STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
BOARD OF REGISTERED NURSING
BOARD MEETING MINUTES

DRAFT

Date: May 23, 2024

9:01 a.m. **Start Time:** 9:00 a.m.

Location: **The Board of Registered Nursing (Board) held a public meeting, accessible both in-person and via a teleconference platform, in accordance with Government Code section 11123.2.**

Department of Consumer Affairs
1625 North Market Blvd. Main Hearing Room (Suite S-102)
Sacramento, CA 95834

Thursday May, 23-24, 2024 - 9:00 a.m. BRN Board Meeting

9:01 a.m. **1.0** **Call to Order/Roll Call/Establishment of a Quorum**

Dolores Trujillo, RN, President, called the meeting to order at: 9:01 a.m. All members present. Quorum was established at 9:02 a.m.

Board Members:
Dolores Trujillo, RN – President
Mary Fagan, PhD, RN, NEA-BC-Vice President
Jovita Dominguez, BSN, RN
Patricia "Tricia" Wynne, Esq.
Roi David Lollar
Vicki Granowitz
Alison Cormack
Nilu Patel

BRN Staff:
Loretta (Lori) Melby, RN, MSN – Executive Officer
Reza Pejuhesh – DCA Legal Attorney

9:04 a.m. **2.0** **General instructions for the format of a teleconference call**

9:06 a.m. **3.0** **Public Comment for Items Not on the Agenda; Items for Future Agendas**

Public Comment for Agenda Item 3.0:
No public comment on WebEx or at the Sacramento location.

9:07 a.m. **4.0** **Review and Vote on Whether to Approve Previous Meeting Minutes**

4.1 November 15-16, 2023
4.2 February 28-29, 2024

Public Comment: Anthony: Asked if it possible to get a transcript of the last meeting and asked how a member of the public would go about getting a transcription.

Loretta Melby asked if it was from the board meetings and said the recording will be available a few days after the board meeting. She also said the webcast is linked on the board's website and that it is possible to get the transcript from the video once it is placed on the DCA YouTube channel.

Motion: **Alison Cormack:** Motion to Approve Board Meeting Minutes from November 15-16, 2023, and February 28-29-2024, and allow BRN Staff to make non-substantive changes to correct name misspellings and/or typos that may be discovered in the document.

Second: **Nilu Patel**

Vote:

	DT	MF	JD	PW	DL	VG	AC	NP
Vote:	Y	Y	Y	Y	Y	Y	Y	Y
	Key: Yes: Y | No: N | Abstain: A | Absent for Vote: AB							

Motion Passed

9:13 a.m. **5.0** **Report of the Administrative Committee**

5.1 Executive Officer report

Board Discussion: Alison Cormack asked about a chat bot or box possibility for the website.

Loretta Melby said that it is many of the things the BRN is considering to improved public access. The priority is to revamp and work on providing more concise information on the rn.ca.gov website as the chat bot uses the website info to respond to inquiries.

Patricia Wynne said she's been hearing about IV spas and asked if the BRN is involved in this.

Loretta Melby said if any RNs are involved then the BRN is involved but there are many different licensees from various boards that are involved.

Patricia Wynne asked if this is a wait and see situation.

Loretta Melby said the BRN is receiving complaints and actively investigating them.

Nilu Patel asked if the BRN is actively doing education for RNs as to what they are and not allowed to do. She asked if there is anything on social media or any other avenues.

Loretta Melby said she's working on a compounding presentation with other DCA entities and that once approved by DCA Legal will be posted to the BRN's website and a social media push.

Public Comment for Agenda Item 5.1:

Diane Matthews, RN, Esquire: Asked if there is a clearinghouse of complaints for boards unrelated to medical professionals.

Loretta Melby asked for clarification. She said they are with various boards and accusations for RNs are posted on the BRN's website attached to a nurse's license.

Diane Matthews: Asked if there are common types of complaints in statistics with potential injuries to the public.

Loretta Melby asked if this is specific to med spas or in general.

Diane Matthews said med spas because these are the complaints that are rolling in.

Loretta Melby said this is a new kind of specialty and there are various other agencies involved with licensing and business as well.

Janina Teoco: Asked how the regulatory body can balance between legal actions versus reprimand to a nurse to prevent fear and promote error reporting.

Loretta Melby said there are several different ways to manage reporting. It can be done anonymously with pertinent details reported. Any investigation is not punitive, but to protect the public and the RNs. If someone is seeking help with addiction or mental health the intervention program is available and probation is focused on rehabilitation as well. There is a lot of outreach and education in the

Executive Officer report with meetings that are attended to spread the word and increase knowledge.

Janina Teoco: Asked how the BRN partners with others to reach nurses.

Loretta Melby said there are several resources including social media and emails that are blasted out along with working with employers and California Hospital Association. Commenter said she's an educator and would like to be able to partner with the BRN.

There were no additional comments from the Sacramento location.

9:34 a.m. **5.2** **Information only:** 2022-2025 Strategic Plan and goal progression

Board Discussion: Patricia Wynne appreciates the Strategic Plan and progress being made but she cannot tell what issues are still outstanding.

Loretta Melby said any issues listed as not met. She said she is not confident that all the issues will be completed by the end of 2025.

Evon Lenerd Tapps (BRN, Assistant Executive Officer): Said Outreach will always be ongoing and carry over.

Alison Cormack said its easier to see what's been accomplished and appreciates the change. She appreciates the information about IT. She would like more detail in the data on 42A2C regarding clinical placements.

Loretta Melby said there are recommendations from a State Audit in 2019 that DCA OIS is working on to achieve the recommendations regarding clinical placement. The system is not collecting clinic settings outside California Department of Public Health. The EDP-P-18 was updated to add more information and that is still being worked on. The BRN only has jurisdiction over the academic partners and is working with the other partners to achieve the data collection.

Alison Cormack asked for a ballpark timeframe to achieve this goal to know where the BRN is headed.

Loretta Melby said there will be a phase 1 for the NECs to use for the clinical facilities this year.

Alison Cormack asked about the BRN satisfaction survey being released and if this is public.

Loretta Melby said the survey was sent out to RNs and are in the process of collecting the responses.

Alison Cormack is excited to see the results.

Loretta Melby said before the survey is updated, she wants to update the website and social media regarding what the BRN does and does not do.

Dolores Trujillo had to step away from the meeting momentarily at 10:00 a.m.

Mary Fagan asked if there is a way to add a percentage to see how much progress has been made.

Loretta Melby said it is not an easy ask because progress is made and then something happens to move further away from the goal. She said the issues seem to be more complex than initially thought.

Mary Fagan said some might be less complex and leaving a blank is difficult. She also suggested looking at other healing arts boards for their survey questions.

Dolores Trujillo returned to the meeting at 10:03 a.m.

Public Comment for Agenda Item 5.2: No public comment on WebEx or at the Sacramento location.

10:04 a.m. **5.3** **Information only:** Registered Nursing Fund Condition (presentation by DCA Budget Office)

Board Discussion: Dolores Trujillo asked about page 38 in the supplemental materials and asked for a few examples of personal services. Suzanne Balkis said it is for personnel.

Patricia Wynne asked about page 41 Revenues. She asked about the loan repayment from General Fund and to General Fund. She said it is confusing.

Loretta Melby said during Covid $30 million was loaned and has been repaid with interest. Another loan for $65 million was made to the General Fund and it is unknown when that will be repaid but it will be done with interest. She said the BRN is one of a few that are fiscally

solvent due to fee increases in 2019. She said the money in BRN reserve will be used to float other boards that are insolvent.

Alison Cormack appreciates the level of detail provided. She said page 39 is super helpful. She asked about ProRata and to clarify what that high cost is which is to pay to be part of DCA. She said page 40-41 shows the other regulatory permits revenue is declining as expected. She spoke about the funds in reserve dropping due to the outstanding loans to General Fund. She is not concerned with the reduction as she knows the loan will be repaid. She appreciates the level of transparency.

Nilu Patel asked if there is something in writing regarding a minimum or maximum for loans being made.

Suzanne Balkis said DCA works with the Department of Finance who makes the final determination of which funds contribute and what is an acceptable amount.

Public Comment for Agenda Item 5.3: No public comment on WebEx or at the Sacramento location.

10:21 a.m. **5.4** **Information only:** Presentation of the roles and responsibilities of the Board, Board members, state agency organizational structure and Board staff.

Board Discussion: Patricia Wynne asked where Reza Pejuhesh sits on the Org chart.

Loretta Melby said he is not a BRN employee and would not appear on the BRN organizational chart.

Reza Pejuhesh further explained ProRata and that he is employed by DCA and BRN is his primary assigned client.

Loretta Melby added more context for the work done by BRN with DCA as part of ProRata.

David Lollar stated that he appreciates the information and comments.

Vicki Granowitz asks how reappointment of board members is done.

Loretta Melby said the BRN has no say and is done by the appointing powers.

Vicki Granowitz said Mary Fagan still has knowledge, so it doesn't make sense for her to leave. She said it would make sense for a person to continue to serve until replaced. She asked if this could be addressed in a sunset bill.

Loretta Melby explained the legislative process for the sunset bill.

Nilu Patel asked about the vacant RN bedside nurse and whether any appointment has been made.

Loretta Melby said no appointment has been made and beginning June 1st there will be seven board members.

Public Comment for Agenda Item 5.4: Jaqueline: Appreciates the informative meeting and the clarification to make it easy to understand.

No additional public comment from the Sacramento location.

Break from 10:50 – 11:02 a.m.

6.0 BRN future priorities and proposals for review and possible action

There were no agenda items for 6.0 for the May 23-24 Board Meeting

Quorum re-established at 11:03 a.m.

11:03 a.m. 7.0 Report of the Nursing Practice Committee

7.1 Information only: Advisory Committee updates:

- **7.1.1** Nurse Practitioner Advisory Committee (NPAC)
- **7.1.2** Nurse-Midwifery Advisory Committee (NMAC)
- **7.1.3** Clinical Nurse Specialist Advisory Committee (CNSAC)
- **7.1.4** Certified Registered Nurse Anesthetist Advisory Committee (CRNAAC)
- **7.1.5** Nursing Education and Workforce Advisory Committee (NEWAC)

Board Discussion: No comments or questions.

Public Comment for Agenda Item 7.1: No public comment on WebEx or at the Sacramento location.

11:07 a.m. **7.2 Discussion and possible action:** Regarding the NEWAC recommendations on proposed draft regulatory language for standards on simulation in clinical education

Board Discussion: Nilu Patel asked how simulation would be implemented in public programs and have budgets and educators been considered.

Garrett Chan (NEWAC, Chair) said there are many types of simulation, high fidelity which is costly, such as the mannequin. Low fidelity with a standardized participant who plays role of patient or family member. Computer based simulation as well. There are free programs in prelicensure programs. He said if it's a requirement of the BRN it makes the budget justification easier. He also said there is a national certification for educators (Certified Healthcare Simulation Educator) to get people prepared for simulation.

Vicki Granowitz said when she was a young psychotherapist training it was taped and it was traumatizing to her, and she can still hear her employer laughing at her. She read through all the materials, and it is fascinating. She said it needs to rely on the sensitivity to the person that's implementing the education and wonders how that would be followed up on.

Garrett Chan said there is debriefing as one of the major areas of vulnerability for learners and there is significant education training and standards that are set forth to ensure psychological safety for those involved in the simulation. This is why NEWAC wants to move forward with regulations so there is oversight to ensure people are not exposed to that type of situation.

David Lollar asked about the kinds of training done in simulation or is it for everything. He gave an example about blood draws in different people. He struggles to find it effective in comparison to in person clinical training.

Loretta Melby spoke about clinical regulatory requirements and the use of simulation.

Garrett Chan spoke about establishing learning objectives to every course and every clinical rotation for students. He explained several situations where a student or new nurse would not want to experience

for the first time when an event happens such as decompensation, cardiac arrest, acute psychosis. When situations are critical and or high emotion, we don't want a student to figure it out when it is happening because it is unsafe for the person, nursing students and nurses. This also includes difficult conversations about death and dying. He wants to prepare the students before they get into the situation and have some background to navigate through them.

Loretta Melby explained Garrett Chan's background as CEO of HealthImpact which is part of the California Simulation Alliance and is an expert and amazing resource as chair of NEWAC. Loretta Melby gave additional context and clarification.

Jovita Dominguez, as an educator, sees the need for sim, but it should augment bedside because there's nothing to replace real life bedside true patients. She has seen the hardship created from COVID and extensive use of sim as a disservice that she doesn't want to see in the future.

Loretta Melby said this would not be a replacement of direct patient care, it would be an augmentation. There is a 500-hour requirement for direct patient care.

Alison Cormack asked if the board is possibly taking action on the draft.

Loretta Melby said the board could take action on the draft to allow board staff to work with legal and DCA's regulatory attorney.

Alison Cormack read from the draft language regarding whether an organization is accredited or endorsed as proof then the language does not apply to them, while section two is all the details.

Garrett Chan said the language is similar to the sunrise legislation that allows nationally accredited organization, prelicensure organizations to submit that accreditation or endorsement as proof they meet all the requirements set forth by the regulations. She asked what percentage of the programs are endorsed or accredited.

Garrett Chan said nine at this point, nine out of 157.

Alison Cormack asked if the psychological issue is bullying in a simulation experience because it is not in front of an actual patient.

Garrett Chan agreed that this is an issue. It was clarified that the need for this regulation is nursing students are being negatively affected during simulation and or clinical training by bullying by faculty.

Mary Fagan appreciates the discussion about psychological safety here and beyond in nursing practice. She would like this to be looked at more broadly in the future.

After Public Comment:
Garrett Chan thanked the board and Carmen Comsti for her comments and that this is a starting point. He also thanked Mary Fagan for her service.

12:06 pm **Motion:** **Mary Fagan:** Motion to ***Accept*** the recommendation of the Nursing Practice Committee to approve the NEWAC recommendations on proposed draft regulatory language for standards on simulation in clinical education and authorize Board staff to initiate drafting regulatory language for revisions and/or additions to California Code of Regulations (CCR), title 16, Article 3 Prelicensure Nursing Programs

Second: **Jovita Dominguez**

Public Comment for Agenda Item 7.2: Marie Gilbert: Agreed with Mary Fagan about the discussion. She is the director at the Central California Center for Excellence in Nursing and a certified simulation educator since 2006. She said there is evidence that the sim community is becoming increasingly concerned regarding the psychological safety of students in sim experiences and as sim expands in prelicensure nursing there is a concurrent rise for potential of inadequately trained educators to inadvertently and unintentionally traumatize students. She does not think its intentional but that they don't know any better. Studies have found that untrained simulation educators often believe that students will perform well without pre-briefing. There's a belief that they need a sense of reality so they may stray a bit from the objectives and that has been shown to be harmful for students. They hope the recommendations and how things are now with health care standards and best practice and a simulation code of ethics would be sufficient to ensure high quality simulations experiences. However, they're seeing things currently stand today that isn't occurring and she thanks the board for getting the schools accountable to follow simulation best practices because it not only keeps students safe but promotes their learning experiences so they reach their full potential.

Charlotte: Explained thatshe's a nurse instructor at a university in California. She does sim and is in OB. She is saddened to hear pre-

conferences and debriefings are not being done and is important in the learning process. She said making someone feel bad or foolish about decision making or judgment is highly discouraged. They focus on strengths as well as weaknesses that could be improved. What do they need to work on is where real learning takes place.

Judy Corless: Stated that she appreciates the presentation and stays in touch with former board member Jeanine Graves and is excited to see the new standards. She is shocked at the trauma students are having.

Lawson: Said she was a faculty for 13 years and director a nursing program. She wants to know what's being done to hold schools that are not BRN accredited accountable as they're using a lot of simulation.

Loretta Melbysaid all schools are BRN approved, not accredited. Accreditation is different than board approval. If a school is not in compliance the BRN can help to bring them back in compliance and they can come before the board.

Carmen Comsti, California Nurses Association (CNA) NEWAC Member): Stated that she wanted to emphasize EO Melby the role of simulation standards adopted by BRN through regulation or non-regulatory guidance should ensure the BRN and NECs can identify any issues with simulation and the experience nursing students are experiencing to be able to act flexibly to correct any problems or concerns found with simulatioand that those can being addressed. This is a draft and starting point for discussion of what standards should or should not be adopted by BRN.

No additional public comment from the Sacramento location.

