BACKGROUND PAPER FOR THE BOARD OF REGISTERED NURSING

Joint Sunset Review Oversight Hearing, March 14, 2022
Senate Committee on Business, Professions and Economic Development
and Assembly Committee on Business and Professions

BACKGROUND, IDENTIFIED ISSUES, AND RECOMMENDATIONS

BRIEF OVERVIEW OF THE BOARD

The Board of Registered Nursing (BRN) is a licensing entity within the Department of Consumer Affairs (DCA). The BRN is responsible for administering and enforcing the Nursing Practice Act.[1] The act is the chapter of laws that establish the BRN and outline the regulatory framework for the practice, licensing, education, and discipline of registered nurses (RNs) and advanced practice registered nurses (APRNs). APRNs include certified nurse mid-wives (CNMs), nurse anesthetists, nurse practitioners (NPs), and clinical nurse specialists (CNSs).[2] The BRN also issues certificates to RNs who qualify as public health nurses (PHNs).[3] The BRN also maintains a list of RNs who specialize in psychiatric-mental health nursing for purposes of statutory requirements relating to counseling services for victims of crime.[4]

RNs 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.[5]

They may also 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.[6]

[1] Business and Professions Code (BPC) §§ 2700-2838.4.
[2] BPC § 2725.5.
[3] BPC §§ 2816-2820.
[4] See AB 1253 (Matthews), Chapter 420, Statutes of 2001 and AB 1017 (Jackson), Chapter 712, Statutes of 2001.
[5] BPC § 2725.
[6] BPC § 2725(c)(2), California Code of Regulations (CCR), tit. 16, §§ 1379, 1470-1474.

APRNs, PHNs, and psychiatric-mental health nurses are RNs that have additional education and training in specific areas of nursing practice. Historically, the APRN and PHN designations were intended to establish uniform titles and training in response to conflicting definitions of APRNs being created by state agencies and private organizations and therefore did not modify their statutory scope of practice.[7] However, the additional training and experience usually qualify them to perform more advanced functions under standardized procedures.

The two exceptions are CNMs and NPs. Both CNMs and NPs are specifically authorized to order and furnish drugs and medical devices under standardized procedures if they obtain a furnishing number from the BRN.[8] CNMs are also authorized to attend cases of low-risk pregnancy and childbirth, provide prenatal, intra partum, and postpartum care, and perform specified procedures.[9] NPs are authorized to order durable medical equipment, certify disability, and approve, sign, modify, or add to a plan of treatment or plan of care.

California educational programs that offer a course of instruction leading to an RN license must have approval from the BRN to operate in California.[10] Students that attend out-of-state programs must have their education evaluated for equivalency.[11]

As of October 5, 2020, the BRN reported a total of 458,165 active RNs, including 3,391 CNSs, 2,682 nurse anesthetists, 1,349 CNMs, 27,640 NPs, 36,196 PHNs, and 230 psychiatric-mental health nurses. As of January 2021, the BRN reported a total of 146 approved RN programs, including 91 Associate Degree in Nursing (ADN) programs, 43 Bachelor of Science in Nursing (BSN) programs, and 12 Entry-Level Master's (ELM) programs.

The BRN's mission is:[12]

> The California Board of Registered Nursing protects and advocates for the health and safety of the public by ensuring the highest quality of registered nurses in the State of California.

Legislative History

In 1905,[13] the University of California Board of Regents was given power by the Legislature to set standards, administer exams, approve educational programs, issue certificates, and revoke certificates of

[7] See BPC §§ 2818(b), 2820, 2833.6, 2834, 2837, 2838.4.
[8] BPC §§ 2746.51, 2836.1.
[9] BPC §§ 2746.5, 2746.52.
[10] BPC §§ 2785-2789, 2798.
[11] BPC § 2736(a)(2).
[12] BRN, *2018-21 Strategic Plan*, *at* 7.
[13] SB 677 (Irish), Chapter CDVI (405), Statutes of 1905.

registered nurses. That law made the use of the title "registered nurse" without certification a misdemeanor.

In 1913,[14] the Legislature formed the Bureau of Registration of Nurses under the State Board of Health. The bureau was charged with administering the exam, registering qualified RNs, accrediting nursing schools, and revoking licenses of nurses found to be unsafe to practice.

In 1939,[15] The Board of Nurse Examiners was created by legislation within the Department of Professional and Vocational Standards. This established the mandatory Nursing Practice Act, regulating nursing through licensure of a defined scope of practice. Five RN board members were appointed by the Governor.

In 1975, the board's name was changed to the current BRN. The Nursing Practice Act was amended significantly to provide the current description of nursing and established certification of nurse-midwives.

In 1977, the BRN's board member composition was first established. It included three public members, three direct care RNs, one educator, one RN administrator, and one physician. A restructure in 2006 changed the physician member to be another public member. The composition remains the same today.

Board Membership

The Nursing Practice Act specifies that the BRN is composed of a nine-member professional member majority—five professional members and four public members. The Governor appoints all of the professional members and two of the public members, while the Senate Rules Committee and the Speaker of the Assembly appoint the remaining two public members. The professional members must include two RNs, one APRN, one RN active as an educator or administrator of an approved program, and one RN who is an administrator of a nursing service. There are no qualifications for the appointment of public members, except that they may not be licensees of any healing arts board or have monetary interests in the provision of health care services.

The BRN is required to meet at least once every three months and to meet in northern and southern California. Meetings are public, pursuant to the Bagley-Keene Open Meetings Act.[16] Members are not paid but receive a per diem of $100 for each day spent in the discharge of official duties and are reimbursed for traveling and other expenses necessarily incurred in the performance of official duties.

[14] SB 526 (Hewitt), Chapter 319, Statutes of 1913.
[15] See AB 620 (Cronin), Chapter 807, Statutes of 1939.
[16] Government Code §§ 11120-11132.

The current BRN members and their backgrounds are listed as follows:

Board Members	Appointment	Term Expiration	Appointing Authority
Dolores Trujillo, President, RN Direct Care Member, has been a bedside neonatal intensive care unit (ICU) nurse at Kaiser Roseville since 2010 and was previously an ICU charge nurse and pediatric ICU nurse at Kaiser Sacramento from 2000 to 2010.	1/21/20	6/1/24	Governor
Mary Fagan, Vice President, Nurse Services Administrator Member, is the vice president for patient care services and chief nursing officer at Rady Children's Hospital San Diego. She practiced as a pediatric ICU nurse and educator in St. Louis, MO and New Haven, CT, and has been with Rady Children's Hospital since 1987 in various roles including manager and director of critical care services, quality management director and has been the chief nursing officer since 2010. She received her BSN from St. Louis University, a Master's Degree in Nursing from Yale University, and a PhD in Nursing from the University of San Diego.	8/10/20	6/1/23	Governor
Imelda Ceja-Butkiewicz, Public Member, has been a project specialist at Kern County Public Health Services Department since 1999. She has served in multiple positions at the Kern County Department of Public Health. She also held multiple positions at the Kern County Economic Opportunity Corporation from 1995 to 1998. She worked as a legal secretary in Bakersfield from 1986 to 1995. Ms. Ceja-Butkiewicz is a member and has served on several professional and community organizations, including the Kern Homeless Collaborative, International Women's Program, Central Democratic Party Committee, Democratic Women of Kern (past President), Inyo, Kern Central Labor Council, and Service Employees International Union Local 521.	2/6/14	6/1/21	Governor
Jovita Domingues, RN Educator Member, has been a staff nurse III at Salinas Valley Memorial Hospital since 1987 and a clinical instructor for Hartnell College since 1999. She is a member of the American Society of PeriAnesthesia Nurses and California Nurses Association and a Delegate of the California Democratic Party.	3/2/21	6/1/25	Governor
Susan Naranjo, Public Member, is the public affairs director and staff executive team member of the Committee of Interns and Residents local of the Service Employees International Union. For more than 10 years, Susan has worked with workers across multiple industries to form and strengthen their union at their workplace and advance policies that protect working families. She holds a BA in Political Science from California State University, San Bernardino.	11/16/20	6/1/24	Assembly
Elizabeth (Betty) Woods, APRN Member, is a volunteer NP at the Jewish Community Free Clinic. Previously she was a labor representative with the California Nurses Association from 1994 to 2007 and a family NP at Kaiser Permanente, Santa Rosa from 1976 to 1994 in Family Medicine and a member of the HIV Consult Team. From 1984 to 1994, she was an adjunct clinical professor for NP students at Sonoma State University, and from 1982 to 1988 an NP sexual assault examiner at Sonoma County Community Hospital. Before earning her NP certification and MSN from Sonoma State University, Ms. Woods was an ICU and medical/surgical nurse.	6/18/18	6/1/22	Governor

Board Members	Appointment	Term Expiration	Appointing Authority
Patricia "Tricia" Wynne, Esq., Public Member, was Deputy State Treasurer in the Office of the State Treasurer from 2006 to 2013. She was Special Assistant Attorney General in the Office of the California State Attorney General from 1998 to 2006, Policy Director to State Senate President Pro Tempore Bill Lockyer from 1994 to 1998, and Senate Judiciary Committee Counsel for Chairman Bill Lockyer from 1983 to 1994. She earned a Juris Doctor degree from the University of San Diego School of Law.	12/20/21	6/1/25	Governor
Vacancy, RN direct care member			Governor
Vacancy, public member			Senate

Committees

The BRN has five standing committees composed of two to four BRN members. The board members work through a committee structure with staff support to assess issues, set policy, and make enforcement decisions. The following are from the BRN's Board Member Orientation:

- **Administrative Committee**: proposes administrative policy, determines the need for an emergency meeting, and is consulted by the executive officer on day-to-day implementation or interpretation of BRN policy.

- **Education/Licensing Committee**: advises the BRN on matters relating to nursing education, including approval of nursing programs, curriculum changes, licensing examination pass rates, and other nursing education issues; "assures a job related, non-discriminatory examination by screening item development experts for the National Council"; advises the BRN on the development of examination related guidelines and procedures; monitors National Council of State Boards of Nursing correspondence; monitors the mandatory continuing education program; and receives recommendations from the Nurse-Midwifery Advisory Committee.

- **Enforcement/Intervention Committee**: advises and makes recommendations to the BRN on matters related to laws and regulations on intervention and discipline.

- **Legislative Committee**: provides information and makes recommendations to the BRN on matters relating to legislation affecting RNs.

- **NP Advisory Committee**: Consists of four qualified NPs, two physicians and surgeons with demonstrated experience working with NPs, and one public member, and advises and makes recommendations to the BRN on all matters relating to NPs, including, but not limited to, education, appropriate standard of care, and other matters specified by the BRN. The committee also provides recommendations or guidance to the BRN when the BRN is considering disciplinary action against an NP.

- **Nurse-Midwifery Advisory Committee**: Consists of four qualified CNMs, two qualified physicians and surgeons, including obstetricians or family physicians, and one public member. Makes recommendations to the BRN on all matters related to midwifery practice, education, appropriate standard of care, and other matters as specified by the BRN. The committee also provides recommendations or guidance on care when the BRN is considering disciplinary action against a CNM.

- **Nursing Practice Committee**: advises the BRN on matters relating to nursing practice, including common nursing practice issues and advanced practice issues in the practice of CNMs, nurse anesthetists, and NPs. The committee also reviews all staff responses to proposed regulation changes that may affect nursing practice.

The BRN has also established two advisory/ad hoc committees and workgroups:

- **Advanced Practice Registered Nursing Advisory Committee (APRNAC)**. Established in 2017 and makes recommendations to the BRN, through the Nursing Practice Committee, on issues involving advanced practice by clarifying and articulating the sufficiency of the four APRN roles and recommend changes to the Nursing Practice Act, regulations, and policy, developing recommendations for joint statements related to the APRN scope of practice and functions, reviewing national trends in regulation of APRNs, and collaborating with other committees on matters of mutual interest. The committee consists of two CNSs, four NPs, two CNMs, and two nurse anesthetists. With the passage of SB 1237 and AB 890, the BRN reports that it is evaluating the future of this committee as it has overlapping functions outlined in the statutory guidelines for the NPAC and NMAC. The BRN states that it understands the need for CNS and CRNA specialties to continue to work on matters that affect their practice and, therefore, will evaluate and determine the appropriate next steps.

- **Nursing Workforce Advisory Committee (NEWAC)**. Advises the BRN on current and projected issues affecting the nursing workforce and education in California and reviews and provides input on the BRN biennial RN survey instrument, Annual School Survey, and other research related to the RN workforce in California.

Staffing

The BRN's current executive officer was appointed June 4, 2020, and has served as acting executive officer since February 2, 2020. The BRN is unique in that the executive officer must be a licensed RN. The BRN's executive officer requirement is discussed further on page 23 under Current Sunset Review Issues, Issue #4: Executive Officer Requirement.

As of October 20, 2020, the BRN has a total of 237.1 authorized staff positions. As of February 12, 2021, the BRN reported an overall vacancy rate of 13.15%.

In 2019, the BRN submitted a Budget Change Proposal (BCP) to request additional staff to meet its daily operational needs throughout all program areas. The BCP requested 67 positions and was approved. The BRN reports that the additional staff will be used to improve customer service, processing times, and other essential operations of the BRN.

Fiscal and Fund Analysis

The BRN is a special fund agency and receives no support from the General Fund.[17] The BRN's fund, the Board of Registered Nursing Fund,[18] is primarily funded through licensing fees and administrative fee revenues. The largest and most consistent source of revenue is renewal fees. It may also collect revenue from fines and reimbursement from enforcement cost recovery.

The BRN and other licensing boards also try to maintain a healthy fund reserve, a fund balance that can cover economic uncertainties, potential litigation, salary or price increases, and other unexpected expenditures. In its *2020 Sunset Review Report*, the BRN reported that, at the end of FY 2019-20, the BRN had a fund balance of approximately $47.5 million, which represents around 9 months in reserve.

Due to the BRN's healthy fund condition, in FY 2020-21, it made a $30,000,000 General Fund loan to help aid with COVID-19. No interest or payments have been scheduled to reimburse the BRN, but the loan is expected to be repaid by FY 2024-25. After the loan, the reserve is projected to decline to less than 5 months in FY 2021-22. The BRN also made a $2,942,000 loan to the General Fund per Control Section 3.92 of the Budget Act of 2020, for purposes of agreed-upon employee compensation reductions.[19]

Still, the BRN's fund is projected to continue to grow its reserve over the next two FYs. As a result, the BRN reports that its fund is stable and an increase of current fees, or reduction in those fees, is not anticipated.

If the BRN does require a fee increase, it must report to the appropriate policy and fiscal committees of each house of the Legislature whenever it proposes or adopts an increase in any fee imposed under the Nursing Practice Act. The BRN must specify the reasons for each fee increase and identify the percentage of the funds derived from an increase in any fee that will be used for investigational or enforcement-related activities.[20]

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[17] For more information related to state funds, see Department of Finance, *Glossary of Budget Terms*, http://www.dof.ca.gov/budget/resources_for_departments/budget_analyst_guide/glossary.pdf.
[18] BPC § 205(a)(30).
[19] SB 74 (Mitchell), Chapter 6, Statutes of 2020.
[20] BPC § 2815.7.

Fund Condition (Dollars in Thousands)						
	FY 2017-18	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**	**FY 2021-22***	**FY 2022-23***
Beginning Balance**	$9,957	$16,408	$33,933	$46,989	$34,853	$49,294
Loans to General Fund	N/A	N/A	N/A	$30,000	N/A	N/A
Total Revenues and Transfers	$48,892	$63,172	$67,228	$41,742	$74,736	$70,131
Total Resources	$58,849	$79,580	$101,161	$88,731	$109,589	$119,425
Authorized Budget	$42,824	$45,480	$57,918	$57,164	$60,509	N/A
Total Expenditures	$41,800	$45,019	$53,643	$53,878	$60,295	$63,892
Fund Balance	$17,050	$34,561	$47,518	$34,853	$49,294	$55,533
Months in Reserve	4.5	7.7	9.3	6.9	9.3	10.1

** Projections—may not reflect actuals at the end of the FY.*
***May not match prior fund balance due to prior year adjustments.*

Expenditures by Program Component

The BRN's expenditures can be broken down based on its administrative, licensing and education, and enforcement costs, although administrative costs are distributed across all programs. All licensing boards also pay a pro rata contribution to cover various administrative services provided by the DCA, which include training and planning, legal affairs, legislative affairs, information technology, communications, public affairs, and investigative services, among others.

In FY 2016-17, the BRN's enforcement expenditures were approximately 42% of its total expenditures. Licensing and education expenses were approximately 11%, and administrative expenses were approximately 13%. Its DCA pro rata contribution was approximately 34% of its total expenditures.

In FY 2017-18, enforcement expenses were approximately 41% of the total expenditures. Licensing and education expenses were approximately 14%, and administrative expenses were approximately 14%. The pro rata contribution was approximately 32%.

In FY 2018-19, the enforcement expenses were approximately 43% of the total expenditures. Licensing and education expenses were approximately 14%, and administrative expenses were approximately 13%. The pro rata contribution was approximately 30%.

