Nursing Education and Workforce Advisory Committee Meeting

MEETING MATERIALS

June 25, 2025

Updated 6/24/2025

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Agenda Item 2.0

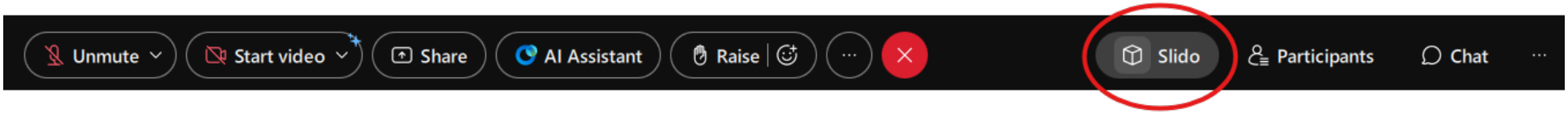
General instructions for the format of a teleconference meeting

Nursing Education and Workforce Advisory Committee (NEWAC) Meeting | June 25, 2025

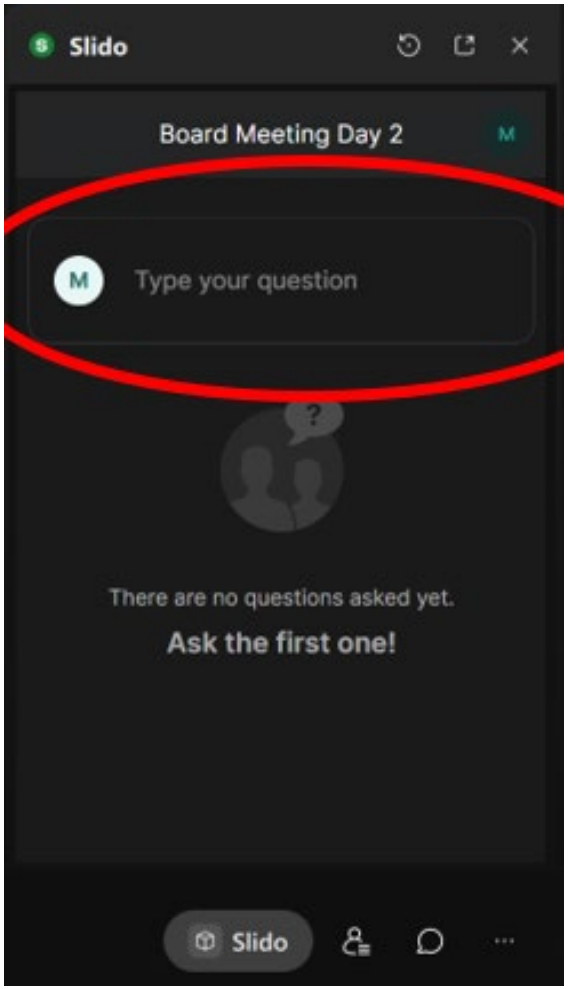
Participating During a Public Comment Period

If you would like to make a public comment:

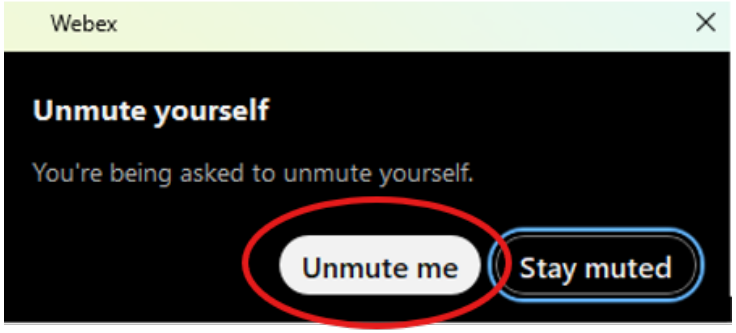
1. Click on the 'Slido' or  button at the lower right of your Webex session (you may need to click the three dots (…) and the Advanced tab to find this option, if joined by smart phone or another mobile device).



2. The 'Slido' panel will appear. (Your screen may look slightly different than pictured depending on Webex version.)



3. In the 'Slido' Q&A panel, type "I would like to make a comment." You will be identified by the name or moniker you used to join the Webex session, and your line will be opened. On the "Unmute yourself" pop-up, click the '**Unmute me**' button (this may be hidden behind other open applications), and you will have **2 minutes** to provide comment. Every effort is made to take comments in the order which they are requested.



