

BACKGROUND PAPER FOR THE BOARD OF REGISTERED NURSING

BOARD RESPONSES TO IDENTIFIED ISSUES AND STAFF RECOMMENDATIONS

Joint Sunset Review Oversight Hearing, March 10, 2026

Senate Committee on Business, Professions and Economic Development and
Assembly Committee on Business and Professions

On Tuesday, March 10, 2026, the Senate Business, Professions, and Economic Development Committee and the Assembly Business and Professions Committee held a joint sunset review oversight hearing for the Board of Registered Nursing (BRN/Board). In connection with the hearing, legislative staff posted a Background Paper, which posed issues and questions for the Board. Below are the BRN's responses to these issues and questions.

ADMINISTRATIVE ISSUES

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

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

BRN Response and Action

The BRN operates within a uniquely complex regulatory and practice environment, one that differs from other healing arts boards and underscores the need for a Registered Nurse (RN) to serve as its Executive Officer (EO). Nursing practice involves independent clinical judgment, patient advocacy, care coordination, and the delegation and supervision of care across diverse settings. These responsibilities require a deep understanding of clinical practice and healthcare systems that can only come from professional nursing experience.

The EO role is rooted in clinical judgment, nursing education oversight, and the interpretation and enforcement of the Nursing Practice Act (NPA). These duties go far beyond administrative management. The EO must evaluate standards of nursing practice, assess violations of the NPA, and determine whether conduct meets expectations for safe and competent patient care, duties that require nursing expertise.

The EO also represents the BRN in statewide and national nursing organizations, a role that demands credibility as an experienced nurse leader. This aligns with national practice as 45

of the 55 boards of nursing in the United States place an RN in an executive decision-making role. These responsibilities require far more than holding an RN license; they demand deep clinical expertise, nursing education knowledge, regulatory and educational experience, and the professional authority to lead the state's nursing regulatory body. For this reason, the statutory requirement that the EO be an RN, with additional qualifications set by the Board, is both appropriate and essential.

The BRN oversees one of the largest licensee populations among the healing arts boards, with responsibilities spanning education program approval, licensure, and enforcement of the NPA. The intersection of clinical standards, patient safety, and regulatory requirements necessitates leadership with direct knowledge of nursing practice and standards of care. While other healing arts boards regulate important professions, their scopes of practice and regulatory demands do not always require the same level of clinical integration at the executive level.

Nursing, by contrast, operates across the full continuum of care and serves as the backbone of healthcare delivery. It is inherently interdisciplinary, requiring constant coordination with physicians, allied health professionals, administrators, and patients. Effective oversight of such a profession requires leadership that understands both regulatory frameworks and the realities of clinical practice, workforce dynamics, and healthcare system operations.

The size and scope of the nursing workforce, combined with the BRN's broad responsibilities, require a level of operational and clinical integration that only an RN EO can provide. An RN EO is uniquely equipped to understand how regulatory decisions affect frontline practice, anticipate unintended consequences, and balance public protection with workforce realities. Nurse executives are trained collaborative leaders who navigate complex systems, manage competing priorities, and make high-stakes decisions that influence patient outcomes and organizational performance. Their ability to interpret clinical data, advocate for patient safety, and guide strategic initiatives aligns directly with the BRN's statutory mandate.

A nurse EO brings a comprehensive perspective that bridges clinical realities with executive decision-making. Like nurse leaders in healthcare organizations, the EO can translate complex clinical and patient-care considerations into effective policy and regulatory action. This ensures that Board decisions reflect real-world implications for patient safety, quality of care, and workforce sustainability.

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

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

BRN Response and Action

The BRN has evaluated the fiscal, administrative, and public-access implications of transitioning away from the statutory requirement that meetings be held in both Northern and Southern California. Based on recent experience, the Board anticipates that moving to a model that does not require statewide travel, while maintaining a virtual attendance option, would result in meaningful cost savings and improved operational efficiency. Virtual meeting options have significantly broadened public access and engagement. Remote attendance allows working nurses, educators, and consumers to participate more consistently without the barriers of travel, cost, or scheduling conflicts. Because most stakeholders are working professionals who rely on the ability to join meetings while fulfilling their responsibilities, virtual participation has become the most practical and accessible way for the public to engage with the Board's work.

As noted, meetings held outside Sacramento cost approximately \$38,000 per meeting due to travel, lodging, and facility expenses. Eliminating the requirement to alternate between Northern and Southern California would allow these funds, and the associated staff time, to be redirected toward initiatives that more directly support the Board's mission of public protection. Additionally, the BRN does not believe that eliminating the regional meeting requirement would diminish public participation. In fact, current attendance patterns demonstrate that remote participation far exceeds in-person attendance. The Board remains committed to ensuring transparency, accessibility, and robust public participation regardless of the meeting format.

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

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

BRN Response and Action

The BreEZe platform is a supported licensing and enforcement system that successfully serves millions of active users statewide. Its infrastructure is capable of supporting the BRN's current and projected workload, and system performance has demonstrated that BRN-related demand is within BreEZe's operational capacity. Like any enterprise platform, BreEZe includes configurable guardrails that define the boundaries of its native functionality. Within those

parameters, BRN has dedicated resources who continue to build, refine, and maintain business processes that operate effectively inside the system.

Where BRN business needs extend beyond Breeze's inherent guardrails, BRN and DCA have demonstrated the ability to jointly identify and implement complementary systems to meet those requirements. This approach has allowed BRN to expand its operational capabilities without compromising system stability or overextending BreEZe beyond its intended design.

BRN's internal resources are being deployed in alignment with approved project documentation and historical funding expectations. DCA's role should continue to be that of a strategic partner, system administrator, and implementation lead for BreEZe. In this capacity, DCA provides essential services, including business analysis, configuration, testing, security oversight, and system upgrades, that ensure BreEZe remains stable, secure, and responsive to BRN's evolving needs. When BRN's business requirements exceed BreEZe's configurable limits, BRN and DCA collaborate to identify alternative solutions that improve efficiency while preserving the integrity of the core platform. These solutions may include but are not limited to, securing an Information Technology (IT) Specialist IV dedicated exclusively to BRN projects and reporting directly to DCA as well as requesting additional BRN staff to support preliminary issue analysis, reporting, and user acceptance testing. Expanding staffing in these areas would significantly improve our ability to keep pace with workload demands and maintain timely processing.