In FY 2019-20, the enforcement expenses were approximately 47% of the total expenditures. Licensing and education expenses were approximately 15%, and administrative expenses were approximately 15%. The pro rata contribution was approximately 29%.

Cost Recovery

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

Attorney General's Office that result in the filing of an accusation has 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 award.

One significant barrier to collecting funds is the inability to collect penalties before the reinstatement of the license. 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.

However, 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 they become ineligible for reinstatement. As a result, there is a significant percentage of cost recovery that will never become available to collect. One potential way to address this issue is the fee proposed by the BRN's recent fee audit, which is discussed on page 19 under Current Sunset Review Issues, Issue #1: Fee Audit.

Licensing

In general, licensing programs serve to protect the consumers of professional services and the public from undue risk of harm. The programs require anyone who wishes to practice in a licensed profession to meet a minimum level of competency and fitness to practice criteria, among other consumer protection requirements.

To that end, all BRN license applicants demonstrate competency and fitness to practice by submitting primary source documentation, which includes educational transcripts, experience records, license verification from other states, and professional certifications. 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 and the Federal Bureau of Investigation.

On October 5, 2020, the BRN reported a total of 458,165 active RN licensees, including:

- 3,391 CNS
- 2,682 Nurse Anesthetists
- 1,349 CNMs
- 27,640 NPs
- 230 Psychiatric-Mental Health Nurses
- 36,196 PHNs

In FY 2020-21, BRN issued 43,066 new RN licenses and issued 214,223 RN renewals.

RN Application Requirements. The BRN's primary license type is RNs. To qualify for an RN license, applicants must complete a high school education in the U.S. or its equivalent, complete an RN course

of instruction prescribed by the BRN or its equivalent, pass the National Council Licensure Examination for RNs (NCLEX-RN), and pass a background check.[21]

RNs may apply for a California license either by examination or by endorsement.[22] Applicants seeking licensure by examination are required to meet BRN's education requirements to qualify to take the NCLEX-RN.[23] RN applicants may qualify to take the NCLEX-RN via one of the following methods:

1) Graduate from a BRN-approved RN pre-licensure educational program in California.

2) Graduate from an RN pre-licensure educational program in another state that the BRN determines is equivalent to the minimum requirements established for an approved RN program in California.

3) Graduate from an RN pre-licensure educational program in another country that the BRN determines is equivalent to the minimum requirements established for an approved RN program in California.

4) Complete a BRN-approved licensed vocational nurse (LVN) to RN "bridge" program, which provides additional education not to exceed a maximum of 30-semester or 45-quarter units.[24]

Licensure by endorsement is available to applicants who are actively licensed in another state, U.S. territory, or Canada.[25] Applicants must have completed an educational program that meets California requirements and passed the NCLEX-RN or the historical State Board Test Pool Examination (SBTPE). The BRN website specifies that the Canadian Comprehensive Examination is not accepted. Applicants licensed in other countries who have not passed either national examination are not eligible for endorsement and must qualify for and pass the NCLEX-RN as described under 3) above.

RN Scope of Practice. Once licensed, RNs 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.

They may also 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.[26]

[21] BPC § 2736, CCR, tit. 16, § 1412,
[22] BPC § 2732.1.
[23] BPC §§ 2866, 2872.2.
[24] BPC § 2736.6, CCR, tit. 16, § 1429.
[25] BPC § 2732.1(b).
[26] BPC § 2725(c)(2), CCR, tit. 16, §§ 1379, 1470-1474.

The following are APRN Certifications:

Clinical Nurse Specialist (CNS): CNSs are RNs with advanced education who participate in expert clinical practice, education, research, consultation, and clinical leadership. BRN certification may be obtained by successful completion of a master's program in a clinical field of nursing or a clinical field related to nursing with specified coursework.

Certified Registered Nurse Anesthetist (CRNA): CRNA's are RNs who provide anesthesia services at the direction of a physician, dentist, or podiatrist. Nurse anesthetist applicants must provide evidence of certification by the Council on Certification of Nurse Anesthetists and Council on Recertification of Nurse Anesthetists.

Certified Nurse-Midwife: 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. BRN 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. There is an equivalency method for applicants who completed a non-BRN-approved midwifery program and who are not nationally certified.

CNMs in California may apply for a furnishing number, enabling them to write a medication order and furnish drugs to a patient. To obtain a furnishing number, a CNM must satisfactorily complete a course in pharmacology, as specified, Upon completion of the course and notification to the BRN, the CNM then applies to the Drug Enforcement Administration (DEA) to obtain a DEA number.

Nurse Practitioner (NP): 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. BRN certification can be obtained by successful completion of a program that meets BRN standards or by certification through a national organization 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. There is an equivalency method for RNs who have completed an NP program that does not meet BRN standards. These applicants must submit verification of clinical competence and experience verified by an NP or physician.

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 and complete physician-supervised experience in the furnishing of drugs or devices. Upon completion of the course and notification to the BRN, the NP then applies to the DEA to obtain a DEA number. However, the practice and standardized procedure requirements of NPs will change as a result of AB 890 (Wood), Chapter 265, Statutes of 2020, discussed further on page 38 under Current Sunset Review Issues, Issue #12: Implementation of Recent Legislation Impacting Advanced Practice Nurses.

Psychiatric/Mental Health Nurse Listing: The BRN maintains a listing 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 clinical specialist in psychiatric/mental health nursing. This voluntary listing enables the psychiatric/mental health nurse to receive direct insurance reimbursement for counseling services.

Public Health Nurse (PHN) Certification: PHNs provide direct patient care and services related to maintaining the public and community's health and safety. To be considered for BRN 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.

Education

RN prelicensure educational programs must have BRN approval to operate.[27] The purpose of BRN approval is to ensure approved programs include the minimum number of units of theory and clinical experience necessary to achieve essential clinical competency for the entry-level RN. The Nursing Practice Act requires all schools to provide clinical instruction in all phases of the educational process, except as necessary to accommodate military education and experience, and Educational programs are also subject to periodic inspection and review, as determined by the BRN.[28]

As of January 2021, the BRN reported the following educational program approval statistics:

- 146 approved RN programs, including 91 Associate Degree in Nursing (ADN) programs, 43 Bachelor of Science in Nursing (BSN) programs, and 12 Entry-Level Master's (ELM) programs.
- 21 proposed programs undergoing initial approval review.

Starting in 2013, educational programs seeking BRN approval must pay fees for various stages of the process.[29] The only increase to the BRN's approval fees occurred in 2018.[30] The BRN's current approval fee schedule is as follows:[31]

- Initial approval fee for an institution of higher education or a private postsecondary school of nursing of $40,000 (up to a statutory maximum of $80,000). Previously the fee was $5,000.

[27] BPC §§ 2785-2789, 2798.
[28] BPC § 2788.
[29] SB 122 (Price), Chapter 789, Statutes of 2012.
[30] SB 1039 (Hill), Chapter 799, Statutes of 2016.
[31] BPC § 2786.5.

- Continuing approval fee of a nursing program established after January 1, 2013, of $15,000. Previously the fee was $3,500.

- Substantive change approval fee of $2,500. Previously the fee was $500.

The BRN's regulations further outline the specific requirements for RN pre-licensure educational programs.[32] The regulations specify application procedures, reporting requirements, curriculum, and clinical experience. They also include faculty, resource, and facility requirements, although the Nursing Practice Act is silent on the duty to establish the latter requirements.

The California Private Postsecondary Education Act of 2009 also specifies separate requirements for private postsecondary institutions that offer RN pre-licensure educational programs.[33] Private institutions must obtain prior approval from the Bureau for Private Postsecondary Education (BPPE), or an exemption, before becoming eligible for BRN approval.

While BRN approval is to ensure that the offered course of instruction is consistent with the requirements for licensure, the purpose of the BPPE regulation is to ensure a minimal level of overall quality. Specifically, the BPPE establishes and enforces standards that: 1) aim to protect consumers and students against fraud, misrepresentation, or other business practices that may lead to loss of students' tuition and related funds and 2) promote ethical business practices, health and safety, fiscal integrity, instructional quality, and institutional stability.

Given the overlap in approval responsibilities, the BRN is required to have a memorandum of understanding with the BPPE to delineate the powers of the BRN to review and approve schools of nursing and the powers of the BPPE to protect the interest of students attending institutions governed by the California Private Postsecondary Education Act of 2009. Approval overlap is discussed further on page 54 under Current Sunset Review Issues, Issue #23: Duplication of Program Review.

Continuing Education

The BRN requires 30 hours of continuing education (CE) every two years to ensure RNs maintain continuing competence and familiarity with developing industry trends.[34] The standards for CE are established in the BRN's regulations and must ensure that a variety of CE is available to licensees, including online, academic studies, in-service education, institutes, seminars, lectures, conferences, workshops, extension studies, and home study programs. The standards must consider specialized areas of practice, and content must be relevant to the practice of nursing and related to the scientific knowledge or technical skills required for the practice of nursing or be related to the direct or indirect patient or

[32] CCR, tit. 16, §§1420-1432.
[33] BPC §§ 94800-94950.
[34] BPC § 2811.5, CCR, tit. 16, § 1450-1459.1.

client care. The BRN is prohibited from requiring more than 30 hours of direct participation or equivalent units of measure.

Enforcement

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

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

For minor violations, 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 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.

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.

In FY 2019-20, the BRN received 8,191 complaints, 3,877 of which were arrest/conviction notices. Of the complaints, 4,309 were referred for investigation.

Additionally, the DCA's 2010 Consumer Protection Enforcement Initiative (CPEI) introduced performance measures and set target cycle timelines with the aim of resolving investigations and disciplinary proceedings in a timely manner. Consumers, licensees, and the public benefit from the expedient resolution of investigations and disciplinary proceedings. The CPEI timelines track statistics for every stage of the enforcement process, including the following statistics quarterly:

- New complaint intake and the average number of days to close a complaint or assign it for an investigation (target average of 10 days).

- Investigation cases completed and the average number of days to complete an investigation (target average of 360 days).

- Formal disciplinary actions completed and the average number of days to complete a disciplinary action (target average of 540 days).

- Total probationers and probation completions.

- New probationers and the average number of days from assignment to first contact (target average 15 days).

- Probation violations and the average number of days to initiate appropriate action (target average 30 days).

The statistics reported by the BRN indicate that its average cycle times have mostly met or exceeded the performance targets since FY 2016-17, although individual months in some quarters may not have met the target. Specifically, the BRN did not meet the following targets:

1) The target 100 days to close non-formal discipline cases (PM3) in Q2 of FY 2017-18 by 9 days. It met the overall average target all other times, but it went over the target time in 2 individual months, October of Q2 of FY 2016-17 by 18 days and October of Q2 of FY 2018-19 by 27 days.

2) The target 2 days to respond to probation violations (PM8) in Q4 of FY 2016-17 by 1 day and Q1 of FY 2017-18 by 1 day. It met the overall average target all other times, but it went over the target time in the month of December of Q2 of FY2018-19 by 2 days.

3) The target 540 days (18 months) to complete formal discipline cases referred to the Office of the Attorney General, also known as Performance Measure 4 (PM4), at all, reporting average cycle times between 72 and 184 days over the target timeline. However, few boards, including the BRN, report meeting this target cycle time. PM4 target timelines are discussed further on page 61 under Current Sunset Review Issues, Issue #29: Formal Discipline Timelines.

Substance Abuse Intervention Program

The BRN's Intervention Program was created in 1985 as an alternative to disciplinary action for RNs whose practice may be impaired due to chemical dependency or mental disorders. The BRN relies on a contractor to provide oversight and treatment of its licensees. Those who have substance abuse problems can avoid license sanctions by taking part in a confidential "intervention" program of drug testing, treatment, and practice restrictions. In an attempt to provide uniform operational standards for health care boards' diversion programs, legislation required the DCA to put forth "Uniform Standards Regarding Substance-Abusing Healing Arts Licensees" (Uniform Standards).[35] The BRN reports following the DCA's released Uniform Standards and is working on incorporating additional changes to Uniform Standard #4 related to drug testing.[36]

[35] SB 1441 (Ridley-Thomas) Chapter 548, Statutes of 2008.
[36] SB 796 (Hill), Chapter 600, Statutes of 2017.

Additional Background Information

For additional information regarding the BRN's responsibilities, operations, and functions, please see the BRN's *2020 Sunset Review Report* and attachments. The reports are available on the Assembly Committee on Business and Professions website: abp.assembly.ca.gov/reports.

PRIOR SUNSET REVIEWS: CHANGES AND IMPROVEMENTS

The BRN's last review by the Legislature was in 2017, and in 2015 before that. In January 2021, the BRN submitted its required sunset report to the Senate Committee on Business, Professions and Economic Development and the Assembly Committee on Business and Professions (Committees). In the BRN's 2021 Sunset Review Report, the BRN describes actions it has taken since its prior reviews in 2017 and 2015, to address the recommendations made in staff background papers. For additional information on the BRN's responses to prior sunset review issues, please visit the BRN's website, rn.ca.gov. The issues which have not been fully addressed or which may still be of concern to the Committees, are discussed more thoroughly under "Current Sunset Review Issues."

- **Is the BRN meeting the goals and objectives of its strategic plan?** The BRN reports that overall, the BRN is meeting the goals and objectives of its strategic plan. An example is that the BRN is processing disciplinary cases more efficiently; however, the BRN is not processing within the targeted timeframe, which was a focus in the CSA Enforcement Audit (2016-046). See Issue #29 under Current Sunset Review Issues for further discussion on current formal discipline timelines.

- **Additional improvements needed to the approval process for nursing schools/programs**. The BRN reports that it facilitates a workgroup of deans and directors to explore opportunities to streamline the current nursing program approval process, including but not limited to, efforts to align, in part, the BRN approval and the accreditation processes. Additionally, the BRN states that it has increased the Joint NEC meeting frequency to every other week to provide training and collaboration to ensure rules and regulations are applied consistently throughout the State. See Issue #18 under Current Sunset Review Issues for further discussion on school approvals.

- **Appropriate oversight of current nursing programs, require accreditation for all nursing programs, and additional information needed regarding program/school performance**. The BRN provides oversight of nursing programs through the approval and monitoring of nursing programs. In the past, there was confusion, as 'approved' and 'accredited' were used interchangeably in reference to the nursing program approval process which is incorrect as they are not the same process and outcome. Currently, the Nursing Practice Act does not require nursing programs to be accredited.

  The BRN reports that it strives to keep the public informed about information related to BRN-approved nursing programs through the BRN website, The BRN Report, and published annual school survey reports. Some of the available information include, but are not limited to, annual NCLEX-

RN pass rate for the past five years; accreditation status, if applicable; attrition; and on-time completion rates. All allegations of unlicensed activity are investigated, and outcomes posted, if appropriate.

Since the last sunset, the BRN placed five nursing programs in a warning status, which is reflected on the BRN website. There have been no withdrawals of any program's approval. For those nursing programs struggling to meet statutes and regulations, the BRN continues to have an active role in working with the nursing programs to maintain program approval. See Issue #18 under Current Sunset Review Issues for further discussion on school oversight.

- **Nursing graduates are having difficulty in finding employment, and is there still, or will there continue to be, a nursing workforce shortage?** Through various collaboration efforts, the BRN reports that it has been working to improve RN graduates' employability and continued practice in the nursing profession. An example is the partnership with HealthImpact on the California Newly Licensed RN Employment Survey Report. The BRN supports new RN graduate transition and residency programs. See Issue #22 under Current Sunset Review Issues for further discussion on nursing employment and workforce shortages.

- **Is there still a severe lack of diversity in the nursing profession?** The BRN states that it recognizes the value of cultural diversity in the nursing workforce and requires that the curriculum of nursing programs includes cultural diversity in their instructional content (16 CCR § 1426(d)). The BRN works with nursing programs and other stakeholders to support and encourage diversity in the RN workforce. In efforts to increase the diversity in the nursing profession, the BRN launched social media campaigns, released publications, and participated in stakeholder engagements.

- **Should the funding for the nurse's scholarship program be increased?** Currently, RNs pay a $10 fee upon license renewal. This fee funds the BRN Registered Nurse Education Fund and, through the Health Professions Education Foundation, provides scholarship and loan repayment programs for RNs agreeing to practice direct patient care at a qualified facility in California for a specified time. Funds not distributed revert to the Fund and are not directed to the General Fund. The BRN continues to have one staff representative on the Health Professions Education Foundation's Nursing Advisory Committee who has indicated there is no plan at this time to recommend an increase to the $10 fee for renewing RNs.

- **Increase Continuing Education audit of RNs and providers.** The BRN conducts CE audits of licensees through a random selection process. Over the past four FYs, the BRN conducted an average of over 8,700 RN CE audits. The BRN was approved to obtain staff dedicated to conducting increased RN audits and begin again the audit of CEPs. Unfortunately, until all staff is hired, CEP audits are only been completed when a complaint is received. The BRN continues to be involved with and evaluate national continued competence research, including clinical competency, and will

make recommendations for changes as appropriate. See Issue #32 under Current Sunset Review Issues for further discussion of CEP audits.