Agenda Item 4.0

Discussion and possible action: Discussion of various concerns and recommendations outlined in letters received from California Association of Colleges of Nursing (CACN) and from Copper Mountain College, generally summarized as follows (copies of original letters will be included in meeting materials):

- **Ongoing challenges in securing clinical placements for registered and advanced practice nursing students**
- **Administrative obligations imposed on nursing schools by BRN regulations and processes**
- **Implementation of AB 2684 (Reg. Sess., 2021-22)**
- **Consistency and remediation for program director approvals**
- **Communication with NECs**

BOARD OF REGISTERED NURSING
Nursing Education and Workforce Advisory Committee Meeting
Agenda Item Summary

AGENDA ITEM: 4.0
DATE: June 25, 2025

ACTION REQUESTED: **Discussion and possible action:** Discussion of various concerns and recommendations outlined in letters received from California Association of Colleges of Nursing (CACN) and from Copper Mountain College, generally summarized as follows:

- Ongoing challenges in securing clinical placements for registered and advanced practice nursing students
- Administrative obligations imposed on nursing schools by BRN regulations and processes
- Implementation of AB 2684 (Reg. Sess., 2021-22)
- Consistency and remediation for program director approvals
- Communication with NECs

REQUESTED BY: Garrett Chan, PhD, RN, APRN, FAEN, FPCN, FCNS, FNAP, FAAN
Chair of the Nursing Education and Workforce Advisory Committee

BACKGROUND:

On January 31, 2025, the BRN and NEWAC received a letter from Daren Otten, President of Copper Mountain College, and on February 2, 2025, the BRN and NEWAC received a letter from Kimberly Perris, President of CACN, each detailing a number of concerns.

Following this AIS is a chart that shows the areas/concerns outlined in the letters for further discussion; and copies of the original letters are located on pages 20-29 of these materials.

RESOURCES:

NEXT STEPS:

FISCAL IMPACT, IF ANY: None

PERSON(S) TO CONTACT:

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Topic	Issue(s) outlined in letter(s)	Recommendation(s) in letter(s)	BRN response/background
Ongoing challenges in securing clinical placements for registered and advanced practice nursing students	The BRN's strictly adheres to a defined threshold of 500 direct patient care hours, with a minimum of 30 hours per specialty (CA Bus. & Prof. Code. § 2786 (a)(2)). The accompanying implementation requires that concurrent education in theory and clinical practice shall be "in the following nursing areas: geriatrics, medical-surgical, mental health/psychiatric nursing, obstetrics, and pediatrics" (CA Code Reg. §1426(d)). Clinical placement and faculty qualification reporting documents utilized by the BRN also specify these five nursing areas – all of which are most readily associated with the acute care environment. The delivery of health care and nursing care continues to undergo radical transformation (e.g., Telemedicine, Centers for Medicare & Medicaid Services "Acute Hospital Care At Home" program, etc.). Distinctions between acute care and community-based care have blurred substantially. Persistent use of the distinct specialty categories of geriatrics, medical-surgical, mental health/psychiatric nursing, obstetrics, and pediatrics limits innovation in nursing and the preparation of workforce capable of working in the evolving health care environment. Further, inconsistencies in interpretation by Nursing Education Consultants (NECs) of whether a clinical experience is "sufficiently" a specialty as opposed to community health creates confusion among and within programs. Lastly, strict adherence to the use of these specialty terms exacerbates the shortage of clinical placements as all schools vie for the limited acute care placements, especially in areas such as obstetrics and mental/psychiatric health.	Revise 16 CCR §1426(d) to redefine nursing care areas to address: Adult and aging, childhood and adolescence, reproduction and child-bearing, and behavioral health.	Mapping the curriculum for competency-based education needs to specifically state what learners "do" and needs to be specific about patient groups. Gerry Altmiller shared this information at the Spring CACN conference: Gerry Altmiller, CACN presentation on Implementing a Competency-Based Curriculum: Structure, Process, Outcome. (slide 22) Additionally, this regulation establishes the licensing standard for all nursing applicants (in state, out of state, and international). Any changes to this standard could affect reciprocity and limit the ability to license nurses whose education differs from the requirements outlined in the regulation.

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(Continued from above)	The use of low-, medium- and high-fidelity simulation, including the use of virtual and augmented reality, remains a strong, evidence-based method for augmenting and/or replacing direct care clinical hours required for nursing education. Ample evidence supports the use of these learning modalities and the majority of U.S. nursing regulatory boards allow the use of simulation to satisfy mandated clinical hours. Importantly, no evidence supports *any* specific minimum number of clinical hours associated with competency attainment in nursing education, while evidence provided by the National Council of State Boards of Nursing substantiates substitution up to fifty percent simulation in place of direct care hours.	Work with the legislature to revise CA Bus. & Prof. Code. § 2786 (a)(2) to allow schools to substitute simulation to meet up to 50 percent of the 500 direct care hour requirement for nursing specialty areas adult and aging, childhood and adolescence, reproduction and child-bearing, and behavioral health, if the school demonstrates alignment with simulation standards promulgated by the Society for Simulation in Healthcare (SSH) or the International Nursing Association of Clinical Simulation and Learning (INACSL).	500 hours direct patient care clinical: The BRN requires 18 semester units of clinical practice for licensure. That is typically calculated out to 864 clinical hours; based on that figure, with the 500 hour direct care requirement, the BRN offers up to 42% of clinical hours to be leveraged for simulation or other modalities that meet the course/clinical objectives. According to the NCSBN Education Survey 2024: No United States Board of Nursing (BON) has set minimum clinical hours less than 250. • States/territories requiring 250-500 hours: DC, DE, GU, RI, VA • States/territories requiring 501-700 hours: • AS, CA, CO, WA • States/territories requiring 751-1000 hours: LA, VI • States/territories requiring 1000+ hours: HI, NJ All programs participating in the National Simulation Study (Hayden, Smiley, Alexander, Kardong-Edgren, & Jeffries, 2014) required at least 600 hours of clinical experience in the pre-licensure curriculum. No evidence is available regarding the outcomes of substituting traditional direct patient care clinical experience with simulation when the program has less than 600 hours The demographic characteristics across the three study groups were generally similar; however, the 50% group experienced a higher dropout rate. Those who left the study were more likely to be older, male, and from minority backgrounds. Despite this, students who remained in the 25% and 50% groups rated their simulation experiences positively, as reflected in their CLECS scores. Further research may be necessary to determine whether simulation is an effective learning method for all student populations.