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

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

BRN Response and Action

The Intervention Evaluation Committees (IEC) are responsible for reviewing highly sensitive and confidential matters involving licensees participating in the Board's Intervention Program, including substance use disorders, mental health conditions, and compliance with treatment and monitoring requirements. The nature of this work requires that the majority of IEC discussions occur in closed session, as they involve protected health information, confidential program records, and personnel-related determinations that cannot legally be disclosed to the public. This leads to a typical IEC meeting structure that begins with a 30-minute open session to establish quorum, vote on meeting minutes, and provide updates. The committee then moves into closed session for up to eight hours to review confidential information, followed by a brief five-minute return to open session to formally adjourn. The Bagley-Keene Open Meeting Act (Bagley-Keene Act) imposes public access and notice requirements that offer limited practical benefit in this context, since nearly all substantive IEC business must remain confidential. These requirements also contribute to ongoing

quorum challenges, as IEC members must travel to in-person meetings across the state and comply with rigid meeting-format rules even though the public cannot attend or participate in the vast majority of the proceedings. An exemption from the Bagley-Keene Act would allow the IEC to meet more reliably, reduce administrative burden, and improve the timeliness of case reviews, ultimately strengthening oversight of the Intervention Program, while also having little to no impact on the public's involvement with the IECs' business.

Administrative efficiencies would also be significant. Staff time currently spent preparing public agendas, securing publicly accessible meeting locations, and managing procedural requirements for meetings that are almost entirely closed could be redirected toward program monitoring, case management, and compliance activities. Eliminating mandatory in-person meetings would also reduce travel-related costs for both members and staff.

Although the BRN is not aware of any regulatory body exempt from the Bagley-Keene Act, IECs are not regulatory bodies. Their structure more closely resembles advisory committees, which are subject to more limited Bagley-Keene Act requirements. However, even within that framework, IECs differ in critical ways as the nature of their work is highly confidential, and, as mentioned above, the vast majority of the work cannot be conducted in open session. Their functions therefore differ substantially from traditional advisory committees, which rely upon public participation, reinforcing both the need for closed-session proceedings and the justification for an exception to the Bagley-Keene Act.

For these reasons, the BRN believes that exempting the IECs from the Bagley-Keene Act would enhance the committees' ability to fulfill their statutory duties while preserving all required confidentiality protections. Importantly, this exemption would also directly benefit Intervention Program participants by enabling more timely case reviews, reducing delays in treatment and monitoring decisions, and ensuring that participants receive prompt, clinically informed oversight necessary to support their recovery and protect patient safety. By allowing the IECs to operate in a manner consistent with the confidential nature of their work, the Board can better serve both program participants and the public.

ISSUE #4: (\$10 SURCHARGE ON ALL RN LICENSE RENEWALS) RN license renewal applications include a designated amount of money to fund a scholarship and loan repayment program for nurses who work in medically underserved areas. What is the status of the program?

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

BRN Response and Action

The BRN collects the \$10 surcharge as part of the RN license renewal process and transfers those funds to HCAI to support its scholarship and loan repayment programs for nurses who commit to working in medically underserved areas. Although the BRN administers the collection and transfer of these funds, HCAI administers the program itself, including applicant selection, distribution of awards, and monitoring program outcomes.

Currently, the primary information the BRN receives from HCAI consists of annual funding recap data that reflects the total surcharge revenue received each month and the corresponding awards funded from those surcharges. This includes high-level information such as:

- Monthly revenue received by HCAI from the BRN surcharge (e.g., approximately \$2.3M-\$2.5M annually in recent cycles).
- Award activity by program type (e.g., BSN Loan Repayment Program, ADN Scholarships, LVN-to-ADN Scholarships).
- Annual totals of awards granted and dollars distributed across these programs.

While this information provides a financial picture of surcharge revenue and general award distribution, the BRN does not currently receive detailed program-specific data such as applicant volume, geographic placement of awardees, service completion rates, or program outcomes related to underserved-area staffing.

Additionally, the BRN will request HCAI to provide annual presentations to the Board that summarize surcharge revenues, award activity, and available program outcomes. The BRN will also publish aggregated, non-confidential information on its website so licensees, stakeholders, and the public can better understand how these funds are being used and the results being achieved.

The BRN remains committed to collaborating with HCAI to enhance data transparency, improve reporting, and ensure the surcharge-funded program effectively supports the nursing workforce in underserved communities while advancing public protection.

FISCAL, FUND, AND FEE ISSUES

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

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

BRN Response and Action

In 2015, the BRN commissioned Capital Accounting Partners, LLC to conduct a comprehensive fee audit, which resulted in statutory and regulatory fee increases to better align the fee structure with the actual cost of administering BRN programs. In June 2019, the BRN contracted with CPS HR Consulting to conduct a cost-basis analysis to determine the appropriate fees for nine processes that previously had no separate fee structure, ensuring that fees were directly tied to the staff workload required to support each process.

The consulting companies used a five-step methodology to establish the recommended fees:

- Step 1: Collect Data
- Step 2: Building Cost Structures
- Step 3: Allocating Enforcement Activities
- Step 4: Set Cost Recovery Policy
- Step 5: Set Fees.

Steps 3 and 4 were particularly significant because they incorporated the full cost of enforcement activities into the fee model. In Step 3, enforcement-related costs were distributed across each license and certificate type to determine the full cost of service. This step was critical, as a substantial portion of the BRN's overall expenditures are tied to enforcement. Step 4 focused on establishing the cost-recovery policy, which depended on Board policy decisions regarding how much of the total cost should be recovered for each license type. The analysis noted that the Board may choose to subsidize certain license types with revenue generated from others, depending on policy priorities.

Under the current fee structure, both initial applications (including temporary license applications) and renewal applications, include enforcement-related cost allocations. These enforcement allocations exceed the direct unit costs but remain lower than the allocated support costs, generally ranging from approximately \$40 to \$80 per transaction. This is also the section that the \$10 HCAI scholarship fund fee is allocated from.

The BRN recognizes the importance of clearly articulating the rationale for the funding structure of the Intervention Program and its benefit to public protection. The Intervention Program is designed as a proactive, rehabilitative alternative to traditional enforcement, allowing eligible nurses to receive monitoring and support while maintaining accountability for safe practice. Unfortunately, the costs associated with participation in the program can be quite significant, and can be seen as a deterrent or a prohibitive burden for many potential participants.

By sharing in the cost, all licensees are investing in the integrity and safety of the profession as a whole. Early intervention and structured monitoring reduce the likelihood of more serious violations, which can be significantly more costly in terms of enforcement resources, patient risk, and workforce disruption. Additionally, the Intervention Program supports nurses in safely returning to practice, helping to preserve the workforce and mitigate shortages without compromising public safety.

Ultimately, this proposal benefits the public by strengthening oversight, promoting early identification and intervention, and ensuring that only safe, competent practitioners provide care. The shared funding model that is already established within its current fee structure enables the BRN to sustain a program that prioritizes rehabilitation where appropriate, while maintaining its core mission of protecting the health and safety of consumers.

LICENSING ISSUES

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

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

BRN Response and Action

Currently, under Business and Professions Code (BPC) section 2837.103(a)(1)(D), nurse practitioners (NP) licensed in other states must complete 4,600 hours or three years of clinical experience in California within five years of applying. This direct patient care mentorship-based experience must occur in California and be attested to by a physician or a 103/104 NP. At this time, California does not permit completion of the transition-to-practice (TTP) requirement in another state. However, the BRN would support removing this restriction and allowing NPs to satisfy TTP requirements through equivalent supervised experience obtained outside California. Allowing NPs to meet TTP requirements through equivalent experience obtained in other states would expand practice opportunities for qualified NPs and reduce unnecessary barriers to licensure.