- **Does the BRN receive sufficient information on nurses who violated the law or have issues regarding their competency?** The BRN writes that all renewal applicants are required to disclose all misdemeanor and felony convictions as well as all disciplinary action against any license or certificate held in California or 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. If a conviction or disciplinary action is disclosed, additional information regarding the matter is requested to determine what, if any, action is needed. 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. There can be processing delays in the reporting by law enforcement and court of convictions to DOJ and obtaining information from these entities, which can delay the BRN processes.

- **Protracted process to suspend the license of an RN.** Pursuant to BPC § 494, the BRN continues to pursue an Interim Suspension Order (ISO) for those who pose an immediate threat to the public. When an ISO is issued through the administrative court, there is limited time to file an accusation. The BRN also has the capability of pursuing action should the case be currently held in criminal court. The BRN may pursue suspension of practice or conditions placed on a license, ordered by the judge presiding over the criminal case (PEN § 23).

- **Inconsistent reporting of prior disciplinary or criminal convictions of nurses.** Disciplinary action taken against a licensee is available on DCA's license search page. Additionally, employers may subscribe to a service called e-notify available from NCSBN's NURSYS system, which automatically notifies employers of publicly available discipline, and license status updates for the nurses for whom they request this information.

- **There is still a severe lack of staffing for BRN's enforcement program.** Over the last four years, the BRN was approved for and filled additional enforcement positions. With these positions, the BRN reports that it is adequately staffed in the Enforcement Division to handle the workload and ensure timeframes are met or, at minimum, progress continues to be made. The goal of completing discipline cases in an average of 12 to 18 months relies on other agencies and activities, which are beyond the control of the BRN. The BRN continues quality improvement efforts resulting in positive outcomes. See Issue #29 under Current Sunset Review Issues for further information on enforcement delays.

CURRENT SUNSET REVIEW ISSUES

The following are unresolved issues pertaining to the BRN and other areas of concern for the Committees to consider along with background information concerning the issues. There are also recommendations the Committee staff have made regarding issues or problem areas that need to be addressed. The BRN and other interested parties, including the professions, have been provided with this Background Paper and can respond to the issues presented and the recommendations of staff.

BUDGET ISSUES

ISSUE #1: FEE AUDIT. ***The BRN's 2019 fee audit recommended fee amounts for functions that have workload but are not associated with a fee. However, the BRN currently operates at a surplus and recently made two General Fund loans totaling more than $32 million. Should the BRN be authorized to establish the new fees?***

Background: In June 2019, BRN contracted with Cooperative Personnel Services (CPS) HR Consulting to review nine specific processes that the BRN identified as having no associated fee.[37] The BRN does not officially support or oppose any of the following recommended fees, and the BRN staff aim to have the fees prepared for the full board to act on by the end of the current FY 2020-21.

The audit fee recommendations include:

1) Re-evaluation of an International Graduate Application for Licensure (Examination): The BRN notes that international registered nursing applicants who were initially deemed not eligible can be reevaluated by providing documentation showing completion of an educational program meeting all California requirements. Recommended fee of $130.
2) Re-evaluation of an International Graduate Application for Licensure (Endorsement): International registered nursing applicants who were initially deemed not eligible can be reevaluated through an endorsement if they hold a current active RN license in another state, US territory, or Canada, have completed an educational program meeting all California requirements, and have passed either the NCLEX-RN or State Board Test Pool Examination. Recommended fee of $140.
3) Re-evaluation of an International Graduate Application for Licensure (Repeater/Reapply): International registered nursing applicants who were initially deemed not eligible can be reevaluated by reapplying for the licensing examination after clearing reasons for initial ineligibility and providing documentation showing completion of an educational program meeting all California requirements. Recommended fee of $70.
4) Petition for Modification or Non-Settlement Early Termination: A nurse on probationary status may petition to change a condition of the probation or have the probationary status removed early, pleading their case in a hearing after BRN staff have reviewed the application and updated the

[37] BRN, *2020 Sunset Report*, pages 147-149.

probationer compliance report, with involved BRN staff attending the hearings. Recommended fee of $1,530 per petition.

5) Petition for Early Termination by Stipulated Settlement: A nurse with probationary status may petition to end the probationary status after BRN staff have conducted an eligibility and compliance report review, the case has been reviewed by the Office of the Attorney General and a settlement has been agreed upon, and the settlement has been approved by the BRN Board Members. Recommended fee of $465 per petition.
6) Petition for Reinstatement with Administrative Law Judge: A nurse with a revoked license may petition for reinstatement of the license by attending a hearing with an Administrative Law Judge who then proposes a decision. The BRN Board then votes whether to adopt the decision. Recommended fee of $1,170 per petition.
7) Out of State Nurse Practitioner Education Program Process: Nursing programs outside of California request approval for program students to complete their clinical placement requirements in a California practice, demonstrating the nursing program meets California curriculum requirements and the preceptors are qualified to instruct in the designated study area. The BRN notes that this process is new and still under refinement, so the times are based on subject matter expert estimations based on similar processes. Recommended fees of $200 per application in addition to $55 per program and $65 per preceptor.
8) CEP Initial Application Process: BRN staff review applications (and appeals) from CEPs, verifying the submitted course content meets regulatory compliance requirements and instructors are qualified, with only one course being reviewed currently but a regulatory change is anticipated that will require all courses to be evaluated. The recommendation is that the CEP audit process be incorporated into the recommended base fee since a new provider could receive an audit during the first two years. Recommended fee of $670 ($475 + $195) and $115 per additional course submitted.
9) CEP Audit Process: Each continuing education provider must be audited at least once every five years to ensure continued adherence to regulatory requirements and instructor qualifications, with BRN withholding or rescinding approval for violations. Recommended fee of $195 to be incorporated into each CEP renewal application.

While it is common for fees to be associated with board processes that take up workload and benefit an applicant or licensee, it is unclear whether the BRN needs the additional fee revenue. The BRN currently operates at a significant surplus (between FYs 2016-17 and 2019-20, between $7 million and $17 million in excess revenue per FY). In FY 2020-21, the BRN also provided a $30 million general fund loan to assist with COVID-19 cost pressures, and the loan is expected to be repaid by FY 2024-25.

For the re-evaluation fees specific to international graduates, there is no analogous fee for other types of applicants. The BRN staff reports that this is because U.S. pre-licensure programs are generally more consistent in that they prepare students for the NCLEX-RN, even if there are variations between states. International applicants may have significantly different programs that were not established with the NCLEX-RN in mind, so there may be additional workload when reviewing those applicants.

The petition fees appear to be somewhat unique to the BRN. Most fees and penalties are associated with the cost of disciplinary proceedings and attached to an order or settlement, which licensees must pay before having their licenses renewed or reinstated. A fee on the petition itself would require payment upfront, regardless of the outcome of the petition.

Compared to the two boards that do have some initial petition fees, the proposed fees seem high. The Respiratory Care Board requires a fee for a petition of reinstatement (it is unclear if that fee also applies to modifications or settlements), and the fee is the cost incurred by the board to review information plus an initial application fee (not more than $300), and then a renewal fee for the reinstatements granted ($350).[38] The Board of Chiropractic Examiners fee is $371 for petitions for reinstatement, early termination of probation, and reduction of penalty.[39] The BRN's proposed petition fees are between $465 and $1,530.

Staff Recommendation: ***The BRN should discuss whether other boards have similar fees, whether the fees are equitably applied between applicant types, and whether the fees are currently necessary. If seeking legislation upon board approval to do so, the BRN should complete and submit the Committees' fee bill questionnaire at the time of the request.***

ISSUE #2: ATTORNEY GENERAL BILLING RATE. ***In 2019, the Attorney General suddenly and significantly increased its billing rate for all DCA licensing boards in disciplinary matters. Will the cost pressures generated by the increase create difficulties for the BRN's fund?***

Background: In July of 2019, the California Department of Justice announced that it was utilizing language included in the Governor's Budget authorizing it to increase the amount it billed to client agencies for legal services. The change was substantial: the attorney rate increased by nearly 30% from $170 to $220, the paralegal rate increased over 70% from $120 to $205, and the analyst rate increased 97% from $99 to $195. While justification was provided for why an adjustment to the rates was needed, the rate hike occurred almost immediately and without any meaningful notice to any client agencies.

Staff Recommendation: ***The BRN should discuss the impact of the Attorney General's rate increase and whether any action is needed by the Administration or the Legislature to safeguard the health of its special fund.***

[38] BPC §§ 3775(a), 3775(h).
[39] BPC § 1006.5(t)-(v).

ISSUE #3: LICENSING VS. PROMOTION OF THE PROFESSION. ***The long-standing policy of the Committees is that the purpose of licensing is to protect consumers through the least restrictive means, not to guarantee the highest quality practitioners. Are the BRN's mission and actions consistent with this policy?***

Background: The BRN's mission, per its 2018-21 Strategic Plan, is to protect consumers by guaranteeing high-quality practitioners:

> The California Board of Registered Nursing protects and advocates for the health and safety of the public by ensuring the highest quality of registered nurses in the State of California.

However, the goal of occupational licensing is not to guarantee the highest quality practitioners. The primary purpose of professional licensing is to protect consumers from businesses and services that would result in frequent or irreparable harm to the consumers if left unregulated. However, licensing restrictions are barriers to entry, limiting or even preventing new businesses and professionals from entering the market.[40]

Constitutionally, statutory requirements may only restrict a person from a profession if they are unfit to practice or incompetent.[41] From a policy standpoint, the negative economic and access to care effects of licensing restrictions are well-studied and therefore should be avoided or reduced when possible.[42] To meet these goals, licensing requirements should impose only the minimally acceptable level of competence needed to promote the safety of consumers. Additionally, the benefit to consumers should be weighed against the burden on the profession on an ongoing basis, particularly in professions with consistent change, where benefits may diminish or new burdens may emerge.

While there may be collateral benefits to licensing, such as increased professionalization, standardization of qualifications, and increased consumer certainty, when unrelated to specific consumer harms, the use of licensing requirements to achieve them tends to be protectionist (benefits licensees at the detriment of non-licensees). "[I]mposing requirements on people seeking to enter licensed professions—such as

[40] See generally, Little Hoover Commission, *Boards and Commissions: California's Hidden Government*, Report 97, July 1989; Little Hoover Commission, *Jobs for Californians: Strategies to Ease Occupational Licensing Barriers*, Report 234, October 2016.

[41] "It is axiomatic that the right of an individual to engage in any of the common occupations of life is among the several fundamental liberties protected by the due process and equal protection clauses of the Fourteenth Amendment. [Citations]. Therefore, for example, a statute constitutionally can prohibit an individual from practicing a lawful profession only for reasons related to [their] fitness or competence to practice that profession." *Hughes v. Board of Architectural Examiners*, 17 Cal 4th 763 at 30-31.

[42] See generally, *Occupational Licensing: Framework for Policymakers*, prepared by the U.S. Department of the Treasury Office of Economic Policy, the Council of Economic Advisers, and the Department of Labor (White House, Washington, DC, July 2015).

additional training and education, fees, exams, and paperwork—licensing reduces employment in the licensed occupation and hence competition, driving up the price of goods and services for consumers. This could benefit licensed practitioners, who might earn more than they would in an unlicensed market, or the financial benefits could flow elsewhere, such as to educational institutions or other licensing entities."[43]

While higher quality licensees could potentially reduce harm to consumers, "the quality, health, and safety benefits of licensing do not always materialize."[44] "Quality can be defined in many ways and is often difficult to measure, but the evidence on licensing's effects on prices is unequivocal: many studies find that more restrictive licensing laws lead to higher prices for consumers."[45] Also, in extreme cases, licensing boards that are overly involved in excluding others from the practice of a profession may violate federal antitrust laws.[46]

By way of comparison, the Medical Board's mission is:

> The mission of the Medical Board of California is to protect health care consumers through the proper licensing and regulation of physicians and surgeons and certain allied health care professionals and through the vigorous, objective enforcement of the Medical Practice Act, and to promote access to quality medical care through the Board's licensing and regulatory functions.

The Board of Vocational Nursing and Psychiatric Technician's mission is:

> The Board serves and protects the public by licensing qualified and competent vocational nurses and psychiatric technicians through ongoing educational oversight, regulation, and enforcement.

Staff Recommendation: ***The BRN should discuss why its primary mission is to protect the public by ensuring the highest quality of RNs, rather than to protect the public through the objective regulation of the profession.***

ISSUE #4: EXECUTIVE OFFICER REQUIREMENTS. ***The Nursing Practice Act is the only licensing law in California that requires the executive officer to be a licensee. Why is this requirement necessary?***

Background: Generally, every DCA licensing entity is authorized to appoint an executive officer. The purpose of an executive officer is to serve as the chief executive of the organization and manage board

[43] *Occupational Licensing: Framework for Policymakers, at* 12.
[44] *Occupational Licensing: Framework for Policymakers, at* 12
[45] *Occupational Licensing: Framework for Policymakers, at* 14.
[46] In N.C. State Bd. of Dental Exam'rs v. FTC - 717 F.3d 359 (4th Cir. 2013), the Supreme Court of the United States held that substantial evidence supported a conclusion that the North Carolina Board of Dental Examiners had engaged in concerted action that amounted to an unreasonable restraint of trade under 15 U.S.C.S. § 1.

matters. Because the executive officer is tasked with the overall management of the organization, most boards do not limit the selection of an executive officer by their status as a licensee. The BRN is the only licensing board under the DCA that is required to select an executive officer that is actively licensed as an RN.

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

ISSUE #5: PRIOR SEXUAL HARASSMENT AND MISCONDUCT ALLEGATIONS. *What was the outcome of the investigation into the prior executive officer?*

Background: Starting 2019, the committees received several communications from BRN staff alleging various allegations of misconduct by the former executive officer, including sexual harassment. Complaints of this nature are normally considered personnel issues that should be handled through the DCA legal affairs or the equal employment opportunity (EEO) officer, depending on the nature of the complaint. At the time, the BRN reported that it worked with the DCA to contract with an outside legal firm to guarantee objectivity.

Subsequently, the executive officer resigned for medical and personal reasons effective February 14, 2020. The BRN reported that the investigation continued to progress, and ultimately, although discussed in a closed session, there was no finding of impropriety at the board member or staff level.

Staff Recommendation: ***The BRN should provide any available updates, including whether any recommendations for change were suggested or adopted.***

ISSUE #6: WHISTLEBLOWER AUDIT. *A whistleblower revealed that the prior BRN executives falsified data sent to the State Auditor to meet a 2016 audit recommendation. While recommendations 1 and 2 from the audit have been implemented, what is the status of recommendation 3? What is the result of the following DCA internal audit?*

Background: In June of 2020, the California State Auditor, as authorized by the California Whistleblower Protection Act, investigated allegations that BRN executives intentionally manipulated data and delivered a falsified report to the auditor in 2018 to satisfy a recommendation made during a 2016 audit of BRN's enforcement program.

The 2016 audit resulted from the BRN's 2015 sunset review. At the time, the committees found that the BRN was not meeting its CPEI enforcement targets. After the release of the BRN's *2015 Sunset Report*, a BRN staff member, an attorney who represented multiple licensees and a sanctioned licensee contacted the Senate Business, Professions and Economic Development Committee with information that raised significant concerns about the BRN's enforcement program. Because the BRN had not demonstrated consistency in its administration of discipline or adherence to its disciplinary guidelines, its 2015 sunset

bill initially required that a third-party performance monitor observe the BRN's enforcement program until March 31, 2016.[47]

At the end of the 2015 sunset process, due to the recent changes to the BRN's management and BRN's commitment to addressing the issues raised, some of the issues appeared to have been resolved. However, an independent audit was still recommended to ensure that any remaining issues are resolved. As a result, the bill was amended to remove the requirement for an enforcement monitor and instead require the State Auditor to conduct an audit of the BRN.[48]

In December 2016, the State Auditor released the audit report for the BRN's enforcement program.[49] The audit confirmed there were systemic issues with its complaint processes. Specifically, the audit team found that the BRN consistently failed to process complaints in a timely manner. As of July 2016, the failure contributed to a backlog of more than 180 complaints (awaiting assignment to an investigator). The audit team also concluded that unnecessary delays in the complaint process enabled nurses who were the subject of serious allegations to continue practicing and may have posed a risk to patient safety.

The audit report made several recommendations to the BRN, including that it establish a plan to eliminate its backlog of complaints awaiting assignment to a BRN investigator (Recommendation 7). In the BRN's 60-day response to the audit, it claimed to have eliminated the backlog by increasing the number of cases it assigned to its investigators from 20 to 25, among other things. However, the audit team concluded redistributing cases was not the same as eliminating cases because the BRN's chief of investigations had confirmed that a full caseload for investigators was 20 cases. For the next year and a half, the BRN continued to claim that it had fully implemented the recommendation, but because BRN never provided evidence that it had reduced investigator caseloads, the audit team did not agree.