Topic	Issue(s) outlined in letter(s)	Recommendation(s) in letter(s)	BRN response/background
(Continued from above)	(Continued from above)	(Continued from above)	Additionally, the following article discuses concurrent theory and clinical education: Nursing science as a federally-recognized STEM degree: A call to action for the US with global implications. It summarizes that STEM education is an experiential learning pedagogy and relies heavily on active learning. Practice and theory focus on instruction that expose students to practice and theory emphasizing hands-on experiences of solving authentic problems. It gives students opportunities to see the connection between the content they are studying and the application of the content in authentic and relevant ways.
	The process of review for approval for new or expansion of prelicensure programs is arbitrary and lacks consistent reason or rationale. The BRN routinely approves new programs or expansion of programs despite soundly documented concerns of clinical site impaction provided by regional programs and schools. The BRN places the responsibility of communicating with existing programs and schools with the new or expanding program, which is a direct conflict of interest. The new or expanding program has no incentive to be honest or transparent with regional counterparts. Moreover, out-of-state programs appear to have equal access to a limited state resource (clinical placements), which negatively impacts programs and schools that are supported by and committed to meeting the needs of the residents of California.	The prelicensure program approval process must be substantially overhauled to include a BRN assessment of the distribution of nursing educational slots as well as clinical placement capacity across regions within the state. Impaction thresholds informed by these data must be implemented. The BRN must publicly disclose the rationale for their decision, addressing each of the factors articulated in CA Bus. & Prof. Code. § 2786.2(b)(F).	There are two types of nursing education program approval: 1) initial approval of new programs before they open for enrollment, and 2) ongoing monitoring and continued approval of existing programs. The purpose of initial approval is to ensure that the programs comprehensively cover the knowledge and skills needed for licensure and safe practice. This review also evaluates the program's ability to support the student from enrollment to graduation by ensuring that the program has the proper resources. Based on this review process, an enrollment number is granted. The process for continued approval of an established program is based upon monitoring of program performance outcomes and continued compliance with BRN statute/regulations If an approved nursing program wishes to grow its student population, it may present its request to the Board. When considering such requests, the Board is permitted to review the program outcomes, such as licensing examination pass rates, graduation and retention rates, and any verified complaints

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(Continued from above)	(Continued from above)	(Continued from above)	received. These indicators are used to evaluate the quality of the program to ensure that they are continuing to graduate students who are prepared to practice safely as new graduate nurses. Once program quality is established, the Board will consider the request to grow the enrollment of the program and will consider factors, such as adequacy of resources, the availability of clinical placements, and the impact to other currently approved nursing programs in that geographic area. For programs wishing to expand to a new campus location or start a new nursing program they must produce evidence of availability of clinical placements for students of the proposed program. Clinical placements of the new program must take into consideration the impact on the use of the clinical facility by existing prelicensure registered nursing programs and must be coordinated with any process for clinical placement, such as consortium for regional planning. Programs should include a description of the collaboration and coordination efforts with any existing registered nursing programs and any regional planning consortium. Entities requesting a new nursing program in California and currently approved nursing programs who want to open a new campus must follow the process outlined in the EDP-I-01. (16 CCR 1421) Programs that are already approved that want to grow their program by taking on additional students shall take into consideration the impact that an additional group of students would have on students of other nursing programs already assigned to the agency or facility. (16 CCR 1427)

Topic	Issue(s) outlined in letter(s)	Recommendation(s) in letter(s)	BRN response/background
(Continued from above)	(Continued from above)	(Continued from above)	The program requesting the new program/campus approval or increase in enrollment is required to show they have the resources to support the student from enrollment to graduation (BPC 2786.2 (b)(1)(F)). The ability to support a student from enrollment to graduation relies on the resources available to all schools, including existing programs and students. The program requesting approval to grow is not required to ask for other schools to approve its growth. The requirement is that the requesting school, when working with healthcare facilities to obtain the clinical placement resources, ask the facility what other nursing programs rely on them to complete their student's clinical experiences for program completion and licensure. The program is should then required to work with only those programs identified by that healthcare facility to ensure that they will not negatively affect their current enrollment patterns. These collaborative and coordination efforts are then shared with the nursing education consultant to prepare reports for the Board. If no impact is identified, or if an impact is identified but the schools are able to resolve it, then it is brought before the Board. The Board then reviews all statutorily required areas and considers whether to approve the request. If an unresolved impact is identified, particularly one that could affect students already enrolled or accepted into an approved nursing program, the Board must evaluate the request with consumer protection as the primary consideration. In this

