace or practice restrictions placed on the participant for instance, no access to controlled substances.

As part of the BRN's 2026 Sunset Review Report, the BRN raised the issue of providing a stipend to IP participants. The funding for these stipends as proposed by the BRN would come from the nursing fund. The BRN is a special fund agency, relying solely on fees specified in statute and collected for licensure and renewal, and for school approval and reapproval. The BRN does not receive GF fund money. Any stipends paid to RNs in the IP would be generated by fees from licensees, continuing education providers, and schools.

The BRN reports other states have remedied this problem by providing a stipend to IP participants. For example, Washington recently passed House Bill 1255³⁵ which established a stipend program to defray the out-of-pocket expenses incurred in connection with participation in the Washington State Board of Nursing's approved substance use disorder monitoring program. The BRN believes that assisting with program related costs will remove barriers to involvement and allow participants to better focus on their recovery and return to safe practice.

The BRN recently transitioned its contract with Maximus as the IP administrator and replaced it with Premier Health Group. In FY 2024/2025, 33 RNs enrolled in the program and six were previous participants who had successfully completed in the past and have returned.

Staff Recommendation: *The BRN should explain to the Committees why licensees and education providers should be required to subsidize the cost for participation in the IP and how this proposal benefits the public.*

LICENSING ISSUES

ISSUE #7: (TRANSITION TO PRACTICE) Should NPs licensed outside of California, who have practiced independently longer than three years, still be required to complete the transition to practice in California or should the out-of-state experience be equivalent?

Background: AB 890 (Wood, Chapter 256, Statutes of 2020) authorized certain NPs to practice independent of physician supervision. AB 890 created a multi-tiered framework for NPs to practice in California. Under current law, NPs may practice independent of physician supervision in a defined health care setting (*i.e.* general acute care hospital, intermediate care facility, nursing facility), outside of one of those defined settings (a private practice), or NPs may practice in any healthcare facility under established protocols and procedures *with* physician supervision.

AB 890 specified education and experience requirements for an NP to be eligible to practice independent of physician supervision. NPs who seek independent practice in a defined healthcare setting are referred to as "103 NPs". Applicants for a 103 NP designation are required to pass a national NP examination, obtain certification as an NP from an accredited national certifying body, and

³⁵ <https://legiscan.com/WA/text/HB1255/id/2788729/Washington-2023-HB1255-Chaptered.pdf>

complete a transition to practice (TTP). Notably, the law limits these individuals to having to complete the TTP in California. The TTP consists of a minimum of three full-time equivalent years of practice or 4,600 hours. NPs who want to practice independently outside of a defined healthcare setting, are referred to as “104 NPs.” 104 NPs are required to meet all the above requirements and provide proof of practice for three-years as a 103 NP in good standing, in addition to satisfying the TTP requirement.

Twenty-seven states allow NPs to practice independent of physician supervision. However, the scope of NP practice varies. According to information from *The Nurse Practitioner*, 11 states grant full practice authority for NPs, but require a TTP. California is one of 10 states that grant restricted practice for independent practicing NPs with a TTP requirement. Sixteen states grant full practice authority without a TTP. Out of the 21 states that require a TTP, four states require more hours for a TTP than California. Arkansas is the highest with 6,240-hours of post licensure practice. California, West Virginia, and Virginia require NPs to complete 3-years or 4,600 hours (Virginia is 3-years or 5,400 hours).

In recognition that some of the BRN’s TTP regulations did not align with the original intent of AB 890 and were more stringent than the original legislation, SB 1451 (Ashby, Chapter 481, Statutes of 2024) deleted the requirements for the TTP to be completed in a specified practice area and that the individual attesting to the NPs completion of the TTP be in the same practice area as well. In an earlier version of SB 1451, language was included to better reflect the reality of competent and qualified NPs in other states becoming licensed in California by striking the limitation on the TTP being only completed in California. The language was subsequently amended so pursuant to current law, a TTP completed in another state or decades of experience do not count. BPC §§ 2837.103 NPs still must complete the TTP in California. However, there are many NPs who are authorized to practice independently outside of California who have met TTP guidelines in other states but are not permitted to count that experience towards certification as a 103 or 104 NP in California.

Staff Recommendation: *The BRN should advise the Committees on how NPs from other states complete the TTP requirements in California. The Committees may wish to delete the requirement that the TTP be completed in California in order to facilitate additional practice opportunities for qualified NPs.*

ISSUE #8: (NATIONAL CERTIFICATION FOR ADVANCED PRACTICE REGISTERED NURSES) BRN believes there should there be a mandate for Certified Nurse Midwives, Nurse Practitioners and Clinical Nurse Specialists to obtain national certification to practice in California. There are numerous challenges with this, including the fact that many national certifications obtained by APRNs practicing today no longer exist. Is this requirement feasible and will patients, the public, and licensees benefit?

Background: The BRN oversees four distinct categories of APRNs: CRNAs, NPs, CNMs, and CNSs. Recognition of these APRNs is called “certification” by BRN. These individuals also may be nationally certified by an organization overseeing their particular practice.

- CNSs are RNs with advanced training and education who provide expert clinical practice, education, research, consultation, and clinical leadership as the major components of their role. CNSs work in direct patient care and indirect patient care activities that affect a broad range of

patients. CNSs in California typically serve leadership-type roles in larger healthcare systems, redesigning systems to improve access, quality, and safety in a cost-effective manner, by ensuring that evidence-based practices and innovations are incorporated. There are two pathways in California to obtain BRN certification as a CNS: 1) successful completion of a master's degree in a clinical field of nursing or clinical field related to nursing that meets the BRN's requirements as specified in the practice act, or 2) certification by a national organization/association whose standards are equivalent to those that meet the BRN's requirements.

- CNMs are RNs who are authorized to attend low-risk pregnancy and childbirth and to provide prenatal, intrapartum and postpartum care, including immediate care for the newborn, interconception care, family planning, and care for common gynecologic conditions.³⁶ California NMs may also apply for a NM furnishing number, enabling them to write a medication order to a pharmacy to be filled. BRN certification as a CNM may be obtained by completing a BRN-approved nurse-midwifery program or by completing an out-of-state nurse-midwifery program that is not approved by the BRN and obtaining certification from a national certifying body. The BRN currently recognizes only recognizes one national certifying body, the American Midwifery Certification Board, as this is currently the only credentialing agency that offers a CNM-Women's Health/Gender Specific National Board Certification.
- NPs are RNs who possess additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs as specified in regulations. This includes assessing, diagnosing and treating, ordering and interpreting diagnostic tests, patient education and counseling, managing and providing comprehensive patient care, and prescribing medications if they hold a furnishing certificate. NP certification by the BRN can be obtained by successful completion of a program which meets BRN standards or by completing an out-of-state nurse practitioner program not approved by the BRN and obtaining certification from a national certifying body. NPs may also separately apply for an NP furnishing number, enabling them to write a medication order for a pharmacy to be filled.

“103 NPs” are those who are allowed to practice without standardized procedures with a physician if they have met specific education, national certification, and experience requirements. These NPs are authorized to practice in defined group settings in which one or more physicians and surgeons practice with the NP, marking an initial step toward independent practice.

“104 NPs” are those who have successfully transitioned to full independent practice authority after meeting the requirements to be a 103 NP and subsequently practicing as a 103 NP in good standing for three years of full-time equivalent experience (4,600 hours).

Unlike CNSs, CNMs, and NPs, the qualification to obtain BRN-certification as a 103 or 104 NP requires the applicant to hold a NP certificate from a national certifying body accredited by the National Commission for Certifying Agencies or the American Board of Nursing Specialties and recognized by the BRN.

³⁶ Business and Professions Code §§ 2746-2746.8

- CRNAs are RNs who provide anesthesia services ordered by a physician, dentist, or podiatrist. Anesthesia services can be provided by a CRNA when ordered by a physician on an individualized patient basis. Standard practice and the education and training of a CRNA make it clear that a CRNA is not authorized to “order” anesthesia services for a patient (determine that the patient’s condition or treatment necessitates anesthesia services); however, once that order is made by the appropriate provider, the CRNA is able to provide anesthesia services. Neither physician supervision nor standardized procedures are required for this to occur. CRNAs may also have varying supervisory or collaborative requirements depending on their practice settings and applicable state laws. Similar to 103 and 104 NPs, to obtain BRN certification in California as a CRNA, the individual must provide evidence that they are certified by the National Board of Certification and Recertification of Nurse Anesthetists (NBCRNA). The NBCRNA has developed standards for certification as well as core competencies that are used nationally and by the BRN. There is no equivalency method for CRNA certification.

The BRN raised the issue in its 2026 Sunset Review Report that, apart from 103 and 104 NPs and CRNAs, other categories of APRNs are not required to obtain certification from a national certifying body in their respective advanced practice specialty.

In 2008, after recognition that states had variances for certification and practice standards for APRNs, the NCSBN APRN Committee along with Advanced Practice Nursing Consensus Work Group created the *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education* (Consensus Model). The purpose was to create a model regulatory framework for states to follow to help provide consistency for training and education, consistent titles for practitioners, practice/specialty areas along with strategies for implementation, among others. Since the inception of the consensus model, the BRN notes that states have been working to implement the recommendations in the consensus model presented by the workgroup. There were seven main elements in the consensus model’s regulatory framework which includes the following:

1. **Title:** Advanced Practice Registered Nurse
2. **License:** Holds an APRN license
3. **Four Roles:** CRNAs, NMs, CNSs and Certified NPs
4. **Education:** Completion of postgraduate education is required
5. **National Certification:** APRNs must pass a nationally accredited certification exam
6. **Independent Practice:** APRNs are granted authority to practice independently without physician oversight such as collaborative/supervisory agreement
7. **Independent Prescribing:** APRNs are granted authority to prescribe without physician oversight such as collaborative/supervisory agreement

The BRN notes that California remains one of only three states, along with New York and Indiana, that do not require national certification for APRNs in accordance with recommendation #5 in the Consensus Model. According to the BRN, national certification is an advanced credential demonstrating a nurse’s expertise and clinical competence in a chosen specialty after completing a master’s or doctoral degree. It requires passing a national certification examination from an accredited body which validates their specialized knowledge and skills. Certifications must also be renewed every

four to five years to remain current. In addition, national certification is also required for an APRN to be eligible to bill to the Medi-Cal and federal Medicare program. This means that although it's not required for licensure in California, it can often be a requirement for employment.

The BRN states that "Requiring national certifications as a condition of licensure for all APRNs moving forward would not only ensure alignment with the APRN consensus model and assist in the interstate mobility of healthcare providers, but it would also add another layer of oversight in ensuring that APRNs are competent and safe providers." The BRN has requested a grandfathering provision that exempts currently licensed APRNs from this requirement, unless otherwise mandated by statute.

APRN certifications are typically administered by national, accredited certifying bodies. There have been instances where these certifying bodies have sunset examinations for certain types of certifications. This means that some certifications are no longer available. APRNs who were nationally certified many years ago through a now-obsolete certificate could be unintentionally put in an unviable situation if BRN requires them to be nationally certified in order to have their license renewed. Additionally, new APRN licensees may not be able to meet requirements for national certification if BRN requires this of all APRNs in the event that their certifying body no longer exists. Requiring national certification for profession designations that have never required this would clearly impact people's employment options and may not be feasible for many thousands of currently practicing APRNs providing quality care throughout the state.

Staff Recommendation: *The BRN should advise the Committees on the patient safety that would be gained by creating this new administrative hurdle for many APRNs. The BRN should advise the Committees of the number of APRNs in California who do not hold a national certification, the potential cost and time impact for licensees to obtain certification, and the evaluations BRN has done on what entering a certification program could mean for licensees and the public alike. BRN should advise the Committees whether there sufficient access to these programs and how this change would impact current practicing APRNs who do not have a national certification.*

ISSUE #9: (APRN CERTIFICATION SPECIALTY DESIGNATIONS) APRN certification in a particular specialty does not take away from the fact that these individuals are still RNs. RNs can of course provide a wide range of care to a wide range of patients in a wide range of settings. How does a limitation on practice settings and thus a limitation on patients by APRNs promote safe care? Should APRNs be limited in their practice based on the type of certification specialty they have?