Vote:

Vote:	**DT**	**MF**	**JD**	**PW**	**DL**	**VG**	**AC**	**NP**
	Y	Y	Y	Y	Y	Y	Y	Y
	Key: Yes: Y | No: N | Abstain: A | Absent for Vote: AB							

Motion Passed

Lunch Break from 12:22 – 1:30 p.m.
Quorum re-established at 1:31 p.m.

1:31 p.m. **7.3** **Discussion and possible action:** Regarding the NPAC and NMAC recommendations on proposed draft regulatory language to amend the Recommended Guidelines for Disciplinary Orders and Conditions of Probation

Board Discussion: Alison Cormack is interested in the financial relationship option for E3.

Loretta Melby explained the discussion in NMAC and NPAC about the financial aspect and whether or not it should be allowed. If the financial relationship is prohibited the supervisor would have to perform services for free and without any type of compensation.

Alison Cormack asked about person-to-person communication and the method.

Loretta Melby said home health nurses have telephone or telecommunication contact with the person providing supervision. It could also be some type of video conferencing technology depending on internet service. It does not mean face to face in person but not texting.

Public Comment for Agenda Item 7.3: No public comment on WebEx or at the Sacramento location.

Motion: **Mary Fagan**: Motion to *Accept* the recommendation of the Nursing Practice Committee to approve the NPAC and NMAC recommendations on proposed draft regulatory language to amend the Recommended Guidelines for Disciplinary Orders and Conditions of Probation and authorize Board staff to initiate drafting regulatory language for revisions and/or additions to California Code of Regulations (CCR), title 16, Article 4 Grounds for Discipline, Disciplinary Proceedings and Rehabilitation

Second: **Dolores Trujillo**

Vote:

	DT	MF	JD	PW	DL	VG	AC	NP
Vote:	Y	Y	Y	Y	Y	Y	Y	Y
	Key: Yes: Y | No: N | Abstain: A | Absent for Vote: AB							

Motion Passed

1:45 p.m. **7.4** **Information only:** Overview of Certified Registered Nurse Anesthetist (CRNA) scope of practice and oversight

Board Discussion: No comments or questions.

Public Comment for Agenda Item 7.4: Melanie Rowe, CRNA Practice Director – She spoke about the requirements to become a CRNA to include board certification that requires the Doctorate degree. CRNAs are the sole providers in the military and rural areas. Their education prepares them to deliver high quality and safe care independently. Nilu Patel asked for a brief history of where CRNAs come from. Nurse anesthesiology was the first profession to own the responsibility of anesthesia dating back over 150 years at the Mayo Clinic. In 1931, CRNA was formed. In 1936, the first court case of a physician charging the nurse was practicing medicine and the court affirmed she was not and was carrying out the orders of the surgeon. Over the last 40 years, multiple state agencies support the practice of CRNAs, including BRN, who has requested and provided legal opinions to clarify CRNA practice. Nilu Patel asked about specific training and things done with physician colleagues in the operating room treating hemorrhage situations, trauma, obstetrics, and such. Ms. Rowe said CRNAs use the same textbooks and medications that cover all parts of anesthesia. She explained various ways CRNAs can assist during patient treatment.

Loretta Melby provided additional comments regarding CRNAs.

Mary Fagan asked if California presents similarly to other states relative to CRNAs. Nilu Patel said Texas and Florida have similar numbers to California.

Ms. Rowe said Texas and Florida are larger. She said California is usually in the top five or six in the nation. Loretta Melby said there are about 13-14% in California and gave stats for midwives, Nurse Practitioners, and clinical nurse specialists.

Nilu Patel provided more information about the numbers who are members of the national associations which is equivalent to anesthesiologists. She also said there are not enough CRNAs.

Loretta Melby spoke about schools and the BRN does not approve them.

Ms. Rowe continued and said there are five CRNA programs and they strive to keep their graduates in California. She said the programs in California attract students from all over the nation.

2:06 p.m. **8.0** **Report of the Education/Licensing Committee (ELC)**

8.1 Discussion and possible action regarding ELC recommendations on agenda items

Note: *Items 8.1.1 – 8.4 were discussed in the ELC meeting held on April 18, 2024; these were treated as consent agenda items. Agenda items within 8.5 were presented to the full board for consideration.*

8.1.1 Discussion and possible action regarding board approval of ELC recommendation to approve minor curriculum revisions (16 CCR § 1426), acknowledge program progress reports (16 CCR § 1423), and accept clinical facility approvals (16 CCR § 1427) Schools under consideration are identified in meeting materials within the tables

ELC Vote: J. Dominguez – Yes; M. Fagan – Yes; D. Trujillo – Yes; P. Wynne – Yes

8.1.2 Discussion and possible action regarding board approval of ELC recommendations to grant:

Continuing approval of prelicensure nursing programs (BPC § 2788; 16 CCR §§ 1421 & 1423)
California State University Northridge Baccalaureate Degree Nursing Program
Loma Linda University Baccalaureate Degree Nursing Program
Bakersfield College Associate Degree Nursing Program
College of the Desert Associate Degree Nursing Program
San Bernardino Valley College Associate Degree Nursing Program

Continuing approval of an advanced practice (nurse practitioner) nursing program (BPC § 2788; 16 CCR § 1483.1)
Loma Linda University Nurse Practitioner Program
San Francisco State University Nurse Practitioner Program

Approval of prelicensure nursing program curriculum unit adjustment or other changes (16 CCR § 1426)
Westmont College Baccalaureate Degree Nursing Program
College of San Mateo Associate Degree Nursing Program
College of the Redwoods Associate Degree Nursing Program

ELC Vote: J. Dominguez – Yes; M. Fagan – Yes; D. Trujillo – Yes; P. Wynne – Yes

8.2 Discussion and possible action regarding board approval of ELC recommendations to defer taking action on the continuing approval status of Copper Mountain College Associate Degree Nursing program while they work to clear the areas of non-

compliance, with quarterly reports to the NEC, and return to ELC/Board in one year (April/May 2025) (BPC § 2788; 16 CCR § 1423)

ELC Vote: J. Dominguez – Yes; M. Fagan – Yes; D. Trujillo – Yes; P. Wynne – Yes

8.3 Discussion and possible action regarding board approval of ELC recommendations to accept the substantive change requests (16 CCR § 1432) for:

8.3.1 Samuel Merritt University Baccalaureate Degree Nursing Program (feasibility study for alternate campus in Fresno, CA) State

8.3.2 Loma Linda University Baccalaureate Degree Nursing Program (enrollment increase)

8.3.3 Mount San Jacinto Associate Degree Nursing Program (enrollment increase)

8.3.4 Monterey Peninsula Associate Degree Nursing Program (enrollment increase)

8.3.5 Los Medanos Associate Degree Nursing Program

8.3.6 College of Marin Associate Degree Nursing Program (enrollment increase)

8.3.7 College of Redwoods Associate Degree Nursing Program (enrollment increase)

8.3.8 University of Massachusetts Global Nurse Practitioner program (teach out and closure)

ELC Vote: J. Dominguez – Yes; M. Fagan – Yes; D. Trujillo – Yes; P. Wynne – Yes

8.4 Discussion and possible action regarding board approval of ELC recommendation to accept the initial self-study to grant initial approval for the new prelicensure program requested by California Northstate University for a Baccalaureate Degree Nursing Program (BPC § 2788; 16 CCR § 1421)

ELC Vote: J. Dominguez – Yes; M. Fagan – Yes; D. Trujillo – Yes; P. Wynne – Yes

Board Discussion: No board questions or comments.

Motion: **Jovita Dominguez**: Accept the recommendations of the Education and Licensing Committee for agenda items 8.1.1 through 8.4 with the curriculum change for California Baptist.

Second: **Vicki Granowitz**

Public Comment for Agenda Item 8.1 - 8.4 No public comment on WebEx or at the Sacramento location.

Vote:

Vote:	DT	MF	JD	PW	DL	VG	AC	NP
	Y	Y	Y	Y	Y	Y	Y	Y
	Key: Yes: Y | No: N | Abstain: A | Absent for Vote: AB							

Motion Passed

2:12 p.m. **8.5 Discussion and possible action regarding acceptance of substantive changes to an approved program (BPC § 2788; 16 CCR § 1432)**

8.5.1 Marsha Fuerst School of Nursing Associate Degree Nursing Program (feasibility for an alternate campus in Citrus Heights, CA)

Board Discussion: Dolores Trujillo is curious about the information from the twelve nursing programs.

Gloria Blatti said she heard from nine of the programs that are impacted but spoke about different innovative ways they could work together to try to resolve this. She said there is a great demand for student slots and so many applicants are being turned away. There is good collaboration and two groups that meet, a psych mental health and a consortium. It is important that they do both. She's gone to one site, but the consortium has not met yet. The area is somewhat clinically impacted for different reasons but they're willing to talk and look at the different things they're doing in southern California for northern California. She did agree the area is impacted for various reasons including nurses leaving the area, new nurses coming into the clinical sites, and low census which was all discussed with the various facilities.

Dolores Trujillo asked for a couple of the innovative suggestions that were suggested.

Gloria Blatti said they have a regional person who helps with placement and knows CCPS very well to get ideas to get the clinicals.

She said they went to their programs and looked at what spots were left, including nights and weekends and other vacancies but the facilities said they could be low on staff or patients. She pointed out that there are a lot of what if's but there are 74% of qualified applicants who are turned away from nursing programs. She said they spoke about the model they have at Adventist Glendale. She said the group was thinking about this model recently but has never been able to get it. Ms. Blatti said she would be happy to help them with it. She explained the success of it and how the hospital hired half their nurses because the facility got to know them over the entirety of the program which saves money on orientation. She said they were the main education partner during their magnet status and met with magnet who were very impresses with what they were able to do. She said it wasn't easy and took time. She talked a lot with the community colleges about how they could try to work something like that out and they said they would work with her if Marsha Fuerst came up and she agreed. She gave them all the data that was asked for. She said they are still impacted in LA but they don't take people's sites and they don't pay for them either. She works with the hospitals and schools. She gave them her commitment.

Loretta Melby spoke about applicants versus applications.

Gloria Blatti added that she spoke with one of the UC's who is also very tight right now and did not request anything from them because she understands. She only took spots that were open and available. She said the conversations took about three weeks trying to get people on the phone.

Patricia Wynne appreciates the work done before coming to the committee. The proposal is kind of a non-starter in terms of adding a lot more students into a heavily impacted area. She appreciates the pivoting and efforts to approach the twelve other nursing programs and hearing your attitude towards working together to use leftover slots. She appreciates Gloria Blatti for taking the concerns to heart. Patricia Wynne asked about the Riverside location that was approved a little over a year ago.

Gloria Blatti said their first nursing class is in with 31 students who are at the four-week mark in fundamentals and pharmacology. They are doing very well. Many came from their feeder LVN schools while the rest in the usual manner. Regular students come in with their general ed requirements and take their science pre-reqs with them. They just built a new building which is beautiful.

Vicki Granowitz said she feels like a broken record when she speaks about programs going into impacted areas and saying they will not take any slots from anyone but there are no assurances, and they are seeing programs closed. She knows we need more nurses and keeps hearing that they're in the pipeline. Hearing that programs want to expand or be created is not logical to her except that they're for-profit schools wanting to make money. She does not understand why the board considers programs in impacted areas. She said the applicant said they came up with creative solutions but didn't hear one specific solution. She said Ms. Blatti mentioned things that have been heard before such as nights and weekends, but the board is aware of these ideas. She is not persuaded by the information.

Gloria Blatti spoke up about their Glendale location that took a lot of work and effort and wasn't the same as what everybody else does. She said the students are interviewed from the very beginning by facility and their staffs. A group of students were picked based on who the facility would like to work with to see how they worked out. All clinicals except pediatrics was done in the same facility. By the time the students got to the final semester the facility would make a decision whether to interview them and about 90% were hired by the hospital. They're in the process of writing a paper because they have less orientation and travelers and has been quite successful. She did not expect it to be as successful as it is.

Vicki Granowitz said she wanted to hear about impaction and not about a program that worked someplace else or maybe didn't work is not helpful to her. She is sure Ms. Blatti does a wonderful job and does not need to be persuaded on that point.

Gloria Blatti said she wanted to provide a specific example about a program that was implemented.

Alison Cormack said she's starting to develop a specialty in reconciling past NCLEX pass rates. She's trying to reconcile the number the applicant provides on page 128 which is a seven year average above 90 with a pass rate last year of 94.44 with the data provided by staff on page 123 which shows the most recent pass rate of 85.16. She asked for clarification of the scores.

Gloria Blatti provided additional context and rationale for her data and ended with most recent score of 92.2%.

Mary Ann McCarthy explained that NECs use published annual NCLEX rates and does not include 23/24 because it is not released until later this year. The last year would be 22/23.

Alison Cormack said she does not understand where 94% comes from and says she'll use the numbers from page 123 and says she's concerned about the 21% attrition rates. She asked Ms. Blatti to address this.

Gloria Blatti said the attrition is quite high and had discussed it the last time. She said they give a lot of people who might not have had a chance to come into their program and many turn out to be wonderful nurses, but life happens, some are single mothers with children at home and cannot get through the program. Some take a leave of absence or return at a later time when they have more support at home. They allow a 2.7 GPA and ATI score of 60 while others require 80-90. They give a lot of chances to students who may not be able to gain admission elsewhere and they're grateful.

Alison Cormack asked about additional resources to assist students who struggle and if they have sufficient resources.

Gloria Blatti said they have various types of tutoring and book resources. They work with students to be successful to be able to move on and finish their degree. She also said the 94% is from the most recent quarter.

Alison Cormack says it is not clear in the materials but appreciates the clarification. She explained the board uses the annual rate and not quarterly rate. Alison Cormack asked Mary Ann McCarthy if there are sufficient clinical placements for this school. She spoke about Kaiser in southern California but does not see that same relationship with northern California Kaiser. Because Kaiser is two different companies in the state, she does not see how its replicable. She doesn't think there are enough clinical sites, and it may be too early to tell or have a definitive answer. Alison Cormack continued that she missed this information at ELC and would have asked for it at board and would have resulted in the school being taken off the board meeting agenda. She explained the situation with Samuel Merritt who said they would not be able to get specific information in the month between committee and board and they were then scheduled for the next board meeting which was four months away. Then they came back with support from the consortium and the community. She spoke about the program reaching out to twelve with nine responses being fantastic but there are still three that are missing a response which may never come. She said a lot of work was needed in three weeks which was acknowledged by Ms. Blatti but it may not have been enough time for the public to respond appropriately. She said some program directors were unable to attend and or submit a letter so

there may still be some public that needs to be heard from and considered. She would be more comfortable deferring this until the information the applicant provided verbally is documented in a format the public and board can review.

David Lollar asked how the attrition rate compares to other schools. He did say this program has different admissions criteria than Title 5 that community colleges have to follow which is very prescriptive. He said that if the program accepts different students, then the program needs additional resources to help them be successful. The other issues he's concerned with is completion data or attrition data for recently approved locations or expansions. He spoke about program enrollment increases that been deferred recently asked them to return after they receive new NCLEX pass rates. There is a regulation for 75% NCLEX pass rate cutoff but nothing for attrition. There is a mention in the sunrise bill that says attrition can be considered for enrollment growth. Adding a new campus is enrollment growth so the board can look at attrition trends to see if they're going up. The board can look at NCLEX trends, even if they are not at the floor, they can be trending downwards which might mean the school is at risk and you may not want to grow now. The program may need time to settle to see they are not at risk. A data point he considers is the California Community College growth initiative that looks at a 16% attrition rate or higher is not going to grow while any school less than 16% could be considered for growth. The board doesn't have any regulation or law that states a cutoff.

Gloria Blatti asked if Mitchell Furest could be elevated and Loretta Melby answered in the affirmative.

Jovita Domingquez asked how many students leave with a hardship and do not go through full matriculation. Asked if the fact thaey take on risky students and if there is concern about the program cost of $79,000. Stated that it would be helpful these were documented for consideration.