Topic	Issue(s) outlined in letter(s)	Recommendation(s) in letter(s)	BRN response/background
(Continued from above)	Out-of-state Nurse Practitioner (NP) programs are rapidly displacing in-state programs for clinical placements. There are 59 out-of-state programs now approved for clinical placement within California compared to the less than 30 BRN approved NP programs in the state. The BRN imposes substantial regulatory control and administrative burden on in-state programs while only requiring minimal administrative effort by the out-of-state programs. The process of procuring authorization for an out-of-state program to gain access to California clinical placements for both prelicensure and postlicensure APRN programs is *easier* than for in-state programs! Further, anecdotally, deans/directors report unscrupulous "pay to play" practices employed by some APRN programs, which places California programs, especially public programs and their students at a significant disadvantage.	The BRN should hold all APRN programs, in-state and out-of-state, to the same regulatory and administrative standards and processes, including those for clinical placements	context, the primary consumer group needing protection is the current or incoming students that have already committed themselves and invested in beginning their nursing education, with the risk of not being able to complete it if clinical placements become too scarce. The BRN agrees that work to align these processes is needed. Currently, both are held to the same standards. However, the administrative burden is not the same for in-state and out-of-state programs. This will need to be addressed to ensure equitable access and consumer protection is maintained for California residents attending both in-state and out-of-state NP programs.
Administrative obligations imposed on nursing schools by BRN regulations and processes	The 30-unit LVN to RN option (16 CCR § 1429) is an outdated approach to nursing workforce development and not in the best interest of patient care or the licensed vocational nurse. Maintaining this option imposes an administrative burden on nursing programs and schools even though many report no substantial use of the program in many years. Importantly, this path provides *no* degree, not even an Associate Degree in Nursing (ADN) to the student and as a result, most other states do not recognize California's LVN 30 Unit Option and will not issue RN licenses to these LVNs, substantially limiting their future mobility and employment opportunities. In addition, most health care systems across the state and nationally require a degree in nursing in addition to licensure to obtain employment.	Eliminate the 30-unit LVN to RN option (16 CCR § 1429). Incentivize programs and schools of nursing through funding mechanisms to voluntarily develop and administer LVN to ADN and LVN to BSN educational pathways.	On April 2, 2025, the Governor unveiled a plan to create high-paying, fulfilling careers for more Californians regardless of college degrees. The Master Plan for Career Education aims to strengthen career pathways, prioritize hands-on learning and real-life skills, and advance educational access and affordability. This makes it easier for Californians, including veterans, to receive college credit for their real-world experience. BPC 2736.6 requires that a school approved by the board offer an educational pathway to a LVN that allows them to be eligible to sit for the NCLEX-RN and that pathway shall not require more than 30 units in nursing and related science subjects to satisfy such preparation.

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(Continued from above)	(Continued from above)	(Continued from above)	The BRN does not specify a degree requirement for licensure and only sets curriculum requirements that must be met (16 CCR 1426). This allows for multiple pathways to licensure. Additionally, 16 CCR 1423.1 and 1430 require an approved prelicensure nursing program to evaluate and grant credit for previous education, including military education, and other acquired knowledge in the field of nursing through equivalence, challenge examinations, or other methods of evaluation. The BRN cannot legally incentivize, influence, or offer funding for nursing programs.
	The EDP-P-18 BRN Clinical Placement form is administratively onerous and provides little actionable information to the BRN to justify its use. The form requires excessive specificity regarding placements causing confusion resulting in the collection of inconsistent and inaccurate data. In addition, the form requires time and effort by the clinical agency staff, over whom the BRN has no jurisdiction, frequently resulting in delays that penalize the nursing program or school.	Eliminate the EDP-P-18. Work with the CA Department of Health Care Access and Information (HCAI) to develop efficient and accurate reporting process to determine clinical placement usage across the state.	In the California State Auditor's (CSA) Report 2019-120, recommendations 4 and 5 stated that the BRN should do the following: update its clinical facility approval form (EDP-P-18) to capture annual capacity estimates from clinical facilities, as well as clinical placement needs of programs and to revise regulations to require nursing programs to report any changes they make to their use of clinical facilities within 90 days of making a change and report annually if the program has made no changes. The EDP-P-18 is a suggested form and is not required by regulations. Per the CSA recommendation, the BRN did update the form and updated 16 CCR 1427. Additionally, the data collected by the EDP-P-18 helps the Board approve clinical facilities. 16 CCR 1427 states that each program must submit evidence that it has complied with the requirements.