Background: The scope of practice of an RN is specified in the Act and includes basic health care, that helps people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all the following:

- (1) Direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients, and the performance of disease prevention and restorative measures.
- (2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or

rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code.

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

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

Once licensed, RNs are authorized to perform health care functions that require a substantial amount of scientific knowledge or technical skill, including direct and indirect patient care; disease prevention and restorative measures; administration of medication and therapeutic agents; skin tests; immunizations; blood withdrawal; patient assessment, analysis, planning, and treatment implementation; and laboratory tests. RNs perform additional functions under policies and protocols known as standardized procedures. While there are technically no limits on the functions that can be authorized under a standardized procedure, all standardized procedures must comply with BRN and Medical Board regulations, which require the functions to be tied to an RN's individual competence and the scope of physician or podiatrist supervision. RNs may be employed in a variety of healthcare settings and in a variety of healthcare specialty areas such as geriatrics, cardiology, dermatology, etc. When an RN seeks to increase the level of services and expand their scope of practice, RNs seek certification in advanced practice.

There are currently seven NCSBN-approved APRN certification organizations. There is one approved certifying body for CNSs, 5 approved certifying bodies for NPs, one approved certifying body for CRNAs, and two approved certifying bodies for CNSs. Specifically for NP and CNS certification, those seeking advanced practice certificates must choose a certificate specialty area. For example, NP certification is available in adult-gerontology primary care, psychiatric mental health, women's health/gender specific, neonatal, pediatric acute and pediatric primary care. In addition, CNSs may obtain certification in designated specialties such as neonatal, adult gerontology and pediatrics. The certification designations, however do not necessarily reflect the career opportunities or employment areas that an NP or CNS may practice in.

However, for purposes of 103 and 104 NP designations, BRN promulgated regulations that limit these individuals to only practice in a specified practice category. 16 CCR §1481 establishes six categories of NPs and also says that NPs who have met additional training and experience requirements are authorized to work without standardized procedures. 103 NPs are only authorized to practice without standardized procedures in a group setting and in one of the specific categories, while 104 NPs are only authorized to practice without standardized procedures inside or outside of a group setting and in one of the specific categories. BPC § 2837.104 specifies that these NPs are only authorized to practice "within the scope of their clinical and professional education and training, including specific areas of concentration and shall only practice within the limits of their knowledge and experience and national certification". BRN's regulation deviates from statute significantly by saying that these trained and certified individuals can only practice in one of the six categories it delineated through regulations,

since the statute authorizes NPs to practice without standardized procedures in accordance with their education and training.

Staff Recommendation: The BRN should advise the Committees on the process of maintaining APRN-certification designations when a certifying body ceases to provide any examination. The BRN should advise the Committees on how certification specialties correlate in practice in settings.

ISSUE #10: (DOCUMENTATION VERIFICATION) CE compliance remains a challenge for BRN to enforce. Should renewal applications include proof or documentation of completed CE coursework? Are the fine amounts appropriate for non-compliance?

Background: Pursuant to BPC § 2811.5, all RNs must complete 30-hours of CE every two years to be eligible for licensure renewal. The BRN is required to establish the standards for CE through regulations. Current regulations include a variety of formats to complete CE such as online, academic studies, in-service education, institutes, seminars, lectures, conferences and workshops among others. CE courses must be relevant to the practice of nursing or related to the direct patient care of a client and enhance the knowledge of the RN at a level above that required for licensure. The BRN is responsible for both approving CE providers and auditing CE providers to ensure that coursework providers are adhering to the BRN’s regulatory requirements. Certain APRNs (NPs) who provide primary care to a patient population which 25% is 65 years of age or older, must complete at least 20% or 7.5 hours of CE coursework in gerontology, the special care needs of patients with dementia, or the care of older patients at the time of renewal. Otherwise, licensees have discretion in the types and subject of the CE they obtain.

During the licensure renewal process, licensees must submit proof to the BRN of successful completion of the required CE hours. Currently, licensees provide “proof” to the BRN by signing a statement under penalty of perjury indicating compliance.³⁷ Licensees are required to keep certificates of completion or other records of attendance for four years. Licensees do not need to submit completion records at the time of renewal; however, if the BRN requests the documentation, a licensee is required to submit upon request.

To ensure compliance with the CE mandates, the BRN conducts random audits of its licensee population. At the time of an audit (after the renewal license has been issued) the BRN may request the records of CE compliance from the licensee. Unfortunately, the BRN has not been successful in the last four FYs with conducting audits and verifying completion of CE. As reported in the BRN’s 2026 Sunset Review Report, “The Board is unable to provide a complete set of statistics for its CE audits because staffing issues/limitations and management constraints impeded data collection. These operational challenges restricted the Board’s ability to validate audit results, leaving verified counts and outcomes available only for March 2025 forward.”

In the BRN’s 2020 Sunset Review Report, the BRN reported more consistent audit numbers, averaging over 8,700 CE audits for the FYs 2016/17-2019/2020. According to these past figures, the BRN was conducting audits of only slightly over 2% of its licensing population.

³⁷ California Code of Regulations, Title 16, § 1451(b)

If a licensee fails an audit of CE compliance (which may occur after the licensure renewal), they may be subject to a citation and or fine. Since 1996, the BRN has issued citations and fines to RNs who violate the CE requirements. The fine amounts are \$1,500 for submitting fraudulent CE certificates and \$250 for RNs who cannot provide evidence of CE course completion; however, current statute and regulations do not provide clear language on how fines are assessed so the BRN reports that it has been issuing citations without fines. Serious violations are referred to the AG for disciplinary action.

Given that audits are time consuming for the BRN to conduct when there are multiple steps in the process including contacting a licensee, waiting for a response, receiving documentation that must be verified, could the process be streamlined if licensees were required or allowed to submit completion of CE at the time of renewal? This would likely eliminate the need for audits as CE would be verifiable at the time of renewal.

Staff Recommendation: *The BRN should advise the Committees on any process updates that might ensure greater compliance and accountability with CE mandates. Would it be beneficial for licensees to submit proof of completion at the time of renewal? Should fine amounts for CE compliance violations be increased in statute?*

ISSUE #11: (FURNISHING NUMBER) Can the process for BRN renewing furnishing numbers to APRNs be streamlined? Should there be one combined application for APRN renewal and furnishing number renewal?

Background: In California, designated APRNs may prescribe or furnish certain drugs and substances. CNMs and NPs may prescribe according to statutorily specified protocols and procedures while 103 and 104 NPs are authorized to prescribe independently. All APRNs are only permitted to furnish medications that fall within the scope of practice of their respective certification level. Furthermore, for an NP whose furnishing is subject to standardized procedures and protocols, they must be supervised by a physician and surgeon. The furnishing law requires that a physician supervise no more than four NPs at one time. If NPs are not furnishing, there are no limitations on the number of NPs a physician may supervise.

The authority to furnish in the practice act provides authority to NPs or CNMs to order medication but not prescribe. They must also register with the DEA to prescribe schedule II medications and for all prescriptions to be filled by pharmacies. Those seeking furnishing authority must meet specified coursework in pharmacology covering the drugs or devices to be furnished by the licensee. Current law requires NPs that hold a furnishing number to register with the DEA and authorizes them to furnish Schedule II controlled substances either through protocols and procedures or by holding a 103 or 104 designation, and also requires them, as part of CE, to complete a course that includes Schedule II controlled substances and the risks of addiction associated with their use based on the standards developed by the BRN. CNMs must also complete this Schedule II substances CE. CNMs are authorized to furnish or order schedule II or III controlled substances pursuant to policies and procedures mutually agreed upon with a physician and surgeon.

Prior to the BRN's last sunset review, NPs and CNMs would need to apply for their advanced practice certification from BRN on one form and then separately apply to the BRN for a furnishing number.

This resulted in two applications and two fees. AB 2684 (Berman, Chapter 413, Statutes of 2022) authorized the BRN to combine the application for a furnishing number into the same application for BRN-certification as an NP and CNM. Pursuant to BPC §§ and 2746.51, 2836.3, the BRN may issue a furnishing number upon initial application and, if approved by the Board, the applicant is not required to make a separate application. However, the change does not affect renewal applications. NPs and CNMs with furnishing numbers must separately reapply for renewal for each of their certificates and the furnishing number. The current renewal fee for an NP and CNM is \$150. The separate renewal fee for furnishing renewal is \$162. The BRN requests authority to further streamline and automate the certification process to allow a furnishing number application to be automatically included in an application for renewal. According to BRN, combining, at a minimum, the renewal application, as it has done with the initial application, would likely reduce processing times and reduce costs to licensees, as this would likely eliminate the additional \$162 furnishing application fee.

Additionally, the BRN would like to streamline the application process to allow for furnishing upon NP and CNM licensure without issuing a separate furnishing number with their appropriate APRN application. The BRN notes that this would align with all other states and DEA, as the DEA currently utilizes the NP license number and not the furnishing license number, as they are the same in their system.

Staff Recommendation: *The BRN should advise the Committees on the cost saving and time saving efficiencies associated with combining the renewal application. The BRN should advise the Committee on any potential stakeholder concerns.*

WORKFORCE ISSUES

ISSUE #12: (SUPERVISION RATIOS) Should the 1-4 ratio for physician supervision of furnishing NPs be eliminated or are other statutory clarifications necessary?

Background: Current law permits NPs to furnish or order drugs or devices if the NP meets the necessary conditions specified in statute. NPs are required to take a course in pharmacology covering those drugs which will be furnished or ordered. NPs must hold an active furnishing number with the BRN, complete CE specific to Schedule II controlled substances (if ordering or furnishing those) and be registered with the DEA. The drugs or devices are furnished or ordered by the NP in accordance with standardized procedures or protocols developed by the NP and the supervising physician. NPs operate under standardized procedures that specify which drugs or devices may be furnished or ordered, under what circumstances, the extent of supervision, the method for review of the NP's competence, including peer review, and a review of the standardized procedures. Current law prohibits any physician from supervising more than four furnishing NPs at one time.

The BRN notes in its 2026 Sunset Review Report that the current ratio in statute is required for NPs who use Standardized Procedures to support their practice which is no longer a requirement for all furnishing APRNs. The BRN would like to statutorily clarify that the level of supervision and the ratio requirement instead be covered in the standardized procedures they practice within. The BRN notes that it consistently receives inquiries from employers and practitioners requesting clarification as to what the "one to four" ratio looks like in practice. For example, does it mean a physician and surgeon can supervise four furnishing NPs at any given moment, four NPs over the course of one shift, four

NPs over a 24-hour period, etc. The Board also receives questions about whether physicians can supervise more than four NPs, if the additional NPs either don't have a furnishing license or have a furnishing license but are not actively furnishing during their shift. As a result, the BRN states that revised statutory clarification, "would allow for greater flexibility, better alignment with the operational needs of healthcare settings, and more effective oversight tailored to the qualifications of individual providers and the complexity of care being delivered."

Staff Recommendation: *The BRN should advise the Committees on any discussions it has had with stakeholders, including facilities and those who supervise.*

ISSUE #13: (DELEGATION AUTHORITY) BRN believes statutory updates are necessary to ensure that APRNs who are not subject to standardized procedures and protocols are statutorily authorized to delegate duties to RNs. Is the Nursing Practice Act the appropriate place to specify employer-based decisions?

Background: RNs are required to operate pursuant to standardized procedures as defined in the Act. This allows RNs and APRNs to delegate certain tasks, including the ordering of nursing services, as determined through the standardized procedures both at a facility and the standardized procedures between some NPs and supervising physicians. However, as recent legislative changes have granted authority for APRNs, including NPs, CRNAs, and CNMs to operate independent of standardized procedures, BRN believes there is ambiguity related to independently practicing APRNs and their authority to delegate or order tasks to other RNs. The BRN noted in its 2026 Sunset Review Report, "From both an operational and access-to-care standpoint, the ability for APRNs to direct RNs is critical. Consequently, nurse scope of practice needs to be updated to make clear that APRNs can still direct RNs without the use of standardized procedures."