Mitchell Fuerst said he's been listening to the dialogue and said the Fuerst School of nursing has a proven track record going back many years of graduating competent, caring, and safe nurses that pass the boards. He said the board is looking at one snapshot in time of retention. If you look over a long-protracted period of many years graduating students, this is outside the scope of the review at hand and he doesn't think is relevant to the situation of their expansion request. They are looking to go to northern California which the BRN has identified as a shortage for nursing. He said they have many clinical affiliations already in northern California that believe in the

Fuerst School of Nursing. He said they have the EDP-P-18s which is a commitment from the clinical sites that they would support their program. He's surprised by the dialogue because they have a proven track record and one metric that is being looked at is a snapshot that the board may think is too high even though the board member spoke about the risky population admitted. They take pride and celebrate those students they are able to train and graduate who make safe, competent, and caring nurses. This population in many cases are minority students they are giving the opportunity to become qualified nurses. He said they've been around for 57 years and training RNs for a long time. They have a proven track record for this feasibility study and have more hurdles now to go over. He would appreciate the board's support and confidence in their institution because they've spent a lot of time developing the clinical relationships and planning and allocating a lot of resources to provide nurses in northern California that are needed for healthcare.

Loretta Melby said Business and Professions Code section 2786.2 speaks of clinical placements, verified complaints from students, faculty or other interested parties, licensing exam pass rates, graduation rates, and retention rates. The information being considered by the board is within their purview and is strictly outlined in law that they consider those items. The board shall not consider the nursing workforce issues, including those identified under section 2717 as factors. She said the school administrator mentioned a workforce need in the area which is accurate, but the board cannot take that into consideration when looking at this request for a new campus and enrollment increase.

David Lollar said he agrees with Member Cormack's suggestion to defer until there is more data if that's necessary because he is not sure which way he wants to vote on this and would like additional consideration of Member Granowitz's comment as a counter argument. He speaks about a board meeting with a school who wanted to increase enrollment by 1,000 students. He said someone was able to gaslight the board about this very impacted LA county area. He doesn't know if it impacted matters or not and is unsure what the answer is. He needs to hear more about this because he doesn't know what to do about this school today.

Alison Cormack said she would like to be able to approve this and thinks it could eventually. She does not feel there is the same quantity and caliber of data in this application as they've had with prior ones. She said EO Melby said the board could defer this to have the opportunity to see information that was presented orally documented. She encourages the applicant to carefully review other successful

applications that are public information and include more information to support students with challenges than tutoring. They can also ensure all numbers are accurate including attrition which EO Melby said could be considered by the board when making a decision.

After most Public Comments:
Mitchell Fuerst said he knows Jackie very well and said she's very supportive of their program because they know how innovative they are. He said the EDP-P-18s are very specific in the information requested and doesn't know what more can be provided to support their clinical placements and that they do not displace any other programs. He wants their program to be treated fairly. Loretta Melby read CCR section 1421 which states the requirements regarding clinical placements. She explained that it wasn't a question of number of clinical placements but whether or not they would displace any existing programs. She said there has been confusion with the data asked for on the EDP-P-18 and what has been reported by clinical facilities.

Mary Fagan after Sergey Karsachian public comment. She said the school had the information already and is surprised to hear the contact to other schools was so quick. She understands it takes time to gather the information the board needs and is unsure the information received is accurate.

Motion: **Alison Cormack:** Defer consideration of this application for an alternate campus to a future board meeting. (Defer this to a future board meeting to add data to include: NCLEX data tied to official published rates, more information about support services for students, specific documentation to show clinical placements at each location.)

Loretta Melby cited CCR section 1432 under substantive change for a new campus location along with section 1421 speaking about form EDP-I-01 which must be completed in the feasibility. She referenced section E which speaks about support areas including faculty and resources. The school needs more robust information. NCLEX information for the past five years along with other data required on the form. This will give the program an additional three months to provide complete and full documentation to the board for their consideration at the August board meeting to make the right decision.

Second: **Jovita Dominguez**

Public Comment for Agenda Item 8.5.1:

Baylor Meza, COO Marsha Fuerst School of Nursing: He wanted to reassure the board that he has an email saying it did not need all of the information that is being asked for now because they applied in the middle of the regulation change and in limbo as to what is needed to apply. He will include the email for the future board meeting. He would like to know what the definition of impaction means – whether it is perceived or actual impaction. He said they have an established track record and if they took any slots from any other program then they would pull out. He asks the board to consider the definition.

Loretta Melby agreed there was a law change and regulatory update and a few programs who applied for enrollment increases. She pointed the board members to the data dashboard on the BRNs website.

Mary Ann McCarthy said the program submitted 11 I-01s to their assigned NEC with EDP-P-18s for sites signed off as being available for clinical.

Kimberly Dunker, Pacific Union College: She said she was surprised that Adventist Health is a facility who accepted these students since they have a long-standing relationship and several MOUs with them. She contacted her person at Adventist and that person had no idea what was going on. She appreciates the Board's due diligence in looking at the information from this program. She said the EDP-P-18s are a problem because the people filling them out do not understand what displacement means.

Jennifer Miller, Assistant Dean for Willem Jessep University: She said they are a relatively new BSN program approved three years ago. She spoke about the EDP-P-18 and said they had all of them signed but they have not been able to get any students approved to attend clinicals at their facility. She has had to work really hard to go out and find additional clinical placements for her students even on weekends and evenings when the facilities have said they don't have much support to have students.

Ann Stoltz, Director of University of the Pacific: Also a fairly new program. (difficult to hear her comments from cell phone, Loretta Melby asked to try calling again)

Dolores Trujillo asked to give Ann Stoltz an additional opportunity to make a comment if she is able to do so.

Ann Stoltz: At the last second director's meeting she was very surprised at the way they were asked for information from the school.

She said that the director's as a group said they did not support them because they are impacted. They are having to cut back their hours to accommodate the growth with the existing programs. She asked if they would get the kind of quality clinicals needed in each area. Loretta Melby said possible future growth of existing schools cannot be considered in decision making.

Sergey Kasachian: Chief Compliance Officer, Marsha Fuerst – Retention rate is above the national accreditors benchmark. They are accredited by Bureau of Health Education Schools. He said they offer support to students including tutors. He serves on the Adventist Health Foundation board, and they work with them because of their innovative partnership. Loretta Melby said accreditation standards are national and not California specific. She explained the completion rates to determine attrition rates.

No additional public comments in the Sacramento location.

Vote:

Vote:	DT	MF	JD	PW	DL	VG	AC	NP
	Y	Y	Y	Y	Y	N	Y	Y
	Key: Yes: Y | No: N | Abstain: A | Absent for Vote: AB							

Motion Passed

3:31 p.m.

8.5.2 Samuel Merritt University Baccalaureate Degree Nursing Program (self-study for an alternate campus in Fresno, CA)

Board Discussion: Alison Cormack said she's trying to reconcile the data from page 136 to 142.

Loretta Melby said the data is provided by the NEC and PearsonVue on the Agenda Item Summary.

Alison Cormack said there is a discrepancy of 90 versus 84 in 2021. She also said the attrition rates on page 142 are far below the average on the dashboard. But they are much more in the range of appropriate.

Loretta Melby said she'll work with the NECs on the data.

Jovita Dominguez asked Mary Ann McCarthy if this school spoke with the consortium.

Mary Ann McCarthy said they came forward in January and February and they were sent back to contact the consortiums and to contact programs in the area. The program was given time to go gather the

additional information. They did the feasibility report and now they're back for the self-study.

Loretta Melby said it took about three to four months to come back to the board for consideration.

Alison Cormack said the NCLEX pass rates are on a declining path but above the 75%.

Dr. Steven Rush, Dean of College of Nursing at Samuel Merritt, explainedthere arealways dips and rises in pass rates and EO Melby explained it well. He said the pass rates are on the incline for this year and they pride themselves on their pass rates.

Alison Cormack asked if the program sees the scores being in the 90's

Dr. Rush answered if the affirmative.

After Board Vote:
Dr. Steven Rush thanked NEC, Kimberly Knight, who was very patient. He was a Nursing Board Member in another state and thanks the Board for their consideration.

Motion: **Jovita Dominguez**: Motion to approve the substantive change(s) requested by an approved program and Approve the initial self-study for an alternative campus in Fresno, CA for Samuel Merritt University Baccalaureate Degree Nursing Program with an enrollment pattern of 48 students twice a year.

Second: **David Lollar**

3:42 p.m. **Public Comment for Agenda Item 8.5:** No public comment on WebEx or at the Sacramento location.

Vote:

Vote:	DT	MF	JD	PW	DL	VG	AC	NP
	Y	Y	Y	Y	Y	Y	Y	Y
	Key: Yes: Y | No: N | Abstain: A | Absent for Vote: AB							

Motion Passed

3:44 p.m. **8.6 Information only: NCLEX update**

8.7 Information only: Licensing update

Board Discussion: Alison Cormack noted the average NCLEX pass rate is 94.2 and something to keep in mind. She can see the endorsement applications are dropping off as expected and it's helpful to see the data on a regular basis and appreciates it.

Public Comment for Agenda Item 8.6 and 8.7: No public comment on WebEx or at the Sacramento location.

Break from 3:48 – 4:00 pm
Quorum re-established at 4:00 pm

4:00 p.m. **9.0** **Report of the Enforcement/Intervention Committee (EIC)**
Reza Pejuhesh discussed the agenda for the meeting with one hour remaining. He said 9.1 and 9.2 will be discussed. The presentation and discussion for 9.3 (9.3.1 and 9.3.2) will be done tomorrow morning so members of the public who have been holding are aware. Public comment will be taken on those agenda items today for anyone if they want to speak today.

4:03 p.m. **9.1** **Information only:** Enforcement and Investigation update

Board Discussion: Patricia Wynne asked if the number of cases per investigator at 22 at 42 for probation was where they should be.

Shannon Johnson said yes and explained staff had been requested previously to reduce the numbers.

Alison Cormack said she's excited about the probation video to educate the public. She appreciates the graphs on page 10.

Loretta Melby said the investigator caseload was previously set at 20 and the auditor came in and surveyed staff to raise the caseload to 30. They are working with DCA and other health care boards to see if this is reasonable.

Vicki Granowitz discussed decisions for DUIs where some are 35 months and others are 36. She wanted to know if the circumstances are taken into consideration because it doesn't make sense to her.

Shannon Johnson said they do. She explained what each of the decisions means for a nurse to petition the board for early termination of probation.

Vicki Granowitz said she understands that part of the process but does not understand staff reasoning as to why each decision is either

35 or 36 months based on the circumstances. She has decided to hold them for discussion because they don't seem to be consistent.

Shannon Johnson said they could develop training for the board members.

Vicki Granowitz said if the information is up front in the materials it might be more helpful.

Shannon Johnson said there are several Deputy Attorneys General and there is a format they are supposed to follow.

Patricia Wynne said proposed decisions are in a different format than stipulated decisions.

Reza Pejuhesh wondered the same thing. He said the proposed decision is in a different format than a stipulated decision. A summary cannot be added to a proposed decision.

Shannon Johnson asked for more specific information to help figure out what training is needed.

Vicki Granowitz said there are different levels of information about the respondent.

Patricia Wynne agreed that training is a great idea.

Mary Fagan asked about the expert consultant positions. She asked about the 10 years of experience with 5 years clinical and whether it was decided by BRN and whether it might be shortened.

Shannon Johnson said the Attorney General (AG) came up with the time frame for witness credibility purposes. The AG must be able to ensure the expert has enough experience in the field.

Mary Fagan thought the time frame was 10 licensed with 5 clinical.

Loretta Melby read the requirements for an expert practice consultant.

Mary Fagan said she thought she saw a report from someone she knows as an administrator and opined on a practice case, which could be a one-off situation.

Public Comment for Agenda Item 9.1:

Matthew: Said Ms. Johnson spoke about an attorney general report provided to the board members about investigations and asked if there is an equivalent report for the diversion program.

Chris Else, Nursing Supoort Group Facilitator: Thanked Shannon Johnson for the recent training since it has been a number of years since the last training. It was very informative and appreciated. He asked if the board members could attend the nurse support groups because Lorraine Clark attended in 2015 on a regular basis. Loretta Melby said Lorraine is board staff and not a board member who needs to maintain a buffer between themselves and licensees they may make discipline decisions for. Reza also made the differentiation of board staff and members. Commenter said at a January meeting the board members said they were interested in attending a NSG meeting and he wanted to provide the invitation to them.

Loretta Melby pointed the commenter to agenda item 5.4 that delineates the layers of the organization.

Reza Pejuhesh provided additional context and clarified why the board members cannot have direct contact with licensees who may come before the board for a disciplinary action.

Scott Sukow – Said he has comments for agenda item 10. Reza said comments for that agenda item will need to wait until tomorrow.

No additional public comments in the Sacramento location.

4:37 p.m.

9.2 Discussion and possible action: Appointment of Intervention Evaluation Committee (IEC) members

Name	Member Type	IEC	Appointment Type	Term Expiration
Scott Guenter	Nurse	7	Reappointment	06/30/2028
David Liu	Physician	9	Reappointment	06/30/2028
Julius Musenze	Physician	10	Reappointment	06/30/2028

Board Discussion: No comments or questions.

Motion: **Patricia Wynne:** Motion to Accept appointment of Intervention Evaluation Committee members

Second: **Alison Cormack**

Public Comment for Agenda Item 9.2: No public comment on WebEx or at the Sacramento location.

Vote:

Vote:	DT	MF	PW	DL	VG	AC	NP	JD
	Y	Y	Y	Y	Y	Y	Y	Y
	Key: Yes: Y | No: N | Abstain: A | Absent for Vote: AB							

Motion Passed

4:42 p.m.

9.3 Information only: Presentation of the Intervention Program (IP) (contracted program vendor; general requirements; legislation, regulations, and Uniform Standards governing the IP; recovery agreements; IEC member appointment, terms, responsibilities, and training; difference between IP and probation; etc.)

Public comment was taken on 9.3, 9.3.1, and 9.3.2 on May 23, 2024, while the agenda items will be presented on May 24, 2024.

Public Comment for Agenda Item 9.3.1: May 23, 2024 –
Sacramento Commenter: She's strongly encouraging the board to not approve this item. Many nurses that enter the program have never worked in patient care. They come from all types of patient nursing. So to make the requirement to do so now is punitive. When participants are granted return to work privileges is a slow progression and usually in non-patient care. Case management calls under advice nurse, they like the regular hours and less stress. Ageism is alive and well and if a person has never worked in patient care and all of a sudden must now do so is a recipe for failure. I served on IEC 1 and ended June 2023. I watched the program work as it saved careers, marriages, relationships with children, all while protecting the public and sending safe recovered nurses back into the workplace. However, her last year of service was challenging and frustrating. Suddenly Bagley-Keene seemed more important than trying to guide a recovery nurse through the program. Many changes were implemented. As consultants, our input was stifled, and you could only speak through the chair. She felt and expressed this. (Time Ended)

Reza Pejuhesh reminds commenters that if they are Intervention Program participants do not need to identify themselves as the program is confidential. There is no obligation to identify yourself if you are a participant because you may waive some confidentiality if you choose to do so and comments can be made anonymously.

Dr. Carol Stanford: She worked for the BRN for over 20 years in enforcement and intervention program and said she loves the BRN. She understands what is being done and she cares about the RNs. She said the previous commenter also worked for the BRN before she became a committee member. She is on the IEC committee and is working with whatever she can to enhance the program. She said there was a subcommittee for the discipline committee that met twice a year, once in north and once in south, which could have alleviated many of the issues today. The Executive Officer would attend, DCA Legal would attend, each IEC chairperson attended, with a non-nurse from the north and south, and a representative from the Nurse Support Group Facilitators. She appreciated the board wanting to hear from the stakeholders because it is important. (Time Ended)

Clara: She's a participant in the diversion program and also works in education. She wants to know why these changes are being proposed as far as patient care and narcotic access. Everything in nursing is evidence-based practice. She would like to know what data is being used as to why these new requirements are being considered being enforced. She needs that question answered. There is a financial hardship of trying to remain in the program and causes nurses who realize they have a problem to not come forward and seek help not because of punitive actions but because they're worried, they'll lose their job, reputation. She's been told patient care and narcotic access will not be granted at the same time, so she'll have to job hop which is impractical. Once done with program requirements she'll then have to find another job. Her offense had nothing to do with narcotics, so she doesn't understand.

Yolanda Tominac: She successfully completed the program in 2016. She was a NSGF since 2017. She could tell participants what they could expect and how to move forward to successfully complete the program. It has been completely demeaning and has deteriorated the nurses. She was able to maintain one job while completing the program but now the nurses in the program cannot. This seems to be very punitive and run much more like probation. She is very angry and does not feel this is fair to participants.