Subsequently, the Auditor received a whistleblower complaint alleging that BRN executives intentionally manipulated the data used to create a report.[50] The investigation found that three executives (Executives A, B, and C) conceived and carried out a plan in late 2018 to manipulate data and deliberately mislead the State Auditor.

The whistleblower investigation revealed that the three executives specifically convened a meeting to plan to manipulate caseload data by redistributing 38 backlogged cases in a way that appeared to both eliminate the backlog and keep investigator caseload under 20 cases. The plan was to temporarily assign cases to staff who do not ordinarily carry a caseload, such as an investigator on extended leave and a

[47] SB 466 (Hill), as amended April 20, 2015.
[48] SB 466 (Hill), Chapter 489, Statutes of 2015.
[49] California State Auditor, *Board of Registered Nursing: Significant Delays and Inadequate Oversight of the Complaint Resolution Process Have Allowed Some Nurses Who May Pose a Risk to Patient Safety to Continue Practicing*, Report 2016-046, December 2016.
[50] California State Auditor, *Board of Registered Nursing: Executives Violated State Law When They Falsified Data to Deceive the State Auditor's Office*, Investigative Report I2020-0027, June 2020.

manager. After the State Auditor accepted the new caseload report and deemed the recommendation implemented, the executives reassigned the cases to their original investigators.

Ultimately, the auditor found that the executives' behavior "constituted gross misconduct: they violated several laws, including the obstruction statute, by presenting intentionally manipulated data to deceive the State Auditor—and ultimately the Legislature."[51]

The State Auditor reported that the investigation did not find any evidence of further false, incomplete, or inaccurate information related to the other 2016 audit recommendations. The State Auditor did note that "due to the nature of the misconduct we discovered, the State Auditor will likely have to spend additional resources on future engagements with BRN to mitigate the risk that BRN might provide further incomplete or inaccurate information."

To remedy the effects of the improper activities identified in the investigation and to prevent the activities from happening again, the State Auditor recommended the three following actions:

Recommendation 1: Within 90 days, take appropriate corrective action against Executives B and C, and consider placing a notice of the investigation in Executive A's personnel file, as that individual has left BRN.

State Auditor's Assessment of Status: Fully Implemented. The BRN told the State Auditor that it takes the investigative findings and recommendations very seriously, and that it initiated its investigation and will take the appropriate corrective action based on the results of its investigation and that it plans to place a notice of the investigation in Executive A's personnel file. In September 2020, the BRN reported that it served notices of dismissal to Executives B and C. In August 2020, the BRN reported that it placed a notice of the investigation in Executive A's personnel file.

The BRN also stated that DCA's DOI is investigating the findings of the report. That investigation is in its final review, and BRN is working with DCA regarding the appropriate next steps. The DCA reports that the audit is anticipated to be completed by early April.

Recommendation 2: Within 30 days, reassess investigator caseloads and determine the maximum number of cases that investigators should be assigned based on clear criteria.

State Auditor's Assessment of Status: Fully Implemented. In September 2020, the BRN reported that it implemented a policy that outlines that investigators should be assigned no more than 30 cases (12 cases for retired annuitants). The policy clarifies that cases that begin as one case and then split into "companion cases" are counted as one case. Further, the policy provides four alternatives for reducing a caseload when an investigator reaches the maximum number of cases.

[51] State Auditor, *Investigative Report*, *at* 7.

Recommendation 3: Within 90 days, work with the audit team to develop a satisfactory approach for fully implementing 2016 audit recommendation 7: to ensure that the BRN resolves complaints regarding nurses in a timely manner, by March 1, 2017, it should establish a plan to eliminate its backlog of complaints awaiting assignment to an investigator.

State Auditor's Assessment of Status: Fully Implemented. BNR reported that it is working with the audit team and providing data as requested so the audit team can evaluate BRN's progress on the 2016 audit recommendation. As BRN has demonstrated a good-faith effort to work with the audit team to develop a satisfactory approach for fully implementing the 2016 audit recommendation, we deem this recommendation fully implemented.

However, the State Auditor has still not deemed the outstanding 2016 recommendation fully implemented.[52] Specifically, it wrote:

> Although, in October 2021, BRN once again asserted that it had fully implemented this recommendation and provided a report similar to the one it provided in 2018 to support its claim, we have no assurance that it has actually reduced its investigator caseload and fully implemented this recommendation. Specifically, in December 2020, BRN provided a report indicating that its investigators only have 30 or fewer cases assigned to them. However, because it was able to falsify data in this report previously, we would need to perform additional work to determine whether it manipulated the data in this report to verify whether it has actually reduced investigator caseloads and fully implemented our recommendation. Therefore, at this time, we are assessing this recommendation status as pending until we are able to perform the additional analysis needed to verify whether the investigator caseloads it reported are accurate.

Staff Recommendation: ***The BRN should update the Committees on its progress in implementing the State Auditor's recommendations and continue to work with the State Auditor on full implementation.***

ISSUE #7: NEC RECRUITMENT AND RETENTION. *The BRN reports that it continues to have difficulty recruiting and retaining NECs due to the non-competitive salary. What changes are necessary to improve recruitment and retention?*

Background: The BRN is responsible for the review of RN educational programs offering courses of instruction leading to RN licensure. Due to the complexity of the task, the BRN's Education Division utilizes subject matter experts, known as nurse education consultants (NECs). NECs must have an active RN license, a master's degree in nursing or a related field, and at least five years of professional experience in the clinical or academic areas. NECs utilize their expertise to conduct approval reviews that include in-depth analysis of program compliance with the BRN rules and regulations.

[52] California State Auditor, "Report 2016-046 Recommendation 7 Responses," available at https://www.auditor.ca.gov/reports/responses/2016-046/7, last accessed March 7, 2022.

The BRN reports that it has difficulty in recruiting and retaining NECs due to the non-competitive salary compared to RNs in practice and other state agencies. Specifically, it also reports that NEC top salaries at the BRN are 44 to 47 percent lower than the top salaries for some equivalent positions in other state agencies. For example, a BRN Supervising NEC (SNEC) earns a maximum of $9,515 monthly when a Nurse Consultant I at DHCS earns $12,718 monthly.

As of December 2021, the BRN had an NEC/SNEC vacancy rate of 53%. There were 9 vacancies out of a total of 17 authorized positions, not including retired annuitants.

Because NEC salary is low when compared to other state RN positions, the BRN requests authorization to hire above the minimum, which may still mean a decrease in the applicant's salary, even at the top of the NEC pay scale. According to the BRN, the NEC and SNEC workload is complex, and a vacancy compounds the amount and difficulty of that workload. The BRN writes that this has contributed to its current high vacancy rate.

This issue is not new. In 2015 for example, the issue was discussed under Issue #11: Delays in Approving Nursing School Programs. In the background paper, committee staff wrote:

> The BRN states that it is working with the DCA and the State Personnel Board to reconcile salary differences. In the meantime, the [BRN] has not engaged in other means of attracting talent, such as alternative working arrangements. Comparatively lower salaries are also an issue with nursing instructors, but many instructors have managed to compensate for the difference by teaching part-time and working in private practice. Although the BRN has a successful NEC who works part-time as a retired annuitant, it resists a full discussion of job-sharing; the BRN states that it would be "very difficult" to assign other NECs as a backup. When pressed, the BRN acknowledged that despite the salary, they have an adequate supply of NEC candidates and do not need to explore alternative working arrangements.
>
> Staff Recommendation: The BRN should reconsider energy spent on NEC salary concerns, given the [BRN's] projected budget shortfalls and the absence of actual recruitment problems. If recruitment and retention again become an issue, the BRN should fully explore alternative working arrangements for NECs. The BRN should also reevaluate NEC workload and pare responsibilities down to NECs' core functions relating to program approval and compliance, and consider delegating other duties, such as public inquiries and legislation, to less specialized staff.

In response, the BRN wrote:

> The BRN worked with DCA to submit two salary packages within the past 10 years. The BRN/DCA was not successful with either submission.

> If recruitment and retention becomes an issue the BRN will fully explore alternative working arrangements for NECs. It should be noted that the NECs belong to Bargaining Unit 21 and the position requires the incumbent to work as many hours as it takes to get the job done without any additional compensation. It may be difficult to limit an NEC to a specific number of hours given these limitations.
>
> The BRN has one [NEC] vacancy and proposes to interview qualified candidates by the end of April 2015.
>
> The BRN did not have the authority to hire a legislative staff person but redirected an enforcement position in 2013 and now these duties have been delegated to that staff person.[53]

Given the current vacancy rate and the historical difficulties in adjusting NEC pay scales, it may be worth simultaneously revisiting alternatives to salary increases. The BRN currently has a full-time chief of legislation and two legislative analysts, as well as a significant number of public information and consumer services, so public inquiries and legislation are not an issue. However, there may be additional NEC functions that may be delegated. For example, there may be stages of an application review that a non-NEC analyst can be trained to perform or assist with, in the same way a non-RN investigator can be trained to identify facts and evidence relevant to nursing practice complaints.

Also, there may be opportunities to reduce NEC workload by streamlining the educational approval and review processes. For example, the BRN reports that it facilitates a workgroup of deans and directors to explore opportunities to streamline the current nursing program approval process, including efforts to align the BRN approval and the accreditation processes.[54] It also reports increasing its Joint NEC meeting frequency to every other week to provide training and collaboration to ensure rules and regulations are consistently applied. These discussions may provide additional opportunities to identify unnecessary workload. The issue of duplicative approval functions is discussed on page 54, Issue #23: Duplication of Program Review.

Staff Recommendation: ***The BRN should discuss its current efforts to work with the DCA and State Personnel Board, and whether it is exploring additional avenues to address the NEC recruitment and retention issue.***

ISSUE #8: CONSUMER SATISFACTION. ***Consumer satisfaction with the BRN is low, particularly in areas related to complaints, endorsements, and consumer contact. What can be done to improve consumer satisfaction, and are there ways to improve the utility of consumer surveys?***

Background: Since 2011, the BRN has experienced low consumer satisfaction scores. At the time, the committee staff noted that there were a number of factors out of the BRN's control, including a low

[53] BRN, *Responses to 2015 Sunset Review Issues*, submitted in response to the BRN *2015 Background Paper*, April 2015.
[54] BRN, *2020 Sunset Review Report*, *at* 140.

response rate early on (an average of 21 responses) and a lack of control of the implementation of the new BreEZe IT system, which generated a significant increase in consumer complaints. Still, the committees asked whether the BRN was proactively taking steps at the board level to improve consumer satisfaction. One significant issue at the time was that the BRN call center would receive over 2,000 calls per day, of which only 25% could be answered. Those put on hold often remain for over 60 minutes. Today, consumers complain of multi-hour hold times. The issue of hold times for licensees is discussed further on page 33, Issue #9: Licensing Timelines and Responsiveness.

Today, there are relatively high response rates, and "Not at all Satisfied" ratings tended to be high only in the areas of complaints, license endorsements, and consumer contact. The survey format changed in 2018, so there is only consistent data from FYs 2018-19 and 2019-20, but the questions that reached a 20% or more "Not at all Satisfied" rating were:[55]

1) How satisfied are you with the process of **filing a complaint(s)**?
    a) Not at all Satisfied: 22.7% (1,608 out of 7,091 respondents)
2) How satisfied are you with the BRN **follow-up on a complaint(s)**?
    a) Not at all Satisfied: 25.2% (1,986 out of 7,869 respondents)
3) How satisfied are you with the **time to get your endorsement application approved (into California)?**
    a) Not at all Satisfied: 23.1% (1,087 out of 4,702 respondents)
4) How satisfied are you with the **endorsement process (into California)**?
    a) Not at all Satisfied: 20.1% (2,598 out of 12,936 respondents)
5) How satisfied are you with the **endorsement process (out of California)**?
    a) Not at all Satisfied: 26.1% (2,117 out of 8,113 respondents)
6) How satisfied are you with your **experience(s) with the BRN call center representative(s)**?
    a) Not at all Satisfied: 39.8% (3,283 out of 8,241 respondents)
7) How satisfied are you with the **BRN's outreach services (i.e., Intervention Video, Pre-licensure presentation(s), Board updates, etc.)**?

[55] The remaining percentage of responses included the following replies: "Somewhat Dissatisfied," "Somewhat Satisfied," and "Totally Satisfied."

a) Not at all Satisfied: 20.8% (1,547 out of 7,442 respondents)

8) How satisfied are you with the ways in which you **contacted the BRN by phone**?

a) Not at all Satisfied: 36.5% (6,328 out of 17,073 respondents)

9) How satisfied are you with the ways in which you **contacted the BRN by email**?

a) Not at all Satisfied: 23.8% (3,780 out of 15,866 respondents)

10) How satisfied are you with the ways in which you **contacted the BRN by fax**?

a) Not at all Satisfied: 35.4% (1,307 out of 3,687 respondents)

11) How satisfied are you with the ways in which you **contacted the BRN by written communication**?

a) Not at all Satisfied: 29.4% (2,234 out of 7,608 respondents)

12) How satisfied are you with the ways in which you **contacted the BRN in person**?

a) Not at all Satisfied: 25.2% (837 out of 3,315 respondents)

In response to the low consumer satisfaction numbers, the BRN reports that:

> The BRN was approved for 67 positions in FY 2019/2020 to address deficiencies throughout the organization. When all these positions are filled and subsequently trained BRN will be able to reduce delays in the application processing and business processing times and provide better customer service to consumers, applicants, licensees, and stakeholders. These positions will also allow the BRN to better serve and protect the public by responding to discipline cases in a timely manner, reducing delays in case processing time, alleviating case backlogs, and improve the BRN's capacity to monitor disciplined nurses.
>
> Although there are areas where consumers are unsatisfied with the BRN, there are areas where the BRN improved consumer satisfaction. Additionally, the BRN continues to strive to improve customer service and continues to implement strategies to achieve this goal.

Issues with Survey Construction. The structure of the BRN's survey questions and responses may create measurement errors or contribute to response bias that may reduce the reliability or validity of the survey. For example, before the 2018 update to the surveys, there were only four responses (typical Likert Scale):

1) Very Satisfied
2) Satisfied

3) Unsatisfied
4) Very Unsatisfied

After 2018, the survey included a third positive response but left only two negative responses:

1) Totally Satisfied
2) Satisfied
3) Somewhat Satisfied
4) Somewhat Dissatisfied
5) Not at all Satisfied.

It is unclear why a third positive response would improve the survey. Further, the imbalance between positive and negative response options can generate response bias and threaten the validity of the overall survey, artificially skewing responses in a positive direction.[56]

Also, several of the survey questions may reduce the usefulness of the responses. For example, there are overly general questions (compound questions), which can confuse respondents by making it unclear what part of the question they are answering. One question on the survey asks, "How satisfied were you with the BRN Committee (i.e., Education and Licensing, Legislative, Intervention/Discipline, Nursing Practice) meeting(s)?[57] If the respondent answers satisfied, it is not clear what the respondent is satisfied with. The respondent could be satisfied with the format of the meetings, the outcome of the meetings, the amount of public input at the meetings, the number of meetings, or any combination of those in relation to any combination of committee meetings.

The BRN staff reports that the surveys are developed with the DCA's SOLID Unit and that it analyzed all comments using the commercial software MAXQDA, which resulted in the comprehensive analysis of the overall results.

Staff Recommendation: ***The BRN should discuss what specific steps, other than the augmentation of staff, it is taking to address the low levels of consumer satisfaction. It should also discuss its survey development process, and what the comprehensive analysis of the surveys has revealed so far.***

[56] "Response bias is a general term that refers to conditions or factors that take place during the process of responding to surveys, affecting the way responses are provided. Such circumstances lead to a nonrandom deviation of the answers from their true value. Because this deviation takes on average the same direction among respondents, it creates a systematic error of the measure, or bias. The effect is analogous to that of collecting height data with a ruler that consistently adds (or subtracts) an inch to the observed units. The final outcome is an overestimation (or underestimation) of the true population parameter." Paul J. Lavrakas, *Encyclopedia of Survey Research Methods*. Thousand Oaks, CA: Sage Publications, Inc., 2008
[57] BRN, 2020 Sunset Report, *at* 74.

ISSUE #9: LICENSING TIMELINES AND RESPONSIVENESS. ***The Committees have received a steady stream of complaints from applicants about lack of responsiveness and extended processing timelines. What prevents the BRN from responding in a timely manner, and can the target timeframes be shortened?***

Background: Because licenses are necessary for RNs to practice, the goal of licensing entities is to process licenses in an effective but efficient manner. Licensing timelines that are unnecessarily long prohibit otherwise competent practitioners from entering their profession of choice.

According to the BRN's current regulations, which were last updated in 1991, its internal targets for application processing timelines are:[58]

- **90 calendar days** to inform an applicant for a license by examination or endorsement whether 1) the application is complete and accepted for filing or 2) that it is deficient and what specific information or documentation is required to complete the application.

- **390 calendar days** from the filing of a completed application for licensure by examination to inform an applicant of whether the applicant qualifies for licensure.

- **365 calendar days** from the filing of a completed application to inform the applicant in writing of its decision regarding the application.