The BRN recommends the Act be amended to allow an APRN to direct the RN to provide direct and indirect patient care services including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen. It would be helpful for the Committees to understand how current law limits the ability for APRNs to work with partner RNs in practice settings governed by various employment requirements and other facility-specific rules.

Staff Recommendation: *The BRN should advise the Committees on discussions with stakeholders and provide the proposed statutory updates that would provide clarity.*

ISSUE #14: (BSN vs ADN). What is the difference in these types of degrees when it comes to employment opportunities?

Background: There are three separate pathways to become an RN in California; 1) complete an education program including an ADN, a BSN or a MSN, 2) transition from an LVN to an RN; or 3) complete and meet specified requirements through military education and training. All three pathways lead to licensure in California. If an individual seeks to become an advanced practice RN and practice as an NP, CNM, CRNA, or a CNS, a minimum of an MSN is then required. Otherwise, the scope and

licensing requirements of the entry level RN license is the same regardless of the pathway to licensure including degree.

Staff Recommendation: *The BRN should advise the Committees of discussions about employer preference, if certain RN degree holders are provided more favorable employment opportunities, and whether there is added value for one pathway to licensure or another when it comes to marketplace opportunities like wages, salary, and employment. The Committees, BRN, education providers, and stakeholders should work together to explore avenues to increase access to ADN to BSN bridge programs or other modular opportunities and should evaluate how those opportunities can assist ADN holders in furthering their education and training*

ISSUE #15: (LVN TO RN) Are there sufficient opportunities for an LVN to acquire an RN license? Is the LVN to RN 30-unit optional pathway still appropriate for today's nursing practice?

Background: LVNs are licensed and regulated by the BVNPT. LVNs operate under the direction of a licensed physician or RN, to perform those services requiring technical and manual skills acquired in a BVNPT-approved vocational nursing school. According to the Vocational Nursing Practice Act and the BVNPT's regulations, services requiring technical and manual skills include the following:

- Basic nursing services, which means basic assessment (data collection), participation in planning, execution of interventions per a treatment plan, and contribution to the evaluation of individualized interventions related to the care plan or treatment plan.
- Administration of medications, including by hypodermic injection when directed by a physician.
- Application of communication skills for patient or client care and education.
- Contribution to the development and implementation of a teaching plan related to self-care for the patient or client.
- The performance of the following when directed by a physician and if additional training requirements are met:
 - The start and superimposition of intravenous fluids.
 - Blood withdrawal.
 - Tuberculin skin tests, coccidiosis skin tests, and histoplasma skin tests within the course of a tuberculosis control program.
 - Immunizations under written guidelines adopted by a hospital or medical group with whom the supervising physician is associated.

The LVN program is typically a one-year program. LVNs may consider an RN license for career advancement. A RN license may provide higher income opportunities, potentially more available employment, expanded scope of work, or an ability to work within a chosen focus or a specific nursing specialty.

For those LVNs interested in acquiring an RN license there are three pathways. LVNs can apply for admission to an ADN, BSN, or ELM program (similar to non-licensed general public), apply for an advance placement LVN to RN track offered as part of those degree granting approved prelicensure

nursing programs, (there are five BRN-approved pre-licensure nursing programs that only offer this track and do not offer a general public degree option), or the LVNs may opt for the LVN-RN, 30 Unit Option which grants only a certificate that allows the LVN to be eligible to take the NCLEX.

The 30-unit option is designed as a career ladder for LVNs seeking RN licensure. This option takes approximately 12 months and is only offered if space is available within the BRN approved enrollment numbers at any given nursing program. The BRN notes that no degree is granted upon completion and that no other state recognizes the LVN-RN 30-unit pathway certification and therefore CA RNs who have utilized that pathway may not be able to obtain an RN license in other states without potentially completing additional coursework, experience or degree. Additionally, all BRN approved prelicensure nursing programs must offer this track, but it is not typically pursued by the LVN. Instead, LVNs may prefer to complete a degree granting program to have the flexibility to get an RN license in other states. The BRN reports that all BRN approved programs will give LVNs credit for some of the coursework they completed to become an LVN. In addition, when the BRN considers the approved enrollment numbers for a nursing program, all pathways including the non-licensed public pathway are inclusive in the one approved enrollment number as they all require clinical allotments, faculty oversight, and other resources.

Staff Recommendation: *The BRN should advise the Committees on any recent discussions about the 30-unit pathway and any consideration about whether it should continue if underutilized.*

ISSUE #16: (WORKFORCE DATA) Numerous data collection opportunities exist to identify the presence of nurses in the healthcare delivery system. What is the status of data reporting?

Background: RNs and APRNs play a critical role in California’s healthcare delivery system. Data is useful to help determine where, or if a provider shortage may exist, as well as the distribution of practice areas, fluctuations in licensees, the license type (RN or APRN), demographics of practitioners, among many other information sets. To that end, there have been multiple enhanced efforts by the Legislature and others to ensure that RN and APRN workforce is available.

Pursuant to BPC § 502, the BRN, along with all other healing arts licensing boards, collects workforce data from their respective licensees for future workforce planning. Data is voluntarily collected at the time of licensure renewal for those entities that utilize an electronic renewal format. The law specifies that the requested information from licensees should, at a minimum, contain the following:

- Anticipated year of retirement.
- Area of practice or specialty.
- City, county, and ZIP Code of practice.
- Date of birth.
- Educational background and the highest level attained at time of licensure or registration.
- Gender or gender identity.
- Hours spent in direct patient care, including telehealth hours as a subcategory, training, research, and administration.
- Languages spoken.

- National Provider Identifier.
- Race or ethnicity.
- Type of employer or classification of primary practice site among the types of practice sites specified by the board, including, but not limited to, clinic, hospital, managed care organization, or private practice.
- Work hours.
- Sexual orientation.
- Disability status.

The BRN collects the data and provides it to HCAI, home of the California Health Workforce Research and Data Center, which serves as the state’s central source of health workforce and health profession education data and informs state policy regarding health care workforce issues. Health and Safety Code § 128051 requires HCAI to work with the Employment Development Department’s Labor Market Information Division, state licensing boards, and state higher education entities to collect, to the extent available, all of the following data:

- The current supply of health care workers, by specialty.
- The geographical distribution of health care workers, by specialty.
- The diversity of the health care workforce, by specialty, including, but not necessarily limited to, data on race, ethnicity, and languages spoken.
- The current and forecasted demand for health care workers, by specialty.
- The educational capacity to produce trained, certified, and licensed health care workers, by specialty and by geographical distribution, including, but not necessarily limited to, the number of educational slots, the number of enrollments, the attrition rate, and wait time to enter the program of study.

HCAI is responsible for the collection, analysis, and distribution of information on the educational and employment trends for health care occupations and geographic distribution across the state. HCAI produces an annual report to the legislature that: a) Identifies education and employment trends in the health care professions. b) Reports the current supply and demand for health care workers in California and gaps in the educational pipeline producing workers in specific occupations and geographic areas. c) Recommends state policy to address issues of health workforce shortage and distribution. d) describes outcomes and effectiveness of the state’s health workforce programs.

As part of data collection, licensees may be asked about specialty areas of practice, practice locations (including addresses), and any specialty/primary area of practice, among other general personal demographic information. For the BRN respondents practice areas range from acute health to pulmonary, oncology, sports medicine, dermatology, gerontology, to name a few.

HCAI is in the process of making the 2026 Health Workforce Research Data Center Annual Report accessible online. The 2025 annual report³⁸ is currently available and captures specific data related to California’s APRN licensing population including regions where APRNs practice, the number of new practicing APRNs, and a distribution index of practitioners.

³⁸ <https://hcai.ca.gov/wp-content/uploads/2025/06/Health-Workforce-Research-Data-Center-Annual-Report-to-the-Legislature-April-2025-2.pdf>

In September 2024, the California Healthcare Foundation also conducted a survey study of California's NP workforce to assess demographics, education and scope of practice.

In addition, the BRN contracts with the University of San Francisco, Health Policy Studies to produce a regional forecast of the RN workforce in California.

Staff Recommendation: *The BRN should advise the Committees if it believes any additional data or reporting metrics would be valuable to assess the RN and APRN workforce or if it believes the current data collection tools are sufficient.*

ISSUE #17: (NATIONAL NURSE LICENSURE COMPACT) The question of California joining professional licensure compacts has been raised for a number of years. What is the benefit to California licensees and patients?

Background: California currently does not participate in any professional licensing compacts. Compacts have proven to be problematic and challenging for California licensees and regulatory programs alike, in terms of compact governance, enforcement options, parity in licensure qualifications, and other aspects of compact pathways. When a state joins a compact, it is subject to the rules of the compact and the bylaws established by a compact governing body. While a member state may have a vote or voice in the governance of a compact and may have some say in the development and amendment of bylaws, that is not the case for all licensing compacts.

Many licensing priorities in California may not be reflected in compacts, such as the ability for individuals in California to become licensed using an individual taxpayer identification number, rather than only a social security number. Compact rules and specifications cannot be amended by a single member state and updates are not always subject to the transparent and open discussions held in the Legislature or by California regulatory programs subject to the Bagley-Keene Act. Some compacts group categories of licensees together who may be licensed by a separate licensing entity, and there are often a number of key differences between the rules and processes of a compact and the practice acts administered by a California program.

Military spouses, historically one of the populations with the most sympathy surrounding the need for greater licensure portability given the frequency of their movement to other states, are already taken care of and covered by federal action taken in 2023. They can now practice temporarily with their license from another state if they have orders stationing them in California.

Many professions for which a national licensing compact has been established, like nursing, already enjoy streamlined approaches to licensure that California regulatory boards offer out-of-state providers. So far, members of the Legislature have not been convinced that joining compacts, particularly given the pathways available to out-of-state providers to legally engage with California patients and clients, is necessary. Concerns have been raised about the potential for individuals from states with policies and priorities that do not align with California being more easily able to take jobs that California licensees, who attended California schools, would have to compete for. Issues have also arisen about how enforcement works for compact licensees practicing in a state other than their home

state and where California's strong consumer protection laws in general could possibly take a back seat to a state that does not prioritize patient and client safety in the same way.

Out-of-state licensed health care practitioners (including RNs and APRNs) are permitted to temporarily practice in California at the request of, and at the direction of the Director of the Emergency Medical Services Authority (EMSA), during a declared state of emergency. This was a common practice during the COVID-19 Pandemic. In 2020, EMSA provided data that approximately 1,600 RNs were permitted to practice in California without separately obtaining a California license during the state of emergency pursuant to BPC § 900.

For all other out-of-state licensed RNs who seek licensure in California, the BRN grants licensure by endorsement. The licensure by endorsement process requires an applicant to hold a current and active RN license in another state which is validated through NURSYS, or directly from the state where the applicant holds the license, have completed an educational program meeting all California education requirements verified through review of official school transcripts and/or the review of the nursing program curriculum, obtained appropriate fingerprint background clearance, and passed the NCLEX. If the applicant is deficient in any of the educational components, they are required to complete an approved course prior to obtaining licensure. Recently adopted regulations, 16 CCR § 1410.5 updated nursing education requirements to waive the laboratory component of anatomy, physiology, or microbiology courses for out of state endorsement applicants that have been practicing in good standing for at least two years. Applicants licensed in other countries who have not passed the national examination are not eligible for endorsement and may become licensed through the examination process. The current fee for an endorsement application is \$350.

The BRN reports that over the past four FYs, the BRN has experienced a decrease in endorsement applications, from 34,888 in FY 2021/22 to 23,825 in FY 2024/25, which represents a 32% reduction. The BRN notes that the decline corresponds with the post-pandemic stabilization of interstate nurse mobility and the conclusion of temporary authorization to practice in California. In prior years, concerns were raised that the BRN's application processing timelines, including endorsement applications, were slow and resulted in licensure delays. In FY 2020/21, the BRN reported 79 days for a complete endorsement application, and it was 75 days in FY 2017/18. The BRN reports in its 2026 Sunset Review Report that the processing timeframe for complete endorsement applications is now within 40 days.