However, it's important to note the Board's current process for attesting to the completion of TTP hours is completed through a system that only recognizes California based licensees. Currently the 103 NP applicant is asked to submit information of the provider(s) who can attest to the completion of the 4,600 hours of direct patient care that meet the TTP requirements. The Board then verifies the attesting provider has an active California license using the California Medical Board's Identify Verification and License Access (IDEAL) system. The IDEAL system then sends an email to the attesting provider(s) asking them to validate that the applicant completed the required hours.

The system is only used for healthcare providers with California licenses. It cannot be accessed by the general public or healthcare providers from other states.

Therefore, the only way the Board could utilize this current attestation system to validate transition to practice experience obtained in another state would be to require the applicant who worked out of state to find a California licensed physician or 103/104NP to review their portfolio and attest to the completion of the required hours.

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

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

BRN Response and Action

The BRN supports requiring national certification for all advanced practice registered nurses (APRN) as an important step toward strengthening public protection, promoting consistency in advanced practice standards, and aligning California with the majority of states that already require national certification for APRN practice. National certification provides an external, competency-based validation of advanced clinical knowledge and is widely recognized as a benchmark for ensuring safe, high-quality care. Additionally, this proposal would align with the requirement that the Centers for Medicare and Medicaid Services (CMS) already holds for all APRNs as it requires national certification for all billing completed on behalf of an APRN provider.

While California has historically relied on BRN review and approval of California-based academic institutions, reviewing their education standards and allowing for a state-based certification, the Board believes that adopting a national certification requirement will enhance transparency, portability, and uniformity in APRN qualifications while also aligning the in-state application requirements with the application requirements for all endorsing APRN applicants seeking certification in California.

Requiring national certification would also reduce the duplication of effort that currently occurs when the BRN conducts its own licensing review of advanced practice applicants. This state-based review often mirrors, though is less robust than, the comprehensive evaluation already completed by national certifying bodies. Aligning the licensing process with national standards would streamline regulatory review, improve efficiency, and allow the BRN to focus resources on higher-value public protection activities.

To support the Committees' assessment of the scope and impact of this transition, the table below identifies the number of APRNs licensed in California who do and do not hold national certification. This information reflects only what individual applicants reported to the BRN during the licensure application and renewal process; however, the BRN does not comprehensively track national certification status for all APRNs. As a result, these figures should not be viewed as exhaustive or fully accurate. Instead, they offer a general snapshot

intended to support the Committees' review, with the understanding that the actual number of nationally certified APRNs may differ from what is captured in the application data.

Fiscal Year	Licensed	APRN Profession			
		CNS	CRNA	NM	NP
2021/22	National Certification	27	254	70	2,402
	No National Certification	35	0	22	1,338
	Total	62	254	92	3,740
2022/23	National Certification	30	308	52	2,750
	No National Certification	31	0	26	1,559
	Total	61	308	78	4,309
2023/24	National Certification	37	275	66	2,863
	No National Certification	49	0	27	1,850
	Total	71	275	93	4,713
2024/25	National Certification	25	244	59	3,426
	No National Certification	46	0	18	1,594
	Total	71	244	77	5,020
2025/26 (3 Qtrs.)	National Certification	14	152	55	1,718
	No National Certification	19	0	10	802
	Total	33	152	65	2,520

The Board also recognizes that certification costs vary significantly, ranging from approximately \$255 to nearly \$1,000 for initial exams, with renewal fees from \$85 to more than \$375. Licensees may also incur additional expenses for exam preparation, continuing education, and time away from work. However, the BRN believes these costs are justified by the long-term benefits of standardized competency assessment and improved mobility for APRNs across states. Access to certification programs remains robust, with multiple national certifying bodies offering computer-based testing and well-established renewal pathways, though the Board acknowledges that some legacy APRNs may require tailored transition or grandfathering options.

Overall, the BRN supports moving toward a national certification requirement and is committed to working with the Committee to ensure that implementation enhances patient safety while minimizing disruption to the existing workforce.

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

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

BRN Response and Action

Maintenance of APRN certification designations remains tied to ongoing competency, regardless of whether a certifying body continues to offer an examination. APRNs can show continued competency through education, clinical practice, and ongoing certification that aligns with their clinical role and population focus. While the initial examination confirms entry level knowledge and competency, renewal requirements serve as the mechanism to ensure competency is continually maintained throughout an APRN's career. This framework is consistent with all nursing certifications.

Therefore, when an exam is discontinued, the loss of the examination pathway does not indicate the loss of competency. It simply removes the option for future APRNs to use that specific exam as a pathway to demonstrate competence. Certifying bodies create renewal requirements for their certification through established competency mechanisms such as continuing education, practice hour attestation, or portfolio review. APRNs who hold a current, valid certification continue to be recognized as long as they meet the certifying body's established recertification requirements.

Practice correlation is determined by competency alignment. An RN or APRN may only practice in a setting when their educational preparation, training, and demonstrated competencies directly align with the patient population or practice specialty they serve. For example, an RN who has competency in adult medical-surgical may not be able to demonstrate competency in pediatrics, even though their initial nursing education included pediatric exposure. The same principle applies to APRNs.

While APRNs share a core foundation of advanced practice preparation, each APRN completes additional specialized training and clinical preparation specific to their designated role and population focus. These specialty pathways require mastery of population-specific competencies that ensure safe and effective care. Although some clinical skills may be transferable, many population-specific competencies are critical to patient outcomes and, if absent, can lead to delayed diagnosis, inappropriate treatment, preventable harm, or even death.

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

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

BRN Response and Action

The BRN supports process improvements that would strengthen compliance and accountability with continuing education (CE) requirements. Currently, BreZE allows, but does not require, licensees to upload CE documentation at the time of renewal. Making this submission mandatory would meaningfully enhance oversight and may require a regulatory

update. The California Code of Regulations (CCR), title 16, section 1451(d) specifies that licensees must retain CE certificates for four years and provide them to the Board upon request. Requiring CE documents to be uploaded at renewal would allow staff to conduct random audits directly through BreEZe without requesting additional materials from licensees. It would also allow BreEZe to serve as the official repository for the four-year retention period, improving efficiency, reducing administrative burden, and ensuring more consistent verification of CE compliance.

With respect to fine amounts, the BRN is willing to work with the Committees to assess whether statutory fines would further support compliance; however, the Board does not believe such changes are necessary at this time. Strengthening the documentation process through BreEZe would address the primary operational challenges, and any adjustments to fine levels could serve only as a supplemental measure to reinforce the importance of meeting CE requirements.