The BRN staff acknowledge that the timelines are significantly out of date, particularly the 390 and 365 calendar day targets, which were developed when the licensing examination was administered in paper form. The BRN has also generally met the 90-day processing timeline for completed applications and generally aims to process applications as soon as possible. However, it has difficulty meeting the 90-day target for incomplete applications:

Target 90 days	Exam Complete	Exam Incomplete	Endorse Complete	Endorse Incomplete
FY 2017-18	52	94	75	119
FY 2018-19	37	83	58	98
FY 2019-20	38	79	52	88
FY 2020-21	54	117	79	142

Public Complaints. The committees have also received various communications from applicants for RN licenses who are dissatisfied with the BRN's licensing process and overall responsiveness. While many of the complainant's issues were resolved after elevation to the BRN's chief of enforcement or executive officer, the following are examples of specific issues raised:

[58] CCR, tit. 16, 1410.1.

- Consistent multi-hour long hold times (between 3-6 hours), no voicemail callbacks, and no email responses (except when elevated).
- Incorrectly identified deficiencies in an endorsement application, resulting in a 5-month waiting period that was resolved once elevated.
- Losing a new graduate residency due to the 3-month licensing timeline.
- A BreEZe issue that caused an applicant's authorization to test to lapse after 1 year instead of 2 years.
- An NP who practiced in Nevada as an RN for 24 years and an NP for 10 years who sent school transcripts several times, ultimately taking 9 months to receive their CA license.
- An applicant was told their application was deficient after their check was cashed, but the deficiency was due to a staff error.

The BRN staff have acknowledged that improvements can be made, and note that they are working on the following improvements:

- Implementing a new phone system by March 2, 2021, that will provide estimated hold times and allow callbacks. The BRN website as of March 9, 2021, has an alert stating "Starting March 2, 2021, [BRN] will be upgrading to a new phone system for the BRN Main Line ((916) 322-3350). Please be patient as these upgrades may cause increased wait times, and as a result call volumes may increase. Upon completion of this phase of the project, the BRN main phone system will have many enhancements and key features that will improve the experience for the end-user."
- Participating in the DCA Enlighten Program, a pilot peer-review program among boards. BRN staff report that the first change will be a direct transcript and graduation date upload.
- Hiring an internal IT position and moving payment and document submission online.

The BRN had 67 positions approved for FY 2019/2020 to address deficiencies throughout the organization. When all these positions are filled and subsequently trained, BRN believes it will be able to reduce delays in the application processing and business processing times and provide better customer service to consumers, applicants, licensees, and stakeholders. The BRN also states that these positions will also allow it to better serve and protect the public by responding to discipline cases in a timely manner, reducing delays in case processing time, alleviating case backlogs, and improve the BRN's capacity to monitor disciplined nurses.

Staff Recommendation: ***The BRN should discuss its progress on updating its internal licensing processing target timelines and reducing errors in the application process.***

ISSUE #10: LICENSE RECIPROCITY. ***The Nursing Practice Act allows licensees from other states to apply for a CA license via endorsement of their existing license, but it can be a lengthy process that involves a rigorous review of education, background, and other requirements. What are the unique CA standards that other state licenses do not meet?***

Background: In nursing, the issue of license reciprocity is an ongoing conversation. Given the heavy burdens of licensing, there are many benefits to reciprocity. However, the purpose of licensing is consumer protection. If license requirements are not standard across state lines, the question is what the minimum standard should be for reciprocal licenses. Professions that do not have significant practice differences between states should have fewer differences between standards.

The current endorsement process in California specifies that those licensed in other states must meet the equivalent California standards, as established by the BRN. The BRN does not actively approve out-of-state RN educational programs. As a result, every out-of-state licensee that applies for a California license via endorsement must submit to a full review of the licensee's pre-licensure education.

Nurse Licensure Compact. One proposed solution to the issue of differences between states is an interstate compact, where each participating state agrees to abide by a uniform system that allows licensees to travel between states, regardless of each state's specific requirements. The current interstate compact for nurses is called the Nurse Licensure Compact (NLC).

Under the NLC, an RN or licensed vocational nurse (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. However, RNs or LVNs who change their primary state are still required to apply for a license in that state. Two recent bills have proposed the statutory changes required to enter into the compact. There was one bill last session, SB 1053 (Moorlach) of 2020, and one bill this session AB 410 (Fong).

In 2016, the Little Hoover Commission produced a report on occupational licensing, outlining both the benefits and burdens. It also specifically discussed license reciprocity, writing that:

> License transferability across state lines is important to people who need immediately to begin working following a move to California. It is particularly important to military spouses, who move frequently. Licensing authorities should grant reciprocity to applicants licensed in other states. In occupations with dramatically differing requirements across the country, California should grant partial reciprocity to states with similar requirements as its own. California should start by assessing reciprocity in the occupations facing significant worker shortages, such as teachers and nurses. There may be some licenses for which California's standards are so unique that reciprocity is not an

option, and in those cases, the licensing authority should justify why reciprocity or partial reciprocity is not feasible.[59]

To that end, the Commission recommended that "[t]he Legislature should require reciprocity for all professionals licensed in other states as the default, and through the existing sunset review process, require boards to justify why certain licenses should be excluded. Specifically, licensing boards should be required to:

1) Identify whether licensing requirements are the same or substantially different in other states.

2) Grant partial reciprocity for professionals licensed in states with appropriately comparable testing and education requirements.

Staff Recommendation: ***The BRN should discuss possible options for improving reciprocity, such as streamlining its endorsement process or other available solutions, and discuss any licensing requirements that reduce the feasibility of reciprocity.***

ISSUE #11: CA LICENSE PORTABILITY. ***Licensed CA RNs that wish to practice out of state must endorse to other states' nursing boards through the BRN, which can be costly and time-consuming. How can the out-of-state endorsement process be improved?***

Background: One of the BRN's functions is verifying the licenses of California registered nurses who travel to other states and apply to out-of-state nursing boards to practice in those states. According to the BRN's website, the process to do so is to complete the application packet for the relevant state's nursing board and to submit that packet to the BRN. If the application packet includes a form to request verification of licensure, the applicant fills out their personal information, including their California RN license number. Otherwise, the applicant must write a letter detailing the request that includes their name, California RN license number, and a contact phone number.

The fee for processing endorsement papers to other states is set at a minimum of $100 and a maximum of $200 in statute. The BRN's regulations currently set the fee at $100.[60] According to the BRN's website, as of March 10, 2021, it will take approximately 4-6 weeks for the BRN to complete an endorsement for practicing out of state (for license numbers 500000 and above).

AB 3016 (Dalhe) of 2020, proposed utilizing Nursys to reduce fees on licensees and streamline the out-of-state endorsement process. Nursys is the only national database for verification of nurse licensure, discipline, and practice privileges for RNs and licensed vocational nurses licensed in participating boards of nursing.

[59] Little Hoover Commission, *Jobs for Californians: Strategies to Ease Occupational Licensing Barriers*, Report #234, October 2016, *at* 7.
[60] CCR, tit. 16, § 1417(aw).

Among other things, Nursys provides online license verification services. All states, including California, participate in the QuickConfirm feature (Michigan license information is in a temporary hold status as of the publication of this analysis). The QuickConfirm database is a basic online license verification for looking up an individual's license status.

Nursys also offers verification for endorsement to a nurse requesting to practice in another state and anyone who wants an official verification of a nurse license. As noted above, in California, this process is currently handled by the BRN.

For Nursys-participating boards of nursing, verifications for endorsement are processed online and the verification for endorsement report is immediately available in Nursys. The fee to verify a license is $30.00 per license type for each state being endorsed into.

California, Michigan, and Pennsylvania are the only states that do not use Nursys for license verification to other boards. Not all the participating states are members of the NLC. Of the 47 other states that participate, 34 are NLC members.

The BRN previously opposed utilizing Nursys for out-of-state endorsements, stating that it would lose "approximately $2 million in revenue would be lost from contracting the business of the state to a private entity. This revenue supports other areas within the BRN such as enforcement and discipline which maintains public safety."[61]

Instead, the BRN proposed the following solutions:

- An online application and payment abilities through the DCA Breeze portal where all licensees already have an account. This will simplify the process for licensees and shorten the processing time to 5 business days or less. This was previously implemented; however, due to unexpected issues, the BRN was forced to discontinue this feature. We are working with DCA to make the adjustments in BreEZe.
- Contract to convert microfilm data to electronic files for easier access and viewing.
- Continue to cross-train staff and apply continuous quality improvement efforts. Beginning in 2020, the BRN had approximately 3,000 pending transactions and as of mid-May, there were less than 400 pending transactions. Our past three-year data shows an average of 1,100 license verification requests per month.
- As a result of the Budget Change Proposal passed by the legislature effective July 2019, the BRN has increased staffing for this process from .5 staff to 1.5 staff.
- The fee difference of $30 for a Nursys verification versus the $100 the BRN charges is an issue that we would not object to statutory revisions lowering the fee. Our fees are outlined in statute and regulation.

[61] BRN, *RE: AB 3016 (Dahle)- OPPOSITION*, Department of Consumer Affairs, May 29, 2020.

The BRN wrote that "[t]hese resolutions can be done by end of year 2020 barring any unforeseen delays."

More recently, the BRN has stated it has begun initiating a contract with Nursys to implement the Nursys online license verification system for CA licensed nurses seeking to practice out of state, to be completed by March 10, 2022.

Staff Recommendation: ***The BRN should update the Committees on its progress in implementing the changes proposed and whether there are further solutions to improve the portability of CA licenses.***

ISSUE #12: IMPLEMENTATION OF RECENT LEGISLATION IMPACTING ADVANCED PRACTICE NURSES. ***In 2020, the Legislature passed two bills that the Governor signed into law clarifying independent practice authority for advanced practice nurses. Specifically, AB 890 paved the way for NPs to practice independently while SB 1237 established parameters for CNM independence. While BRN is implementing both measures, code cleanup is necessary to fully achieve the intent of both measures.***

Background: In 2020, the Legislature passed and the Governor signed into law, two bills that established a framework for the independent practice of advanced practice nurses. AB 890 (Wood), Chapter 265, Statutes of 2020 provided NPs clear pathways to independent practice while SB 1237 (Dodd), Chapter 88, Statutes of 2020 provided parameters for CNM independence. NPs and CNMs are both licensed and certified by the BRN and before obtaining an advance practice certificate, NPs and CNMs must first hold an RN license.

AB 890 authorized NPs to practice independently (without physician supervision) in two distinct categories: defined healthcare settings and outside of those defined settings. To practice independently in a defined healthcare setting, the 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. For those NPs seeking to practice independently outside of a defined healthcare setting, the NP will be required to meet all of the above requirements and have three years of practice as an NP in addition to the transition to practice.

As Committee staff noted when this bill was under consideration in 2020, while intended to provide a bridge to independent practice, the transition to practice language was not defined and poses a challenge, as the BRN is required to define it through regulations. Leaving the transition to practice completely up to the BRN, without specifying the minimum components that should be contained, and what expertise BRN should consult with while promulgating regulations, could prove challenging in the ultimate adoption of standards required to successfully practice. The BRN is currently in the process of establishing the advisory committee required by the bill, and will only begin to determine the requirements of the transition to practice. This could take time and delay the ability of NPs to practice independently. Further, AB 890 did not provide pathways or accommodation to NPs who have been in

practice in California for decades, thus may not need to complete a transition to practice that a recently certified NP or recent graduate may benefit from.

Additionally, both AB 890 and SB 1237 required the BRN to establish advisory committees that include NPs or CNMs along with two physician and surgeon members. In appointing members to the AB 890 required committee, concerns were raised that some of the members do not fully represent the diverse regions and practice areas where NPs provide care throughout California. For example, two potential appointees to the NP advisory committee, practice at the same hospital in Southern California as the former Board President. The requirements for membership in both bills were general and may warrant revisiting to ensure that the BRN receives input from appropriate representatives in determining regulation for both categories of practitioners.

Further, since 2011, the issue of whether the BRN was properly addressing CNM practice issues through the Nurse-Midwifery Advisory Committee (NMAC). Now that there is a new statutory NMAC that has specific recommendation duties, it may be worth exploring how the BRN will process those recommendations.

In implementing AB 890, it also remains unclear whether BRN has the appropriate authority necessary to collect a fee, which will allow the BRN to provide a license to independently practicing NPs. Additionally, the issue of the appropriate examination to determine independent NP competency was not resolved, and questions remain whether the exam analysis done for the national exam necessary for certification will take into consideration necessary updates for the existing exam for NPs who do not practice independently, as many may continue to choose this option in their practices. There are also many references to providers sprinkled throughout California law that need to be updated to properly reflect the new authority AB 890 and SB 1237 provided advanced practice nurses.

Staff Recommendation: ***The Committees may wish to amend the Act to ensure that AB 890 and SB 1237 can be properly implemented. The BRN should provide an update on the implementation of these measures.***

ISSUE #13: FURNISHING VS. PRESCRIBING. ***The BRN has requested replacing the term "furnishing" with "prescriptive authority." What is the necessity for this change and is the change appropriate?***

Background: The BRN writes that it recommends that the Nursing Practice Act be amended to change the term "furnishing" to "prescriptive authority." Specifically, it writes that "California is the only state using the term 'furnishing' and can often be misunderstood without the knowledge of the definition. Amending the terms 'furnishing or ordering drugs or devices' to 'prescribing drugs or devices,' as authorized by BPC § 2746.51 for CNMs and § 2836.1 for NPs, would support the BRN's recommendation for prescriptive authority. Amending the language to prescriptive authority would better align the NPA with federal and other state drug classification laws, thereby reducing the number of potential amendments."

Currently, both CNMs and NPs are allowed to order drugs for patients, and all references to "prescription" in the Business and Professions Code and Health and Safety Code include drug orders issued by CNMs and NPs.[62] Further, the term "prescription" is defined as "an oral, written, or electronic transmission order" that, among other things, is issued by a CNM or NP pursuant to BPC §§ 2746.51 and 2836.1.

Staff Recommendation: ***The BRN should discuss the benefits of making the statutory changes to the terms in light of the existing cross-references and definitions that accomplish the same goal.***

ISSUE #14: APRN REPRESENTATION. ***Given the new Nurse-Midwifery Advisory Committee (NMAC) and Nurse Practitioner Advisory Committee (NPAC) established pursuant to SB 1237 (Dodd) and AB 890 (Wood), the role of the APRN Advisory Committee (APRNAC) is likely to change. Should the APRNAC be maintained, and if so, in what fashion?***

Background: The APRNAC previously consisted of two CNSs, four NPs, two CNMs, and two CRNAs. With the passage of SB 1237 and AB 890, the BRN reports that it is evaluating the future of this committee as it has overlapping functions outlined in the statutory guidelines for the NPAC and NMAC. The BRN states that it understands the need for CNS and CRNA specialties to continue to work on matters that affect their practice and will evaluate and determine the appropriate next steps.

While not technically APRNs, an additional consideration might be to include public health nurses (PHNs). The population of PHNs appears to be dwindling. In FY 2017-18 the BRN issued 2,927 new PHN certificates and renewed 26,615 certificates. However, in FY 2019-20, the BRN only issued 1371 new PHN certificates and renewed 17,889. Given the important role of PHNs generally, and likely more so given the pandemic and its fall-out, it may be worth including PHNs on the APRNAC as well.

Lastly, stakeholders have expressed concerns over the representation of APRNs generally at the BRN. Specifically, APRN stakeholders have expressed concern over the lack of responsiveness to APRN practice issues.

Staff Recommendation: ***The BRN should provide an update on its plans and goals for the APRNAC going forward.***

[62] BPC §§ 2746.51(e), 2836.1(i).

ISSUE #15: PHISHING SCAMS. ***RN Licensees are being specifically targeted by scammers. Are there steps that can be taken to help address the issue?***

Background: The BRN has mentioned at its board meetings that there have been phishing scams specifically directed at RNs. The NCSBN has also put out its bulletin.[63]

Staff Recommendation: ***The BRN should discuss what steps it has taken to inform licensees and any additional solutions it is considering going forward.***

ISSUE #16: INDEPENDENT CONTRACTORS. ***Does the new test for determining employment status, as prescribed in the court decision Dynamex Operations West Inc. v. Superior Court, have any unresolved implications for BRN licensees working as independent contractors?***

Background: In the Spring of 2018, the California Supreme Court issued a decision in *Dynamex Operations West, Inc. v. Superior Court* (4 Cal.5th 903) that significantly changed the factors that determine whether a worker is legally an employee or an independent contractor. In a case involving the classification of delivery drivers, the California Supreme Court adopted a new test comprised of three elements:

A. That the worker is free from the control and direction of the hirer in connection with the performance of the work, both under the contract for the performance of such work and in fact;

B. That the worker performs work that is outside the usual course of the hiring entity's business; and

C. That the worker is customarily engaged in an independently established trade, occupation, or business of the same nature as the work performed for the hiring entity.