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(Continued from above)	(Continued from above)	(Continued from above)	This form requests information on the program, the clinical facility and the content areas supported and captures the data recommended by the CSA audit. The BRN agrees that this form resulted in the collection of inconsistent and inaccurate data; therefore, on May 1, 2025, the BRN released the Clinical Facility Authorization (CFA) portal and is no longer using the EDP-P-18 forms. The CFA portal and databank was developed to answer the CSA recommendations 6, 7 and 9. Once the data from the paper EDP-P-18 forms is cleaned and organized within the database, it will be published on the website for access by the public and the Board. Additionally, BPC 2786(c)(3)(A)–(c)(4)(B) was updated to support the CSA recommendations and made the data on the EDP-P-18 forms a requirement for collection by the BRN. The BRN will also work with the Department of Health Care Access and Information (HCAI) to clarify the information contained in the CFA such that it can be leveraged to help implement the provisions in Health and Safety Code section 127776(c)(2).
Implementation of AB 2684 (Reg. Sess., 2021-22)	The BRN regulations and the Program Director Handbook continue to require approval of faculty by the BRN despite statutory language to the contrary in CA Business and Professions Code §2786.2(b)(1)(C). In fact, throughout the academic year 2023-2024 and into the current academic year, 2024-2025, the BRN continues to apply existing regulations, which conflict with AB 2684. The BRN has failed to provide timely guidance to deans and directors. No Program Director Handbook for the 2024-2025 Academic Year has been distributed. Further, while the	The provisions of AB 2684 as codified in the CA Business and Professions Code § 2786.2(b)(1)(A)-(E) are clear and self-executing. The BRN must immediately notify all programs and schools of nursing of changes in process that will ensure that	The implementation of AB 2684, in January 2023, required the Board's Executive Officer (EO) to develop uniform methods for evaluating requests and granting approvals. Until these uniform methods are complete and posted to the website, the Director's Handbook is utilized. The 2023–24 handbook was revised to incorporate the changes outlined in the sunset bill. However, in Spring 2024, it was discovered that the guidance regarding faculty approval requirements was inaccurate due to a different interpretation of the recent statutory change.

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(Continued from above)	BRN has finally acknowledged that under AB 2684, it is required to accept hiring decisions made by the approved program director of a nationally accredited program, it has not widely promulgated that determination and the BRN has continued to require completion of the EDP-P-02 forms for faculty – a BRN approval process	these programs and schools may benefit from the provisions of this law. The BRN must act swiftly and without further delay and obfuscation to accept the self-study required by programmatic accreditors as a substitute for board self-study or data collection if the statutory provisions are met and accept continuing accreditation decisions from accreditors.	The EO released updated guidance at the following conferences: Spring 2024 COADN conference, Spring 2024 CACN conference, Fall 2024 COAND/CACN joint conference, Spring 2025 COADN conference and Spring 2025 CACN conference. Additionally, an email was sent out to all Program Directors in Spring 2024 and training was provided to the NECs. The EO opted not to update the Director's Handbook for Fall 2025 in order to avoid duplicative efforts, choosing instead to incorporate the necessary changes into the uniform methods. The 2023–24 handbook remains applicable, with the exception of the faculty approval process noted above. Program approval is a process that is conducted by state (i.e. state boards of nursing) under the authority of state law and ensures that standards set forth in state law are met. Accreditors assess the quality of nursing programs based on their own standards and requirements from a national perspective. Since 2023, the BRN has been conducting continuing approval visits (CAVs) in collaboration with three separate accrediting agencies. This has required the BRN to understand and adapt to each agency's specific requirements while ensuring continued compliance with standards established in state law. Under BPC 2786.2(b)(1)(D), the Board may request addendums to accreditation reports if they do not address state law requirements. This determination is made based on the school's completed crosswalk, which is reviewed by the NECs.

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(Continued from above)	(Continued from above)	(Continued from above)	This has been a continuous learning process for Program Directors, accrediting agencies, and the NECs. The BRN acknowledges that there is room for improvement and remains committed to streamlining the joint CAV process. The Uniform Methods will be published on the website, after which the use of the Director's Handbook will be phased out.
Consistency and remediation for program director approvals	The lack of a remediation pathway for Program Directors is especially troubling. If remediation is indeed an option, it should be clear, standardized, and accessible.	Establish a centralized database of pre-approved Nursing Directors and Assistant Directors. Implement a transparent appeals process for denied approvals. Clarify and codify a remediation pathway—just as AB 2015 did for faculty—so qualified often local candidate administrators are not arbitrarily excluded.	Program Director and Assistant Director approvals are outlined in 16 CCR 1425, subdivisions (a)(3) and (a)(5). A Program Director must have one year validated experience as an administrator that meets the definition in 16 CCR 1420(h), two years' teaching experience in a pre- or post-licensure RN program, and one year continuous, full time or its equivalent experience direct patient care as a RN; or equivalent experience and/or education as determined by the Board. The Assistant Director is required to meet all of the above with the exception of the one year validated experience as an administrator. To apply equivalency to the one year experience as an administrator, the BRN must look at 16 CCR 1420, which defines Director under subdivision (h), and states that it is "the registered nurse administrator or faculty member who meets the qualifications of 16 CCR 1425(a) and has the authority and responsibility to administer the program. The director coordinates and directs all activities in developing, implementing, and managing a nursing program, including its fiscal planning."