Tony: She asked about the contract between BRN and Maximus ending at the end of this year. This is more uncertainty for participants on top of everything else. For those participants who should have completed before all this happened, they don't know how they move forward if they can't find jobs by the end of the year. She asked if there are any contingency plans being made for this. She said the board has discussed psychological trauma today but what about them

and how they're being treated. Most of the participants have done what is being asked and then the goal posts changed and there still is no clarity of when they can complete. She hopes to hear what BRN's plan is to navigate through this.

Loretta Melby said the items tomorrow will address these issues. She explained the contract process.

Reza Pejuhesh further provided context regarding the competitive bidding process for the intervention program contract. He said for those in the program they will continue to be in the program next year. Tony said she hopes to have her last Diversion Evaluation Committee meeting at the end of the year so she asked if she would have to continue into next year.

Reza Pejuhesh said those who are in the program will continue in a BRN intervention program without disruption.

Loretta Melby said the contract process does not change any participants status in the program.

Tony said she's fulfilled most of the requirements of her contract.

Anonymous California: Stated that a board member made the comment that she is pleased that there will be a discussion on the gravity of the nurse practice act in regard to enforcement and diversion program. The person would like it to be noted that passive aggressive comments implying nurses in diversion program don't appreciate the gravity. They stated that they feel that making comments such as this show there is a bias against nurses in diversion or probation based on the actions of nurses who are in an ADA protected class.

5:10 p.m. **12.0** **Recess to May 24, 2024**

- Dolores Trujillo, President, recessed the meeting at 5:10 p.m.

Friday, May 24, 2024 – 9:00 a.m. Board Meeting

9:00 a.m. **1.0** **Call to Order/Roll Call/Establishment of a Quorum**

Dolores Trujillo, RN, President, called the meeting to order at: 9:00 a.m. All members present. Quorum was established at 9:02 a.m.

Board Members: Dolores Trujillo, RN – President
Mary Fagan, PhD, RN, NEA-BC-Vice President

Alison Cormack
Jovita Dominguez, BSN, RN
Vicki Granowitz
Roi David Lollar
Patricia “Tricia” Wynne, Esq.
Nilu Patel

BRN Staff: Loretta (Lori) Melby, RN, MSN – Executive Officer
Reza Pejuhesh – DCA Legal Attorney

9:02 a.m. **9.3** **Information only:** Presentation of the Intervention Program (IP) (contracted program vendor; general requirements; legislation, regulations, and Uniform Standards governing the IP; recovery agreements; IEC member appointment, terms, responsibilities, and training; difference between IP and probation; etc.)

Board Discussion: Alison Cormack said it's very helpful to get this level of detail because the intervention program is confidential and in the almost one year she’s been on the board, she has gotten very little information and, she appreciates learning more. She said one of the things she talks about a lot is metrics and time about how long it takes from the slide where there's a phone intake until the first IEC meeting.

Shannon Johnson said they try to identify the importance of getting them before an IEC. Participants are assigned to a specific IEC, but if that IEC is not meeting for three months because they typically meet about once every quarter, if that IEC is not meeting, we try to get them to the next IEC regardless if that will be their permanent IEC to review the initial documents and make a decision on whether they're going to be accepted into the program because we want to get them started in their recovery process, not just that pre entry phase. It could take anywhere from a few weeks up to three months. It's how often they meet because we haven't called an emergency IEC meeting yet because there are several, nine IECs, and they meet on a quarterly basis. There are 36 meetings throughout the year and there's usually at least one per month.

Alison Cormack asked if that seems like an appropriate length of time for someone who is asking for treatment. She said as a member of the public, getting help can be hard. This is why people are sent to ERs when that's not the greatest option for everyone. She would like to know if the board is happy with this. Is this the right length of time for someone who is asking for help and does staff track the amount of time? Because she’s not hearing an answer that it’s being tracked.

Shannon Johnson said it is tracked because most program participants in the intervention program come in through a complaint from the board. Data for RNs who go into the program is tracked: the date contact is made, the first initial intake date, the clinical diagnostic evaluation date, and for some people, we need to wait on that clinical diagnostic evaluation because if they have the evaluation and it is determined by the clinician that they do not meet the requirements of the program then they may not be substance abusing. If it was a single one-time DUI and they don't feel that they're substance abusing and that they would benefit from the program, or they just don't meet those criteria. We need to make sure from that clinical diagnostic evaluation that we are applying the correct rehabilitation for starting baseline and that could take a couple weeks to get them in to see that clinician for the full assessment. This also includes the 820, when a nurse is compelled to a mental or physical evaluation through our disciplinary process. It takes at least two weeks to get them to the clinical diagnostic evaluation and staff tries to get them in within a few weeks to the IEC. That is probably the best or appropriate amount of time. In the real world it would be nice if we could get them a clinical diagnostic evaluation within 24 or 48 hours. It would be nice if we could get them before an IEC within a shorter amount of time, but it's not feasibly possible.

Alison Cormack said there are metrics, that's something perhaps when the IEC committee meets, could be a regular part of the review and the same way we look at, how long it takes for, someone to go through a license process or someone to go through formal probation. Otherwise, we're relying on folks in a confidential program to come forward and say there's a problem and that seems like a high bar. She’s sure there's some things she doesn't understand, but if this is data that is tracked that is not about who the participants are, but about how long it takes to get into the program, that seems like something we could look at.

Shannon Johnson agreed and said at the last meeting, she came before the board with identified areas that will be brought before the board for a regulation package because they've identified some areas within the regulation for change. With all of these meetings and all of these items that are coming before you, you can identify some additional issues that you would like us to come up with a regulation change.

Alison Cormack said her next question is about the cost.

Reza Pejuhesh spoke up to say he thinks staff, as far as the time frame to get folks into the program who need services is lost on them

and that shorter is always better. He wanted to draw the board members attention to Business and Professions Code section 2770.8 and staff are doing their best to be responsive and get services administered as quickly as possible but also run the program according to statutory requirements. The section that he mentioned outlines the duties and responsibilities of the Intervention Evaluation Committees. Subdivision A is to evaluate those registered nurses who request participation in the program according to the guidelines prescribed by the board and to make recommendations. Subdivision B is to review and designate those treatment services to which registered nurses in an intervention program may be referred, etc. There are a few additional subdivisions, but the first two that get the ball rolling with them, is to get before an IEC and under Bagley-Keene, which must also be followed, are making great efforts to ensure that the IECs are operating according to Bagley-Keene. There are limitations on getting participants before an IEC as Shannon said. The meetings occur so often, and they are taking steps to address that as best they can by getting an applicant in front of another IEC that might be meeting sooner rather than the one that they'll permanently be assigned to if they're admitted into the program. He wanted to add this because he heard a reference from public comment yesterday.

Alison Cormack asked how Bagley-Keene affects the agenda if a person’s name is not published and does not see the problem getting folks in front of an IEC quicker. If one of the advantages is that applicants and participants names are not published on the agenda, then a new applicant can go to a different IEC and get reviewed more quickly.

Reza Pejuhesh said IECs must abide by the same Bagley-Keene requirements as this board, as advisory committees, which means posting agenda ten days prior to a meeting, even if the agenda doesn’t identify their names. The locations must be public, even if the majority of what they do occurs in closed session without the public. There are all these formalities, so their meetings cannot meet weekly or as needed. There is technically a provision where meetings can be held more frequently, but there is a cost and there's a practical limitation to how often they can meet.

Alison Cormack said the information provided by Reza is super helpful. She formally requests that the board’s IEC committee have a meeting and discuss how many IECs there are, how many times they meet, how helpful is it for the same IEC committee to follow a participant from the beginning to the end, etc. She thinks there's some work here to do, and now is not the time to do it in an informational

setting, so hopefully the IEC committee can take some time to delve into this cause.

Alison Cormack asked what the costs of drug testing are and how often are they tested.

Shannon Johnson said costs are dictated by the uniform standard number four, the drug testing standard. In the first-year testing is 52-104 times per year. Second level is 1-2 times per week and drops down to 36-104 times. There is flexibility within the standard. If the nurse is not working, then testing can drop down to 12 times per year.

Alison Cormack asked about the phrase that the IEC makes recommendations to the program manager. She asked if the program manager is Maximus.

Shannon Johnson said Virginia Matthews is the Program Director for Maximus but the program manager is the Executive Officer, Lori Melby who has given Jaspreet Pabla, an Enforcement Deputy Chief, the authority as the Program Manager.

Patricia Wynne asked if a person could seek treatment on their own outside of the program.

Shannon Johnson said they could. She also said if the person is in distress and needs emergency help, we help direct them to residential treatment. Maximus has a 24-hour line and if someone needs emergency services they are directed to where they can go and the board is notified immediately for a quicker response for the participant.

David Lollar appreciates the presentation. He noticed throughout the slides they said the program was for both drug abuse and mental illness issues. One of the questions the board heard yesterday and at the last meeting, more than once from the nurses was when the offense has nothing to do with narcotics then why are they in this program? He assumes the reason is therefore because it’s a mental health issue.

Shannon Johnson said she thought the comment yesterday was based on diverting, but her issue wasn't with diverting narcotics from the hospital, so it may have been a use issue or maybe alcohol outside of the workplace. She thinks that may have been what the comment was referring to yesterday, but in the next agenda item, she is going to go over return to work, in patient, nonpatient care with or without access.

Mary Fagan said she has 35 years of nursing leadership experience. She has lots of experience with the intervention program and asked Virginia Matthews if she could validate that the vast majority of people, she's known that go into intervention notifies the workplace when they're coming back to work. The reason they went into intervention in the first place was because something happened at work. Either the nurse came impaired or there was diversion and then they're no longer working until this gets resolved. Most of them then start seeking help immediately before they even get into the program. Is that correct?

Virginia Matthews said most often nurses come in, and she doesn't have any statistics off the top of her head, but most often they come in for incidents in the workplace. There are a fair number of DUIs, but many of them are work related issues and most often they seek treatment on their own or because their employer has referred them into treatment or EAP.

Mary Fagan added that if employers refer them then they're no longer working, so they're no longer a risk to the public in their position.

Virginia Matthews answered in the affirmative.

Dolores Trujillo asked Viriginia Matthews if participants have to leave their job or go into a position where they will have to handle narcotics.

Shannon Johnson said she will be covering that in one of the upcoming agenda items.

Jovita Dominguez said she has similar concerns to Dolores Trujillo and wonders about nurses who have been away from the bedside for years and is now asked to return to handle narcotics where the public may be endangered.

Shannon Johnson reiterated she will be covering this information in another agenda item.

Loretta Melby said the BRN collaborates nationwide through NCSBN with other boards of nursing who have alternate to discipline programs. Maximus participates in many studies done on the efficacy of the program and good processes that are evidence based. They say three years without relapse, daily check ins including holidays and weekends, minimum random testing two times a month, structured support group two times a month, RN specific group at least one time. There are great success rates that are proven with

programs that use those kinds of tactics to assist in recovery. Yesterday, Shannon said the BRN is participating in a substance use disorder study that NCSBN is completing. NCSBN came in September to give a presentation and she will ask them to return and give an update. She said there is a movement across the nation within boards of nursing about reimagining discipline and looking at risk taking behaviors versus reckless behaviors while looking through the lens of just culture which are pivotal as the board looks at these programs and the way the programs are administered through the regulatory process and have guidelines for this which is an ongoing process. She said they are doing a deep dive into every program offered throughout BRN along with mapping processes, regulations, and statutes. While looking it was seen that Intervention needed attention and Assistant Executive Officer, Evon Lenerd, Reza Pejuhesh, and herself are looking into this. This presentation is a baseline to get this information to everybody. Nothing is set in stone and more discussions can be had. While they were reviewing the processes it was seen that some participants were being brought before the IECs too soon.

Alison Cormack asked if the recovery agreements are actual contracts that are enforceable.

Reza Pejuhesh said they're not binding contracts in the contract sense. Even if both parties have signed the contract, it doesn't mean it can never be changed. If a participant is in the program and circumstances suddenly change with a bad relapse, then the terms of the contract can change against the will of the participant. It's the program's job to determine the individual is safe to graduate from the program.

Loretta Melby added additional context to the contract process.

Reza Pejuhesh added that it's a recovery plan that lays out terms the participant has to follow. If they don't follow the terms, the program can enforce them. The program can terminate them from the program or alter the terms of the agreement.

10:13 a.m. **Public Comment for Agenda Item 9.3:**

Matthew A.:Thanked Mr. Pejuhesh for the one-sided agreement that is enforceable on the Maximus side. He said for every one participant that speaks out there are probably 10 more who are afraid to do so. Ms. Matthews stated the recovery agreement says the criteria for completion or for what's going forward, but that's absolutely false. Current participants are being required to do things that are not listed in any recovery agreements such as handling narcotics, but they're required to do it anyway. Participants attend IEC meetings and are

praised and told they're doing a great job and will get a decision about the IECs decision in two weeks but it's longer than that. The Maximus case manager calls participants and tells them the IEC slashed the BRN's decision, they can't tell them why the decision was made, or any specifics of newly added requirements or how long they'll need to follow the new requirements. All the while, participants with impeccable compliance for years are extended indefinitely without any direction, criteria, or light at the end of the tunnel. They continue to jump through new hoops imposed and are indefinitely extended without any reasoning. Since the last board meeting in February, he has been contacted by about two dozen other participants who have told the same story. This is not an isolated incident. The BRN continues to use the general criteria that participants are "able to practice safely", but that's a red herring for the BRN to continue to fail to provide any objective evidence-based criteria. There's also a real conflict of interest as the BRN enforcement forces participants to obtain clinical evaluations years into the program from a BRN paid site. Not surprisingly, the psychologist after 15 min of speaking with the participant for the first time tells the BRN what they want to hear and extends participants in the program and Maximus and the BRN continue to benefit from the nurse's participation in the program. As Miss Millie mentioned yesterday ironically, right before she was cut off, IEC members are also being silenced. The desperation and hopelessness he heard from nurses makes him feel something tragic is about to happen to these nurses, and the last thing he wants to do is come to the next quarterly meeting or after that saying I told you so. Thank you for your time today and he appreciates the discussion.

Tony: The contracts are one sided and for some who've been in the program for years and have gone before complete IEC boards with BRN members and Maximus representatives and are praised. They held a job for three years with worksite monitor oversight and when going to transition, which was the way the program was set up, and in the last year right before going to their last IEC meeting to be released because no issues were raised. As Lori pointed out, something has to change, and we have to be flexible with the contract. No issues were raised and there's been 100% compliance and then we're told that we can't have the meeting. There are participants that have physical disabilities that have submitted doctors notes that have been blatantly disregarded and they've been told to find something, so they looked for full time jobs and jobs on the weekend. It's incredibly hard to find a job when you're in this program. So now to find a job with all the extra restrictions that have been put on them, for some, their recovery agreement has been the same, and they've completed every single thing in the agreement, and some have not even been before their IEC in over a year. He cannot

imagine what has changed, what issue has been brought up that would keep them extended in this program, with impeccable compliance. No issues have been raised, so he's confused by what Lori is saying. He understands the board has every right to make changes. These changes should have been thought out and wrote out in a cohesive manner and the people that. (Time Ended)

Chris Else, Nursing Support Group Facilitator, San Luis Obispo: Explained that he is appointed by the board and supports nurses in recovery and helps them navigate through probation and diversion. Probation and diversion have different types of treatment plans which may change from time to time. They're concerned about whether the treatment plans are legal or not legal. He gave an example of a nurse with a treatment plan that is being told they have to do a certain thing, but it is not documented in the treatment plan. He has been in contact with Maximus, and they tell him it's a requirement.

Julie – participant in Intervention: Said there has been a lot of discussion about metrics and statistics that the board or Maximus said they make every effort to get a participant to an IEC as quickly as possible and it sounds like there will be more discovery of actual statistics behind that but she wants to echo Ms. Cormac's concerns and let the board know from a personal standpoint, they said they do everything they can to connect them but that's not what is happening. When she personally joined, she did research and saw the IECs meet every three months and was hopeful that when she joined and inactivated her license that the next IEC would be soon. She was elated to find out it would be soon and in two or three weeks but then was told the IEC was full and would have to wait an additional three months. She had to fight to get granted to go to the earlier meeting. Even though it was said 12-step meetings are not required, it is an unspoken requirement. She tried every other type of meeting due to religious trauma and found one she really liked but due to the fac there is no sponsor program, a sponsor is required. It was difficult to stay in a non-twelve step meeting. She said it's the verbiage but hey definitely require it even if they say it can't be required. She thinks that needs to be evaluated. It's something that could be changed and looked into further.