The test, commonly referred to as the "ABC test," potentially reaches into numerous fields and industries utilizing workers previously believed to be independent contractors, including occupations regulated by entities under the DCA. In addition, Assembly Bill 5 (Gonzalez), Chapter 296, Statutes of 2019 effectively codified the *Dynamex* ABC test while providing for clarifications and carve-outs for certain professions. Specifically, physicians and surgeons, dentists, podiatrists, psychologists, and veterinarians were among those professions that were allowed to continue operating under the previous framework for independent contractors. As a result, the new ABC test must be applied and interpreted for all non-exempted licensed professionals.

For example, AB 890 (Wood), Chapter 265, Statutes of 2020 created a new class of independent NPs and prohibited those NPs from being employed by corporate entities in the same way that physicians are

[63] NCSBN, "Be on High Alert for Spear Phishing Scams," https://www.ncsbn.org/NCSBNAlert-SpearPhishing-final.pdf, last accessed March 9, 2021.

under BPC § 2400.[64] However, physicians received an AB 5 exemption while NPs did not. It is unclear whether the new ABC test will conflict with the prohibition on the ban on corporate practice.

Staff Recommendation: ***The BRN should inform the committees of any discussions it has had about the Dynamex decision and AB 5, and whether there is potential to impact the current landscape of the profession unless an exemption is provided.***

ISSUE #17: FAIR CHANCE LICENSING ACT. ***What is the status of the BRN's implementation of AB 2138 (Chiu/Low) and are any statutory changes needed to enable the Board to better carry out the intent of the Fair Chance Licensing Act?***

Background: In 2018, AB 2138 (Chiu/Low), Chapter 995, Statutes of 2018 was signed into law, making substantial reforms to the license application process for individuals with criminal records. Under AB 2138, an application may only be denied based on prior misconduct if the applicant was formally convicted of a substantially related crime or was subject to formal discipline by a licensing board. Further, prior conviction and discipline histories are ineligible for disqualification of applications after seven years, with the exception of serious and registerable felonies, as well as financial crimes for certain boards. Among other provisions, the bill additionally requires each board to report data on license denials, publish its criteria on determining if a prior offense is substantially related to licensure, and provide denied applicants with information about how to appeal the decision and how to request a copy of their conviction history. The provisions took effect July 1, 2020.

Because AB 2138 significantly modifies current practice for boards in their review of applications for licensure, its implementation requires changes to current regulations for every board impacted by the bill. In its *2020 Sunset Review Report*, the BRN wrote that it changed the initial application and license renewal conviction reporting question and will be reporting out the required specific metrics annually. However, the BRN states it has not seen any impact on public protection as the licensees continue to go through fingerprinting for criminal history.

Staff Recommendation: ***The BRN should provide an update on its implementation of the Fair Chance Licensing Act, as well as relay any recommendations it has for statutory changes.***

EDUCATION ISSUES

ISSUE #18: RN EDUCATIONAL PROGRAM APPROVAL. ***The BRN is one of a few licensing boards that continues to actively approve educational programs. Should the BRN continue to approve RN educational programs, and if so, are there improvements that should be made?***

Background: The BRN is one of the few DCA licensing boards statutorily required to inspect and approve educational programs that offer courses of instruction for professional licensure. During the

[64] BPC § 2837.105(g).

BRN's last several sunset reviews, the Committees asked whether the BRN's school approval process can be updated to make it more effective and efficient.

In general, the BRN's current process requires institutions seeking approval for an RN program to first submit a letter of intent with minor details about the name, contact, type, location, and then start date. Next, the proposed program submits a feasibility study, which is a detailed proposal that outlines 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 proposed program will then work with an NEC to review the feasibility study and address any deficiencies. If the study comes back deficient too many times, the program starts over. When the feasibility study is deemed complete, it will be submitted to the BRN's Education/Licensing Committee (ELC) for discussion and action at a regularly scheduled meeting. The meeting is open to the public, and there are opportunities for public comment.

The ELC's recommendation on the feasibility study will be submitted for BRN discussion and action at a regularly scheduled board meeting. The board meeting is also open to the public, with opportunities for public comment. The BRN may accept or not accept the study or may defer action on the study to provide the program applicant with an opportunity to provide additional information.

Upon acceptance of the feasibility study, the program applicant appoints a director who meets the requirements of CCR, tit. 16, § 1425(a). Upon the BRN's acceptance of the feasibility study, an NEC will be assigned as the BRN liaison for the proposed program, and after a self-study, the NEC will perform a site visit. The NEC's written report is submitted to the ELC for discussion and action at a regularly scheduled Committee meeting. The Committee may recommend that the BRN grant or deny approval or may defer action on the initial program approval to provide the program applicant a specified period to resolve any problems and to resubmit to the ELC. A certificate of approval will be issued by the BRN once it grants initial approval.

The underlying question regarding the approval of educational programs is whether the BRN or other licensing boards are the most appropriate entities for approving educational programs. The Bureau for Private Postsecondary Education (BPPE) and other institutional and programmatic accreditors that are approved by the U.S. Department of Education may perform many of the same functions.

The only other DCA healing arts licensing board that approves educational programs to the extent that the BRN does is the Board Vocational Nursing and Psychiatric Technicians (BVNPT). There is one other DCA healing arts board that actively approves educational programs, the Acupuncture Board, but it only reviews curriculum content and otherwise relies on a national programmatic accreditor, the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM).

Otherwise, most modern licensing boards focus on the regulation of licensees. To ensure programmatic and institutional quality, other practice acts rely on private accreditation or approval by the BPPE. For example, the Medical Board approves national accrediting agencies recognized by the U.S. Department of Education (USDE), and medical schools that are accredited by those agencies are deemed approved by the Medical Board.[65] Neither the BRN nor the BVNPT is recognized by the USDE for the approval of nurse education.[66]

Both the BRN and the BPPE are undergoing sunset review this year, and there were a number of recommendations from the BRN's recent education audit (discussed under Issue #21) suggesting there may be overlapping functions with accreditors (discussed under Issue #23).[67] There may be additional recommendations that arise from the audit or the sunset review process given the shared jurisdiction with the BPPE. Therefore, it may be helpful to revisit the BRN's process after the BPPE review and add any relevant findings to any issues with the BRN's education division, including the difficulty in recruiting NECs (Issue #7).

Staff Recommendation: ***The BRN should continue to work with the Committees on the BRN's role and scope in approving and reviewing RN educational programs.***

ISSUE #19: NURSE EDUCATOR MEMBER. ***The BRN is required to have a member who is "an educator or administrator in an approved program." Should the educator member qualifications be more specific?***

Background: Currently, the BRN is required to have a board member who is a licensed RN that is active as an educator or administrator in an approved RN program. Ostensibly, the purpose of the requirement is to bring education expertise to the RN education and training functions of the BRN. The BRN's Administrative Manual does not list duties specific to the educator member.

Given the scope of the BRN's work and broad authority in approving schools, some stakeholders have asked whether the educator member's requirements should be more specific to school administration or directing a program.

On the other hand, all of the members are also relying on their NECs and other staff to provide them with data and expertise. As discussed under Issue #20, they also have an Education/Licensing Committee that can be utilized to work through complex issues.

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[65] BPC § 2084.

[66] Only five state agencies have been recognized: the Kansas State Board of Nursing; the Maryland Board of Nursing; the Missouri State Board of Nursing; the New York State Board of Regents, State Education Department, Office of the Professions (Nursing Education); and the North Dakota Board of Nursing. See U.S. Department of Education, *Accreditation in the United States*, last modified February 4, 2021, https://www2.ed.gov/admins/finaid/accred/accreditation_pg20.html.

[67] Auditor of the state of California, Board of Registered Nursing, *It Has Failed to Use Sufficient Information When Considering Enrollment Decisions for New and Existing Nursing Programs*, July 2020.

Staff Recommendation: ***The BRN should discuss the role and expectations of the RN educator member and whether additional qualifications would be beneficial to the BRN's education functions.***

ISSUE #20: EDUCATION COMMITTEE COMPOSITION. ***The BRN has established an Education/Licensing Committee to approve and review schools, among other functions. Should there be more representation of program directors and interested stakeholders?***

Background: Similar to Issue #19, several stakeholders have raised whether the BRN's Education/Licensing Committee (ELC) should have members with more diverse experiences, such as in curriculum development, accreditation, or management of clinical sites.

Also, many stakeholders have voiced that they would appreciate more opportunities to directly interact with the ELC. For example, the committees have heard from stakeholders who feel that their only opportunity to speak is during public comment. Public comment is a difficult forum to raise complex issues, concerns, or suggestions. There are time limits, and discussion is mostly limited to what is on the agenda. Unless a board member takes the initiative to discuss the issue or ask to put it on the agenda for the next meeting, testimony can appear very one-sided.

If the ELC held regular forums (schedules permitting) where ideas could be presented in a more interactive way, members of the public might feel more like their suggestions or concerns are being considered. Also, it would be an opportunity for ELC members to hear more regularly from non-program directors, such as students, faculty, or other subject matter experts.

That is not to say that BRN members do not currently consider public comment. It is just that the structural limitations of a formal board meeting, particularly those held remotely due to COVID-19, make it difficult to discern how information is being processed when there are limited opportunities for feedback. In addition, there may be time constraints as members take time from work, so they are understandably occupied with accomplishing the business at hand. Having a forum with time set aside for discussion can be one option for avoiding those barriers.

Staff Recommendation: ***The BRN should discuss options for improving the ELC's stakeholder representation and input.***

ISSUE #21: JLAC AUDIT RECOMMENDATIONS. ***The State Auditor found that the BRN fails to use sufficient info when considering enrollment decisions and that its work overlaps with the work of accreditors. What is the status of the recommendations, and are additional statutory changes necessary?***

Background: As directed by the Joint Legislative Audit Committee, the State Auditor conducted an audit of the BRN to assess its oversight of prelicensure nursing educational programs. The audit report detailed the determination that the BRN has failed to use sufficient information when considering the

number of students new and existing nursing programs propose to enroll. The following summary is drawn from the State Auditor's letter regarding the audit findings.

The BRN makes decisions about the number of students that new and existing nursing programs are allowed to enroll. The State Auditor wrote that two of the key factors that should influence BRN's enrollment decisions are the forecasted supply of nurses that the state will need to fulfill demand and the available number of clinical placement slots—placements at a health care facility for students to gain required clinical experience. The State Auditor found that the BRN's 2017 forecast of the state's future nursing workforce indicated that the statewide nursing supply would meet demand, but it did not identify regional nursing shortages that California is currently experiencing and is expected to encounter in the future.

Another finding was that the BRN lacks critical information about clinical placement slots when making enrollment decisions, which hampers its ability to prevent nursing students from being displaced because other nursing programs took their clinical spots. The State Auditor noted that the BRN does not gather and share with board members information about the total number of placement slots that a clinical facility can accommodate annually or how many slots the programs that use the facility will need each year.

The Auditor specified that, without that key information, the BRN cannot properly gauge the risk of such student displacement— reported to have affected 2,300 students in academic year 2017–18—when its board makes enrollment decisions.

Lastly, the State Auditor found that some of BRN's requirements for nursing programs overlap with standards imposed by national nursing program accreditors. The State Auditor recommended, as part of the Legislature's 2021 review of the BRN, it could consider the appropriateness of restructuring the BRN's oversight to leverage portions of the accreditors' review in order to reduce duplication and more efficiently use state resources (discussed further under Issue #23). The following is a summary of the recommendations and current status.

Recommendation 1

> To better ensure that California has an appropriate number of nurses in the future, BRN should do the following by January 1, 2021: revise the scope of work of its contract for workforce forecasting services to direct the contractor to incorporate regional analyses.

California State Auditor's Assessment of Annual Follow-Up Status: Fully Implemented

> We have reviewed the revised scope of work of its contract for registered nurse (RN) surveys and forecasts. We found that it includes a task of developing regional projections of future supply and demand of RNs, summarizing that information in a report, and

comparing those supply and demand projections with projections published by other organizations.

Recommendation 2

To better ensure that California has an appropriate number of nurses in the future, BRN should do the following by January 1, 2021: ensure that the governing board's enrollment decisions and other actions adequately take into consideration the regional analyses in BRN's future workforce forecasts. Specifically, it should amend its policies to require that when its staff present information to the education committee and the governing board to inform them on pending enrollment decisions, staff should include relevant information related to BRN's most recent forecast of the nursing workforce.

Reported complete January 2021:

The BRN updated the ELC Liaison manual and the New Hire Orientation manual. Additionally, the BRN completed the NEC training and sent an email reminder to all NECs that the policy is to ensure that the AIS contained in the Board meeting materials and in presentations to the Board by NECs contain relevant information related to BRN's most recent forecast of the nursing workforce, and other relevant regional data, so that such information may be taken into consideration when making enrollment decisions.

State Auditor's Assessment of 6-Month Status: Fully Implemented:

We reviewed the sections of the ELC Liaison manual and New Hire Orientation manual that BRN provided, as well as its email communication to nursing education staff requiring them to include the relevant regional forecast information and notifying them of the revisions to the manuals. If followed, these policy changes should better ensure the governing board's enrollment decisions and other actions adequately take into consideration the regional analyses in BRN's future workforce forecasts.

Recommendation 3

To ensure that nursing education staff members provide complete information to the governing board when it is considering enrollment decisions, by January 1, 2021, BRN should establish in policy the specific information that its staff should present to the education committee and governing board, including data about clinical facilities that nursing programs use for placements, the content areas for which the programs use those facilities, and the total number of available placement slots and the risk of clinical displacements at the facilities.

Reported complete January 2021:

The BRN previously amended the optional clinical facility approval form (EDP-P-18) and the EDP-I-15 Instruction form and presented them to the Deans and Directors at the California Organization of Associate Degree Nursing/California Association of College Nursing (COADN/CACN) meeting on October 7, 2020. The BRN requested all approved prelicensure programs update each of their EDP-P-18s to reflect the current up-to-date information with a goal to be completed by January 2021. The BRN updated the ELC Liaison manual and the New Hire Orientation manual to reflect these amendments. Additionally, the EO held training sessions for the Deans and Directors where questions were asked and answered on Monday, December 22nd, Tuesday, December 23rd, and Thursday, December 31st after it was expressed that there was confusion around the completion of these forms and whether the BRN had the authority to request and collect this information.

State Auditor's Assessment of 6-Month Status: Fully Implemented:

We reviewed documentation BRN provided and believe its guidance documentation for the nursing education staff, if followed, would ensure they provide complete information to the governing board. Specifically, we reviewed the Agenda Item Summary template used for preparing board meeting agendas and the checklist of information that must be provided for ELC and Board meetings and found they require the nursing education staff to provide information that addresses our recommendation. However, as Recommendation 6 states, once it has compiled and aggregated in a database information about clinical capacity, BRN should also require its nursing education staff to provide that information to the governing board.

Recommendation 4

To ensure that BRN is using up-to-date, accurate, and objective information to inform the governing board's enrollment decisions and to assess clinical capacity for student placements, by April 1, 2021, BRN should do the following: update its clinical facility approval form to capture annual capacity estimates from clinical facilities, as well as annual clinical placement needs of programs.

The BRN previously amended the optional clinical facility approval form (EDP-P-18) and the EDP-I-15 Instruction form. These amended forms were presented to the Deans and Directors at the COADN/CACN Meeting on October 7, 2020. The BRN requested all approved prelicensure programs update each of their EDP-P-18s to reflect the current up-to-date information with a goal to be completed by January 2021.

California State Auditor's Assessment of 6-Month Status: Fully Implemented:

We have reviewed the revised clinical facility approval form, the presentation at COADN/CACN, and BRN's communication to prelicensure programs. The form now includes annual clinical capacity estimates as well as annual clinical placement needs of programs.

Recommendation 5

To ensure that BRN is using up-to-date, accurate, and objective information to inform the governing board's enrollment decisions and to assess clinical capacity for student placements, by April 1, 2021, BRN should do the following: revise its regulations to require nursing programs to report any changes they make to their use of clinical facilities within 90 days of making a change and report annually if the program has made no changes.

Pending:

The BRN commenced the promulgation of a regulation package which proposes to amend CCR, Title 16, sections 1427 and 1432 to require nursing programs to report any changes they make to their use of clinical facilities within 90 days of making the change and report annually if the program has made no changes. Estimated Completion Date: June 2022 Response Date: January 2021

Recommendation 6

To ensure that BRN is using up-to-date, accurate, and objective information to inform the governing board's enrollment decisions and to assess clinical capacity for student placements, by April 1, 2021, BRN should do the following: compile and aggregate the information from the facility approval forms into a database and take reasonable steps to ensure that the information is accurate and current.

Pending: 6-Month Agency Response:

The BRN continues to work with OIS and other internal stakeholders to explore a system that will allow BRN to compile clinical facility and school specific information and receive facility data from CDPH and OSHPD. The first phase requires the BRN to work with DCA Organizational Improvement Office (OIO) to complete a mapping of the current processes and the "could be" processes. The Charter for this project was signed on or about December 4, 2020, by BRN and OIO. Estimated Completion Date: April 2021. Response Date: January 2021.