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

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

BRN Response and Action

Currently, APRNs must renew their RN license, their APRN certification, and their furnishing number separately, which requires multiple applications and multiple fee payments. Although the BRN consolidated the initial NP application and furnishing application during the last sunset review to streamline the licensing process, the corresponding renewal processes were inadvertently left off. Combining the APRN renewal and furnishing number renewal into a single application would extend the same efficiencies achieved on the initial application and could provide meaningful cost-saving and time-saving benefits for both licensees and the Board. When the initial application was combined, applicants saved \$400. Combining of the renewal application would provide an additional savings of \$150. The BRN would continue to collect the Controlled Substance Utilization Review and Evaluation System (CURES) fee on renewal.

From an operational standpoint, combining these processes would reduce the number of separate transactions processed by the BRN, simplify data management, and decrease duplicative administrative workload associated with issuing and tracking multiple renewals for the same licensee. Streamlining these functions can improve processing times, reduce the likelihood of errors or incomplete submissions, and allow staff resources to be allocated more efficiently across licensing program. Additionally, a single, unified application can lower printing, mailing, and system maintenance costs, particularly as the BRN continues to expand and rely on the BreEZe system. For APRNs, a unified renewal process would create a clearer and more predictable renewal cycle, reduce the risk of missed deadlines, and minimize the need to submit overlapping documentation across multiple applications.

Overall, the BRN is supportive of efforts to streamline the renewal process and would work closely with stakeholders to ensure that any transition to a combined renewal process maintains clarity, minimizes disruption, and preserves necessary regulatory oversight.

WORKFORCE ISSUES

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

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

BRN Response and Action

While BRN has not had conversations with facilities and stakeholders about removing the statutory provision, it has received frequent questions from facilities and stakeholders on interpretation and application of the provision. Given the broad nature of the current language, a physician and surgeon that limits the number of furnishing nurse practitioners they supervise to four within the span of fifteen minutes or four within the span of one year could both be argued to be in compliance. This level of variance not only leads to confusion amongst healthcare practitioners but also could reduce the level of public protection that was likely intended by this provision.

The BRN believes that instead requiring the supervision ratio and associated timeframe to be specified within standardized procedures along with all other supervision related details will better meet needs of the facility, physician, and nurse practitioner.

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

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

BRN Response and Action

BPC section 2725 establishes RN scope of practice. It states that RNs can provide direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen, but only when ordered by a physician, dentist, podiatrist, or clinical psychologist. Historically NPs and nurse midwives (NMW) could also initiate orders to RNs using standardized procedures which allowed the NP and NMW to act as an "agent of the physician." This is not an employer-based decision, it is the only way that is currently outlined in statute that allows the RN to practice nursing. An RN may perform specified functions only after receiving an appropriate order. Updating this section to clarify that an RN may also

follow an order issued by an APRN who currently has the ability to order or under the direction of an APRN that does not currently possess that authority is necessary for the RN to continue to practice within their scope.

The passage of Assembly Bill (AB) 890 (Wood, Chapter 265, Statutes of 2020) provided 103 NPs and 104 NPs with the ability to order, perform, and interpret diagnostic procedures, prescribe, order, administer, dispense, procure, and furnish therapeutic measures without the use of standardized procedures. Passage of Senate Bill 1237 (Dodd, Chapter 88, Statutes of 2020) provided NMWs with the ability to order drugs and devices, laboratory and diagnostic testing without the use of standardized procedures. Consequently, statute needs to be updated to make clear that RNs can receive orders from NPs and NMWs that are no longer working under standardized procedures and acting as an agent of the physician.

Relatedly, passage of AB 876 (Flora, Chapter 169, Statutes of 2025) codified that Certified Registered Nurse Anesthetists (CRNA) can select and administer medication, including controlled substances, for preoperative, intraoperative, and postoperative care and for pain management purposes pursuant to an order by a physician, dentist, or podiatrist. While CRNAs are technically still acting as the “agent of the physician,” it would reduce confusion to clarify they also can direct an RN provide treatment for conditions related to the administration of anesthesia, pursuant to an order for anesthesia services by a physician, dentist, or podiatrist. Although these statutory updates have advanced APRN practice, they have created an unintended risk for RNs by leaving gaps in the structures that guide RN practice. Without corresponding updates, RNs may be placed in situations where they are expected to act without the statutory clarity needed to ensure they remain within their legal scope, potentially exposing them to disciplinary action.

The BRN is in ongoing conversations with stakeholders around proposed text that would maintain the existing level of care without inadvertently expanding APRN scope of practice.

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

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

BRN Response and Action

The BRN's recent workforce reports show that both ADN and BSN prepared RNs remain essential to meeting the state's health care needs, yet the data also reflect meaningful differences in employment opportunities, employer preferences, and long-term career paths

associated with each degree pathway. According to the 2022 Survey of Registered Nurses¹, a growing share of employers, particularly acute-care hospitals, favor hiring BSN prepared nurses. BSN educated RNs are more commonly employed in hospital inpatient roles than their ADN prepared counterparts, who are more likely to work in ambulatory, long-term care, and home health settings. Employers are also increasingly encouraging or requiring RNs to obtain a BSN, and many RNs seeking promotions, higher salaries, or access to specialized clinical roles return to school for that purpose.

The survey data reveal clear marketplace advantages associated with higher levels of education. BSN prepared nurses earn noticeably higher incomes on average than ADN prepared nurses, and those with master's or doctoral degrees earn substantially more. BSN education also broadens access to specialty units, public health nursing, academic roles, and case management. In contrast, ADN prepared nurses face more limited access to roles in acute care hospitals and to positions with greater autonomy or advancement potential. This emerging pattern underscores the value that employers place on BSN preparation in relation to clinical complexity, leadership readiness, and workforce flexibility.

Despite these differences, the ADN pathway continues to be a vital point of entry into California's nursing workforce, representing a large portion of the state's initial RN preparation. The ADN pathway is typically sought after by the non-traditional student, second career students, and minorities. This pathway also carries lesser tuition and a faster progression to the profession.

Many ADN graduates subsequently advance their education, with a sizeable share completing BSN degrees after licensure. This progression highlights the importance of maintaining strong educational mobility between ADN and BSN programs, especially because ADN programs play a crucial role in producing new nurses for regions with limited access to four-year institutions or where workforce shortages are most acute. The data also support ongoing collaboration among the BRN, educational institutions, employers, and other stakeholders to expand ADN-to-BSN bridge programs and modular pathways that make continued education more attainable. Ensuring that ADN prepared nurses can continue their academic progression will not only strengthen the nursing workforce, but also help California meet long-term demand for a highly educated and adaptable RN labor force.

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

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

BRN Response and Action

According to data reported in the BRN's Annual School Surveys, the LVN 30-Unit Option figures are presented in the table below. Based on the information submitted by nursing

¹ <https://www.rn.ca.gov/pdfs/forms/survey2022.pdf>

programs, utilization of this pathway has remained consistently low over the past four fiscal years and demonstrates that the 30-unit option is used by a very small proportion of LVNs seeking RN licensure.