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(Continued from above)	(Continued from above)	(Continued from above)	If the BRN is able to verify that a person has met this experience, approval can be provided without a person completing one academic year (two semesters) serving as an Assistant Director. There is also the option of equivalency for the requirement of two years' teaching in a pre- or post-licensure program. In alignment with BRN faculty approval standards, completion of a post-baccalaureate course that includes supervised teaching practice in registered nursing may be accepted as equivalent to one year of teaching experience. The additional year can be met by teaching in a pre- or post-licensure program for one academic year (two semesters). A person could consider teaching in a post-licensure nursing program (RN to BSN) or a prelicensure program that has a nursing specific accreditation, as both of those nursing programs do not require BRN faculty approval. Additionally, some curriculum in prelicensure nursing programs have courses that are not counted towards the 36 semester units that have a nursing content designation for licensure that could count towards obtaining this teaching experience and those courses do not require a BRN faculty approval. Currently, the BRN does not maintain a list of individuals who meet the qualifications for faculty or assistant/director of nursing positions. However, efforts are underway to collect this data and develop a database that can support and provide this information in the future. Additionally, faculty, Director, and Assistant Director information is on BreEZe and is accessible on license lookup. The BRN is working on a report that can pull this information based on these specific modifiers.

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Communication with NECs	Attempts to seek clarity from the NEC regarding our situation have been met with delays, frustration, and a refusal to engage with senior college leadership. Further compounding the issue, my outreach to the BRN Executive Director initially went unanswered for three weeks	Require NECs to engage directly with campus leadership, including Deans and Vice Presidents. Improve response times and transparency in decision-making. Foster a culture of support, not intimidation, when colleges seek clarity on regulations and processes	The BRN does not approve or regulate the institution of higher education (e.g. community colleges offering associate degrees; private postsecondary institutions offering associate, baccalaureate or entry level master's degrees). The BRN's oversight is limited to the nursing program within those institutions and therefore, communication is primarily directed to the program director and assistant director of the nursing program. Additionally, per the NECs duty statement, they provide ongoing orientation and support to program directors, assistant directors, and faculty, and interpret regulations for institutional administrators when needed. Below are regulations that may be relevant: • 16 CCR 1420(h) defines Director and states that it is the registered nurse administrator or faculty member who meets the qualifications of section 1425(a) and has the authority and responsibility to administer the program. The director coordinates and directs all activities in developing, implementing, and managing a nursing program, including its fiscal planning. • 16 CCR 1424(e) states the director and the assistant director shall dedicate sufficient time for the administration of the program. • 16 CCR 1424(f) states the program shall have a board-approved assistant director who is knowledgeable and current regarding the program and the policies and procedures by which it is administered, and who is delegated the authority to perform the director's duties in the director's absence. • 16 CCR 1424(j) states the assistant director shall function under the supervision of the director. Instructors shall function under the supervision of the director or the assistant director. Assistant instructors and clinical

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			teaching assistants shall function under the supervision of an instructor. The BRN agrees that there is a need for collegial interactions and will continue to work towards improving response times and transparency in decision-making and fostering a culture of support.

February 1, 2025

Garrett K. Chan, PhD, RN, APRN, FAEN, FPCN, FCNS, FNAP, FAAN
Chair, Nursing Education and Workforce Advisory Committee
California Board of Registered Nursing

Re: Concerns related to the actions of the California Board of Registered Nursing regarding the Regulation of Nursing Education in the State

Dear Dr. Chan,

This letter is written to express continued concerns regarding the actions of the California Board of Registered Nursing (BRN) as they relate to the regulation of nursing education in the state and, more specifically, as they relate to the implementation of AB 2684 (Berman, 2021-2022). It represents the collective viewpoints of the members of the California Association of Colleges of Nursing (CACN), the professional association that inclusively represents all California baccalaureate, graduate and doctoral nursing education programs, including public and private schools. CACN's mission is to advance innovation, advocacy, and excellence in nursing education and practice with the vision of fostering implementation of evidence-based, transformational nursing education programs throughout the state. Our members are instrumental in assuring that the need for nurses in the state is met, now and in the future.

We believe that the BRN's current interpretation and implementation of the Nurse Practice Act and its accompanying regulations has a persistent and marked negative impact on the timely preparation of nurses for the state and adversely impacts nursing students, practicing nurses, clinical partners and ultimately, patient and community outcomes. We further believe that the BRN's understanding of what constitutes nursing education does not reflect current evidence, is outdated, and limits our ability to prepare a highly skilled workforce capable of adapting to a rapidly changing health care environment.