The National Nurse Licensure Compact (NLC) was originally established in 2000 and underwent a significant revision in 2017. At that time, several changes were made to the provisions of the NLC including the requirement for participants to include both federal and state level criminal background checks as part of the application process. Any state that was a member of the NLC prior to the revision in 2017, was able to transfer to the updated NLC, including those few states that did not previously require background checks. Under the parameters of the NLC, an RN or licensed vocational nurse (LVN) can practice temporarily in any state that is a member of the NLC. The NLC has been enacted in 43 jurisdictions (three of which are in the implementation process). The current NLC for RNs also includes LVNs. Under the NLC, an RN or LVN can practice in any state, under a multistate license, in-person or via telehealth, if that state is a member of the NLC without obtaining a separate license to practice in each state.

Under the operations of the NLC, a multistate license is issued in the home state where the RN or LVN legally resides, not in the states where they intend to practice. However, RNs or LVNs who change their primary state residence are still required to apply for a license in that state within 60 days of moving to a new home state. Three recent bills have proposed the statutory changes required to enter into the compact SB 1053 (Moorlach of 2020), AB 410 (Fong of 2021), and AB 3232 (Dahle of 2024).

The Interstate Commission of Nurse Licensure Compact Administrators (Commission) is the administrator of the NLC. The Commission is comprised of certain state boards of nursing of NLC member states and has the rulemaking authority related to the provisions and articles governing the NLC. Unlike California's regulatory boards, bureaus, committees under the DCA, the Commission does not have public participants.

The rules promulgated by the Commission must be directly related to the NLC statutes. NLC rules do not change a member state's RN or LVN practice acts related to scope of practice but rather are related to the implementation and operations of the NLC including licensure requirements, education and training and violations specific to the home state. If an RN or LVN has a multistate license, they are required to abide by the practice acts and laws in each state in which they are practicing. It is unclear how RNs and LVNs, who practice under a multistate license are informed or educated about the various practice acts of other member states and what occurs if a violation of the practice act occurs in the practicing state but is not considered disciplinary in the licensing state.

The leadership of the Commission is comprised of a chair, vice chair, a treasurer, and four at-large members, all of whom are the nursing board presidents, representing the member states participating in the Commission. Current state members on the Commission include Tennessee, New Jersey, South Dakota, Kentucky, Colorado, North Carolina, and Texas. Not every participating state is a leader of the Commission. The Commission is required to meet either face-to-face or by electronic means at least twice each calendar year. Additional meetings are held as specified in the Commission's bylaws. Commission meetings happen both via teleconference and in-person. According to information provided from the Commission, meetings are open for public participation, unless the Commission meets in closed session to discuss party state compliance, personnel or personal matters, litigation, contracts, sharing privileged information, disclosure of investigatory records, and other matters exempt from federal or state statute. Commission meetings are not subject to California's Bagley-Keene Act or Public Records Act.

The Commission is ultimately responsible for determining the language and specifications contained in the NLC and the rules and bylaws for the operation of the Commission. The Commission solicits feedback from the public during the rulemaking process. In many other states the regulatory entity for RN and LVNs is under the same regulatory board; however, in California RNs are licensed and regulated by the BRN and LVNs are licensed and regulated by the BVNPT yet would only have one participant representing California on the Commission if California were to join the NLC.

An RN or LVN can practice in any state that is a member of the NLC and there are no time restrictions on how long they may practice in any state that is a member of the NLC. A multistate license is issued in the state where the RN or LVN legally resides, not in the states where they want to practice. RNs or LVNs who move to a new state are required to reapply for a new license each time they move.

Article III of the NLC specifies the requirements that an applicant must meet to obtain a multistate license. Applicants must, at a minimum, meet the qualifications for licensure as determined by their home state (the state where they reside). After meeting the home state's minimum requirements for licensure, the applicant must additionally meet the following:

- Graduate from a licensing board approved RN/LVN pre-licensure education program.
- Graduate from a foreign RN/LVN pre-licensure program, as specified; and if that foreign pre-licensure program was not taught in English, or if English is not that individual's native language, they must pass an "English proficiency examination" that includes the components of reading, speaking, writing and listening.
- Pass the NCLEX-RN or NCLEX-PN.
- Be eligible for or hold an active, unencumbered license.
- Submit fingerprints or other biometric data for FBI and the agency responsible for retaining that state's criminal records.
- Not been convicted or found guilty, or has entered into an agreed disposition, of a felony offense under applicable state or federal criminal law.
- Not been convicted or found guilty, or has entered into an agreed disposition, of a misdemeanor offense related to the practice of nursing as determined on a case-by-case basis.
- Not currently enrolled in an alternative program.
- Is subject to self-disclosure requirements regarding current participation in an alternative program; and,
- Has a valid United States Social Security number.

Although a variation of the above-mentioned licensing requirements is likely required by many states, there may be some notable differences in education and clinical hours required. LVNs are required to meet approximately 954 hours of clinical experience to obtain a license in California, while some other states do not have the same requirement. In addition, the requirement for RNs to complete CE varies across states. California requires 30 hours of CE every two years for licensure renewal while other states' CE requirements vary. Some states require 15 hours, some 24 hours every two years and a few state states require no CE for licensure renewal. As a member of the NLC, RNs who do not meet the same CE requirements as CA RNs, may provide services in this state.

In California, an applicant for licensure must present either a valid Social Security number or an Individual Taxpayer Identification number. If California were a member of the NLC, and a California RN applied for a multistate license in California and had only an Individual Taxpayer Identification number, in this instance, that applicant would meet California's requirement for a license, but they would not meet the requirements for the multistate license without a valid Social Security number. This would allow some California licensees to participate in the NLC while others would not meet the requirements of the NLC.

The NLC is not applicable to any of the APRNs authorized in California. Although these advanced practice nurses would be eligible to practice in California or any NLC member state, they are only permitted to practice under the scope of practice of an RN as defined in that state's RN or LVN practice acts.

Under Article V of the NLC, a member state is authorized to take adverse action against a nurse practicing in that state under the NLC; however, only the home state where that nurse obtained its multistate license (where the nurse resides) would be permitted to discipline the RN's or LVN's multistate license. While specified information about an RN or LVN must be made available to other party states through the NLC administrator, a party state licensing board may designate that certain information about an individual may not be shared with non-party states.

Under the NLC, an RN or LVN may not be a participant in alternative programs while practicing under a multistate license. Article V specifies that nothing in the NLC overrides a party state's decision authorizing the use of an alternative program in lieu of an adverse action against the RN or LVN; but the home state must deactivate that licensee's multistate privilege during the duration of the RN or LVN's participation in the alternative program. If permitted in the home state, that licensee would be able to continue to practice in the home state but would need to reactivate.

The language contained in the NLC is identical in every state, and each state must comply with the provisions specified in the articles of the NLC. Any changes to the NLC may only be completed by regulatory actions of the Commission. Because the NLC permits RNs who hold a multistate compact license to provide telehealth services, a multistate license holder could effectively live out-of-state and be employed by a California healthcare provider yet never provide direct patient care services in California. It would be helpful for the Committees to understand whether there is any benefit to California licensees and patients if the state were to join the NLC.

Staff Recommendation: *The BRN should advise the Committees on any recent discussions about joining the NLC, including market factors that could be experienced with a proliferation of more nurses in the state as well as any barriers to California licensees benefitting from NLC membership.*

EDUCATION ISSUES

ISSUE #18: (CLINICAL PLACEMENTS) Is access to clinical placements for education programs improving?

Background: Nursing student clinical experience is a foundational element for nursing education. Clinical experience gained during a prelicensure nursing program provides an opportunity for students to connect their classroom training with real-world nursing practice. Clinical experience enables students to hone their skills through hands-on experience in a live setting and aims to help desired RNs be competent upon graduation and entering the workforce. Through in-person training, students may complete patient-centered tasks such as diagnosing and managing patients under the direct supervision of qualified nurse faculty in a functioning health care facility.

The lack of clinical placement access and availability has been a long-standing challenge for education programs. Access to space in facilities designated for learning opportunities and the necessary faculty needed to supervise is in short supply across California and the nation. The critical shortage of nursing clinical placements is often cited as a top barrier to expanding nursing school capacity which

ultimately precludes many qualified applicants from entering a nursing education program because there is not sufficient space to educate the students in the field.

The Committees have previously raised and continue to focus on the availability of clinical placements for nursing students. The availability of student placements for clinical experiences is based on clinical facilities, such as hospitals or clinics, that are willing to accept and teach students. While there are no requirements that facilities accept students, many willingly do because it is necessary for training the workforce and it can help with recruitment. The facilities must have qualified nursing staff to teach and supervise students and often develop contracts with partner educational programs to outline responsibilities, liability, and expectations.

Because there is not a state mandate for facilities to provide clinical opportunities, nursing programs are responsible for coordinating and securing the clinical placements necessary for their students to meet the education requirements. Unlike many professions, health care services are continuous. Many hospital emergency departments, skilled nursing facilities, and psychiatric facilities are continuously providing services to patients. This may provide clinical training opportunities outside of a traditional workday for many. While some education programs may be able to accommodate a midnight clinical training shift, others may not have the resources to accommodate variances. Current law does not preclude clinical education from being completed during hours outside of a traditional day program. Students may also gain clinical education at facilities located outside of California if the nursing program provider is able to offer that connection for clinical training. To facilitate the availability of placements, some nursing programs and clinical facilities utilize local databases known as regional consortiums to share placement availability and coordinate partnerships. The consortiums vary by region, function, and pricing methodologies. However, participation is voluntary.

While the BRN has no direct control over the actual availability of placements, it has been a large part of the ongoing regulatory and sunset discussions. Since the BRN's last sunset review in 2022, legislation has been chaptered into law aiming to address clinical placement capacity concerns. AB 1577 (Low, Chapter 680, Statutes of 2024) requires health facilities and clinics to meet with a community college or a California State University that has a BRN-approved prelicensure nursing program, upon the college's request, and work in good faith to meet the needs of the college's nursing program, including adding additional clinical placement slots to accommodate the nursing program. That bill also required a hospital or clinic if unable to provide additional clinical placement slots, to provide HCAI with a written justification of its lack of capability or capacity within 30 days of the meeting, subject to a \$1,000 fine for failure to provide the justification.

Moreover, SB 1015 (Cortese, Chapter 776, Statutes of 2024) requires the BRN's NEWAC to study and recommend standards regarding how approved schools of nursing or nursing programs manage or coordinate clinical placements, and requires the BRN to annually collect, analyze, and report information related to management of coordination of clinical placements. SB 1015 also requires the BRN to annually publish the report on its website and submit the report to the Legislature. The BRN notes that the NEWAC report along with its annual report remains a work in progress.

According to a May 2, 2023, media release from the American Association of Colleges of Nursing, "According to new data released today by the American Association of Colleges of Nursing (AACN), the number of students in entry-level baccalaureate nursing programs decreased by 1.4% last year,

ending a 20-year period of enrollment growth in programs designed to prepare new registered nurses (RNs). With declines also recorded in master's and PhD programs, collective action must be taken to strengthen pathways into nursing to ensure the nation's healthcare needs are met. *Despite the decrease in enrolled students, nursing schools turned away thousands of qualified applicants last year due largely to a shortage of faculty and clinical training sites.*"

There remains universal concern that insufficient enrollment of prelicensure nursing students affects the outcome of the nursing pipeline and limited clinical education opportunities directly impact program's ability to educate nursing students. The BRN has approved 165 nursing programs in California. Since 2022, the BRN reports that it has approved 62 enrollment increases, denied 3 (1 of which was later deferred, and approved), 3 deferred for a future meeting, and 8 enrollment increase requests were reduced, meaning the BRN approved lesser of an increase than initially requested. All requests for enrollment increase or new program approval are subject to consideration through the Education and Licensing Committee and the full board for consideration.