LVN 30-Unit Option Student Numbers	Fiscal Years			
	2021/22	2022/23	2023/24	2024/25
Number of students enrolled	170	27	35	75
Number of students who reported completion	201	27	0	46

Given its persistently low enrollment, limited completions, and the fact that people who complete this pathway receive a non-degree RN license that is not easily transferrable for licensure in other states, the BRN has not identified any recent discussions or stakeholder interest suggesting a need to expand or retain the option.

The available data indicates that this pathway is underutilized and may no longer function as an effective or meaningful route to RN licensure.

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

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

BRN Response and Action

Existing data collection efforts provide meaningful insight into the current RN and APRN workforce, but there are key areas where additional information would strengthen statewide workforce planning.

First, more detailed reporting on licensees' specialty areas and practice settings would offer a clearer picture of where nurses are actually working. This level of granularity is essential for accurately assessing gaps in primary care capacity and for shaping strategies to close California's provider shortages that may exist.

Second, California lacks a uniform, validated source of statewide data on clinical placements. While the BRN receives placement information from nursing programs, no entity collects corresponding data from the healthcare facilities where students are placed for clinicals. Without a complete view from both educational programs and clinical facilities, the state cannot form an accurate picture of its clinical training capacity. A standardized, statewide data collection framework, such as the model proposed in Senate Bill (SB) 1042 (Roth, 2024), is essential for understanding California's true clinical training capacity and where clinical training impactions exist and how capacity can be expanded. This type of comprehensive data would directly support nursing program growth and strengthen efforts to expand the workforce pipeline.

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

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

BRN Response and Action

While there continues to be discussions on the Nurse Licensure Compact (NLC), the Board must carefully evaluate several policy, consumer protection, and operational considerations before determining whether joining the NLC is appropriate. Federal law already ensures license portability for servicemembers and their spouses, making an interstate compact unnecessary for that population. More broadly, interstate compacts present complex issues because each compact is different in scope, governance, licensing requirements, disciplinary authority, and fee structures. For California, which has large licensee and consumer populations and higher-than-average licensing and enforcement standards, delegating regulatory authority to a multi-state commission with equal voting power across all states essentially commits the state to underrepresentation and raises concerns about consumer protection and the ability to maintain California's rigorous standards.

Compacts may also create funding challenges if fees do not flow to California boards despite increased enforcement obligations. California-specific requirements, including examination standards, scope-of-practice differences, continuing education mandates, fingerprinting and arrest reporting, ITIN acceptance, and the ability to take independent disciplinary action, would all need to be preserved to ensure public safety.

Additionally, an influx of out-of-state practitioners could increase enforcement workload and associated costs. It would also eliminate the Board's ability to conduct workforce tracking or projection modeling, as there would be no reliable way to determine how many out-of-state licensees are practicing in California at any given time. Alternatives such as reciprocity, practice privilege, expedited licensure, and temporary licensure can achieve greater license mobility without compromising California's standards or ceding regulatory authority.

The NLC is not a one-size-fits-all solution, and any consideration of NLC participation must account for the Board's commitment to consumer protection, licensing integrity, fiscal sustainability, and regulatory autonomy.

EDUCATION ISSUES

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

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

BRN Response and Action

The BRN continues to monitor clinical placement availability and its impact on nursing program capacity. As part of this ongoing work, the Nursing Education and Workforce Advisory Committee (NEWAC) met in January² to discuss the requirements of Senate Bill (SB) 1015 and current challenges related to clinical placement access. During that meeting, NEWAC assigned the issue to its Clinical Impaction Subcommittee for further research, analysis, and recommendations. The Subcommittee's work is currently underway and will further support the BRN's efforts to comply with SB 1015 and to provide the Committee with more detailed updates on clinical placement availability and its impact on program growth.

With respect to enrollment expansion, the BRN has received requests from programs seeking to increase student capacity or establish new programs. From 2022 through 2025, 87 actions were presented to the Board, of which the Board approved 79, supporting 4,845 new students across nursing programs. During this same period, the BRN deferred eight requests due to insufficient clinical placement availability, affecting the requested growth of 932 new student placements. Overall, the data show that while most enrollment expansion requests were approved, across all years in which deferrals occurred, all of the deferred actions were attributed to insufficient clinical placement availability, demonstrating that clinical placement limitations remain a consistent barrier to program growth.

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

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

BRN Response and Action

The BRN acknowledges the need to align California's simulation-based learning requirements with current practice and national standards. Updating the statutory framework is essential to ensure that all simulation experiences used for nursing education follow nationally recognized guidelines, such as those developed by the International Nursing Association of

² January 21, 2026 NEWAC Agenda: https://www.rm.ca.gov/pdfs/meetings/newacagenda_jan26.pdf
January 21, 2026 NEWAC Materials: https://www.rm.ca.gov/pdfs/meetings/newac_materials_jan26.pdf;
January 21, 2026 NEWAC Webcast: https://www.youtube.com/watch?v=h3_Ysk8-NTE

Clinical Simulation and Learning (INACSL), the Society for Simulation in Healthcare (SSH) and the National Council of State Boards of Nursing (NCSBN). These updates should clarify expectations related to scenario design, duration, fidelity, debriefing, instructor qualifications, and integration of simulation into program curricula.

The BRN is currently reviewing the Nursing Practice Act and developing proposed statutory language to better align and standardize simulation requirements, which will be provided to the Committees as recommended revisions once complete. These updates will help ensure consistent, high-quality simulation experiences across programs, strengthen educational standards, and enhance overall patient safety.

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

Staff Recommendation: The BRN should advise the Committees about the potential impact to California licensees, students, and California-based nursing educational programs approved by the BRN if it were to authorize students to provide nursing services through clinical education to California patients despite attending a school that is not BRN-approved.

BRN Response and Action

Nursing program approval is a fundamental public protection responsibility of every state's board of nursing, ensuring that nursing education programs meet the standards established in that state's nursing practice act. The initial program review and approval verifies upfront that the program's curriculum, faculty, and clinical preparation comprehensively cover the knowledge and skills necessary for licensure and safe practice. The review also evaluates the program's ability to support the student from enrollment to graduation by ensuring that the program has the proper infrastructure, resources, and student support systems. The continuing program review and approval serve as an ongoing oversight mechanism. The review monitors program performance, verifies sustained compliance with state laws and regulations, and allows the Board to intervene early when risks are identified, before students, patients, or other members of the public are adversely affected.

Given that each state establishes its own laws, clinical standards, and educational expectations, approval of a nursing school in another state does not guarantee that the program meets California's standards for curriculum, faculty oversight, or clinical preparation. Moreover, while programmatic accreditation provides an additional layer of review, it cannot substitute for state approval, as accrediting bodies do not assess compliance with California law. This concern is heightened by recent federal directives to dismantle the United States Department of Education, which would eliminate federal oversight of accrediting bodies and further undermine the reliability of accreditation as a quality assurance mechanism.