We look forward to working collaboratively to address concerns that inhibit the effective and efficient education of California registered and advanced practice nurses.

Issue 1:

The ongoing challenges in securing clinical placements for registered and advanced practice nursing students remains a substantial limiting factor in timely progression and graduation of these students.

(a) The BRN's strictly adheres to a defined threshold of 500 direct patient care hours, with a minimum of 30 hours per specialty (CA Bus. & Prof. Code. § 2786 (a)(2)). The accompanying implementation requires that concurrent education in theory and clinical practice shall be "in the following nursing areas: geriatrics, medical-surgical, mental health/psychiatric nursing, obstetrics, and pediatrics" (CA Code Reg. §1426(d)). Clinical placement and faculty qualification reporting documents utilized by the BRN also specify these five nursing areas – all of which are most readily associated with the acute care environment.

The delivery of health care and nursing care continues to undergo radical transformation (e.g., Telemedicine, Centers for Medicare & Medicaid Services "Acute Hospital Care At Home" program, etc.). Distinctions between acute care and community-based care have blurred substantially. Persistent use of the distinct specialty categories of geriatrics, medical-surgical, mental health/psychiatric nursing, obstetrics, and pediatrics limits innovation in nursing and the preparation of workforce capable of working in the evolving health care environment. Further, inconsistencies in interpretation by Nursing Education Consultants (NECs) of whether a clinical experience is "sufficiently" a specialty as opposed to community health creates confusion among and within programs. Lastly, strict adherence to the use of these specialty terms exacerbates the shortage of clinical placements as all schools vie for the limited acute care placements, especially in areas such as obstetrics and mental/psychiatric health.

Recommendation to resolve Issue 1(a):

Revise CA Code Reg. §1426(d) to redefine nursing care areas to address: Adult and aging, childhood and adolescence, reproduction and child-bearing, and behavioral health.

The National Council Licensure Examination for Registered Nurses (NCLEX-RN) requires the application of nursing knowledge across the life and health continuum and accreditation agencies have adopted a similar approach to nursing education (e.g., AACN Essentials). Therefore, schools have ample incentive to provide and ensure a broad set of clinical experiences for students. CACN's recommended language will stimulate and support educational innovation that can alleviate some clinical placement burden for acute care providers.

(b) The use of low-, medium- and high-fidelity simulation, including the use of virtual and augmented reality, remains a strong, evidence-based method for augmenting and/or

replacing direct care clinical hours required for nursing education. Ample evidence supports the use of these learning modalities and the majority of U.S. nursing regulatory boards allow the use of simulation to satisfy mandated clinical hours. Importantly, no evidence supports *any* specific minimum number of clinical hours associated with competency attainment in nursing education, while evidence provided by the National Council of State Boards of Nursing substantiates substitution up to fifty percent simulation in place of direct care hours.

Recommendation to resolve Issue 1(b):

Work with the legislature to revise CA Bus. & Prof. Code. § 2786 (a)(2) to allow schools to substitute simulation to meet up to 50 percent of the 500 direct care hour requirement for nursing specialty areas adult and aging, childhood and adolescence, reproduction and child-bearing, and behavioral health, if the school demonstrates alignment with simulation standards promulgated by the Society for Simulation in Healthcare (SSH) or the International Nursing Association of Clinical Simulation and Learning (INACSL).

(c) The process of review for approval for new or expansion of prelicensure programs is arbitrary and lacks consistent reason or rationale. The BRN routinely approves new programs or expansion of programs despite soundly documented concerns of clinical site impaction provided by regional programs and schools. The BRN places the responsibility of communicating with existing programs and schools with the new or expanding program, which is a direct conflict of interest. The new or expanding program has no incentive to be honest or transparent with regional counterparts. Moreover, out-of-state programs appear to have equal access to a limited state resource (clinical placements), which negatively impacts programs and schools that are supported by and committed to meeting the needs of the residents of California.

Recommendation to resolve Issue 1(c):

The prelicensure program approval process must be substantially overhauled to include a BRN assessment of the distribution of nursing educational slots as well as clinical placement capacity across regions within the state. Impaction thresholds informed by these data must be implemented. The BRN must publicly disclose the rationale for their decision, addressing each of the factors articulated in CA Bus. & Prof. Code. § 2786.2(b)(F).

(d) Out-of-state Nurse Practitioner (NP) programs are rapidly displacing in-state programs for clinical placements. There are 59 out-of-state programs now approved for clinical placement within California compared to the less than 30 BRN approved NP programs in the state. The BRN imposes substantial regulatory control and administrative burden on in-state programs while only requiring minimal administrative effort by the out-of-state programs. The process of procuring authorization for an out-of-state program to gain access to California clinical placements for both prelicensure and postlicensure APRN programs is *easier* than for in-state programs! Further, anecdotally, deans/directors report unscrupulous “pay to play” practices employed by some APRN

programs, which places California programs, especially public programs and their students at a significant disadvantage.