Staff Recommendation: The BRN should update the Committees on clinical placement access. The BRN should advise the Committees on enrollment increase requests or new programs which were denied due to insufficient clinical placement availability. The BRN should update the Committees on its process to comply with the requirements of SB 1015.

ISSUE #19: (UNIFORM STANDARDS FOR SIMULATION BASED LEARNING). What changes are necessary to align simulation learning requirements with current practice and national standards?

Background: During the COVID-19 pandemic, when education and access to clinical settings became unattainable, AB 2288 (Low, Chapter 282, Statutes of 2020), authorized the director of an approved nursing program, during a state of emergency, to make requests to the BRN for the following: use of clinical simulation up to 50% for medical-surgical and geriatric courses; and up to 75% for psychiatric-mental health nursing, obstetrics, and pediatrics courses, among other provisions. The goal was to provide nursing programs with flexibility in meeting clinical placement needs during a declared state of emergency. The designation in percentages was because at the time, the BRN's regulations required that 75% of a nursing student's clinical hours be in a direct patient care model. Direct patient care means providing services to a live patient, which can include both in-person and telehealth. The changes in AB 2288 are specific to a state of emergency and do not affect overall requirements when there is no state of emergency declaration. In addition, AB 2288 required for the substitute clinical practice hours that are simulation experiences to be based on the best practices published by the International Nursing Association for Clinical Simulation and Learning, the National Council of State Boards of Nursing, the Society for Simulation in Healthcare, or equivalent standards approved by the BRN.

The following year, during the BRN's sunset review discussions, the issue of simulation learning was once again raised. As a result, AB 2684 (Berman, Chapter 413, Statutes of 2022) revised the acceptance of simulation learning by replacing the percentage requirement of direct patient care clinical hours with a new 500 hour minimum number of direct patient care clinical hours that an

approved nursing school or nursing program must meet with a minimum of 30 hours of supervised direct patient care clinical hours dedicated to each nursing area.

This update made the percentage-based simulation standards during a declared state of emergency inconsistent. In addition, when adding the new 500 hour minimum, statute was not updated to require that simulation learning meet any of the national association standards, which is currently required for simulation used during a state of emergency. The BRN requests updates to the Act to replace percentages with actual clinical hours permitted during a state of emergency for consistency purposes, and also specify that any and all clinical simulation reflect national standards for simulation learning from International Nursing Association for Clinical Simulation and Learning, the National Council of State Boards of Nursing, the Society for Simulation in Healthcare, or equivalent standards approved by the BRN.

Staff Recommendation: *The BRN should provide the Committees and stakeholders with the statutory updates needed to align simulation requirements and ensure that all authorized clinical simulation follows national guidelines.*

ISSUE #20: (OUT-OF-STATE NURSING EDUCATION PROGRAMS) Should nurse training programs located in other states that are not approved by BRN and offer online-only education be authorized to offer clinical placement opportunities in California to their California-enrolled students?

Background: To allow students to gain clinical experience, existing law permits nursing services to be provided by a student when the services are incidental to the course of study of a student enrolled in a BRN-approved education program.

The issue of clinical placements for all nursing students remains a challenge for education providers and students in nursing education programs. The lack of clinical slots for students in nursing education programs affect programs seeking BRN-approval, programs that would like to increase student capacity, and even students in programs who lose their clinical placements when a clinical facility no longer offers clinical space.

There is no law in California that requires any healthcare facility to provide, offer, or make available clinical space for nursing education purposes. Student placements for clinical experience are based on clinical facilities, such as hospitals or clinics' willingness to accept and teach students and their ability to accommodate students. Although there are no mandatory requirements, many healthcare settings freely accept students because it is necessary for the workforce and can help with recruitment. The facilities must have staff who are qualified to teach and supervise students and often develop contracts with partner educational programs to outline responsibilities, liability, and expectations. As a result, clinical placements are often difficult to find.

In a slight reversal of the clinical placement issue raised above, which focuses on California-approved schools and clinical access, the Committees have been advised of schools located outside of California that do not offer education through a BRN-approved program (nor do they have BPPE approval) but they provide nursing education to California residents. These programs are online only and students

who are enrolled must acquire clinical education outside of California due to the limitation under current law that allows nursing services to be provided by a student of a BRN-approved program. All in-state nursing programs are required to meet the BRN's regulatory requirements for approved nursing programs and curriculum, and the BRN must determine the areas of coursework required for each program through regulations. Students who attend out-of-state nursing programs must have their education evaluated for equivalency with state requirements, including clinical experience. Those who do not meet the requirements will be denied or considered deficient and required to complete additional remedial education or training. Because the BRN only approves schools which have sought approval and ensures those programs meet the education and clinical standards under California's nurse practice act, the BRN does not review schools located outside of California that have not requested board-approval. These schools are headquartered in other states and chose not to open a location in California or seek BRN-approval.

One distance education provider has over 6,000 students from California enrolled in its program, however, there is no clinical capacity to accommodate those students without likely displacing schools that are within California and have BRN approval. There is nothing in current law which precludes a school headquartered in another state from obtaining BRN-approval and Bureau for Private Postsecondary Education (BPPE) approval so long as they meet the requirements specified in current law. However, with BRN approval there are limitations on enrollment numbers to ensure clinical capacity and avoid displacement. That is likely a challenge for those education institutions and would potentially limit the number of students authorized for enrollment.

When considering a new education program, the BRN's school approval process involves a feasibility study, which entails among other requirements, that each school provides evidence of availability of clinical placements for students of the proposed program. Clinical placements of the new program must take into consideration the impact on the use of the clinical facility by existing nursing education program students. Aspiring programs must include a description of collaboration and coordination efforts with any existing registered nursing programs and any regional planning consortium. The BRN weighs the clinical capacity for nursing education programs when considering a nursing education program to increase enrollment or open a new program.

Theory and clinical combination are an integral part of the foundation of nursing education. If students cannot complete the necessary clinical work, it can affect the students program completion. Limited educational capacity greatly impacts the number of nursing students a program can accept. Usually, there are more students who apply to a nursing program than schools have room to accept.

Community colleges, CSUs, UCs, and private for-profit colleges all offer varying programs for nursing education, and all require clinical space in healthcare facilities to connect the learning between theory and hands on experience. Education programs in California are approved by the BRN and for those private nonprofit and for-profit institutions, they are additionally approved by the BPPE, and the BRN will approve or disapprove the requested number of students for enrollment in a program based on the clinical capacity to train students. A school that is not approved by BRN cannot have its students providing nursing services to California patients, the very work that is done in clinical educational experience.

Staff Recommendation: *The BRN should advise the Committees about the potential impact to California licensees, students, and California-based nursing educational programs approved by the*

BRN if it were to authorize students to provide nursing services through clinical education to California patients despite attending a school that is not BRN-approved.

ISSUE #21: (NURSING PROGRAM DIRECTORS) What happens when a nursing program is unable to find a qualified nursing program director who meets all of BRN's requirements? Are changes necessary to accommodate schools?

Background: If an approved prelicensure nursing program does not hold national accreditation, they must obtain BRN faculty approval prior to hire. Pursuant to current regulations (16 CCR § 1425), the BRN requires nursing program faculty, the director, and the assistant director be approved by the BRN. Nursing education programs are required to report to the changes in the nursing program's director and assistant director of nursing positions to the BRN. Faculty members, program directors, and assistant directors must have an active license, in good-standing, and meet certain qualifications which include the following:

The Program Director

- A master's or higher degree from an accredited college or university which includes course work in nursing, education, or administration.
- One year of experience as an administrator with validated performance of administrative responsibilities.
- Two years of experience teaching in pre-licensure or post-licensure RN programs; and
- One year of continuous, full-time or its equivalent experience direct patient care as a RN.

An Assistant Program Director

- A master's or higher degree from an accredited college or university which includes course work in nursing, education or administration.
- Two years of experience teaching in pre- or post-licensure registered nursing programs; and
- One year of continuous, full-time or its equivalent experience direct patient care as an RN.

For a Faculty Instructor

- A master's or higher degree from an accredited college or university which includes course work in nursing, education or administration.
- Direct patient care experience within the previous five years in the nursing area to which he or she is assigned, as specified.

If a program seeks to have an already approved nursing faculty member teach in a new content area they don't have competency in, the BRN provides an opportunity through the BRN's faculty remediation plan to allow faculty to remediate their clinical competency in that content area through a plan developed by the program director, their content expert and that faculty seeking remediation and provide that to the BRN. The Committees have been advised that some programs located in smaller, rural colleges offering prelicensure programs face challenges finding program directors that meet all

the BRN requirements. Although the BRN does consider equivalencies to meet the four requirements, there is not a process for program directors who do not meet the standards after considering those equivalencies to remediate any deficiencies and therefore nursing programs must find new candidates. Nursing schools have expressed concerns that they cannot find qualified program directors and would like to explore options for when a program director's qualifications are not sufficient. Given the important role that a program director plays in ensuring educational quality, and the assumption that a person directing a program in a particular field of study has experience in that field, it would be helpful to understand the educational value and patient care opportunities that exist if status quo were to be updated.

Staff Recommendation: *The BRN should advise the Committees on efforts to assist colleges when program directors' qualifications are insufficient.*

ISSUE #22: (SCHOOL APPROVAL STANDARDS) Are BRN's standards for nursing program review and approval enough to ensure quality? Are changes necessary to conform to the NCSBN Nursing Education Approval Guidelines, particularly as it relates to quality and warning signs?

Background: Nationally, all state boards of nursing are engaged in the initial approval and subsequent review of prelicensure nursing education programs. States are similar in approach, however, each state board of nursing is individually responsible for the core elements required for each program and thus determines the curriculum requirements, faculty requirements, clinical and simulation standards, among others. This led to multiple approaches for initial approval, continued approval or enrollment increases. The core indicators of a prelicensure educational program's success include NCLEX pass rates, graduation rates, and employment rates. In response to state boards of nursing searching for consistency of educational programs approval process and success rates, the NCSBN conducted three national studies of nursing education outcomes and a literature review. Based on the NCSBN's work, a panel of representatives from state boards of nursing, the College of Nurses Ontario, the National League for Nursing, the American Association of Colleges for Nursing, the Organization of Associate Degree Nursing and NCSBN staff developed guidelines to help guide states boards of nursing in their approval of prelicensure programs and to understand potential warning signs in the process.³⁹ In 2020, the NCSBN published *Guidelines for Prelicensure Nursing Approval*. The guidelines were created to help regulatory boards identify quality indicators while recognizing warning signs at the same time and when they should intervene and provide technical assistance to a program prior to them falling below standards. The guidelines aimed to help provide national consistency and increase transparency for educational programs in the approval and subsequent review of nursing education programs. The NCSBN reviews and updates these guidelines annually, using data collected from state boards of nursing to verify that they continue to support consistent, high-quality outcomes.

According to the BRN in its 2026 Sunset Review Report, it has received criticism for using outdated, inefficient, and inconsistent standards when providing initial and continuing approval to nursing programs. To help establish more consistency and efficiency in the program approval process, the BRN seeks to revise some of its current standards and replace them with evidence-based standards that are recognized at the national level developed through the NCBSN.

³⁹ https://www.ncsbn.org/public-files/Guidelines_for_Prelicensure_Nursing_Program_Approval_FINAL.pdf

Staff Recommendation: *The BRN should specify the statutory changes necessary to implement recommendations from the NCSBN. The BRN should advise the Committees on its communication plans with nursing education providers if there are any changes or updates.*

ISSUE #23: (PROGRAMMATIC ENROLLMENT CAPS AND APPROVALS) How does the BRN consider enrollment increases for public and private nursing education programs? Does the BRN give preference to certain types of programs?

Background: The BRN has approved 160 total prelicensure nursing programs and 55 advanced practice education programs. A mix of both public and private, for-profit colleges have BRN-approval for prelicensure nursing education programs. The processes and procedures for the BRN to review a prelicensure program are specified in statute and regulations. The current fee for approval of a new program is \$40,000 and after the last sunset there is no fee for continuing approval of a new program.