From a public protection standpoint, California lacks a meaningful regulatory framework for overseeing out-of-state institutions. The Bureau for Private Postsecondary Education (BPPE) has limited jurisdiction over schools that are physically located outside California and does not evaluate or oversee quality metrics and program outcomes, nor compel corrective action. Likewise, the BRN does not evaluate the nursing curriculum, clinical standards, or faculty qualifications of out-of-state nursing programs unless they request Board review. Allowing non-approved programs to place students in California clinical sites would introduce students whose preparation has not been evaluated under California's standards. This creates the potential for confusion and inconsistency at clinical sites, where healthcare facilities may have students performing patient care without equal preparation and clear competence.

Furthermore, as out-of-state online programs can enroll California residents without undergoing any California-specific review, this places students at risk of failing to meet licensing standards, becoming vulnerable to predatory practices where institutions cannot deliver what they promise, and accumulating substantial debt without a supportive pathway to the profession. By operating outside the approval process, these institutions effectively bypass the rigorous oversight required of in-state programs, creating an unequal two-tiered system. Some academic institutions may choose to operate in a state with minimal oversight, enabling unchecked program growth even when performance metrics demonstrate significant risk. This can impact a larger number of students, many of whom may not fully understand how these deficiencies could jeopardize their success in the program and their future in the nursing profession.

Another major concern is California's already strained clinical capacity. Clinical placement shortages have forced the BRN to defer new program applications and/or new campus locations, and reduce enrollment increases that have been requested by existing programs. California's public nursing programs are experiencing stalled growth due to limited clinical and faculty resources to the point that some have chosen to reduce their BRN-approved enrollment numbers because they cannot adequately support their current students. Even if state law required prioritization of in-state programs for clinical placement, the BRN has no jurisdiction over health facilities and could not monitor or enforce compliance.

Allowing out-of-state programs to compete for the same limited clinical sites would further disadvantage California institutions, extend waitlists for residents, and undermine the State's ability to expand its own educational and workforce pipeline. Students prefer to attend in-state programs near where they work and live, and increased competition for clinical placements would further restrict those opportunities, making it nearly impossible for California programs to expand.

It is important to note that this challenge is not unique to California and other states are dealing with the same issues. In 2026, Tennessee passed legislation³ that established a two-year moratorium on out-of-state nursing programs placing students in their clinical sites. That pause allows the state to collect and analyze data, assess impacts, and create a more robust monitoring system. The rapid growth of online nursing programs and their impact on clinical capacity is a growing national concern. This reflects a broader recognition that

³ Tennessee Senate Bill 2013: <https://wapp.capitol.tn.gov/apps/BillInfo/Default?BillNumber=HB1905&qa=114>

unregulated growth of out-of-state and online programs can overwhelm local clinical resources and compromise educational quality.

Authorizing clinical placements for students enrolled in out-of-state, non-BRN-approved programs would negatively affect California's patients, licensees, and nursing programs already struggling with limited resources. Out-of-state programs already have a clear and appropriate pathway to use clinical facilities in California - they may establish an in-state presence that meets the Bureau for Private Postsecondary Education's requirements and then apply for BRN approval.

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

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

BRN Response and Action

The California Code of Regulations (CCR), title 16, section 1425(a) outlines the requirements for nursing program directors, including a master's degree in nursing, education, or administration; one year of administrative experience; and two years of teaching experience in a pre- or post-licensure RN program. Most nursing programs are able to grow internally through their faculty development processes. Faculty members who hold an instructor-level designation become eligible for the assistant director role after two years of teaching. After serving as an assistant director for one year, they then qualify to advance into the director position. This creates a structured, step-in progression: two years of instructional experience to qualify as an assistant director, followed by one year of administrative experience to qualify as a program director.

The NECs encourage academic institutions to maintain strong succession plans, including having more than one approved assistant director in training at all times to allow for smooth employment transitions. The assistant director role is typically a faculty member with a set release time to learn the administrative duties.

When an academic institution is unable to identify an internal candidate, the BRN's existing regulatory framework and support processes allow for a nursing program to remain operational. During this time, an assistant director may step into the program director role or a program director can be temporarily loaned from another academic institution, as there is no regulatory requirement for the program director to be physically present or on campus.

When a proposed external candidate for director or assistant director does not fully meet the required qualifications, the BRN allows programs to work directly with their assigned Nursing Education Consultant (NEC) to determine whether the candidate may qualify through equivalent education or experience under CCR, title 16, section 1425(a)(5). In situations where a prospective leader does not yet meet all criteria, the NEC will meet with the program director applicant to discuss other viable options for approval. These conversations

focus on identifying viable options the candidate can pursue to gain the necessary qualifications, including potential training, experience, or developmental steps that would allow them to meet the requirements for program director approval.

These established processes enable the Board to assist colleges proactively who may be facing shortages of fully qualified director candidates, helping them stay on track for compliance without compromising regulatory standards.

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

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

BRN Response and Action

The BRN does not grant special consideration to public or private universities when reviewing program approvals, reapprovals, or requests for enrollment increases. All nursing programs are evaluated using the same statutory and regulatory criteria, and decisions are based solely on a program's demonstrated ability to maintain educational quality and ensure safe clinical preparation for students. Enrollment decisions are made only after program outcomes are evaluated to ensure the program is not at risk. This is done by reviewing student outcomes, compliance with BRN education standards, and the program's history of meeting regulatory requirements. Once that is established the Board analyzes additional objective factors such as faculty availability and clinical placement capacity, and considers any impact that program growth would have on currently approved nursing programs including those shared through public input in Committee and Board meetings. By applying these criteria uniformly, the BRN ensures fairness, consistency, and the protection of student learning and public safety across all nursing education programs.

On the following page is a table summarizing all Board actions over the past four years, which shows that the majority of new student approvals consistently occur in private programs, typically ranging from 68 percent to 85 percent of total new student capacity, while deferred actions, when they occurred, involved only small numbers and only arose with private institutions. This pattern reflects the fact that private programs submit the highest volume of enrollment requests to the Board, rather than indicating any difference in how the BRN evaluates public versus private programs.

Year	Number of Approved Board Actions	New Students in PRIVATE School Setting	New Students in PUBLIC School Setting	TOTAL Number of New Students	Number of Board Actions Deferred	New Students in PRIVATE School Setting Deferred	New Students in PUBLIC School Setting Deferred	TOTAL Number of New Students Deferred
2022	3	180	20	200	0	0	0	0
	3	447	40	487	0	0	0	0
	9	363	147	510	0	0	0	0
	15	990	207	1197	0	0	0	0
		83%	17%			0%	0%	
2023	3	170	20	190	0	0	0	0
	1	135	0	135	0	0	0	0
	22	1697	637	2334	4	725	0	725
	26	2002	657	2659	4	725	0	725
		75%	25%			100%	0%	
2024	1	90	0	90	0	0	0	0
	1	96	0	96	2	135	0	135
	16	320	213	533	0	0	0	0
	18	506	213	719	2	135	0	135
		70%	30%			100%	0%	
2025	3	372	0	372	0	0	0	0
	2	232	0	232	0	0	0	0
	15	476	190	666	2	72	0	72
	20	1080	190	1270	2	72	0	72
		85%	15%			100%	0%	
2026	1	90	0	90	0	0	0	0
	2	120	50	170	1	60	0	60
	6	70	83	153	1	60	0	60
	9	280	133	413	2	120	0	120
		68%	32%			100%	0%	

Together, these findings demonstrate that BRN oversight is applied consistently and impartially across all institutions, with decisions driven by objective educational and regulatory criteria rather than institutional type. By holding every program to the same standards and evaluating each request on its merits, the BRN maintains fairness in the approval process while safeguarding the quality of nursing education and protecting the public.