Anthony: The Board is absolutely correct in their questions and feelings on the Maximus program. When it comes down to this contractual agreement, it is a contract, it has every verbiage and standard and format as a contract. Now we're hearing it's a one-sided contract where Maximus can change it whenever they want to, but if the participant doesn't agree, they're out of the program. But the participant signed the contract with a date and a term limit as every

legal format and standard of a contract. When it's time to get out of the program, many applicants were supposed to be out in December, January and February, and were told they can't meet with their IEC because new requirements have been placed to pass narcotics for three to six months which is unfair because a lot of nurses have physical disabilities that do not allow them to do it. Can you imagine your mother being transferred from one bed to another bed by a nurse who has cages in her back, spinal fusions? You wouldn't want that. Some nurses have case manager jobs where they're at home with their family and now they're being told they have to find another job where they have to do these requirements. Even though the BRN says this is not a requirement, nurses are being held right now and unable to leave the program because of this requirement. When they ask Maximus what they can do, there is no understanding. Can it just be the weekend? How can they get out of the program? Some have been in for three years, four years, five years, and they're still in the program. Then when you talk about testing, you can sometimes get tested three times in a week. You can get tested five, six times a month. The cost is different for blood, hair, and saliva. Imagine getting patches of your hair pulled out once a month. This is completely what the presentation says is nice if it worked. (Time Ended)

LH: Costs for the program. She entered treatment and recovery prior to being notified by the board of a complaint 22 months later. She entered the program with the most basic treatment plan, IOP 52 weeks of after care, and other requirements for testing. Her insurance would not cover IOP because they determined she did not need it because of a strong history of sobriety and treatment and recovery. This was all paid for out of pocket. In the 15 months in the program, she's paid out of pocket over $17,000 but there are many nurses who have paid more. She was not working for the first six months in the program, so she was paying for all of this out of pocket and she has a mountain of debt because of it. She wanted the board to have a better understanding because the cost slide was vague. She also wants to echo what Julie said about the requirements for twelve step or community group. She was never informed there was any other option besides twelve-step from Maximus when she entered. Her case manager told her she has to do twelve step and she's not comfortable for religious reasons in the twelve-step program but is in it because it is a requirement. Than kyou.

Mary Molly Shirk: Stated that folks have to provide quarterly reports from physicians. If the physician fails to do this is the participant going to be held as non-compliant? She feels the intervention program keeps a tighter control than probation that took almost four years to start as the public is aware and they are still working.

Jason: Asked about participants who continue to complete every single requirement in their recovery agreement maintained perfect compliance with the program, continued to show growth as evidence by letters from NSGF, psychologists, sponsors, family, and friends. They've also demonstrated attainable relapse prevention plan and continue to engage in sustainable recovery modalities for three to four years. The only thing that's changed is they've spoken out against all of these changes. What is the BRN looking for from the participants. Reza said participants do not have to identify themselves and a number of folks seem to be accusing himself or staff of the board of retaliating if you speak out. Callers do not have to identify themselves. None of this discussion is driven by retaliation against individuals.

Reza Pejuhesh spoke up to say he's said a number of times nobody in the program needs to identify themselves. He said a number of folks have seemingly accused him or staff or the board of retaliating which was the implication of the last comment. He reiterated that the public does not have to identify themselves and none of the discussion is driven by retaliation against individuals. They've tried to offer a way to keep yourself anonymous if that is a concern you still have. He said the implication that this change is only being made because folks are speaking out is not one, he wants to let stand.

NP Watching: Stated that she a nurse practitioner who is not in the intervention program. She did not select it based on her research. Her main concern was the fact the contract was not really a contract and could be changed over time and her concern was that it could be changed, and she would always be in a state of flux. She is on probation and wanted to say the costs described are profoundly underestimated. She does not feel like you can describe the cost of the program. Thank you.

Amanda – participant in the program: Stated that she was supposed to graduate this month, she's been extended and mandated to pass narcotics and cannot graduate the program until doing so is what she's been told. She's been looking for jobs, interviewed but unable to find a job. She's been off the floor for four years and working in case management because she wasn't allowed to go to the floor when she first started working for two years and now she loves her job. She wants to stay there but what can she do if she can't find a job. She's been told by people she's applied to that they won't accept the Maximus program and they don't have an onsite monitor. She's been off the floor for too long which is bad luck. If something's out of her control and she can't find a job she would like to know what the maximum amount of time she has to stay in the program. What's her

maximum jail sentence, so to speak, to get out if she's compliant and sober. Thank you.

Reza Pejuhesh spoke up again to say the continued comments about job requirements are related to the next agenda item. The rationale for the process is going to be addressed in that agenda item.

Anonymous 25: (Typewritten comment read by BRN Moderator) Why is Maximus implementing something that hasn't been voted on by the board?

No additional public comments from the Sacramento location.

Break 10:40-10:50 am
Quorum re-established at 10:50 am

10:50 a.m.

9.3.1 Discussion and possible action: Regarding working as a registered nurse in a position requiring patient care, with or without narcotic access, prior to successful completion of IP

Board Discussion: Patricia Wynne said there may have been some lax enforcement of this issue and once it came to light it began to be enforced.

Shannon Johnson said the board does not make that determination. It is the responsibility of the committee to look at the diagnoses, look at evaluations, reassessments done, and make that determination based on their violations or based on their drug of choice. They look at what would be appropriate to feel comfortable allowing the nurse to have an unencumbered license. It's the recommendation of the committee.

David Lollar asked how someone would be extended indefinitely. Shannon said she's sat in IECs and never said they have to leave their current job. They've said let's give them an eight-hour shift per week to try to meet this criterion. They've extended hours to 50 hours per week to accommodate this. They want to see them bedside or passing narcotics while monitored. They do not say they have to work a specific amount of time. The participant needs to be reassessed saying they're safe to practice. She said she's seen an IEC complete a participant with and without passing narcotics.

Dolores Trujillo asked about jobs needing to pass narcotics for three to six months when they haven't been in an environment where they needed to do this. This may be difficult to get a job to do this. This seems to be a common thread in the public comments. Is this part of

the contract in the beginning? Are the treatment plans individual, and if so, how is this done?

Shannon Johnson said this is taken into consideration as well as the history, did they divert from their job, was there a DUI, were you in non-direct patient care, were you a case manager or triaging nurse and not at bedside. A lot of the nurses were in the direct patient care environment and had access to narcotics when the violation occurred. When the IEC says a nurse can go back to work, they may start out in a non-direct patient care setting, and they enjoy this work and want to stay in it. But when they get out of the program, they can go back unrestricted which a lot of them do. The IEC must take in all the circumstances to determine what they think would be appropriate on a case-by-case basis. She spoke about transition being on a time frame and not based on the nurse's recovery. This was done universally. The IECs are being asked to look at the individual when they make recommendations.

Dolores Trujillo asked if this is a nurse or physician making the recommendations.

Loretta Melby explained the makeup of the IECs: 3 RNs, 1 MD, 1 public member.

Loretta Melby made comments that said the program has drifted and the participants were going through the program on the same track and not being individualized for each person. She said participants were going through based on time frames. Once it was seen this was happening then board staff began a deep dive into this. Treatment for addiction, mental health, is individualized. Staff started attending all the meetings to peel back the layers and see what was going on. Not all participants have been on public comment. If there is a disability it is being taken into account. Work history is taken into account. If a nurse has never worked bedside then they are not asked to do so now because they don't have the competency to do so. The IEC is supposed to protect the public as is the mandate of the board. You go back and look to see what changed. The program was on auto pilot, and it's been taken off of it now. What is being done and how should it be improved. This is not to be punitive, that is not the intention. It is possible to address the public comments about the goal posts being moved. Communication needs to be addressed and clear about what the steps are in the process. When course corrections are made they have not always been communicated well. Staff will work with Maximus and IECs about what has happened in the last few months. Two NSGF trainings have been provided now but haven't been done in years. The IEC members have onboarding and orientation to bring

them up to speed similar to board members. They are finding opportunities to make improvements. Cost is not part of the agenda item today and can be addressed in the future.

Shannon Johnson said the IEC members were not given complete information to include a complaint summary which was a disadvantage for them to provide a comprehensive treatment plan. There are many areas in need of improvement and change. She said this is why the regulation package is being sought as well.

Dolores Trujillo spoke about an ER nurse passing narcotics versus a nurse who is a case manager for 20 years and then having them go back to bedside is like a new grad going into the environment to pass narcotics to see they don't divert again. She gave an analogy of an alcoholic being sent to a bar to order diet Pepsi. That's a very stressful environment. Why would you send a nurse in a similar situation?

Shannon Johnson said she is not awhere someone who has never worked bedside nursing with narcotics now being forced to go work with narcotics and direct patient care. The nurse always worked with direct patient care, diverted, and are more than likely to go back to direct patient care when they successfully complete. Unfortunately, some of them end up back in the program.

Dolores Trujillo said public comments are saying they do have to do complete this and it concerns her. She said the IEC did not make the recommendation but then they are required to do this.

Shannon Johnson said it is not a one size fits all. If a nurse goes to IEC, they will look at the nurse's case and make a recommendation to the board. She said one nurse is told this and then there's a perception that everyone must do this. Not everyone needs to do this.

Dolores Trujillo asked about the full IEC and having to wait to be seen.

Shannon Johnson said that is a past issue and is not the case now. They work diligently with Maximus to get participants seen by an IEC. They are not putting participants in to see an IEC if they don't have any changes being made.

Loretta Melby said IECs were run differently prior to COVID. There were 14 who met four times each year in person. Participants had to travel to go to IEC. There is no longer a requirement for a participant to travel to be seen by the IEC. They are looking to see if there are

enough IECs and accessible. The limitation is staffing the IECs with members. There are only 250 participants now and there were many more participants previously. There has been a drastic decline in the numbers.

Vicki Granowitz asked about physicians who get in trouble with chemical dependency having to go through this.

Shannon Johnson said the Medical Board is meeting today to discuss their plan for physicians.

Nilu Patel asked if there is a formula for the number of IECs based on the number of licensees.

Shannon Johnson said there used to be 14 and they were reduced to 11 at COVID and further reduced to nine. They can be restarted if needed. She went on to say there were 600-700 participants 7 years ago.

Nilu Patel said she didn't think physicians had to go through the same rigor as nurses do.

Mary Fagan asked Shannon if the only treatment plans that were changed to add the requirement to pass narcotics are people who were previously diverting narcotics.

Shannon Johnson said, no that isn't what she's saying. Plans have changed for individuals who came before the committee and the committee is now looking at the whole picture, every puzzle piece, not just a piece of it. As an example, a participant could go before the committee with a request for an additional shift of overtime. The committee only looked at that request and didn't review everything else such as did they have another assessment, should they have overtime, have they been going to therapy, what are the results. The IECs were not looking at the bigger picture so the BRN has been asking the IEC to look at everything which could result in a plan change based on all the evidence taken into consideration.

Mary Fagan asked for an example of a situation in which a nurse would be required to pass narcotics because based on public comment the nurses have no intent to pass narcotics. Can you give an example of a situation in which someone did not divert narcotics is now being required to pass them before they can be released from the program and what were the individual circumstances that led to that decision.

Shannon Johnson said she could not think of one. She said the recommendations were made because they diverted, were impaired at work, or some similar type of situation.

Mary Fagan asked if they were all narcotics based because many are related to alcohol.

Shannon Johnson said some are related to alcohol and they take that into consideration. Some nurses come to work impaired or get impaired while they're at work with alcohol or narcotics, pull narcotics, steal wastage or take wastage and do not account for it and fill vials with saline. There are all different reasons but the IECs are definitely taking that into consideration when they make their recommendation. She has not personally seen an IEC or been involved in a meeting where someone had never ever had access to medications and been required to go back to bedside or direct patient care.

Mary Fagan asked if Shannon Johnson knows the number of participants whose treatment plans were changed as a result of this, has it increased.

Shannon Johnson said that would be a hard number to get. She would say everyone's has been changed because every time they go before an IEC they get a new recovery plan, even for the slightest one time eight-hour overtime shift they get a new recovery plan sent out to them. The recommendations are sent to the board, and BRN staff review all the notes and send it over to Maximus to incorporate into the individual's portal.

Mary Fagan said this agenda item is specifically related to the requirement to pass narcotics. She wants to understand who the participants are who are being required to pass narcotics. To make some sort of recommendation to start a legislative package, she wants to be clearer on that.

Shannon Johnson said at the next board meeting she could possibly provide general, because its confidential, data starting from specific date until now of how many nurses in the program have been required to find a job with access and give generalized reasoning or partial rational as to why the committee came to their determination.

Patricia Wynne said the IEC should meet to discuss a regulation package before bringing it to the board. There needs to be a public airing of the issues. She also said there's been a drift for years and now this is being addressed.

Mary Fagan asked about the drift and participants who have completed the program and whether they're safe.

Shannon Johnson said they get reports monthly, and they can look the participants up to see if they've received any new complaints filed again and recidivism. She said she'll look back 4-5 years.

Loretta Melby said an Enforcement Investigation Intervention Committee (EIIC) meeting will be scheduled in June to discuss these issues.

Alison Cormack said she echoes Mary Fagan's comments. She wonders if any nurses have been released from the program without being safe. She asked if the IEC members are compensated and how much IEC members are compensated.

Shannon Johnson said they earn $100 per diem per day.

Loretta Melby provided the Government Code section. She asked who chairs the IECs.

Shannon Johnson said each IEC votes for a chair and vice chair.

Alison Cormack asked if it's a good or bad thing that there are fewer nurses in the program. She would like additional data to show if the additional requirements stated in public comments are affecting enrollment or is based on enforcement data.

Shannon Johnson said based on licensee population there have never been the numbers in the program and across the United States, everyone is down almost 30% in their programs. She attended a webinar the other day that they've been declining the last seven years, and no one knows why. She will try to gather statistics for this.

Alison Cormack would like to know if this is abnormal or based on probation. She's trying to follow the treatment plans change. IEC recommends, BRN staff reviews, sent to Maximus and how long does this take.

Shannon Johnson gave an explanation of the process and the contract says it takes 10 days.

Loretta Melby asked if the participant if they attend the meeting and if they're aware of the changes.

Shannon Johnson said they are told at the end of the IEC meeting about the changes, but the final changes are not complete until reviewed by BRN and uploaded in the participant portal by Maximus staff.

Alison Cormack thinks it would be good to address at the IEC the non-religious twelve step option for those who disagree with it and this could affect the RFP going forward. She asked if Shannon would be interested in addressing this.

Shannon Johnson said they are open to many different community options.

Alison Cormack said then the issue may be whether having a sponsor is an issue. She spoke about evidence-based data that shows whether a sponsor is necessary will help the board understand.

Shannon Johnson said the IEC makes the recommendation of whether to have a sponsor. She is not aware of a non-twelve-step program requiring the sponsor.

Alison Cormack said that was just brought up in public comment. She wants to ensure we are not forcing participants to do something that conflicts with their religious beliefs.

David Lollar asked if there is a way to remove the criteria for religious based community support if someone has been involved with religious trauma.

Shannon Johnson said they will definitely look into that.

Loretta Melby addressed the makeup of the IEC with three nurses, one MD, one public member but said the IEC is quorum based so only three members of the five need to be present at a meeting. Three nurses may not be present at each meeting.

Reza Pejuhesh said this agenda item is a potential requirement in intervention for participants to either work in direct patient care or work in direct patient care with access to narcotics. That’s a policy decision the Board could weigh in on. The Board could speak to whether this seems to make good sense, and this is potentially possibly likely going to be an ongoing discussion that may not be resolved today. He continued discussing pros and cons and development of policy in regulations. If the board finds there is no merit, then staff can be directed not to do it. He said uniform standard 12 says there are five criteria to meet in order to successfully

complete including participants must demonstrate they are able to practice safely. Once they complete there is no way for the public to know because they will have an unrestricted license and work in any nursing capacity. There is a risk that the board takes. If a participant says they've never worked bedside or with narcotics they can do so with an unrestricted license. A con brought up by commenters is job hopping that offsets the pro. Putting someone who has susceptibility to using drugs in a situation where there is temptation. A nurse who may be older or who has a physical disability are issues that should be taken into consideration.