Prelicensure Nursing Programs			
Program Type	Private	Public	Total Prelicensure Nursing Programs
ADN	15	80	95
BSN	30	20	50
ELM	10	5	15
TOTAL	55	105	160

* These programs are currently not required to be Board-approved; however, programs have requested Board review.

Nursing education programs are reviewed prior to the initial admission of students; at completion of the first academic year; prior to the graduation of the first admitted cohort; five years after the first cohort’s admission, and thereafter on a continuing basis, every five years for non-accredited programs or in alignment with an accredited program’s accrediting agency schedule. Neither statute nor regulations provide the BRN with authority to choose a certain type of program (public or private school) when considering approving a new program, denying a program, or granting an enrollment increase.

Consideration for enrollment increases or new program approval are made by the education and licensing committee and then the full board for review. Committee meetings and board meetings are noticed prior to hearing and stakeholder participation and comment at BRN meetings are accessible for public participation.

Staff Recommendation: *The BRN should advise the Committees if special consideration is granted to either public universities or private universities when considering program approvals, reapprovals, or any enrollment increases.*

ISSUE #24: (FEDERAL LOAN CAP) What are impacts to California nursing schools and the nursing student pipeline stemming from federal loan borrowing limits? What effect, if any, does this have on the BRN's school approval process?

Background: On July 4, 2025, President Trump signed into law, the One Big Beautiful Bill Act. That bill contained numerous provisions affecting federal taxes, credits, and deductions. Implementation timeframes for the changes varied with some implemented in 2025 while others wait until 2028. A few examples of changes contained in that bill include the creation of Trump Accounts for children born between January 1, 2025-December 1, 2028, new paperwork requirements for SNAP benefits and limits to SNAP access for designated populations, the elimination of taxes on tips up to a designated amount, and the elimination of rebates for both used and new electric vehicles, to name just a few. One of the significant changes in that bill where impacts may be noticed at the BRN, and its licensing population is the new limits proposed for federal student loans.

The One Big Beautiful Bill Act proposed new borrowing limits for some federal student loans. As planned to take effect on July 1, 2026, students enrolled in certain types of graduate degree programs will be limited to annual loans of \$25,000 with a total limit of \$100,000 for a program of study. Students enrolled in a professional degree program (as defined in Code of Federal Regulation) will be capped at \$50,000 annual loans and a total of \$200,000 for a total program. As part of the process to implement loan changes for various professional and non-professional degree programs, the United States Department of Education proposed rulemaking changes which would revise the definition of a "professional program". The revised definition, which is currently under consideration, would remove nursing from the federal definition of professional degree program; thereby capping the federal loan rate at \$100,000. If approved, this change is not scheduled to go into effect until July 1, 2026. Although the State of California has no jurisdiction to address federal loan limits, this issue simply raises the question of whether BRN foresees loan amount caps limiting or reducing nursing education program offerings, or if the BRN foresees any potential reduction in licensing populations?

Staff Recommendation: *The BRN should share with the Committees any nursing pipeline assessment related to the new loan limits.*

ENFORCEMENT ISSUES

ISSUE #25: (INTERVENTION PROGRAM AND UNIFORM STANDARDS) What is the status of the IP? Has the BRN engaged in conversations with DCA and other licensing boards about standards IP participants must meet according to the Uniform Standards all boards follow?

Background: In 1984, state law established the Diversion Program (now Intervention Program) as an alternative to discipline. The law charges the BRN to seek ways and means to identify and rehabilitate registered nurses whose competency may be impaired due to substance use disorder or mental illness, rehabilitate those nurses, and return them to practice in a manner that does not endanger public health and safety. The IP is a voluntary and confidential recovery and monitoring program for RNs whose practice may be impaired by substance use disorder or mental illness. BRN says that the IP protects the

public by providing RNs access to effective treatment services, monitoring their recovery through an individualized plan, and returning them to safe practice.

SB 1441 (Ridley-Thomas, Chapter 548, Statutes of 2008) required the DCA to develop uniform and specific standards to be used by each health professional licensing board in dealing with licensees facing substance use disorders in the following 16 specified areas: (1) clinical and diagnostic evaluation of the licensee; (2) temporary removal of the licensee from practice; (3) communication with licensee's employer about licensee status and condition; (4) testing and frequency of testing while participating in a diversion program or while on probation; (5) group meeting attendance and qualifications for facilitators; (6) determining what type of treatment is necessary; (7) worksite monitoring; (8) procedures to be followed if a licensee tests positive for a banned substance; (9) procedures to be followed when a licensee is confirmed to have ingested a banned substance; (10) consequences for major violations and minor violations of the standards and requirements; (11) return to practice on a full-time basis; (12) reinstatement of a health practitioner's license; (13) use and reliance on a private-sector vendor that provides diversion services; (14) the extent to which participation in a diversion program shall be kept confidential; (15) audits of a private-sector vendor's performance and adherence to the uniform standards and requirements; and (16) measurable criteria and standards to determine how effective diversion programs are in protecting patients and in assisting licensees in recovering from substance abuse in the long term.

As part of the SB 1441 implementation, the DCA convened the Substance Abuse Coordination Committee (SACC), which consisted of representatives from all of the health professional licensing boards. A series of meetings, subject to the Bagley-Keene Open Meeting Act, were held from 2009 to 2011 to discuss and develop the standards. The "Uniform Substance Abuse Standards" (Uniform Standards) were finally adopted in early 2010, with the exception of the frequency of drug testing. The DCA reconvened the SACC in March 2011, where a final vote was taken on an amended schedule for drug testing frequency.

At that time, all of the health care boards were asked to adopt and implement the standards. In response to questions regarding whether adoption of the standards was optional or mandatory, three different legal opinions were issued that opined that the boards were mandated to adopt all of the standards. The only standard that needed statutory authority dealt with the cease practice requirement. SB 1172 (Negrete McLeod, Chapter 517, Statutes of 2010) was enacted, and among other provisions, required healing arts boards to order a licensee to cease practice if the licensee tests positive for any prohibited substance under the terms of the licensee's probation or diversion program.

Concerns have been raised to the BRN that pertain specifically to Uniform Standard 12 which specifies the criteria that a licensee must meet to petition the board for reinstatement of their license. As specified under Uniform Standard 12, a licensee must meet the following criteria to request the return to a full and unrestricted license:

- Demonstrated sustained compliance with the terms of the disciplinary order, if applicable.
- Demonstrated successful completion of recovery program, if required.

- Demonstrated consistent and sustained participation in activities that promote and support their recovery including, but not limited to, ongoing support meetings, therapy, counseling, relapse prevention plan, and community activities.
- Demonstrated that they can practice safely.
- Continuous sobriety for three (3) to five (5) years.

The BRN notes concerns pertaining to demonstration of safe practice, and reports variances in how a licensee may demonstrate that they can practice safely. The BRN notes there are variances in determining what may constitute sufficient evidence of safe practice without specific criteria. In addition, under current law, IEC members are required to evaluate RNs who request participation in the program, review and designate treatment services for participants, review information about RNs, consider the case of each RN participant and whether they may continue with safety or resume the practice of nursing. The consideration of what constitutes “resume to practice safely” with limited specification as to what acts may qualify likely leads to varying determinations by the IECs. In addition, under current law (BPC § 2770.8) which specifies the duties of the IEC members, IEC members are charged with “considering cases of RNs in the IP and whether they may safety continue or resume the practice of nursing. Consistency may be needed to identity the standards necessary to determine what is “safe to resume practice”.

In the BRN’s Sunset Review Report 2026, the BRN recommends updating statute to clarify that successful completion of the IP “may or may not require a participant to work as a RN in a direct patient care role or if, upon review, a participant is found to have mitigating circumstances, such as a disability, health condition, retirement, or a career path that does not involve direct patient care, program completion may still be granted without employment. This clarification would provide greater flexibility in evaluating participant progress and ensure the program accommodates a broader range of professional circumstances while maintaining its rehabilitative intent.”

Staff Recommendation: *The BRN should advise the Committees of its work to broadly discuss provisions in the Uniform Standards to ensure they remain Uniform. The BRN should provide an update on the IP and how it balances patient safety and public protection with program administration.*

ISSUE #26: (TIMELINE TO PETITION FOR REINSTATEMENT) Should the BRN have greater flexibility to determine when to reinstate a revoked license?

Background: According to BPC § 2760.1, a licensee of the BRN, whose license has been revoked can petition the BRN for reinstatement or modification of the penalty subject to the following timing restrictions: 1) at least three years for reinstatement of a license that was revoked, except that the board may, in its sole discretion, specify in its order a lesser period of time provided that the period shall be not less than one year. 2) At least two years for early termination of a probation period of three years or more. Or, 3) At least one year for modification of a condition, or reinstatement of a license revoked for mental or physical illness, or termination of probation of less than three years. The typical outcome is that a licensee must wait at least three years before they can attempt to get their license reinstated if the license was revoked.

As noted by the BRN in its 2026 Sunset Review Report, “while in most cases the three-year timeline is both sufficient and appropriate, the BRN is experiencing a growing number of cases where a licensee is revoked by default.” This means their license was revoked by the BRN because the licensee failed to respond to the accusation or participate in a legal hearing to challenge the BRN’s action against them, leading to a ruling against the licensees without their input.

Under the current disciplinary procedures in California, the disciplinary process begins with the filing of an accusation. The accusation provides the licensee with the acts or omissions engaged by the licensee for which the board seeks to discipline. When a licensee receives the accusation, they are advised to respond to the BRN within 15-calendar days if they seek to have a hearing over the accusations. If the license holder fails to respond within the fifteen days, the BRN is authorized to revoke the license through the “default decision” process. Once the license is revoked, the license holder is subject to the timeframes specified above for reinstatement.

The license remains revoked unless a petition for reinstatement is granted. Occasionally, a license holder will contact the BRN shortly after their license has been revoked through a default decision, stating they were unaware of the disciplinary action until after the revocation became effective. According to the BRN, this typically occurs when the licensee did not receive mailings from the BRN regarding the accusation, often due to being on a traveling contract assignment, an extended leave/vacation, or having recently moved without yet updating their address of record with the Board, etc. Unlike various other boards under the DCA, the BRN does not have statutory authority to require licensees to provide their email address (if available) to the BRN for ease of communication; however, the BRN does require licensees to provide the BRN with address changes within 30 days.⁴⁰

According to the BRN, under current law, the revoked license holder must wait three years for a petition for reinstatement. In these types of scenarios, the BRN would prefer to have the discretion to engage with the licensee and proceed through the standard disciplinary process. However, the BRN currently lacks the statutory authority to set aside a default revocation and reopen the case administratively to allow for a potential lesser enforcement action (maybe probation instead of revocation).

Staff Recommendation: *The BRN should advise the Committees on the number of individuals that would be eligible for licensure reinstatement earlier than three years if current law was updated. In addition, the BRN should advise the Committees what the eligibility criteria would be to reinstate a license earlier than three years.*

ISSUE #27: (UNPROFESSIONAL CONDUCT) Should the BRN have flexibility to not take enforcement action against a licensee for violating provisions related to unprofessional conduct, specifically related to Driving Under the Influence violations?

⁴⁰ Title 16, California Code of Regulations, § 1409.1

Background: Business and Professions Code § 2761 grants the BRN discretion to take disciplinary action against licensees for a multitude of infractions under the umbrella of “unprofessional conduct.” Under current law, unprofessional conduct can include, but is not limited to the following occurrences:

- Incompetence or gross negligence in carrying out usual certified or licensed nursing functions.
- A conviction of practicing medicine without a license.
- False advertising related to nursing.
- Enforcement action by another state or California state body,
- Procuring a certificate or license by fraud, misrepresentation, or mistake.
- Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision of the practice act.
- Providing false information in connection with an application for a certificate or license.
- Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of a RN,
- Impersonating any applicant or acting as proxy for an applicant in any examination.
- Permitting or allowing another person to use their certificate or license.
- Aiding or assisting or agreeing to aid or assist any person in violating provisions of the medical practice act.
- Misrepresenting certification status as an APRN.
- Failing to protect patients by failing to follow infection control guidelines of the board.