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

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

BRN Response and Action

The Proposed Rule narrows the definition of “professional degree,” excluding MSN, DNP, NP, CRNA, and other advanced nursing degrees. This will cause programs offering those degree types to lose access to higher federal loan caps, making them far more expensive and in some cases financially inaccessible. This will likely reduce the number of advanced practice registered nurses entering the workforce in California, since a graduate degree is required to become a nurse practitioner, nurse midwife, certified registered nurse anesthetist, or clinical nurse specialist.

Restricting access to federal borrowing will intensify existing geographic disparities in healthcare access across California. This is especially concerning in rural and medically underserved communities, which are already experiencing critical provider shortages and disproportionately rely on NPs and other APRNs to meet their healthcare needs.

Additionally, the rule will exacerbate the state's existing nurse faculty shortage. Graduate degrees are required to serve in most faculty or administrative roles at nursing programs. By making graduate education more costly and limiting access to federal loans, the Proposed Rule will reduce the number of individuals willing or able to pursue graduate nursing education, thereby worsening faculty shortages and further constraining RN program enrollment statewide.

ENFORCEMENT ISSUES

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

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

BRN Response and Action

The Board currently attends a monthly meeting with the Intervention Program vendor and all other Boards under DCA that have a recovery program to discuss cross-board issues and alignment of policies and procedures.

The Board also holds weekly meetings with the Intervention Program vendor to discuss BRN-specific updates, best practices, training needs, and case collaboration. A common topic of

discussion at these meetings is how to ensure that the Board's IP program is flexible enough to accommodate participants in their individual recovery journeys, while still having the level of structure and consistency necessary to protect the public.

The Board agrees that any amendments or changes to the Uniform Standards require cross-board collaboration, since the implications are wide reaching. Therefore, rather than amending the Uniform Standards to address work requirements, the Board proposes to instead amend Article 3.1 of the Nursing Practice Act which establishes statutory guidance for the Board's IP. One option is to update BPC section 2770.12 to state that it is up to the committee's discretion as to whether a participant must practice nursing prior to successful completion of the program.

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

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

BRN Response and Action

The Board is requesting additional flexibility for reinstatements when a license is revoked by default because the licensee was not aware of the disciplinary action against them.

The Board estimates that approximately 175 licensees would be eligible each year to seek relief under this type of scenario. Of that number, the BRN estimates around 50-75 may request to pursue this option.

In evaluating these petitions, the BRN would apply similar criteria to what is established under Government Code section 11520(c) for vacating a decision and granting a hearing. These criteria could include, but are not limited to:

- Failure of a licensee to receive notice served by the Board.
- Mistake, inadvertence, surprise, or excusable neglect.

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

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

BRN Response and Action

To assist the Committees in evaluating whether the Board should have additional flexibility in responding to unprofessional conduct violations related to driving under the influence (DUI) offenses, the Board conducted a multi-year review of its enforcement data. This analysis

provides a clearer understanding of both the volume of complaints received and the proportion that ultimately result in disciplinary action. The detailed figures referenced throughout this narrative are presented in the table below.

	FY 2022/23	FY 2023/24	FY 2024/25
Total Criminal Complaints Received	2,059	1,958	2,605
DUI Complaints Received	879	812	1,115
Total Number of Disciplinary Actions for DUI Complaints	117	133	59
Disciplinary Action: Probation	94	72	30
Disciplinary Action: Public Reproval	24	26	9
Disciplinary Action: Revocation	27	19	2
Disciplinary Action: Surrender	18	11	10
Disciplinary Action: Application Denied	6	2	8
Disciplinary Action: Other	8	3	0

Over the past three FYs, the Board received between 1,958 and 2,605 criminal complaints annually, reflecting a relatively stable overall caseload. Within that total, complaints referencing driving-related violations represent a significant share. In the most recent fiscal year, 1,115 of the 2,605 complaints, over 40 percent, contained some variation of a driving-related allegation in the complaint summary. This demonstrates that these violations appear frequently at the complaint-intake stage. However, the number of complaints that ultimately result in discipline is smaller. In FY 2024/25, only 59 cases involving these violations led to disciplinary action. This pattern is consistent with prior years, where the number of disciplinary actions ranged from 117 to 133. This downward trend reflects the Board's case-by-case evaluation process, which focuses on whether the conduct presents a risk to patient safety.

The distribution of disciplinary actions further clarifies the underlying nature and severity of these cases. Historically, probation and public reproval have been the most common outcomes, while revocations and surrenders have become increasingly rare. For example, revocations decreased from 27 cases in FY 2021/22 to just two cases in FY 2024/25, indicating that the most severe sanctions are now applied only in exceptional circumstances. Similarly, probation cases declined from 94 to 30 over the same period. These trends suggest that while driving-related violations frequently appear in complaint summaries, only a small subset involve circumstances that warrant formal discipline, and even fewer require the most serious enforcement actions.

Based on the most recent FY, 59 cases would have been directly affected by any statutory change granting the Board additional discretion. This represents a small fraction of the total complaints received and an even smaller fraction of the licensee population. The data suggests that providing the Board with flexibility could allow enforcement resources to be directed toward cases that present clearer risks to public protection, while still preserving the Board's ability to act when necessary.

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

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

BRN Response and Action

To maintain consistency for health facilities, the BRN would prefer to align fine amounts with those established by the Medical Board of California under BPC section 2225.5. The fine amount would be \$1,000 for each day the documents are not submitted past the deadline, not to exceed \$10,000, unless there is good cause for the health care facility being unable to provide the documents.

The BRN currently has five cases in formal subpoena enforcement; however, this figure significantly understates the number of facilities that fail to produce certified records by the subpoena deadline. Because subpoena enforcement is both lengthy and costly, the BRN uses this mechanism only as a last resort. Before referring a case to the Office of the Attorney General (OAG) for enforcement, staff make multiple attempts to obtain the required records through follow-up emails, phone calls, and on-site visits. Once a matter is referred, the OAG also seeks to secure compliance informally, as obtaining a court hearing date often involves substantial delays.

The Board believes that increased accountability for healthcare facilities to respond to requests from the Board in a timely manner will assist in reducing our investigation timelines. It is not an uncommon occurrence for investigations to be subject to prolonged delays pending the receipt of necessary documents from healthcare facilities.