After Public Comment:
Dolores Trujillo asked Shannon Johnson if there's a way to survey participants during the program.

Shannon Johnson said she thought Maximus put out a survey at the end of the program. She can look into it if the board would like.

Dolores Trujillo said it would be nice to have feedback during the program.

Patricia Wynne said this has been a very difficult conversation and the participants are clearly frustrated. They're in a program they'd like them to be in because they want them to get well. She's heard some stories in public comment that confirm their worst fears. She is concerned with the comments being made about nurses with DUIs ready to graduate and now being required to work passing narcotics. She does not know enough to make a good decision and would like to send this item to IECC to meet in a couple months or one month to try to come up with an approach that is fair and respectful to the participants and also meets the needs of the treatment program.

Nilu Patel asked if it's possible to survey the other seven boards to see if they're having similar issues with Maximus.

Shannon Johnson said they meet with them every two weeks so they can be surveyed.

Alison Cormack said it has been a difficult day and it isn't over. She doesn't feel there is enough data to make a decision today about what changes need to occur. She spoke about the probation work requirement of six months and said she has no insight into what the board staff uses to approve a position. She would like to know if a probationer was disciplined for narcotics diversion is it the board's practice to require the work be done in a setting with narcotics? A yes or no question that will help her when deciding how to know if a nurse

is safe to return to work. She doesn't want a big presentation on these crucial issues for a whole different program with people similar, such as a DUI. Does someone with a DUI on probation have their board approved nursing position have to include passing narcotics? She would like statistics for nurses who have completed the program and had problems. She acknowledges this has been a difficult day for the board, staff, and the commenters.

Mary Fagan said she's never been moved by public comment the way she's been moved by these members participating in the intervention program. She thinks whatever changes were made within the last six months needs to be reversed because there has been a lot trauma based on all the public comments received today. She said it appears some change was made without board intervention in the past six months, that even though Shannon said has not been blanket, they've heard from many people who said that they had a DUI and with whatever change was implemented six months ago, a change needs to be made now because not only is the board traumatizing the participants but she thinks as one public commenter they're probably putting the public at risk by forcing people to go out and get a job where they shouldn't be doing it for a multitude of reasons. She's hoping today to take it to committee is definitely the right thing going forward but feels there has to be a mandate to act today and whatever was implemented six months ago or whatever needs to be reviewed and, in many cases, reversed.

Loretta Melby asked Reza Pejuhesh if a special board meeting can be held in the next 10 days to bring statistics to have a discussion on what changes have been made and said she would hate to go back to the prior plan today and asks for that to be reconsidered. It is not necessary to wait a month for the committee or August for the board meeting to make changes.

Reza Pejuhesh clarified that a meeting could had within 10 days if noticed and what needs to occur. She would like to check with Shannon to see how long it would take to get information for a board meeting to have a discussion on those changes. Shannon asked if they would like her to go back to every IEC over an extended period of time, how far back to pull each individual case that was seen, what the outcome was, what was the prior case and then post outcome of the IEC. Then there are mitigating factors in the IEC discussion and closed session that would need to be shared with you for you to understand and in open session that cannot be shared due to the confidentiality of the program. A lot of information was not shared and she needs direction on what exactly is being looked for and then she

would work diligently to have it as soon as possible if you want to meet 10 days from now.

Loretta Melby said any materials would need to go through legal review and would not share anything that is confidential. She agrees with Mary that action needs to be taken sooner rather than later. She said a common theme is communication. She asked Shannon if staff has the ability to communicate with participants.

Shannon Johnson said no communication is had between board staff and participants; their point of contact is the Maximus clinical case manager.

Loretta Melby asked if the changes that are occurring are being communicated by the Clinical Case Manage (CCM) employed by Maximus? Is the BRN aware of what is being communicated? How it's communicated? Any materials or training that went out to them to convey the changes? If there are changes in the recovery plan that are communicated by Maximus is it a blanket statement that everyone must do it? Is it fear based, that they're hearing about it and so everybody think they have this requirement? Is there an ability to address any of the communication issues that may have occurred through this change process that could resend the message that not everybody has to work in narcotics passing if there is a single DUI. Can clarification be provided so they have a sense of what they're signing up for.

Shannon Johnson said they are in communication with Maximus monthly and if a participant wants their case looked at, they can reach out to her to have their case looked at because she is surprised and taken aback at the comments given.

Loretta Melby said it's a very emotionally driven response now.

Shannon Johnson said a participant can reach out to her to have their case looked at. Loretta Melby said communication is with a Maximus CCM, not BRN. She said if a participant is having issues with their CCM then they should reach out to herself, Shannon, Jaspreet or Evon. This is the first time she's hearing this. She wants to address this and is giving her word this will be done in an expeditious manner.

Alison Cormack thinks it is a lot to ask participants to reach out to BRN. She would prefer BRN staff conduct an informal audit as a construct on a systematic basis go in and who are the 250 participants, what stage are they at, do they understand what is left on their plan, the IEC will have to be involved for all who need

modifications or changes. Work needs to be done to understand the scope of the problem and a short term plan to do the modifications. It would be great to the IECs ready to review them because obviously some work needs to get done. She doe think the EIIC should continue to meet in June because there is data that needs to be managed going forward. She agrees with Mary Fagan that something should be done urgently.

Mary Fagan said it doesn't sound as if these issues came from IEC meetings because commenters that they haven't had an IEC meeting in a long time. She wonders if the CCMs are issuing mandates outside of IEC meetings.

Loretta Melby said anything is possible. They will pull data to see if there is a common CCM or IEC or time frame. She thinks the earliest public comment was November that a participant was moved and would narrow the time frame.

Shannon Johnson said this sounds like a long time.

David Lollar asked if this could be discussed during closed session due to the confidentiality of the program participants.

Reza Pejuhesh said there are specific Bagley-Keene requirements to discuss items in closed session.

Vicki Granowitz said she heard at a previous meeting that changes were made because of some specific mandate that had to be put into effect. She said if this is true, it's less important who the messenger was, than figuring out if there was a reason why this change occurred. There's clearly a disconnect and something is wrong. But she'd like to know what is real because there is real pain and lack of certainty.

Loretta Melby said a data pull is needed. The communication happens through Maximus. We need to know how many are affected. Is it communication and how did it happen and needs to be addressed.

Vicki Granowitz thought the board might hear similar comments in the next agenda item. She said this came up at the last board meeting and is surprised that board and staff are surprised about the comments made today. She said if it was her, she would reach out to others and ask them to come to this meeting since they don't feel they're being heard by the board. She also discussed that it doesn't look like all agenda items will be heard today.

Loretta Melby said she will discuss with Reza Pejuhesh during lunch and get back to the board with details about a possible board meeting.

Vicki Granowitz asked if this can be done on an internet meeting platform since many members will not be able to attend in person.

Loretta Melby said there is no motion at this time and asked if they need to vote to not make a motion.

Reza Pejuhesh said there is no need to vote on not taking a motion.

Loretta Melby said there will be a EIIC in June with additional stats.

Reza Pejuhesh summarized what will take place with EIIC and possible special board meeting in 10 days.

Loretta Melby said they'll discuss how to manage the rest of the agenda items for today's meeting.

Break at 1:25 – 2:00 pm

11:50 a.m. **Public Comment for Agenda Item 9.3.1:**

Tony: She's happy there are substantial questions being asked but she's also frustrated because she's hearing things from Lori and Shannon that are simply not true. Every person in the program has their own track and requirements. She hasn't been before a IEC in over one year. She submitted documentation from her own doctor, her medical records are with Maximus's case manager who told her the board said she still has to find a job. It's beyond absurd and all a lie. She has four years of sobriety next month and she did not divert narcotics. The harm that is being caused to the participants is real. She has a IEC scheduled in November now which over 1 ½ years since she went to a IEC. She doesn't have a transcript of what's been said. She is indefinitely being held in the program. She has to find a second job now after working 40 hours and it takes away from her recovery and is not conducive to it. (Time Ended)

Matthew A.: Appreciated the excellent questions from Alison Cormack and Mary Fagan. He said Ms. Johnson is speaking out of both sides of her mouth by saying the IECs are not independent and only recommend treatment and whether participants are safe to practice or successfully complete the program then later on she said the IECs make these decisions to recommend participants work or participants do this. The IEC can only recommend to the program manager who is

Jaspreet Pabla, BRN staff, so BRN staff ultimately have the decision whether a participant completes. He said retaliation is not by the board members but by BRN staff. He's heard from many participants who have written letters to BRN staff and then they appear at their IEC meetings with BRN staff in attendance. They are praised by IEC, make recommendations for the participants, BRN staff make the final decisions. While the board fixes their drift the participants are collateral damage.

Dan: Stated that its eye opening how ignorant the people are about what's going on in this program. He said Ms. Johnson is completely falsifying what's going on with this program. This program needs to be investigated thoroughly. DCA should investigate what's happening because participants are being strung along in order to get an easy paycheck and there's no end in sight. The rules are vague, and the goal posts are being changed while the game is being played. Like all other participants who voice concerns there is no communication. Staff is going to train the facilitators and case managers but the rules will change again. The program is a scam and shamble and should completely redone.

Julie: Appreciated comments from Mary Fagan and Dolores Trujillo. It has been difficult listening to Maximus explain their process since there are many discrepancies with reality of how the participants are treated. She encourages the BRN to do their own research in Maximus's claims and seek out robust understanding before allowing Maximus to require 9.3.1. The most important question to ask is if a pattern has been identified where RNs recidivate into addiction and diversion after completing the program as a direct result of the intervention program failing to monitor them before completion. She tried to answer this question but could not find any data to suggest any need for a change of this magnitude. In fact, on Maximus's website they tout an 87% of participants establish long term recovery through their current methods, which are known to be improving. This is a marked improvement to the 50-70% relapse rate with traditional treatment. A 13% relapse rate is groundbreaking but would it be lower if we monitored nurses passing narcotics before they complete the program. The answer is most likely no. It is unknown how many of the 13% relapse with alcohol making monitoring narcotic access a moot point or how many were already monitored passing narcotics before relapsing. There needs to be a comprehensive breakdown of the data with rates and predictors for relapse and listen to what other less aggressive measures could be taken in lieu of a massive sweeping mandate indiscriminate of circumstance compliance in the program or nature of initial complaint. They are being told that in no uncertain terms they must pass narcotics to complete the program. This is

being mandated before the BRN has been able to opine. Please don’t force them to make a major life change before this has been fully investigated by the BRN. This is unethical and cruel. Thank you.

Anthony: He asked members to imagine being in this program for the past four years and being told at every IEC meeting you’re doing great and you’re completing everything required. You’re last IEC is in October and then they tell you the next meeting is in February, and you should graduate from the program. Then you get a call in January, about a week before the last meeting saying the IEC can’t meet with you now because BRN is making new requirements to pass narcotics and have bedside for three to six months and you don’t know what to do being in limbo. The changes haven’t been fully implemented but participants are on hold.

Jason: He asked members to imagine entering into a recovery program at arguably the lowest and the most vulnerable time of your life. You're told by BRN staff that you'll never regret this decision. Now BRN staff members sits silently along with many other BRN and Maximus staff while you're filled with nothing but regret as this program continues to make change after change resulting in participants being endlessly extended in this program feeling punitive and incredibly unsafe. He is one of a number of participants feeling completely hopeless as they continue to ask for clarity, stability, and transparency. Instead, things continue to just get foggier and increasingly unattainable goals are set. What's worse is that people who can objectively advocate for us are silenced. So as you heard yesterday nurse support group facilitators and IEC members have been advised that they may not advocate for us as it is “against regulations.” Maximum staff continue to encourage participants to speak up for themselves, but then sit idly by as they are intimidated into silence. This is not an environment that promotes any element of recovery and make no mistake, it is creating trauma. As you can see from those speaking up, they are all suffering. There are no voices supporting the actions of this program, and there's never been such a substantial uproar. Please stop dismissing them. They are not a few disgruntled participants. They are human beings and they are being subjected to endless abuse at the hands of Maximus and BRN's enforcement division. He is respectfully requesting to specify exactly what is required to complete this program. They need objective criteria to be able to meet and having everything open to interpretation and continually changing has to stop. As it stands today, endlessly moving the goals for completion is extremely detrimental. So ask yourselves, how many times can you hear you're still not good enough before you lose all hope? No one thrives when they feel hopeless.

C: Stated that they have been in the program for two plus years into the program and never diverted drugs. He just completed his RN when he was referred to this program. He was pursuing a master's degree on his way to becoming a NP. He took a year off from school and Maximus granted him the ability to go back. So he's been back in school and taken out about $70,000 in loans and at his last IEC in November he was told he will not be able to work as an NP, he has to go work as an RN with narcotics access. He's just one of the 250 participants who can speak out and say that despite his success in this program, despite his adherence, he's still being asked to comply with these sorts of cookie cutter standards that are being applied across the board. He has no RN experience for one and he has to also divulge that he's in this program in every interview he attends. As you can imagine, it's probably pretty hard to secure a job that way. He wanted to speak on behalf of his own experience.
and share with the board that there are a lot of them who are being asked to do the same thing and despite the goal of this becoming a bit more individualized. Thank you for your time.

Erin: Stated that she was at workand not fully able to listen, but knows what Shannon Johnson and the other woman said is blatantly false. She doesn't know if this is purposely or not. She had one DUI, alcohol related and was supposed to get out in April of this year. She was told she would have to pass narcotics and your time out is indefinite. She loves her dialysis job and was forced to get a job at a skilled nursing facility to meet this requirement. She has no history of narcotic abuse so doesn't understand why she would have to pass them. She said her Maximus case manager told her everyone has to do this.

Rashaad – mother of participant: Stated that there's a lot reiteration of the requirements but can a nurse request to graduate from the program without passing narcotics? Her daughter has been in the program for years and has remained sober since. Her IEC was scheduled and canceled twice. Now she's in the program even longer and like the nurses have been saying there's no light at the end of the tunnel. The program is individualized yet everyone has this requirement to pass narcotics, and this is absolutely ridiculous. It took her 18 months to find a job and she's going to

Estevan: Stated that Maximus needs to be thoroughly investigated. This program is not conducive to recovery to anyone. It's just a money maker. None of the case managers know what's going on. They haven't had a meeting in over a year because they keep getting canceled. They say they're waiting for the board. The board says something different. They've spent almost $40,000 in the program.

There’s a lot of retaliation with the program if you complain or disagree with anything they automatically send you to drug test the next day and it’s hair or blood and those tests cost $400-500 each.

Mark: Stated that participants are required to have a sponsor as stated in the contract. This program has seriously deviated from a recovery focused program to one that feels punitive and more difficult to complete than probation. He said several colleagues come in with DUIs and are being forced to work with narcotics despite never had any previous history of narcotics access or passing. As was said earlier, you would never request an alcoholic go into a bar and be a bar tender, so I'm not sure why it is in the same logic to force a nurse who had a problem with narcotics to return to bedside and be forced to do something that they do not want to do that is against their will and that lacks clinically validated evidence that would suggest this nurse would have a longer meaningful recovery than a nurse who did not meet this requirement. Recovery cannot be guaranteed by any regulation or any statute. It is a day-by-day process and there is no requirement that can be placed that would increase the safety of that nurse long term. It is something that is a day-by-day basis. As a CCRM, I had to interview 30 times before finding a position an hour away from my house that would allow me to fulfill the requirements.He went one year between IECs and in that one year between IECs, the program requirements flipped on their head and he was told he has to pass narcotics in order to meet the requirements of the program. He must commute one hour each way for a 12 hour shift three times a week to meet his requirement. The program is not more individualized. It is less individualized, and these statutes are being blanketly applied to all participants in the program. Transition was not something that was granted at a time frame. It was a personalized thing that was amended based on your progress through the program. The goal posts are continually moved. They have no idea what to expect. So it is with these statements that he urges you to look further into this program and really evaluate the sentiment that Miss Melby and Miss Johnson are conveying.

NP watching: Stated that they appreciated the discussion. She finds Ms. Melby’s comments quite dismissive. She disagrees with many of the things stated. She would like to know if there is evidence to support the requirements.

B: Stated that their main concern is work stipulations for newer participants. She and other participants are being told they may or may not be approved to work only part time which is a new mandate while those that have been in the program were able to return to full practice immediately. This is an issue with income and benefits.