In addition to the violations listed above, BPC § 2762 specifies that certain actions related to substance use can be included in unprofessional conduct. These include:

- Obtain or possess or prescribe any controlled substance as defined or any dangerous drug or device in violation of law.
- Use any controlled substance or any dangerous drug or dangerous device, or alcoholic beverages to an extent or in a manner dangerous or injurious to themselves or the public or to the extent that such use impairs their ability to safely conduct the practice authorized by their license.
- Be convicted of a criminal offense involving the prescription, consumption, or self-administration of any controlled substances or dangerous drugs or devices, or the possession of, or falsification of a records related to.
- Be committed or confined by a court of competent jurisdiction related to addiction to the use of any controlled substance.
- Falsify or make incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances.

With respect to unprofessional conduct actions related to the use of alcoholic beverages, the BRN reports that it typically takes some form of enforcement action, whether by way of formal discipline or administrative citation, against applicants or licensees who have received a DUI, under broad circumstances. In the BRN’s 2026 Sunset Review Report, the BRN reports in the last four FYs, it has issued 389 citations for DUI convictions and 25 citations for wet and reckless violations.

The BRN notes in its 2026 Sunset Review Report, “some Board members have raised concerns about whether individuals who made a serious mistake outside of the workplace, and who have already been held accountable through the criminal justice system, should also face professional discipline, particularly when there is no evidence of impairment in their nursing practice. While perspectives vary, all Board members collectively agree that these situations require careful, consistent, and fair evaluation to ensure both public protection and equitable treatment of applicants and licensees.”

The BRN notes that other healing arts boards, specifically the Medical Board of California (MBC), have greater flexibility when assessing the level of the enforcement action against a medical board licensee who has violated its unprofessional conduct standards related to DUIs.

Pursuant to BPC § 2239, under the Medical Practice Act, *The use or prescribing for or administering to himself or herself, of any controlled substance; or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the licensee, or to any other person or to the public, or to the extent that such use impairs the ability of the licensee to practice medicine safely or more than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of such unprofessional conduct.* The BRN notes the MBC has broader discretion to consider more than one misdemeanor (including a DUI) or any felony involving the use, consumption, or self-administration of any of the substances when considering unprofessional conduct enforcement-related actions.

The BRN recommends in its Sunset Review 2026 Report, that current statute (BPC § 2762) be amended to more closely mirror the unprofessional conduct statute under the medical practice act to specify that unprofessional conduct includes more than one misdemeanor, or any felony, involving the use, consumption, or self-administration of any controlled substances or alcoholic beverages, or any combination thereof.

The BRN notes the following justification for this change:

“This revision would bring the statute into closer alignment with principles of fairness and public safety by ensuring that disciplinary actions are directed toward serious or repeated offenses that may pose a risk to safe nursing practice. Additionally, this change reflects restorative justice principles by focusing accountability on conduct that demonstrates a pattern of risk while minimizing consequences on professional licensure for isolated incidents, thereby supporting rehabilitation, proportionality, and the opportunity for individuals to return to safe practice.”

Staff Recommendation: *The BRN should advise the Committees on enforcement statistics related to DUIs. The BRN should explain to the Committees the number of enforcement actions that would be impacted by this change.*

ISSUE #28: (CASE DOCUMENTATION) Should the BRN fine healthcare facilities for not complying with record or subpoena requests during an enforcement investigation?

Background: The enforcement process at the BRN typically begins with a complaint. When the BRN receives a complaint against a licensee, they will investigate. Complaints posing the greatest risk receive the highest priority. Investigations and disciplinary functions are handled by the BRN's enforcement division. When information or a complaint is received by the BRN, a written notification is sent to the complainant within 10 days. The information is reviewed to determine if the RN is eligible for the BRN's IP, if additional information is needed, or if the complaint should be forwarded to another agency which has jurisdiction.

Complaints are received from the public, other government agencies, or generated internally by BRN staff. Internal complaints arise when through the course of BRN-staff work, potential violations of a particular act are identified. Complaints are generally kept confidential and specific information contained in a complaint is not made public during the investigation process. However, when an accusation is filed, it becomes a matter of public record and the BRN will disclose the specific charges upon request. Once disciplinary action has been imposed, it becomes a permanent part of the RN's record and is subject to public disclosure.

For investigations that determine whether a licensee has committed a minor violation that does not warrant formal disciplinary action, the licensee may be disciplined through the citation and fine process. For those investigations that determine major violations of the Act have been committed or are of a serious nature in terms of the potential harm to the public by a licensee, those cases move to the formal disciplinary process.

Once the investigation has concluded, the investigator submits a written report of the findings to the BRN for review. If no violation can be substantiated, the case is closed. During the formal investigation process, the BRN may need to obtain additional information/documentation about the enforcement matter, including from an employer.

The BRN raised the issue in its Sunset Review 2026 report, that as part of the investigation process, the BRN enforcement staff may need to request documentation from the healthcare facility where the licensee is employed. In most practice related cases, necessary information to review as part of the investigation may include certified medical records, relevant policies and procedures, audit logs, and the licensee's personnel file. However, the BRN reports experiencing significant delays, and in some cases, no response at all from certain healthcare facilities when asked to provide this required information. The lack of information sharing can cause delays in the investigation process or possibly closing a case that should have resulted in formal discipline.

Currently, the BRN's only enforcement recourse for noncompliance is to issue a subpoena. If both the initial request and subpoena are ignored, the matter is referred to the AG for subpoena enforcement, a process that is both time-consuming and costly. Once assigned, a deputy Attorney General (DAG) contacts the facility or the facility's legal counsel to attempt to obtain the records. If unsuccessful, the DAG files a motion to compel, providing proof of service and noncompliance. If the court finds sufficient cause, it may issue an order requiring the facility to comply. In one ongoing case, the Board has been engaged in subpoena enforcement for nearly a year. The lack of response from healthcare facilities may contribute to the lengthy enforcement processing timelines.

As part of the BRN's enforcement processes, the BRN requests for facilities or licensees to respond within 14 calendar days to record requests and subpoenas. For subpoenas that require a *Notice to Consumer*, (informing a patient or licensee that their personal, confidential records such as medical or

employment records are being subpoenaed by a third party), the BRN extends the response period to 21 days. While extensions may be granted upon request, they often result in an average delay of 30 additional days.

There are other healing arts licensing boards with authority to issue a fine to a health care facility for failure to comply with records requests including the Respiratory Care Board, the Dental Board, Dental Hygiene Board, and the Board of Psychology.⁴¹

The BRN notes, “Granting the Board similar authority would help to reduce investigation timelines by limiting unnecessary delays. It could also reduce the need for administrative subpoenas and costly enforcement proceedings in many cases.”

Current law does not require RN employers to report complaints or discipline to BRN, as employers must do for LVNs and hospitals/medical staff for physicians. For example, BPC § 2878.1(b), related to LVN requires any employer of a LVN to report to the BVNPT the suspension or termination for cause, or resignation for cause, of any LVN in its employ. In the case of LVN employed by the state, the report shall not be made until after the conclusion of the review process specified under current law. The required reporting shall not constitute a waiver of confidentiality of medical records. The information reported or disclosed shall be kept confidential except as specified in current law and may not be subject to discovery in civil cases. Additionally, the failure of an employer to report the required complaint or discipline can result in a fine.

Specific to 103 and 104 NPs, AB 890 (Wood, Chapter 265, Statutes 2020), extended mandatory reporting requirements under BPC section 805. For 103 and 104 NPs, it requires peer review bodies (i.e. hospital staff), to report specified information about licensees directly to the BRN, such as denying or restricting a NP's privileges for disciplinary reasons, and for NP resignations during investigations. An 805 Report must be filed when a licensee faces denial, revocation, restriction, resignation, or suspension of staff privileges, membership, or employment for medical disciplinary reasons. This includes denials of applications, revocations, restrictions lasting 30 days or more within 12 months, resignations or withdrawals during an investigation, and summary suspensions exceeding 14 days.

The issue of non-reporting for RNs has been raised during previous sunset reviews of the BRN. In 2017, SB 799 (Hill, Chapter 520, Statutes of 2017) among other provisions required the California Research Bureau to prepare and deliver a report to the Legislature by January 1, 2019, that evaluated the extent employers voluntarily report disciplined RNs to the Board and offered options for consistent and reasonable reporting mechanisms. Although employer reporting remains voluntary, as is consistent with many other healing arts boards in California, would mandatory reporting from employers’ address some of the concerns with facilities providing requested documentation during an investigation?

Staff Recommendation: The BRN should advise the Committees on what fine amounts the BRN thinks would be necessary to ensure compliance. In addition, the BRN should advise the Committees on the number of facilities that would be subject to a fine under its current enforcement caseload. Does the BRN believe this authority would reduce enforcement timelines?

⁴¹ Business and Professions Code §§ 2969(a)(2), 1955(a)(2), 2225.5(a)(2), 1684.1(a)(2)

ISSUE #29: (INVESTIGATION MATERIALS FROM LICENSEES) Should a licensee be subject to unprofessional conduct when the BRN requests records or other information as part of the investigation process and the licensee does not comply?

Background: The BRN is authorized to take disciplinary action against a licensee for unprofessional conduct as specified in the act.⁴² The BRN’s current regulations further delineate acts that constitute unprofessional conduct, including both a failure to cooperate and participate in any board investigation pending against the licensee, as specified; and, a failure to provide the BRN with, lawfully requested copies of documents within 15 days of receipt of the request or within the time specified in the request, whichever is later, unless the licensee is unable to provide the documents within this time period for good cause, including but not limited to, physical inability to access the records in the time allowed due to illness or travel.

As part of the BRN’s investigation process, when the BRN investigates a complaint against a licensee, an in-person interview with the subject typically occurs. The Board allows 14 calendar days for the subject to respond to the interview request. Often, subjects notify BRN staff near the deadline that they have retained legal counsel, who can then request additional time to review the case, gather records, and prepare a response. The BRN notes, that although the BRN may issue a subpoena to compel the subject’s appearance at a specific date, time, and location, it cannot compel them to cooperate or answer questions. If the subject remains unresponsive, the matter may be referred for subpoena enforcement, which is both costly and time-consuming and even with court enforcement, cooperation during the interview cannot be guaranteed. The lack of response from licensees is a contributing factor contributing to the Board’s lengthy complaint processing timelines. As noted by the BRN, “although it has disciplinary authority for a licensee who fails to cooperate in an investigation, it does not clearly define when delayed cooperation becomes unprofessional conduct. Establishing a statutory deadline for interview participation could help reduce investigation timelines, minimize unnecessary delays, and decrease reliance on administrative subpoenas.”

Current law provides the MBC with statutory authority to take an enforcement action against a licensee who is the subject of an investigation if they fail to attend and participate in an interview no later than 30 calendar days after being notified by the Board⁴³. The BRN would like similar statutory authority to more easily compel the participation of a licensee who is subject to a disciplinary investigation as part of the BRN’s enforcement process. This would require a statutory update to make failure to comply, unprofessional conduct.

Staff Recommendation: *The BRN should advise the Committees on current challenges compelling participation, the costs associated with any enforcement delays, and how a statutory change may help.*

⁴² Business and Professions Code § 2761

⁴³ Business and Professions Code § 2234(g)

ISSUE #30: (ENFORCEMENT TIMEFRAMES) What can be done to improve enforcement times at the BRN? Does the BRN have a higher-than-average enforcement workload compared to other healing arts boards? What external factors impact the BRN's investigation and enforcement process?