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

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

BRN Response and Action

Pursuant to CCR, title 16, section 1441(b), failure to cooperate or participate in a Board investigation constitutes unprofessional conduct. As licensed healthcare professionals, RNs and APRNs are obligated to uphold the highest standards of ethics, transparency, and accountability. When a nurse disregards the Board's requests for information or refuses to engage in an investigation, it represents a serious breach of those standards. Such noncompliance undermines public confidence and violates the core expectation that

healthcare professionals remain answerable to the regulatory bodies charged with ensuring patient safety and professional integrity.

Failure to cooperate also directly impedes the Board's ability to conduct timely, complete, and effective investigations. Withholding or delaying essential information can stall case progress, compromise the integrity of the investigative process, and ultimately weaken the Board's ability to fulfill its mandate to protect the public.

While CCR, title 16, section 1441 (b) appropriately preserves a licensee's constitutional and statutory privileges, the Board encounters situations in which licensees decline to respond to inquiries or questioning, delay the production of records, or otherwise fail to engage in the investigative process. These delays impede the Board's ability to conduct timely, complete investigations and directly affect its capacity to protect the public.

BRN investigators frequently experience delays in the interview process due to the following:

- Last minute requests to reschedule interviews for personal reasons
- Late notification of legal representation accompanied by requests for additional preparation time
- Firms declining to allow their clients to sit for an interview and instead submitting a written "litigation package"

Enforcement delays carry substantial operational and financial costs. When essential information is withheld, or produced only after repeated requests, investigations remain open longer, require additional staff time, and may necessitate multiple follow-up actions. These inefficiencies strain Board resources and prolong the period during which potential risks to the public remain unaddressed.

An investigation typically requires approximately 34 hours to complete and, in the absence of delays, incurs an average cost of approximately \$5,120. Cases that experience significant delays can require 50 to 100 hours, increasing the cost to as much as \$15,060. Pursuant to BPC section 125.3, the Board seeks to recover investigative costs in administrative hearings; however, whether those costs are awarded is ultimately within the discretion of the Administrative Law Judge.

A statutory change establishing clear and objective timelines and a defined consequence for non-participation, while still allowing exceptions for good cause, would strengthen the Board's ability to obtain necessary information within reasonable timeframes and uphold due process. Such clarity would reduce avoidable delays, support more efficient enforcement, and enhance the Board's effectiveness in fulfilling its public protection mandate.

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

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

BRN Response and Action

The BRN believes that having access to the Federal Bureau of Investigation (FBI) Record of Arrest and Prosecution (RAP) Back program would strengthen its enforcement process and promote greater patient safety through public protection.

The FBI's Rap Back program is a service that provides real-time, continuous monitoring of criminal records for authorized employers. Instead of one-time background checks, it alerts agencies immediately when an enrolled individual has new criminal activity, reducing costs and improving security.

According to the 2022 Survey of Registered Nurses⁴ nearly 17 percent of RNs with active California licenses lived in other states. As of May 1, 2026, there are 564,315 RNs with an active California license, 17 percent of which is over 95,000 licensees. For those licensees, if they commit a crime after obtaining their initial licensure and the state where it occurs does not impose discipline, the BRN would have no mechanism to become aware of the offense.

To participate in the federal fingerprinting system, state statutes authorizing fingerprint collection must satisfy several federal requirements. The statute must be enacted by the Legislature; require fingerprinting of applicants who will undergo a national criminal history background check; expressly or implicitly authorize submission of fingerprints to the FBI; clearly identify the specific categories of individuals subject to the requirement; align with public policy; and prohibit the release of criminal history information to any private entity.

Consequently, the BRN would need explicit statutory authority that fully complies with the provisions above in order to enroll in and utilize the federal fingerprinting service.

⁴ <https://www.rn.ca.gov/pdfs/forms/survey2022.pdf>

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

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

BRN Response and Action

The BRN has seen a notable rise in complaints involving med spas and IV hydration clinics, particularly related to RNs and APRNs engaging in drug compounding, an activity that is outside their legal scope of practice. Medical spas and intravenous (IV) hydration services are relatively new for the BRN, and specific BreEZe complaint tracking codes have not yet been established.

According to the Food and Drug Administration's (FDA) IV Hydration Facilities panel discussion, presented in collaboration with the Federation of State Medical Boards, the National Association of Boards of Pharmacy, and the NCSBN on July 26, 2023, California significantly surpasses every other state in the nation in the number of RNs and APRNs offering IV hydration services. It is estimated that the growth in med spas and IV hydration clinics will continue to rise.

In October 2021, the FDA highlighted concerns that IV hydration clinics⁵, medical spas, and mobile IV infusion services may be compounding sterile drug products without meeting federal requirements or state laws. It is often unclear whether these businesses maintain sanitary conditions, whether a licensed prescriber is evaluating patients and issuing prescriptions, or whether sterile products are being prepared in compliance with California regulations. The FDA notes that these types of businesses operate across the country; however, the total number of entities and the extent of their compounding activities remain unclear because compounders operating under section 503A of the Federal Food, Drug, and Cosmetic Act generally do not register with the FDA. When sterile drugs are compounded without proper safeguards, patients face significant risks due to potential contamination or compromised quality. For this reason, sterile compounding performed in settings such as med spas and IV hydration clinics presents ongoing safety concerns and warrants continued oversight.

The Board aligns with the California State Board of Pharmacy's definition of IV hydration clinics. Although often marketed as wellness services, IV hydration involves administering

⁵<https://www.fda.gov/drugs/human-drug-compounding/fda-highlights-concerns-compounding-drug-products-medical-offices-and-clinics-under-insanitary>

substances directly into the bloodstream and carries inherent medical risks, including the potential for severe or life-threatening reactions if the IV solution is improperly mixed, contaminated, or administered in an unsafe manner. The Board is aware of incidents in which patients have experienced harm after receiving IV hydration at these types of establishments. Additionally, IV hydration provided in a clinic setting requires a medical examination by an appropriately licensed prescriber before the treatment is administered. These safeguards are essential to ensure patient safety and to comply with California's regulatory requirements.

Most violations observed in med spas and IV hydration clinics fall into three categories:

- Improper supervision
- Illegal ownership structures
- Practice outside scope and unregulated settings

As the number of med spas and IV hydration clinics continues to grow, the BRN will maintain its enforcement efforts, refine its complaint-tracking processes, and continue coordinating with partner boards to ensure that consumers receive safe and appropriately supervised care.

OTHER ISSUES

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

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

BRN Response and Action

At this time, the BRN does not have any technical changes to request beyond those already submitted to the committees.

CONTINUED REGULATION BY THE BOARD OF REGISTERED NURSING

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

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

BRN Response and Action

The BRN agrees with the Committees' recommendation and thanks the Committees for their support. Additionally, the BRN will continue business process improvements to achieve sustainable long-term solutions.