Tara O’Flarety – Director of Nursing at Life Long Medical: Stated that they are in the process of hiring a number of nurses on probation and diversion. She’s had exceptional experiences with them and finds it incredibly rewarding. She’s had challenges navigating these programs. She’s interviewing a diversion participant now and started watching the meeting. She will not be able to maintain diversion nurses and keep them full time which she needs and depends upon them for multiple programs and patients. She’s been trying to jump through hoops that have been thrown her way, but only verbally, she hasn’t seen anything in writing about how to accommodate the new requirement that they have to pass narcotics. She organized a transgender care clinic so they could pass controlled medication to provide hormone replacement therapy and was told that was not sufficient, it needed to be narcotics.

Amanda: Stated that they want to address being notified about what the contract requirements were at the beginning of the program. When she first entered this program she was told to watch a video on Maximus’s website which didn’t say anything about patient care in order to complete the program. It was to maintain sobriety with a minimum of three to five years in the program. It may have said safely practice as RN which could or could not have been in non-patient care. She disagrees with the fact they were told and informed adequately. She feels like it was very misleading and now it has completely changed. Their contract has completely changed. They were kind of pigeonholed into that contract where it was kind of a lose-lose situation. You either signed this contract and voluntarily enter this program or you may have to get a lawyer and the BRN might be coming after you. It was kind of like alright she guesses she has to sign it even though it might be modified. What is she going to do? Secondly, the individualized care every single one of them by numerous case managers regardless of alcohol, narcotics, whatever it is that brought you into this program has been told that these new requirements to do patient care and pass narcotics is mandated. She doesn't know how it was an individualized thing. She had her IEC recently and she stated her individualized case, which she has very good reasons to be exempt from this new requirement, and they did not exempt her. She still has to meet this requirement and it is not an individualized program in her opinion. She feels like they're trapped and there's no way out and they're all very scared about what will happen. Please take that into consideration. She feels like this new requirement should be for the new people coming on, not for the people that have already had contracts, but for new participants. That she understands, but not for the people that have already signed a

contract that says otherwise. It's completely misleading and false. Thank you.

David: Stated that they have been in the program for a few years. It was great initially and brought him to recovery and he is grateful to be back at work. He thinks the program was initially set up masterfully. He said the issues surfaced for the last few to six months ago. One of the biggest problems is if a drug test is dilute or they forget to check in one day then they are taken off work for 30 days minimum. They are also restricting work hours once they go back to work to part-time instead of testing the individual the next day or maybe waiting for the result. This has catastrophic results for the participant who most likely will lose their job and it's harder to get another job but also for the employer. The employer's not going to want to employ participants who, if they have missed a call or is dilute one time being taken out of work for 30 days, despite having a clean record for years, this just has catastrophic results, and he doesn't know why or who came up with this plan, but this needs to be reevaluated. Another point is, he belongs to a recovery online group of participants in multiple states, and it is well known that California has the most punitive program there is. He understands the heavy hand that needs to take place when a participant first starts the program but there needs to be a track that allows participants to graduate and decreasing the amount of times they're testing, maybe the meeting requirements, maybe these other requirements, so it allows them to transition back to their normal life in a transitionary state rather than just going full steam ahead the entire time. That's not happening either and that's recently changed as well. (Time Ended)

Sherry Gillies – co-facilitator with Molly Shirk in Oakland: – Stated that they went through the nurse facilitator training and that it was more of an overview of the program, there was no clarity given about what was going on and being said by the participants in their support groups. Their support groups sound like the people speaking at this meeting. They are people who had a DUI and now told to give narcotics, change jobs, find other jobs. She has similar concerns to the participants. She was a participant in the program and was devastated that she would not be able to go back to her job at Kaiser but found a home at Life Long and works with Tara and has been an amazing experience and even growing into management positions. It's been great to find an organization that hires nurses going through this process. The fact that this could discourage people from hiring nurses, hurts the nurses, but hurts communities that these organizations serve.

Sarah: Stated that they wanted to clear up a few things. First, there is no communication with the board. Dan expressed this earlier and he's correct. When they meet with IEC it's a simple discussion. They ask how twelve steps was, how are meetings with sponsor, etc. If they ask for a change in the program, such as go back to bedside or back to work, but there is no discussion because they're told they'll consider the change. Any discussion is through the case manager, which means they're playing telephone. There's no written discussion, so they don't have anything other than the contract or the agreement. They don't have any paper trail with emails, so they can say one thing and then say we never said that. They're not considering people who have been working a case management job and have no bedside experience that it will be hard for them to find bedside experience. But what about those of them who have bedside experience, but it's quite expired? They've been working in case management positions for some time because that was what was required of them. On the application they're weeded out immediately. It will say, do you have one year of experience within this field in the last three years, the answer is no, and then they're not a candidate. Combine that with the fact that they're going to ask for that job with no narcotic access meaning we can't fulfill the basic requirements of the job and then it has to magically turn into a narcotic access job. It also has to be day shift. They know no one starts out on days. They have so many restrictions. She pleads for the board to make this a definitive no and that nurses won't have to quit their jobs because they will have to quit. If she works 40 hours and they let you work 48, she's not going to be able to accomplish this. She'll have to quit her job. So, please make it clear to them that they don't have to quit their jobs. Thank you.

Sandra Buenrrostro: Stated that they would like to know the financial aspect between Maximus and BRN. Is it a business model to keep prolonged participation by the RNs. She requests an independent review of Maximus to get a better picture of what is going on.

Ashley: Expressed frustration that there has been zero transparency as to what is required to graduate. It has been unclear from Maximus as to what is required to complete the program.

Sophia: Stated that they have been in the program since 2016, she had a relapse and was extended. She has four years of recovery. She works with foster children as a PHN doing medical case management. Her experience has changed drastically over her time in the program. She's currently being told she has to do bedside care with narcotics access when she's never had a patient care job. She's always worked in a different type of nursing. She was due to complete the program early this month and was again told, nope, "you cannot

complete yet.” She has to return in August. She thinks this is ridiculous. She doesn't understand the logic. It's obviously a non-clinical person making these decisions. However, the fact that in her current position she’s told either she doesn't have to leave her job or not telling you that. Is she supposed to get a second job? They're not telling her that either. So, what exactly are they being told? Because Maximus doesn't know either, they don't understand what's happening. So how can they understand what's happening? This is ridiculous. It's not clinical decision making, and there is no logic behind it. (Time Ended)

Anna: Stated that it’s easy for somebody who isn’t actively looking for a job to say how easy it is to jump from one job to another. It takes months to find a job. It is not easy to graduate from the program. For five plus years, participants were told there are certain requirements that are individualized and that’s why it doesn’t match other participants in the program and now they’re being told they’ve never been individualized that it was standard for everybody. Some participants get transition but if you violate your contract in any way, you get at least 3-6 months if not a year more before you could even ask for transition again. This so-called requirement is being enforced. Nobody’s being transparent about what the participants are told by Maximus and it would be in the best interest of the participants, board, and public safety for the board to look at some of the contracts. Review all of the contracts and look at the differences, dates, changes. Some people have gone for a full year or more without an IEC meeting. They’re being told something that hasn’t been voted in yet to get a narcotics job. Some nurses are senior, older, and need a retirement job. They have no business going into acute patient care or a narcotics job or anything else if they don’t want to do it. She doesn’t know many 50-year-old nurses who want to go back to the chaotic patient care that’s already in the hospital or any organization with narcotic access. There’s a lot more to say but a very short time to do it. She’s thankful the board is asking these. (Time Ended)

Mary Molly Shirk – Nursing Support Group Facilitator:Stated that what the participants are experiencing is not from Maximus but its changes coming from the board.

Chris Else – Nursing Support Group Facilitator, San Luis Obispo: Thanked the board for putting this topic on the agenda. He provided an example of a nurse who has history of a severe chemical dependency and diversion issues, she’s gone through rehabilitation but still has troubled thoughts about narcotics and does not want to be around narcotics in her practice. She’s stressed that her license is

under intervention and likely having problems at home with financial needs and other issues but Maximus or the board has to find a second job to pass narcotics in a nursing home. She comes into contact with your grandmother who is under cancer treatment with sever pain and on lots of narcotics. This nurse who's already on thin ice is taking care of your grandmother. What is going to happen? He thinks it's an inevitability, if using this metric to prove whether nurses are safe to practice, there's eventually going to be a nurse that is going to harm a patient because they're being forced to so something when they know they should not be doing it to placate the program and people will look back at this meeting and ask why this metric was used. Recovery would like to have a good metric to prove they will not relapse again, and he doesn't know if handling narcotics is useful or will prove this. He thinks it will end in disaster. He doesn't think it's safe for the public which is what the board of nursing is here for. He thinks they're looking at this in a different way. He agrees there needs to be a good metric to show if nurses can successfully handle narcotics again, but he doesn't know what it is. He doesn't know if it's more testing, more social work, or psychology, but he doesn't think this is the right metric to be used in this manner at this time.

Mary Hegarty: Stated that she's been involved with BRN since 1997. The agenda item presented by Shannon Johnson is about Uniform Standard 12 that says a nurse needs to return to patient care with or without access to narcotics in order to successfully complete the program. This is not needed and is not relevant to the intervention program. Nurses are monitored very closely on a lot of frontiers to substantiate not only their sobriety but their stage of recovery. She does not see this as necessary change in legislation. The other concern she has is that this has been implemented across the diversion program without having legislative changes. One more quick comment, since Shannon took over as the enforcement division chief and her appointment of the Intervention program manager, they both are coming from a probation background and appear to have very little knowledge of substance abuse or recovery and treatment. The prior manager of the intervention program representing the board of nursing attended all IECs so they could do their input at the meeting and the nurses didn't have to wait up to two weeks to get the report. Thank you, and I hope the board hears the serious issues that are facing all the nurses in the intervention program.

Bob:Stated that a lot of participants are talking, and she hopes people understand how much this is changing everyone's lives. She doesn't think the board thought through any of these things. If the board is going to force them all to get into recovery, work with sponsors, they're supposed to protect their recovery at all costs. To force

participant to go back in to get a different job working with narcotics doesn't make any sense. If a person wants to go back to bedside, then yes, handle narcotics. But for others to handle them, is going to be like in a SNF where they don't want to work, or it's like the gentleman that talked about the grandmother. In her case she's had all these pain issues and you're going to put someone back that has a higher chance of relapsing in that scenario. It doesn't make sense. For my case, she was supposed to graduate on the seventh and they're not letting her graduate until she can go back to work. She has not been able to walk for a year and has been in and out of the hospital all over the place. She's stuck in the program. She has no idea when she's going to be healthy enough to go back to work. She's never had a major noncompliance, she's never relapsed, and then the case manager tells her they could dismiss her from the program even though she's never messed up. She obviously can't change what's happening to her body and she doesn't know when she can go back to work. So, she's going to be spending and going to get a loan to pay for her bills because she can't financially afford anything. She doesn't know, but she thinks the board needs to really think about all of these changes and what they really actually mean for them.

Jody: She can understand having only one RN license and having the ability to pass narcotics but to change a nurse's recovery program for someone in the program for three years with a 100% compliance and tell them they have to get a new job or a new approved BRN therapist after three years. It's very difficult to find a job passing narcotics for eight hours. Lives are being disrupted and it seems like the nurses are being set up for failure.

No additional public comments from the Sacramento location.

Break 1:25 – 2:00 p.m.
Quorum re-established at 2:00 p.m.

2:02 p.m. **Quorum re-established at 2:02 p.m.**

2:03 p.m. Dolores Trujillo reordered the agenda to move agenda item 9.3.2 to the next regularly scheduled board meeting and moving to agenda item 10.0 Legislation.

9.3.2 Discussion and possible action: Regarding needing full clinical diagnostic evaluation(s) and reassessment(s) with a focus on the participants' ability to safely return to work in a capacity as a registered nurse during the IP

Agenda Item moved to a future Board Meeting

2:04 p.m. **10.0** **Report on Legislation**

Legislative update and discussion of bills relevant to the Board from the 2023-2024 legislative session [please click on bill referenced below for hyperlink to bill text]

Board Discussion: Only AB 2015, AB 2578, and SB 1451 will be presented. All other bills will be presented at a future meeting.

2:04 p.m. **1.** AB 2015 (Schiavo) Nursing schools and programs: faculty members, directors, and assistant directors

Board Discussion: Dolores Trujillo asked if this changes the process of how the bill's going to be carried out.

Loretta Melby said if the language is currently in print stays in print, then it is in alignment with BRN regulations and statutes.

Alison Cormack said the description on page 5 says the process would not apply to schools that are not accredited but she's not sure that's what was presented by Marissa Clark.

Marissa Clark said this is a typo in the description.

Motion: **Alison Cormack: Motion to Support**

Second: **Dolores Trujillo**

Public Comment for AB 2015:

Kathy Hughes, SERVICE EMPLOYEES INTERNATIONAL UNION (SEIU) Nurse Alliance – Is proud to support this bill and lobbied on it a couple weeks ago. They support the bill with the amendments.

Vote:

	DT	MF	JD	PW	VG	DL	AC	NP
Vote:	Y	Y	Y	Y	Y	Y	Y	Y
	Key: Yes: Y | No: N | Abstain: A | Absent for Vote: AB							

Motion Passed

2:12 p.m. **Public Comment for 9.3.2:**

Chris Else: He said the Maximus contract is expiring at the end of the year and he does not think the issues are the fault of Maximus and

what is happening should not be held against them. He's had a very good working relationship with them. He thinks the changes are from the board side with Shannon and Jaspreet. He could be wrong, and Maximus may be misrepresenting their side, but he thinks the confusion is coming from board side. He continued to state that Loretta Melby made assurances that this will not occur due to the neutral state contracting process that the BRN does not have any control over and it will be managed appropriately. Additionally, an audit would be a neutral audit and not an audit of Maximus. It would be an audit of the intervention program to see what is being done well and what improvements are needed. It would start with board staff, including himself, then bringing that forward and looking at it downstream as well. It would look at the vendor, look at communication, look at participants, and so forth. It would be very neutral but very. (Time Ended)

2. AB 2526 (Gipson) Nurse anesthetists: general anesthesia or deep sedation

Bill was not taken up.

2:14 p.m. **3.** AB 2578 (Flora) Nursing: students in out-of-state nursing programs

Board Discussion: Dolores Trujillo asked if this is for schools primarily out of state that are looking to have their California students do clinicals here versus out of state where the program is located.

Marissa Clark said this is primarily distance learning for students located in various states.

Dolores Trujillo is concerned with lack of clinical space, and she doesn't understand the $100 fee for each student, it sounds like a bribe to her.

Vicki Granowitz thinks this is a slippery slope and hard to document what's happening. She's not in favor of supporting this bill. She would vote against it.

Patricia Wynne agrees with previously made comments. It would be hard to count how many students are coming in except for following the $100 fee. It would be hard to know where students are training. She would like clarification on this.

Loretta Melby said the BRN doesn't approve out of state schools. The number of California students is unknown, and it would require reliance on self-reporting and there is no language in the bill to know

where clinicals are being done. It would be very difficult to implement this bill as written.

Motion: **Dolores Trujillo: Motion to Oppose**

Second: **Mary Fagan**

Public Comment for AB 2578: Carmen Comsti, California Nurses Assoicaition (CNA): CNA opposed the previous version of this bill and continues to have concerns about the bill despite the amendments made by the bill's sponsors. She reiterates the concerns the board members raised about this bill. The ongoing concerns about out of state distance learning programs exacerbating the problems of the clinical impaction in California and inability of the board to be able to reach and address some of the issues despite amendments made to previous versions of the bill.

Blake Holiday, Nightingale Education Group, bill sponsor: He hears the concerns, the many amendments put into the bill were to address some of the concerns last year and want to remind folks of those amendments put into the bill. The fee was put in to help mitigate the costs for the facility. He said California residents who leave the state every semester to do clinical rotations elsewhere in the country that presents problems for California. There is language in the bill that says no one should displace any other student from an in-state institution.

Loretta Melby said the students are California residents. There's a federal regulation 34 CFR 6668.43 that requires schools to have the upfront conversation with the students before they enroll to let them know what travel costs would be, housing costs, whether schools would meet criteria for license injury in their home state. This requires robust discussions between academic advisors or admission representatives with students enrolling in an out of state program. She said it is not allowable within our law that an out of state nursing program could do clinicals here. The BRN does not have jurisdiction over a healthcare agency or healthcare facilities. If a facility gives a clinical placement to one person that may be their employee enrolled in an out of state school, there is no way to address that to an out of state program if it occurs.