Recommendation 7

To ensure that BRN is using up-to-date, accurate, and objective information to inform the governing board's enrollment decisions and to assess clinical capacity for student placements, by April 1, 2021, BRN should do the following: annually publish clinical capacity information on its website for public use.

Pending: 6-Month Agency Response

The BRN will continue to ensure access to up-to-date, accurate, and objective information is accessible and is used to inform the governing board for their consideration with enrollment decisions and when assessing clinical capacity for student placements. The BRN is in the process of developing a data landing page on its website that will contain all data reports, links, and portals. When collection of the updated EDP-P-18 data is complete, and the platform mentioned in the 60 day response for recommendation 6 is implemented, BRN will input this data to share a clinical capacity report on our website. Estimated Completion Date: October 2021. Response Date: January 2021.

Recommendation 8

To ensure that BRN is using up-to-date, accurate, and objective information to inform the governing board's enrollment decisions and to assess clinical capacity for student placements, by April 1, 2021, BRN should do the following: immediately discontinue its practice of having nursing programs seek statements of support or opposition from neighboring nursing programs when considering requests for new programs or increased enrollment at existing programs.

60-Day Agency Response

As stated in the original response, BRN discontinued its practice of requiring nursing programs to seek statements of support or opposition from neighboring nursing programs when considering requests for new programs or increased enrollment at existing programs. Completion Date: August 2020. Response Date: September 2020.

California State Auditor's Assessment of 60-Day Status: Fully Implemented:

BRN has provided us documentation of the guidance it provided its staff to immediately discontinue its practice of requiring programs to seek letters of support from neighboring programs.

Recommendation 9

To identify additional facilities that might offer clinical placement slots, by October 1, 2021, and annually thereafter, BRN should compare its nursing program database with

OSHPD's list of health care facilities. BRN should share the results of its comparison with nursing programs by publishing this information on its website.

Annual Follow-Up Agency Response From October 2021

The BRN has made progress towards full implementation and will continue its efforts to compare information in our nursing program database to OSHPD's list of health care facilities. Full implementation is dependent on Recommendations 6 and 7 which are in process. Estimated Completion Date: 10/31/2022.

The auditor also made a number of legislative recommendations:

Recommendation 10

Require BRN to incorporate regional forecasts into its biennial analyses of the nursing workforce.

Recommendation 11

Require BRN to develop a plan to address regional areas of shortage identified by its nursing workforce forecast. BRN’s plan should include identifying additional facilities that might offer clinical placement slots.

Recommendation 12

As part of BRN's sunset review in 2021, the Legislature should consider whether the State would be better served by having BRN revise its regulations to leverage portions of the accreditors' reviews to reduce duplication and more efficiently use state resources. For example, it could consider restructuring continuing approval requirements for nursing programs that are accredited and maintain certain high performance standards for consecutive years (for example, licensure exam pass rates, program completion rates, and job placement rates). Additionally, the Legislature should consider whether and how BRN could coordinate its reviews with accreditors to increase efficiency.

Recommendation 13

To ensure that BRN and stakeholders have an understanding of clinical placement capacity in California, the Legislature should amend state law to require BRN to annually collect, analyze, and report information related to the number of clinical placement slots that are available and the location of those clinical placement slots within the State.

Recommendations 10, 11, and 13 are proposed in AB 1015 (Rubio), which is currently pending in the Assembly Committee on Business and Professions.

Staff Recommendation: ***The BRN should provide an update on the implementation of the State Auditor's recommendations, continue to work with the State Auditor on full implementation, and work with the Committees on the State Auditor's Legislative Recommendations.***

ISSUE #22: REGULATION VS. WORKFORCE MANAGEMENT. *The BRN is a regulatory and enforcement agency. Is the BRN the proper entity for workforce management?*

Background: As a licensing agency, the BRN's primary duty is to protect the public by ensuring minimum competence and removing bad actors from the profession. However, given its broad authority over both entry into the profession and over schools, it collects and utilizes workforce data.

Specifically, the BRN writes:

> Through various collaboration efforts, the BRN has been working to improve RN graduates' employability and continued practice in the nursing profession. An example is the partnership with HealthImpact on the California Newly Licensed RN Employment Survey Report (https://healthimpact.org/wp-content/uploads/2020/06/California-Newly-Licensed-RN-Employment-Survey-Report-Fall-2019.pdf). The BRN supports new RN graduate transition and residency programs. The BRN continues its efforts to increase the number of RN graduates through program approval and enrollment increase process for nursing programs. Additionally, the BRN is working with schools to develop collaborations that allow for timely matriculation for students pursuing a higher degree by alleviating course repetition through standardized course requirements and finding ways to increase access to nursing programs, especially for socioeconomically disadvantaged students.
>
> There are many factors that should be considered when analyzing the nursing workforce data. It is a widespread belief in the nursing and health care communities, that as the nursing workforce continues to age, the state's population ages and grows, and the increased demand for health care moves forward, the demand for nursing services will increase in the future. Therefore, when making decisions on approvals for new nursing programs and enrollment changes for existing nursing programs, the Board must be mindful of the community and shared resources within the various California regions.

In sum, the BRN utilizes workforce data to make workforce decisions within the existing regulatory structure. As a result, one way to improve its workforce management role may be to reduce its natural isolation from workforce-specific agencies.

For example, in response to a 2016 bill, the DCA published a report entitled *Barriers And Recommendations To Facilitating Earn And Learn Training Programs In Allied Health Professions*.[68]

[68] AB 2105 (Rodriguez), Chapter 410, Statutes of 2016.

The report was the product of a planning committee of various school segments, trade associations, DCA healing arts boards (including the BRN executive officer at the time), the California Department of Public Health, and the Division of Apprenticeship Standards, among others.

While the report was specifically regarding earn and learn programs, several recommendations were generalizable to workforce management as well as overall workforce development. For example, there was consensus among the stakeholders that not having a single entity responsible for earn and learn training programs in the health care industry or a single point of contact is a barrier to accessing resources and information.

They recommended establishing a workgroup to serve as a centralized task force on earn and learn job training programs including pre-apprenticeship, apprenticeship, youth employment, subsidized employment, and on-the-job training in health care. They also recommended developing "a collaboration between state and regional entities, the Office of Statewide Health Planning and Development (OSHPD), Community Colleges Health Sector navigators, Department of Health Care Services (DHCS), DCA, CDPH, and the Labor Agency to address the barriers across training, education, and health entities in the state. The IACA may provide an effective starting point for addressing this issue."

They also found that it "is difficult to develop career pathways from high school through graduate degree programs when there are overlapping requirements that may require repeating coursework to move between or within professions." When it came to licensing requirements, they pointed out that education was not very modular and therefore difficult to implement an earn and learn program.

Therefore, they recommended:

> Support and expand existing programs, such as the Health Workforce Initiative (HWI) within the California Community Colleges Chancellor's Office, in efforts to align nursing programs and develop a common curriculum for statewide adoption. Model the HWI process for other allied health training programs. Support stackable credentials through the creation of pathways for health care workers.

Earn and learn is one potential tool in the workforce development toolbox that can help address potential bottlenecks by providing alternate pathways. However, the BRN has historically viewed experimental learning as a lowering of educational requirements. In 2015, in response to an issue raised about experiential learning for purposes of licensure, the BRN responded:

> The BRN opposes reducing the education or any standards that qualify an individual for licensure and threatens public safety. The BRN does not want to create a two-tier system of education where applicants who attend a California nursing program are required to attain a higher level of education than those who do not.

However, if the BRN were to work with other agencies and any coordinated efforts per the recommendations noted above, the BRN may be able to avoid the risk of a two-tier system by realigning various aspects of the educational and experiential process.

One of the prior sunset issues raised was the need for the continued work of the BRN's advisory committees on education and workforce issues. The BRN points out that its NEWAC committee, which was formed in 2015, aims to bring together nursing educators, employers, practice representatives, and other key stakeholders to accomplish the following:

- Communicate, collaborate and coordinate with members of the nursing and healthcare professions to identify current nursing education and nursing workforce issues, challenges, and possible solutions including potential regulatory solutions/changes;
- Provide input and guidance on the content of the BRN's RN workforce survey and the RN Annual School nursing education programs pre-licensure and post-licensure survey; and
- Provide information updates and make recommendations to the Board based on relevant nursing education and nursing workforce survey results, evidence-based practice standards, and research.

There may be an avenue for the BRN to use its NEWAC structure as the starting point for longer and broader conversations.

Staff Recommendation: ***The BRN should discuss its current workforce efforts, including upcoming plans for NEWAC and options for coordinating with other workforce agencies and stakeholders.***

ISSUE #23: DUPLICATION OF PROGRAM REVIEW. *Per the JLAC audit, there are duplicated services. Which duplicated services can be reduced?*

Background: The State Auditor found that some of BRN's requirements for nursing programs overlap with standards imposed by national nursing program accreditors. The State Auditor recommended, as part of the Legislature's 2021 review of the BRN, it could consider the appropriateness of restructuring the BRN's oversight to leverage portions of the accreditors' review to reduce duplication and more efficiently use state resources. Specifically, in recommendation 12:

> As part of BRN's sunset review in 2021, the Legislature should consider whether the State would be better served by having BRN revise its regulations to leverage portions of the accreditors' reviews to reduce duplication and more efficiently use state resources. For example, it could consider restructuring continuing approval requirements for nursing programs that are accredited and maintain certain high-performance standards for consecutive years (for example, licensure exam pass rates, program completion rates, and job placement rates). Additionally, the Legislature should consider whether and how BRN could coordinate its reviews with accreditors to increase efficiency.

In general, state approval of an educational program means that the institution has satisfied certain minimum requirements and can begin operating. The goal of accreditation is to ensure that postsecondary institutions (higher education) meet acceptable levels of quality.[69] Institutions must be accredited by a USDE recognized accreditor in order to receive federal student aid.

According to the USDE, there are two basic types of educational accreditation, "institutional" (historically known as regional) and the other referred to as "specialized" or "programmatic" (historically known as national). Institutional accreditation applies to an entire institution, indicating that each part contributes to the institution's learning objectives. For example, a community college that offers an RN program with institutional accreditation would have its entire college reviewed for general quality.

Programmatic accreditation normally applies to specific programs, departments, or schools that are parts of an institution. Therefore, if a community college offers an RN program, it can have that specific program accredited to ensure that it meets standards specific to nursing education.

To qualify for USDE recognition, both institutional and programmatic accreditors must establish expectations for and review the following:

1) Success with respect to student achievement in relation to the institution's mission, which may include different standards for different institutions or programs, as established by the institution, including, as appropriate, consideration of state licensing examinations, course completion, and job placement rates.

2) Curricula.

3) Faculty.

4) Facilities, equipment, and supplies.

5) Fiscal and administrative capacity as appropriate to the specified scale of operations.

6) Student support services.

7) Recruiting and admissions practices, academic calendars, catalogs, publications, grading, and advertising.

8) Measures of program length and the objectives of the degrees or credentials offered.

9) Record of student complaints received by, or available to, the agency.

[69] U.S. Department of Education, Overview of Accreditation in the United States, last modified February 4, 2021, https://www2.ed.gov/admins/finaid/accred/accreditation.html#Overview.

10) Record of compliance with the institution's program responsibilities under Title IV of the federal Higher Education Act of 1965, based on the most recent student loan default rate data, the results of financial or compliance audits, program reviews, and any other information that the USDE provides to the agency.

In California, all public institutions maintain institutional accreditation, so all RN programs offered at community colleges benefit from Western Association of Schools and Colleges, Accrediting Commission for Community and Junior Colleges accreditation. In addition, all private postsecondary institutions that offer educational programs must have BPPE approval. Many of the criteria reviewed by the BRN, including faculty, facilities, and resources are also reviewed by accreditors.

Accreditation can be expensive, so fewer programs have optional programmatic accreditation. Given that the BRN may offer similar services to programmatic accreditation, there may be no reason to seek additional programmatic accreditation.

Staff Recommendation: ***The BRN should identify and discuss any potential duplication of services.***

ISSUE #24: FACULTY APPROVAL. ***The BRN has very specific requirements for faculty. Are these requirements necessary?***

Background: As part of its school approval process, the BRN reviews proposed faculty for their qualifications and requires certain levels of full-time faculty.

Some stakeholders have argued that these requirements may be unnecessary or are duplicative of accreditors. The auditor has noted that there are differences in the BRN's approval requirements, such as the need for 5 years of direct patient care. However, some stakeholders argue that approved program directors should be trusted to select whomever they believe to be most qualified. They have also cited a faculty shortage that they believe they need the flexibility to address.[70]

Community colleges in particular note that NEC control over their faculty makes things unnecessarily difficult. While they agree that full-time faculty are best, they may not always be able to hire them because their budgets are limited and rely on grant funds. Also, they have to consider the faculty needs of the entire college, not just their nursing programs due to the total faculty obligation number (where some full-time positions will need to go to other programs).

Staff Recommendation: ***The BRN should discuss its faculty approval process in relation to the BPPE and accreditors, including any evidence supporting the experiential and minimum faculty requirements.***

[70] https://www.aacnnursing.org/news-information/fact-sheets/nursing-faculty-shortage.

ISSUE #25: CLINICAL SIMULATION. ***The use of simulated clinical experiences is becoming more common, particularly during the COVID-19 pandemic. Should more simulation be allowed, and should there be standards for the use of clinical simulation?***

Background: Historically, clinical experiences were considered those that took place in clinical facilities with live patients. While faculty may have used videos, mannequins, and role-playing in the school setting, these were not considered to be true clinical experiences. Even the term "simulation" is relatively new when used to describe non-direct patient care clinical experiences.

The use of simulated clinical experiences has increased as educational programs and faculty gain expertise in the use of simulation as a pedagogy. The clinical training in the first year fundamentals of nursing course is now generally taught in skills laboratories. In addition, new technologies allow for simulated experiences that were not possible in the past. Newer high-fidelity laboratories, complex mannequins, computer and online programs, virtual reality, and other modalities allow students to experience cases or scenarios that they may never see in a real clinical setting. Further, these simulated experiences allow students to learn from their mistakes and offer the opportunity for significant debriefings. Simulation can also allow individual students to focus on areas that they may have difficulty with.

While experts agree that simulation is never a replacement for direct patient care experiences, when done properly it can be a useful tool to supplement nursing education and fill potential gaps in traditional clinical experiences. However, the traditional lack of use of simulation means that there are no uniform standards for how simulation should be utilized. There are a number of organizations that have promulgated best practices for the use of simulation, such as the International Nursing Association for Clinical Simulation and Learning (INACSL) and the Society for Simulation in Healthcare.

A 2014 study by the National Council of State Boards of Nursing (NCSBN) concluded that clinical simulation, using the INACSL standards with sufficient numbers of faculty members formally trained in simulation pedagogy, could be effectively used "in all prelicensure core nursing courses" under the study conditions.[71] The INACSL standards used to ensure high-quality simulation include terminology, professional integrity of the participant, participant objectives, facilitation, facilitator, the debriefing process, and participant assessment and evaluation.[72] Following the study, the NCSBN also established its own simulation guidelines.[73]

The BRN's last discussion of simulation was at its October 28, 2019, NEWAC meeting. However, no action was taken at that time.

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[71] National Council of State Boards of Nursing (NCSBN), *The NCSBN National Simulation Study: A Longitudinal, Randomized, Controlled Study Replacing Clinical Hours with Simulation in Prelicensure Nursing Education*, July 2014, *at* S38.

[72] INACSL Standards Committee, *INACSL standards of best practice: Simulation*^{SM} *Simulation design*, Clinical Simulation in Nursing, 12(S), S5-S12.

[73] NCSBN, *NCSBN Simulation Guidelines for Prelicensure Nursing Education Programs*, 2016.

The use of clinical simulation has also been proposed as a solution to the lack of in-person clinical placements (Issue #28). Last year, AB 2288 (Low) temporarily granted the flexibility to use up to 75% simulation in obstetrics, pediatrics, and psych/mental health nursing, and 50% in the remaining courses, among other things.

Staff Recommendation: ***The BRN should discuss its current process for overseeing simulation, whether it supports any specific amount of simulation, and whether standards can and should be established.***

ISSUE #26: CONCURRENCY OF THEORY AND CLINICAL. ***Nursing student education is required to have classroom and clinical learning occur at the same time. Should there be additional flexibility to this requirement?***

Background: The BPC requires that clinical experience be taught in all phases of education, and the BRN's regulations require that theory and clinical experience be taught concurrently. The benefit of this is that students can apply what they learn in the classroom soon after they learn it in a clinical setting.

Several stakeholders believe this is unnecessarily rigid and waving the requirements in part would be a helpful solution to the ongoing clinical placement shortage (Issue #28).