Background: In early 2000, the DCA launched the Consumer Protection Enforcement Initiative (CPEI) to help enable healing arts boards to more efficiently investigate and prosecute consumer complaints against licensees under their regulation. At the time, concerns were raised that enforcement cases were taking approximately 3-years to complete. All licensing boards under the DCA now have target cycle timelines to ensure the timely resolution of complaints and disciplinary cases in hopes of reducing the average timeline from 36 months to between 12 and 18 months. In 2016, DCA restructured the CPEI, and revised guidelines were issued for boards to utilize in prioritizing their respective complaint and investigative workloads. As a result, the more complex and urgent cases or complaints that could result in serious patient harm, injury, or death are assigned to DCA's Division of Investigation, and routine cases are assigned to board enforcement staff. The BRN has adopted the timeframes under the DCA's CPEI; however, lengthy enforcement process times remain a challenge for the BRN.

To ensure that DCA and its stakeholders can review DCA's progress in meeting its enforcement goals and targets, DCA developed performance measures (PMs). PMs provide clarity on the enforcement process and help recognize timelines in the enforcement process. PM 1 records the volume of complaints and citations received. PM 2 identifies the timeframe from receipt of a complaint to the date the complaint is assigned to an investigator. PM 3 identifies the average days from intake of a complaint or citation until the entire enforcement process is complete for those cases not referred to the AG for formal discipline. PM4 pertains to the timelines for completion of the formal enforcement process for those cases that rise to the level of formal discipline (referral to the AG), such as license suspension or revocation. The BRN along with other healing arts boards have a goal of processing formal discipline cases within 540-days.

Meeting processing goals for those cases that are in the PM4 category is challenging because it includes investigation and prosecutorial timelines that are often extended due to the serious nature of cases that are referred to the AG. For purposes of tracking the complete enforcement timeline, PM4 does not distinguish between the amount of time a case spends at the BRN, the DCA's Division of Investigation, or the AG office. The target timeline is 540 days, and boards aim to resolve cases within 12-18 months. The BRN reports that it takes approximately 700 days to impose discipline from complaint receipt to imposing formal discipline.

The BRN acknowledges that although it has made significant improvements in the processing timeframes, it has not been able to meet the 540-day goal. Currently, the BRN is completing disciplinary cases within 23 months on average. The BRN notes the following efforts to improve processing times:

- Implemented procedural changes and streamlined internal processes;
- Concluded the pilot with DOI, regarding investigation of Category 1 cases and implemented the appropriate revisions to policies and procedures in processing;
- Increased outreach to stakeholders; and

- Created tutorial videos and other educational materials for applicants and licensees.

The BRN reports that it receives more than 7,000 complaints each FY and opens investigations into the majority of complaints it receives. For FY 2024/25 the BRN reports that out of the 8,000 complaints received, none of those complaints received were closed without a referral to investigation, and between FYs 2021/22-2023/24, the BRN closed less than 35 complaints without referral to investigation.

There are several external factors which impact the BRN's ability to close formal discipline cases within the desired 12–18-month timeframe, manner including, facility information sharing, licensee participation, AG support, high-volume of complaints, among others.

Staff Recommendation: What changes, operational or statutory, would strengthen the BRN's enforcement process to improve enforcement timelines and promote greater patient and public safety?

ISSUE #31: (FACILITY INSPECTION AUTHORITY) BRN believes it should have authority to inspect various businesses and healthcare settings that are not licensed healthcare facilities. What is the value to patients for BRN to engage in this new work?

Background: Over the past decade, the United States has experienced a significant increase in consumer demand for wellness services and beautification enhancements, which may include minimally invasive cosmetic treatments like injectables and laser skin procedures, or other services like weight-loss therapies. This demand has fueled rapid growth in a category of businesses often referred to as medical spas (med spas), which may combine elements of services with spa-style retail settings. These facilities are regulated in California based on the type of treatments and services offered and by the professional licenses required to perform them.

A 2024 article published in the peer-reviewed *Dermatologic Surgery* reported that the med spa industry generated approximately \$17 billion in revenue in 2022 and continues to grow rapidly as consumers seek treatments. Facilities operate in a variety of formats, including physician-owned practices, franchise-style chains, and wellness centers offering treatments, as well as services like IV hydration and weight loss and wellness programs. The demand for aesthetic services has grown through increased consumer interest in anti-aging and cosmetic treatments, advancements in non-surgical technologies such as lasers and injectables, as well as social media and online beauty culture.

As the aesthetics and weight-loss treatment markets have grown, pharmaceutical manufacturers have increasingly taken legal and regulatory steps to protect their products and intellectual property. AbbVie, through its Allergan Aesthetics division, manufactures Botox, one of the most widely used neuromodulator treatments in the world. Federal regulators have reported cases of counterfeit Botox products being distributed and administered outside authorized medical channels. In 2024, the FDA announced that it was working with AbbVie to investigate counterfeit Botox products after reports of adverse reactions linked to injections administered in several states. AbbVie has also pursued litigation against competing manufacturers and distributors over intellectual property and trade-secret claims related to botulinum toxin products.

The rapid growth of the medical weight-loss market has created a similar dynamic around GLP-1 medications such as semaglutide and tirzepatide. During the period when these drugs were listed on the FDA drug-shortage list, compounding pharmacies were permitted under certain conditions to produce compounded versions. However, the FDA announced in late 2024 that shortages of tirzepatide had been resolved and in early 2025 that shortages of semaglutide had also ended. After these determinations, Eli Lilly, the manufacturer of tirzepatide, began taking enforcement actions against companies marketing compounded versions of its drugs. Cease-and-desist letters have been sent to telehealth companies, wellness centers, and medical spas promoting compounded tirzepatide products and lawsuits have been filed against several clinics and compounding pharmacies.

In recent years, California has seen a notable rise in IV hydration and wellness clinics, businesses that offer intravenous infusions of fluids, vitamins, electrolytes, and other substances marketed for benefits such as energy, immune support, recovery from illness, or hangover relief. The insertion of an intravenous line involves venipuncture, which may only be performed by appropriately licensed healthcare professionals acting within their scope of practice, such as physicians, NPs, physician assistants, RNs, and LVNs. Businesses offering IV services using personnel who are not authorized to perform venipuncture could already risk unlicensed practice violations subject to enforcement by the relevant licensing boards.

In California, RNs generally do not have independent authority to compound medications, as medication compounding is tightly regulated under the state's pharmacy laws. The Pharmacy Law (BPC §§4052 and 4127) authorizes licensed pharmacists to compound medications pursuant to a valid prescription or medication order as part of the practice of pharmacy. The Act does, through BPC §2725, authorize RNs to administer medications and therapeutic agents ordered by a licensed provider and perform technical nursing procedures such as venipuncture and medication administration. Board of Pharmacy regulations (CCR Title 16 §1735) state that "Compounding" does not include reconstitution of a drug pursuant to a manufacturer's direction(s)...Typically, reconstituting or preparing a drug according to manufacturer instructions for immediate patient administration is considered part of medication administration and not considered compounding. Accordingly, a clinic or wellness business in California that engages in true medication compounding could face regulatory action from the Board of Pharmacy, and nurses participating in such activities beyond their authority could also face enforcement by the Board of Registered Nursing.

A number of aesthetic procedures, such as injectable neuromodulators or laser treatments, must be performed or supervised by licensed medical professionals. Cosmetologists, estheticians, and electrologists, while licensed professionals and highly qualified in superficial treatments, may never inject the skin, use lasers, or perform certain invasive treatments. BPC §2400 generally prohibits corporations or non-physicians from owning or controlling a medical practice and as a result, many businesses that offer services that are deemed to be invasive, even in a spa type setting, must still be owned and controlled by a licensed physician, often through a professional medical corporation with the physician maintaining majority ownership and authority over clinical decisions. Many California businesses offering various cosmetic services operate through a physician-directed clinical entity that works with a management services organization which handles non-medical business functions while the physician maintains legal responsibility for certain services and supervision of employees and other providers.

BRN advises that it has observed an increase in complaints of BRN licensees practicing outside of their scope of practice in the wellness and med spa space, citing compounding as an area of particular concern. BRN says that RNs are engaging in compounding activities in med spas and IV clinics. BRN says that investigators face significant challenges verifying allegations because the activity often occurs out of public view, either behind closed doors or outside the presence of patients. BRN cites authority that other health professional licensing boards have to inspect facilities and locations where their licensees practice and believes it too should have inspection authority over what it says are “medical spas and other outpatient or community-based clinics”. The BRN suggests in its 2026 Sunset Report that it be should be able to inspect locations where nurses are administering drugs via infusion or injection. It is unclear if BRN has explored the magnitude of this request and how inspections would work in terms of being targeted and related to a specific-complaint or random.

Staff Recommendation: *BRN should advise the Committees on the number of complaints that are verified that justify such an expanded enforcement role. BRN should advise the Committees what it believes constitutes a med spa and a IV hydration clinic. BRN should update the Committees on its investigation work to date and whether responding to complaints has focused on businesses that are providing services without proper licensed personnel at all or whether BRN licensees, who are clearly authorized to provide many of the more popular services consumers seek, are complying with supervision and practice authority rules in ways different than the BRN is accustomed to, in terms of provider relationships in traditional healthcare settings like hospitals that may not be the norm in these business settings.*

OTHER ISSUES

ISSUE #32: (TECHNICAL CLEANUP) Are there any technical changes necessary for any of the practice acts regulated by the Bureau which would improve operations and enhance efficiency?

Background: Pursuant to BPC § 2788, the BRN is required, through its EO, to inspect all schools of nursing at the times deemed necessary. The EO is further required to *provide written reports of those visits to the board, which shall thereupon approve those schools of nursing that meet the requirements provided by the BRN.* Statute specifies that *upon receiving the report of the executive officer, if the board determines that any approved school of nursing is not maintaining the standard required by the board, notice thereof in writing specifying the defect or defects shall be immediately given to the school.* Statute further specifies that, *If the defects are not corrected within a reasonable time, the school of nursing may be removed from the approved list and notice thereof in writing given to it.* Although the BRN should maintain the requirement to inspect schools, this is no longer a task that the BRN’s EO conducts on their own. NECs and other education staff are delegated the authority to conduct school visits, education and curriculum review, faculty approval, etc., while the nursing education and licensing committee and the full board consider the approvals, denials, reapprovals, enrollment increases and decreases, and any curriculum changes of BRN-approved educational providers. As a result, this statute, which was last amended in 1983, should be revised to more appropriately clarify the BRN’s EO role in school approvals.

BPC § 2796 states that it is unlawful for any person or persons not licensed or certified as provided in this chapter to use the title “registered nurse,” the letters “R.N.,” or the words “graduate nurse,”

“trained nurse,” or “nurse anesthetist.” The BRN reports that investigators have recently encountered cases where unlicensed individuals use the designation “RN” without periods, rather than “R.N.” as specified in BPC § 2796. To ensure effective enforcement of existing laws prohibiting unlicensed practice, it is important to clarify that any variation of the title, such as “RN,” “R.N.,” or similar representations, is unlawful when used by individuals who are not licensed nurses.

Staff Recommendation: *The BRN should advise the Committees on any technical changes or updates that may improve stature or create operational efficiencies.*

CONTINUED REGULATION BY THE BOARD OF REGISTERING NURSING

ISSUE #33: (CONTINUED REGULATION BY THE BRN) **Should the licensing and regulation of nurses, advanced practice nurses, and nursing educational programs be continued and be regulated by the current BRN membership?**

Background: The health, safety and welfare of consumers are protected by the presence of a strong licensing and regulatory Board with oversight of RN and APRN professions. The BRN’s role in school approval processes should remain but continue to be periodically assessed to ensure that students are able to enter and graduate from a prelicensure nursing program with the credentials and training necessary for licensure and the requisite preparedness for gainful employment in the nursing workforce. The licensing and regulation of RNs should remain under the jurisdiction of the BRN. The BRN should continue its enforcement operations to ensure all entities who fall under the BRN’s regulatory jurisdiction comply with California law. The BRN should focus on swifter enforcement timelines for formal disciplinary matters which result in the greatest harm to patients; ensure that any requirements placed on licensed RNs from other states are necessary and not overly burdensome given practice history; ensure that the prelicensure nursing program approval process is consistent and flexible; and for the BRN’s highest priority to remain protection of the public.

Staff Recommendation: *The BRN should be continued, to be reviewed again on a future date to be determined.*