Kathy Hughes, SERVICE EMPLOYEES INTERNATIONAL UNION (SEIU) – They have not taken an official position on this bill but have historically opposed bills of this nature for the reasons discussed. She will take it to state council to SERVICE EMPLOYEES

INTERNATIONAL UNION (SEIU) with recommendation to oppose the bill.

Vote:

Vote:	DT	MF	JD	PW	VG	DL	AC	NP
	Y	Y	Y	Y	Y	Y	Y	Y
	Key: Yes: Y | No: N | Abstain: A | Absent for Vote: AB							

Motion Passed

4. AB 2862 (Gipson) Department of Consumer Affairs: African American applicants

Bill was not taken up.

5. AB 3127 (McKinnor) Reporting of crimes: mandated reporters

Bill was not taken up.

6. SB 895 (Roth) Community colleges: Baccalaureate Degree in Nursing Pilot Program

Bill was not taken up.

2:35 p.m.

7. SB 1451 (Ashby) Professions and vocations

Board Discussion: Mary Fagan asked if the transition to practice is from a standard NP to a 103 or is this also a 103 to 104?

Marissa Clark said there's 4,600 hours from standard NP to 103 and another 3 years to go from 103 to 104.

Mary Fagan said she's concerned that someone could do clinical hours in pediatrics and then apply to be a 103 in adult gerontology population. She asked if this is correct because they need to practice in a group setting, right?

Loretta Melby said a NP graduates and is initially licensed in California does so and practices under standardized procedures that are facility specific. To move into not using standardized procedures and work in a group setting without them, which is the role of the 103NP you must complete a transition to practice that is 4,600 hours or 3 years. Some specifics were put into the transition to practice with AB 890. Recommendations from stakeholders to NPAC is while a NP works under standardized procedures is when the transition to practice is completed. So, with the new language the NP could complete a transition to practice in peds, have a national certification

in Adult/Gero and then be used in a group setting without standardized procedures irrespective of national certification and their specific specialty area of education.

Mary Fagan said a person could not get a national certification in Adult/Gero without any Adult/Gero experience.

Loretta Melby agreed but said if this bill passes a NP could have a national certification in Adult/Gero with their education in Adult/Gero but they can then practice without standardized procedures in peds.

Mary Fagan said they would need to be hired in a group setting so somebody would need to bring them into the group with that knowledge and that worries her a little less because they know what they're taking on and they need to train them.

Alison Cormac said that answers her question which was on page 34 about the attestation of the completion not required to specialize in the same category that its linked to the same situation.

Loretta Melby provided some background as they consider this section where they're looking at formulating their opinion. The transition to practice when this was first brought in AB 890 was for the board to put into regulation what that transition of practice was and we were given some guidelines. Points in AB 890 were not to make it overly burdensome, and to define that and she truly believes the NPAC did an amazing job with that. The NPAC took feedback and for the public to be aware is made up of two physicians, four NPs and a public member. They worked on this in subcommittees, came back to the Nurse Practitioner Advisory Committee and then it went to practice committee and the board. Everybody heard this regulatory package went out to public comment, etc. and was approved all the way through. She thinks what's in front of them now is more towards what the board has always been striving for. If you listen as AB 890 was being moved through the legislative session, was Nurse practitioners should have an independent practice, and that should be something that is granted to them on licensure and that independent practice, as long as it's within their scope of education, their scope of clinical practice, etc., should be the golden standard through the 103 and ultimately into the 104, that nurse practitioner now has a pathway to get there. The intention of the 103 transition to practice throughout the entire process working with the NPAC, working with the board was to follow the letter of the law as much as we can. There was some language in there that made it kind of difficult. Further discussion was whether or not the legacy or retired national certification was to be used. That was something the board was in

support of, but there was language that was prohibitive that said we had to evaluate a current exam and then evaluate that ongoing. We cannot do that with a retired or legacy certification because that exam doesn't exist. How this bill addresses that, pulls that out so all legacy and retired national certification holders would be able to transition to the 103 status and that's definitely in line with what the board wanted. The requirement when they're pulling that saying that this can now be completed out of California. That's fantastic because the transition to practice must be completed in California when AB 890 was passed, and so we were limited by requiring you to do it even if you were 20 years licensed practicing independently in another state. In order to get to that independent practice here you had to come back into California and redo a transition of practice. She thinks this bill definitely addresses some of those areas that the board found when looking at implementing this and creating the transition to practice were noticed to be directly a barrier for that. The one thing that she wants to bring to the board's attention is when she's looking at this for implementation the way it's written now, she can't see right now and obviously this is early in and they don't have final language or anything about how to implement this going into a 103 certification. When she remembers going back and reviewing some of the language and some of the presentations that were put on by the Advanced Practice Advisory Committee that we had at our board when this was first passed, and they talked about this being an automatic thing that occurred at three years in and that it wasn't a certification process that came in through the board, and in fact, there was no fee assigned to the completing the transition of practice for a 103. There was nothing turned into the board that needed to be done to vet that. She thinks this more closely aligns to that but the issue that now comes in front of her is if this passes, how does she implement this. That might be something the board considers is at this point we don't shoulder that responsibility of vetting or verifying that these transition to practices are completed, but put that more on as Mary had mentioned, the person that's hiring. Because if she as the EO, not her in particular, but as the BRN, if she doesn't have the ability to hold somebody accountable on an attestation, then why have an attestation? If we don't have to have to have the transition to practice be completed in California and it could be completed elsewhere, how can she vet that? Employment records? W-2s? A letter from somebody that she doesn't know and can't verify that this was actually from a legit person that was there? So those are some of the questions that come to her mind, and she doesn't have those answers. She's asking how do we do this? If you're looking at accepting hours that are not necessarily within your specialty that you were educated on and that you hold your national certification, then what are we verifying hours for? That was some of the conversation

that happened in NPAC when they were developing this is that if your practice is in alignment with your education, your clinical experience, international certification, then we should vet that those hours all line up and that's what we did based on their recommendations. It may be of benefit to retire a 103 and not have a 103 as an option for Nurse Practitioners and have them have an independent practice either on licensure or, she'll correct that because this law requires a national certification. The board does not require a national certification for licensure. It would be on hire of a group setting that they verify that they've been practicing three years and have a national certification and then they can employ them without standardized procedures and have them practice with a physician or surgeon. That really opens that up and she can't say that she knows how that would work out, but she knows the ultimate goal that the board put out previously is independent practice for our nurse practitioners. If we're looking at this from the standpoint of public protection, and there's not something that we're vetting or managing then how is that public protection at this point. At this point the question is did you complete 4600 hours, yes or no, and they move forward. She understands that and she's not saying that's something that's incorrect, but she's looking at how can this be utilized in the board's current role, and she doesn't see that we serve a role or a purpose at this point. If those sections are removed and adjusted, she thinks it ultimately comes more into alignment with independent practice that we all want for our nurse practitioners.

Dolores Trujillo asked Loretta Melby if the board supports the bill and has amendments rather than requiring the board have language be put on employers, she's trying to understand what that means.

Loretta Melby said, Mary put that out there, which really sparked this thought process in her head, it's up to the employer to hire them, right? So if they're doing their transition to practice in an area that they're not educated and trained in, and we know that this occurs, she can tell them as a practice manager of an office with a physician and nurse practitioners and PAs in her prior life, she had a nurse practitioner that was a pediatric nurse practitioner. She did not practice as a pediatric nurse practitioner, she practiced in this facility that she worked in, which was adult GI, and so she was educated and licensed as a pediatric nurse practitioner but was very competent in working and employed as an adult GI nurse practitioner. It happens out there, and people get hired in those facilities who utilize them and they're very competent in all these various ways. As Mary put is an employment aspect, and the board does not get involved in employment. The board does not get involved in specific competencies, that's done at the employers with policies and

procedures and onboarding and sign off sheets etc. The board doesn't do that. The board establishes safe entry into practice, and that may be where we need to have some amendments where the board supports this because the board understands what they're trying to do. Access to care is needed and the board wants the nurse practitioners in the rural settings, to practice to their full scope of practice, and it might be at that point that the 103 part is if you put BRN into that, that that's a barrier, and maybe we just need to remove BRN out of that so that they can manage that outside of us. Then the board looks at it from the original language, which is the board comes in at the 104 where the fee was established. That's where the board rolls it back to that initial interpretation that was presented to the board by the APRN committee and the president of California Nurse Practitioner Association and was how they interpreted it and that might be where we need to land.

Dolores Trujillo asked if support with amendment included language to remove 103.

Loretta Melby said that's what currently happens right now, so if a person has a 103, the employer of the specific group settings are already outlined in law that are not being adjusted, can employ that person and work them without standardized procedures. For the public to understand what standardized procedures are, there's a separate regulation that outlines eleven specific areas that are needed to make up a standardized procedure, and that is a contract or policy procedure document that is utilized by a licensed healthcare facility, a physician, as well as the nurse practitioner, and the three entities come together and make this up and they describe competencies of the NP. They will describe entry into exactly what can be done. They describe what the review processes are, what the oversight process is, etc. and it's very detailed. What the person right now as a 103 does is they can work in a group setting without that specific kind of contract policy procedure known as standardized procedures that we have in our regulations so they're able to do all of that with whatever the facility has on policy and procedure and they follow that. That would maintain, that doesn't change, that's what it is. What they would not have is a 103 certification through the BRN because removing all of those, it begs to have that conversation about what is the board vetting and how are we vetting it, what could we do to even vet that would be of service? Because getting an attestation from an out of state provider that we can't verify license, we don't know anything about signatures, we don't have any authority over their license or anything and then removing any ability to address that here says, okay, what is our public protection? If we're not requiring them to be in their same specialty that they were

educated, trained, and nationally certified in, then they can truly get that experience through many different means, including continuing education, including coursework.

Marissa Clark provided more information about the Legacy Certifications.

Alison Cormack asked if Office of Professional Examination Services (OPES) already exists.

Marissa Clark said it does and exists under DCA.She went on to provide information about Spanish language terminology for the Nurse Practitioner and right to see a physician.

Loretta Melby provided additional context about the language in the bill.

Marissa Clark spoke about language regarding use of “Doctor” by non-physicians.

Loretta Melby added that the language does not prohibit a RN from using their degree to identify themselves.

Nilu Patel has an issue with this like AB 675 that was not previously passed about using “doctor.” She has a doctorate degree and sometimes students address her as doctor. Wouldshe corrects her students when they do this in the educational setting? This would be really limiting for those practitioners who have the education to not be able to use the title doctor, including naturopaths, podiatrists, optometrists.

Patricia Wynne completely agrees with Nilu Patel. We need to recognize if it’s a terminal degree and a person has earned a doctorate then you should not be precluded from using it. There should not be a misrepresentation in the workplace, but this seems overbroad.

Dolores Trujillo thinks this is a cultural issue in Hispanic culture.

Loretta Melby said this was very controversial last year and there was legal action against the board for other individuals who did not appropriately identify themselves as such and is a heated discussion. There were several podcasts about this about people not understanding the use of doctor being confusing. She explained nurse midwives terminology. She spoke about the use of 103

designations publicly. There are no regulations for CNS or CRNA as there are for CNM and NP. There are many nurses in academia who have a doctorate degree and use that designation in the didactic arena where students call them doctor but they then cannot use it in the clinical setting.

Nilu Patel said use of “doctor” in the clinical setting is her primary concern, so she doesn’t get any misdemeanors because of it. The other issue she wanted to bring up since Ms. Melby brought it up with the other advanced practice specialties, she feels this is going to be a slippery slope and it's going to go towards all the other three advanced practice specialties too if we allow this here.

Loretta Melby agreed and spoke about the discussion yesterday of the new entry level education requirements for advance practice nurses. She again reiterated nurses using all their terminal degrees without using doctor.

Reza Pejuhesh said we hear from members of the public saying their patients are advised of their actual role that they are not a medical doctor, but it isn’t cut and dry, but he understands recognizing education. There is a court case going through the legal system right now with the Medical Board.

Mary Fagan has serious concerns with legislation that says a person cannot use the degree they earned is very inappropriate.

Nilu Patel says this language about use of “doctor” already exists in the Medical Practice Act and sees this as redundant language.

Motion: **Dolores Trujillo to Support if Amended – Remove the 103 designation, nurse can use earned title but specify their specialty**

Second: **Patricia Wynne**

Public Comment for AB 2442: Scott Suckow – Executive Director for the Liver Coalition in SD – In support of SB 1451: the liver coalition was formed by medical specialists’,e transplant surgeons, patients, and caregivers to promote liver health and meet the needs of those affected by liver disease. They have NPs that serve on their associate medical advisory committee. These professionals are vital to the delivery of care of those living with one or more of the 150 liver diseases. They support

SB 1451 because it will strengthen our state's primary care system and ensure patients with the most need can see a provider. NPs play an important role in early detection of asymptomatic life-threatening diseases such as non-alcoholic fatty liver disease. Early detection is a key aspect of primary care delivery, and we can improve and save lives if more NPs are granted independent practice to the full extent of their abilities as intended by AB 890.

Janina Teoco : She asked what role current best evidence plays in logistical development and follow up question is how new policies are evaluated for effectiveness and safety.

Diane Nugent, MD: Appreciates robust discussion. She's calling for support of SB 1451, particularly in the realm of sickle cell care NPs who play a crucial role for them to improve access to care.

Vicki Granowitz was excused from the meeting at 3:27 p.m. Board continues with quorum.

Nancy Trego, Geriatric NP – She's one of many legacy NPs in California. She asks the board's support for SB 1451 and thanks EO Melby for her understanding and insight into the bill. She appreciates putting the burden on the employers as making total sense. She said the language in the bill fixes the shortfalls of having the OPES review. Disallowing the legacy NPs, the 103 status diminished the impact of the law that was intended to increase access to care for NPs being able to practice to the full extent of the clinical experience.

Ron Ordona, NP: He does house call visits for homebound elderly patients in Sacramento and surrounding counties. He's co-chair of health policy for CANP. In strong support of SB 1451. This is a beacon of hope for the legacy NPs. There are 28 states that allow independent practice. He shares the dilemma of Dr. Patel as he also trains students in the clinical setting.

Kathy Hughes, SERVICE EMPLOYEES INTERNATIONAL UNION (SEIU) National Alliance: Proud to support SB 1451 as written. Providing clarifying guidance to legacy certifications will help streamline the application process and enable California NPs to expand access to care.

Malik King, LVN, RNc, BSNc, PHNc: In support of SB 1451. Clarifying doctor nurse practitioner may help with the confusion for students in the clinical setting.

Carmen Comsti, California Nurse Association (CNA): – CNA supports sections of 1451 related to addressing clarifications to implement AB 890 to make sure legacy certification and other issues related to implementation of AB 890 and the board's motion to address the varying portions of the bill.

Vote:

Vote:	DT	MF	JD	PW	VG	DL	AC	NP
	Y	Y	Y	Y	AB	Y	Y	Y
	Key: Yes: Y | No: N | Abstain: A | Absent for Vote: AB							

Motion Passed

8. SB 1468 (Ochoa-Bogh) Healing arts boards: informational and educational materials for prescribers of narcotics: federal "Three Day Rule"

3:38 p.m. **Open session ended**

3:38 p.m. **11.0 Closed Session**

11.1 Disciplinary Matters
The Board will convene in closed session pursuant to Government Code section 11126, subdivision (c)(3) to deliberate on disciplinary matters, including stipulations and proposed decisions.

11.2 Pending Litigation
The Board will convene in closed session pursuant to Government Code section 11126, subdivision (e), to discuss pending litigation:

Julie Mae Winters v. California Board of Registered Nursing, Superior Court of California, County of Los Angeles Case Number: 245TCV01833

11.3 Personnel Matters
The Board will meet in closed session pursuant to Government Code section 11126, subdivision (a)(1), to conduct the annual performance evaluation and salary of its Executive Officer.

5:37 p.m. **5.0 Adjournment**

- Dolores Trujillo, President, adjourned the meeting at 5:37 p.m.

Submitted by: **Accepted by:**

Loretta Melby, MSN, RN
Executive Officer
California Board of Registered Nursing

Dolores Trujillo, RN
President
California Board of Registered Nursing