According to the California State University, Office of the Chancellor, flexibility in the requirement could allow programs to maximize the use of available placements by frontloading theory content and immediately follow with the corresponding clinical practicum. They also point out that other educational healthcare programs, such as medicine, physical therapy, and physician assistants, have long-standing practices of theory prior to but not always concurrent with clinical practicum experiences. Also, there is an exception for military students, "Theory and clinical practice requirements of the curriculum will be adjusted in recognition of military education and experiences of the student, when applicable, through an individualized process for evaluating and granting equivalency credit for military education and experience that results in meeting the same course objectives and competency standards."[74]

Last year, in response to the acute clinical placement closures from COVID-19, AB 2288 (Low) waived the concurrency requirement by one academic term so long as theory was taught first and simulation was used concurrently with theory, among other things.

Staff Recommendation: ***The BRN should discuss its concurrency requirement, including any studies or other evidence demonstrating the benefits of concurrency or specifically tying learning outcomes to the timing of theory and clinical experience.***

[74] CCR, tit. 16, § 1426(d)(1).

ISSUE #27: NEC CONSISTENCY. ***NECs follow the same guidelines and regulations. Why do they sometimes make decisions inconsistently?***

Background: Stakeholders have reported that, when comparing notes, they may receive differing decisions or policies. A large number of these reports were in relation to the implementation of the Governor's COVID-19 waivers. As a result, AB 2288 (Low) specifically required the BRN executive officer to develop a uniform standard for approvals under the bill so that NECs would be consistent.

On this topic, the BRN reports that it has increased the Joint NEC meeting frequency to every other week to provide training and collaboration to ensure rules and regulations are applied consistently.

Staff Recommendation: ***The BRN should discuss what may account for NEC inconsistency and develop ways to improve it.***

ISSUE #28: AVAILABILITY OF CLINICAL PLACEMENTS. ***Clinical placements for nursing students are historically limited and are more so as a result of COVID-19. Does the BRN have a plan to resolve this issue?***

Background: The Committees have previously raised, and continue to work on, the issue of the availability of clinical placements for all nursing students, including RNs and licensed vocational nurses. 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 accept students because it is necessary for the workforce and can help with recruitment. The facilities must have staff that is 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, and even more so during the pandemic when partner facilities were turning students away. Unfortunately, because BRN regulations require the theory and clinical experience be concurrent in all courses except year 1 courses, students who are unable to obtain their clinical placements before the end of the term will either have to drop out or receive an incomplete and under either circumstance would have to repeat the course.

This issue also impacts APRNs. For example, only two CNM programs are remaining in the state and stakeholders report that student midwives have faced serious barriers to finding clinical placement sites and preceptors, and it has been made far worse by the pandemic.[75]

While the BRN has little to no direct control over the actual availability of placements, it has been a large part of the ongoing discussion. Issue #9 from 2017 specified that the BRN should contact existing schools that will share clinical placement space with a potential new or expanding program to comprehensively evaluate the impact of new programs before approval. BRN and the Legislature should

[75] portal.midwife.org/education/accredited-programs.

convene a working group with programs and facilities to determine a long-term solution to managing clinical placements. The BRN did convene a regional summit to discuss these issues, but widespread collaboration never caught on.

There are also several tools and options that have been suggested or are currently being used to mitigate the shortage:

- *Enrollment approvals*. As noted by the State Auditor, if the BRN utilizes the proper workforce and clinical availability data, it can tie enrollment numbers to clinical site availability.
- *Use of simulation*. As noted under Issue #25, simulation has been used during the pandemic to supplement lost clinical experience hours that otherwise would not have been made up and resulted in the student having to repeat the course.
- *Concurrency*. As noted under Issue #26, flexibility with the concurrency requirement can maximize the use of clinical partners by allowing creative arrangements, such as front-loading theory, and then staggering the assignment of students.
- *Use alternative clinical sites*. While developing new contracts with clinical partners can be difficult, the BRN reports that many programs were able to creatively utilize new clinical partners when they had lost prior clinical partners during the pandemic.
- *Trust approved faculty to approve sites*. As noted under Issue #24, individual faculty are specifically approved. Some stakeholders believe the BRN should rely on them to make the right choice for their students.
- *Telehealth*. The BRN reported that some programs had success in transitioning some of their students to gain telehealth direct patient care experience in place of lost clinical placements.
- *Prohibit payments in exchange for clinical placements*. If a program can pay for clinical sites, either directly or indirectly through donations, students at public institutions (which have fewer funds) may risk "displacement" when the facility gives the slot to the other program. AB 1364 (Rubio) of 2019 would have made this prohibition.
- *The use of out-of-state sites*. For programs that are much closer to a clinical site that is across the border than one in CA, using the out-of-state clinic would increase options. While the BRN says this is not permissible at this time, the BRN does routinely approve out-of-state applicants who earned their clinical out-of-state. CA LVN programs are also currently allowed to do this under the BVNPT.
- *Consortiums*. Currently, there are groups of schools and clinical sites that work together and share information, making it easy to identify clinical site availability and compare it to the demand. The issue is that they are voluntary, so not all facilities or schools have to participate. It would also be difficult to make mandatory. Alternatively, as suggested by the State Auditor, the BRN could collect the data.

Staff Recommendation: ***The BRN should update the Committees on the current state of clinical placements and potential solutions going forward. The BRN should advise the Committees as to how it selects and uses certain data related to nursing shortage areas, current program enrollment figures,***

simulated learning options, and alternate site availability in making programmatic approval decisions, including decisions on clinical placements.

ENFORCEMENT ISSUES

ISSUE #29: FORMAL DISCIPLINE TIMELINES. ***The BRN is unable to meet its target timelines for cases that rise to the level of formal discipline, Performance Measure 4 (PM4). Can the BRN improve its processes to meet its target, and should PM4 be modified to better reflect the different stages of an enforcement case?***

Background: All licensing boards under the DCA have target cycle timelines to ensure the timely resolution of complaints and disciplinary cases. One measure, PM4, looks at the timelines for cases that rise to the level of formal discipline, such as license suspension or revocation. The target timeline is 540 days, and boards aim to resolve cases within 12-18 months.

However, PM4 is a difficult goal because it includes investigation and prosecutorial timelines that are often extended due to the serious nature of cases that are referred to the Attorney General, and PM4 does not distinguish between the amount of time a case spends at the BRN, the DCA's Division of Investigation, or the Attorney General's office.

The BRN acknowledges that, while it has made improvements in its processing timeframes since 2016, it has not been able to meet the PM4 target timeline (540 days or 18 months). The BRN reports that it will continue to work to improve performance in this area. Currently, the BRN is completing disciplinary cases within 20 months on average. This is an improvement from 2016 when the BRN was at 25 months.

Staff Recommendation: ***The BRN should discuss if there are additional improvements that can be made to its PM4 timelines and whether the PM4 measure can be broken up to better identify where bottlenecks may exist.***

ISSUE #30: PEACE OFFICER AUTHORITY. ***The BRN has requested that its investigators be authorized to exercise specified peace officer powers, including the powers of arrest, to serve warrants, and receive criminal history information. Should the BRN's investigators be granted this authority?***

Background: The BRN 2011 sunset bill would have authorized BRN's investigators to have the authority of peace officers, among other things.[76] However, establishing peace officer status and the attendant pension benefits was contrary to Governor Brown's pension reform plans and he vetoed the bill, eliminating BRN at the end of 2011.

[76] SB 538 (Price) of 2011.

The Assembly Committee analysis at the time stated:

> One of the BRN's goals in obtaining its own investigative staff is to handle more investigations by their own staff instead of relying on DOI for many of its investigations, because DOI has also had problems in pursuing its cases due to increased caseloads and decreased staffing levels. DOI takes on average about 20 months to investigate BRN cases. Providing the opportunity for the BRN to assume major responsibility for investigating cases should have a significant impact on the overall time it takes to complete investigations.

The BRN's current proposal would not make them peace officers but give them the authority of peace officers under Penal Code § 830.11. The BRN writes that:

> Though the need for outside law enforcement assistance would diminish, the BRN would continue to utilize the services of DOI when full peace officer status is needed. This would strengthen the authority of BRN investigators to pursue those who violate the NPA. BRN investigators would continue to exercise high standards for determining if reasonable and probable cause exists to investigate allegations.

Staff Recommendation: ***The BRN should detail how the peace officer authority will assist its investigators in various stages of an investigation, whether there will be any fiscal impacts, and how the investigators with peace officer powers will be integrated into the enforcement division and its partnership with DCA's DOI.***

ISSUE #31: COST RECOVERY. ***During the BRN's 2017 Sunset Review, the BRN reported that it was looking into improvements to its cost recovery functions. What is the status of that research?***

Background: In 2017, the BRN noted a drop in potential cases for cost recovery and that it was investigating alternate means of cost recovery. The issue was discussed under Issue #3 of the 2017 sunset review background paper.

Currently, staff reports that cost recovery payment plans are developed and implemented with licensees who are placed on probation. In cases where the final disciplinary action ordered is probation, the cost recovery ordered in the BRN's decision is not required to be paid to the BRN until three months before the end of the ordered probation term (typically terms are three years). Licensees are encouraged to utilize the online payment process through BreEZe for ease in payments. If payments are not made, the BRN provides three written notices to the licensee and refers those who owe cost recovery to the FTB for collection through state income tax returns. However, the process cannot be used if the individual is living out of state or does not file taxes in California. The BRN also places holds on the renewal of RNs who owe cost recovery pursuant to BPC section 125.3(g)(1) to prevent the renewal of the license until the amount owed is paid in full.

Staff Recommendation: ***The BRN should provide any additional updates on its response to the issue raised and the outcome of its research into cost recovery and trends.***

ISSUE #32: AUDITS OF CE PROVIDERS. ***The BRN notes that it began auditing continuing education providers (CEPs) in 2016, but that the review was labor-intensive and requires additional staff. What is the current status of the CEP audit unit?***

Background: Currently, CEPs self-monitor and the BRN will only audit upon complaint. The BRN reports that it now has a comprehensive plan for CE.[77] However, as noted under Issue #7, the BRN has had NEC staffing issues, so the plan was not previously implemented.

Staff Recommendation: ***The BRN should provide an update on its CE NEC recruitment efforts and any other outstanding implementation of its CEP approval/disapproval plan.***

ISSUE #33: CE COMPLIANCE DOCUMENTATION. ***Licensees are only required to submit CE compliance information once audited. Should licensees instead submit CE compliance information upon renewal?***

Background: Currently, licensees are only required to submit CE compliance information once audited. If a licensee only has paper compliance documents, this may generate more workload for staff. The BRN staff have noted that it may be possible to upload compliance documents directly into the BRN's licensing system, BreEZe, at the time of renewal so the documents are readily available in the event of an audit.

Staff Recommendation: ***The BRN should discuss the feasibility and any potential benefit of allowing licensees to upload CE compliance documents at the time of renewal.***

ISSUE #34: SCHOOL NURSES. ***The BRN reports that it is concerned about the services that unlicensed school nurses provide. What changes, if any, are necessary to ensure the safety and proper care of students?***

Background: The BRN writes that is concerned that school personnel may be providing nursing services that would ordinarily be prohibited in non-school settings. The BRN reports that it continues to provide input and participate in discussions with consumers, the California Department of Education, school nurses, nursing organizations, and other stakeholders to address school health-related issues as they relate to RN practice. The BRN also believes students should receive all healthcare services to which they are entitled, and which are necessary for them to obtain maximum benefit from their educational program, and that such services must be provided by individuals legally authorized to provide the services.

[77] BRN, *Comprehensive Plan for Approving and Disapproving Continuing Education Opportunities*, January 1, 2019.

Staff Recommendation: ***The BRN should discuss any instances of harm it may be aware of and present any solutions it may have to address those instances of harm.***

COVID-19 ISSUES

ISSUE #35: MENTAL HEALTH SERVICES FOR COVID-19 PROVIDERS. U*nder ordinary circumstances, frontline healthcare providers and first responders often face difficult situations that are mentally and emotionally challenging. Are there new issues arising from, or ongoing issues being worsened by, the extreme conditions of the COVID-19 pandemic?*

Background: Throughout the COVID-19 pandemic, frontline healthcare workers and first responders, such as physicians, nurses, respiratory care therapists, paramedics, and more, have been caring for COVID-19 patients through multiple deadly surges, including a record-shattering death toll surge in December of 2020.

The Centers for Disease Control notes that "[p]roviding care to others during the COVID-19 pandemic can lead to stress, anxiety, fear, and other strong emotions…. Experiencing or witnessing life-threatening or traumatic events impacts everyone differently. In some circumstances, the distress can be managed successfully to reduce associated negative health and behavioral outcomes. In other cases, some people may experience clinically significant distress or impairment, such as acute stress disorder, post-traumatic stress disorder (PTSD), or secondary traumatic stress (also known as vicarious traumatization). Compassion fatigue and burnout may also result from chronic workplace stress and exposure to traumatic events during the COVID-19 pandemic."[78]

Frontline healthcare workers are essential to the state of California. Given the length and the unique conditions of the COVID-19 pandemic, it may be beneficial to track trends and identify potential challenges and solutions in delivering mental health care and support for frontline healthcare workers who have been under extreme physical and mental pressure since the start of the coronavirus pandemic.

Staff Recommendation: ***The BRN should discuss any findings related to the mental and behavioral healthcare needs of frontline healthcare providers arising from the COVID-19 pandemic.***

ISSUE #36: COVID-19. ***Since March of 2020, there have been a number of executive-issued waivers, which affect licensees and future licensees alike. Do any of these waivers warrant an extension or statutory changes?***

Background: In response to the COVID-19 pandemic, the Governor instituted a number of actions and issued numerous executive orders to address the immediate crisis, including impacts on the state's healthcare workforce stemming from the virus. On, March 4, 2020, the Governor issued a State of

[78] Centers for Disease Control, *Healthcare Personnel and First Responders: How to Cope with Stress and Build Resilience During the COVID-19 Pandemic*, last updated December 16, 2020, www.cdc.gov/coronavirus/2019-ncov/hcp/mental-health-healthcare.html.

Emergency declaration, as defined in Government Code § 8558, which immediately authorized the Director of the Emergency Medical Services Authority (EMSA) to allow licensed healthcare professionals from outside of California to practice in California without a California license. Under BPC § 900, licensed professionals are authorized to practice in California during a state of emergency declaration as long as they are licensed and have been deployed by the Director of EMSA.

Following that executive order, on March 30, 2020, the Governor issued Executive Order N-39-20 authorizing the Director of DCA to waive any statutory or regulatory professional licensing relating to healing arts during the duration of the COVID-19 pandemic – including rules relating to examination, education, experience, and training. Examples of waivers affecting the BRN and its licensing population include. DCA-20-69 waives for individuals whose active licenses expire between March 31, 2020, and December 31, 2020, any statutory or regulatory requirement that individuals renewing a license take and pass an examination to renew a license; and, any statutory or regulatory requirement that an individual renewing a license complete continuing education requirements to renew a license. These do not apply to any continuing education, training, or examination required under a disciplinary order against a license.

DCA-20-57 waives any statutory or regulatory requirement that an individual seeking to reactivate or restore a license meet CE requirements to reactivate or restore a retired, inactive, or canceled license; and pay any fees to reactivate or restore a retired, inactive, or canceled license (including renewal, delinquency, penalty, or late fees, or any other statutory or regulatory fees). This is only applicable to an individual's license that is in a retired, inactive, or canceled status for no longer than five years.

There were also nursing-specific waivers, including supervision flexibility for CNMs and NPs, flexibility in student clinical placement requirements, and flexibility in the endorsement process for out-of-state licensees.

Staff Recommendation: ***The BRN should advise the Committees on the use of the COVID-19 waivers, including the number of temporary licenses issued to out-of-state licensees and any associated timelines, and the ongoing necessity of any of the waivers.***

EDITS TO THE PRACTICE ACT

ISSUE #37: TECHNICAL EDITS. ***Are there technical changes to the Nursing Practice Act that may improve BRN operations?***

Background: There may be technical changes to the Nursing Practice Act that are necessary to enhance or clarify the act or assist with consumer protection. For example, SB 225 (Durazo), Chapter 790, Statutes 2019, authorized citizens of the state, including specified non-U.S. citizens, to hold an appointed civil office. However, the Nursing Practice Act still specifically states that board members shall be U.S. citizens.

Staff Recommendation: ***The BRN should continue to work with the Committees on potential changes.***

CONTINUED REGULATION OF THE PROFESSION

ISSUE #38: SUNSET EXTENSION. ***Should the current BRN be continued and continue regulating the practice of RNs?***

Background: The BRN appears to have made significant progress in its enforcement processes since 2015, and has completed the majority of the State Auditor's recommendations in that regard. However, that progress was undermined by the misconduct of prior BRN executives in addressing the State Auditor's recommendations.

There are also a number of outstanding questions relating to the BRN's consumer services and satisfaction; license requirements, procedures, and processing timelines; and implementation of recent APRN legislation. Further, there are ongoing conversations around many aspects of the BRN's RN prelicensure approval process and the ongoing implementation of the recent JLAC Audit of its enrollment decision processes. The BRN's executive team is also relatively new but has so far been responsive to the staff of the Committees.

Staff Recommendation: ***The BRN's regulation of RNs should be continued and be reviewed again on a future date to be determined.***