Recommendation to resolve Issue 1(d):

The BRN should hold all APRN programs, in-state and out-of-state, to the same regulatory and administrative standards and processes, including those for clinical placement.

Issue 2:

Administrative obligations imposed by antiquated BRN regulations and processes continue to substantially burden all programs and schools of nursing. Nursing program and school resources are best used to support students and faculty to ensure timely progression to degree attainment and licensure.

(a) The 30-unit LVN to RN option (16 CCR § 1429) is an outdated approach to nursing workforce development and not in the best interest of patient care or the licensed vocational nurse. Maintaining this option imposes an administrative burden on nursing programs and schools even though many report no substantial use of the program in many years. Importantly, this path provides *no* degree, not even an Associate Degree in Nursing (ADN) to the student and as a result, most other states do not recognize California's LVN 30 Unit Option and will not issue RN licenses to these LVNs, substantially limiting their future mobility and employment opportunities. In addition, most health care systems across the state and nationally require a degree in nursing in addition to licensure to obtain employment.

Decades of evidence demonstrates that patients benefit from care delivered by nurses who have earned a bachelor of science degree in nursing (BSN). The state legislature and Governor appear to agree with this assertion given their support for degree articulation agreements between associate degree of nursing (ADN) and BSN programs throughout the state.

Recommendation to resolve Issue 2(a):

Eliminate the 30-unit LVN to RN option (16 CCR § 1429). Incentivize programs and schools of nursing through funding mechanisms to voluntarily develop and administer LVN to ADN and LVN to BSN educational pathways.

(b) The EDP-P-18 BRN Clinical Placement form is administratively onerous and provides little actionable information to the BRN to justify its use. The form requires excessive specificity regarding placements causing confusion resulting in the collection of inconsistent and inaccurate data. In addition, the form requires time and effort by the clinical agency staff, over whom the BRN has no jurisdiction, frequently resulting in delays that penalize the nursing program or school.

Recommendation to resolve Issue 2(b)

Eliminate the EDP-P-18. Work with the CA Department of Health Care Access and Information (HCAI) to develop efficient and accurate reporting process to determine clinical placement usage across the state.

Issue 3:

The BRN has failed to implement, in both letter and spirit, the provisions of AB 2684 (Berman, 2021-2022), effective January 1, 2023.

(a) The BRN regulations and the Program Director Handbook continue to require approval of faculty by the BRN despite statutory language to the contrary in CA Business and Professions Code §2786.2(b)(1)(C). In fact, throughout the academic year 2023-2024 and into the current academic year, 2024-2025, the BRN continues to apply existing regulations, which conflict with AB 2684. The BRN has failed to provide timely guidance to deans and directors. No Program Director Handbook for the 2024-2025 Academic Year has been distributed. Further, while the BRN has finally acknowledged that under AB 2684, it is required to accept hiring decisions made by the approved program director of a nationally accredited program, it has not widely promulgated that determination and the BRN has continued to require completion of the EDP-P-02 forms for faculty – a BRN approval process.

For example, when a CACN member school questioned a BRN Nursing Education Consultant during a Fall 2024 continuing approval process (CAV), the dean/director was told that the school/program needed to *proactively* report to the BRN that they intended to rely on the provisions of AB 2684. Since the school/program had not completed this notification, they were still required to complete forms for all faculty, which required NEC review and approval of those faculty.

Further, deans/directors report substantial inconsistencies in the process for the joint BRN/accreditor site visit, that NECs are still requiring a full separate CAV self-study that conforms to prior standards that have now been nullified by sections 2786.2(b)(1)(B)(D), and continue to require oversight of faculty qualifications hired by nationally accredited programs.

Recommendation to resolve Issue 3(a):

The provisions of AB 2684 as codified in the CA Business and Professions Code § 2786.2(b)(1)(A)-(E) are clear and self-executing. The BRN must immediately notify all programs and schools of nursing of changes in process that will ensure that these programs and schools may benefit from the provisions of this law.

The BRN must act swiftly and without further delay and obfuscation to accept the self-study required by programmatic accreditors as a substitute for board self-study or data

collection if the statutory provisions are met and accept continuing accreditation decisions from accreditors.

Inefficient BRN operations, including conflicting and inconsistent interactions between schools/colleges of nursing and their assigned Nursing Education Consultants (NECs), negatively impact California nursing education programs.

We respectfully offer these concerns and needed actions, which we believe will have a major impact on resolving long-standing issues that have plagued the effective and efficient ability to educate and foster the supply of highly qualified nurses in California. We would be available anytime to expand upon and clarify what we have proposed.

Finally, on behalf of the California Association of Colleges of Nursing, Board of Directors, we thank the NEWAC for its dedication to improving nursing education and offer our ongoing support as California strives to provide the best healthcare and nursing services.

Respectfully,

Kimberly Perris

Kimberly Perris, DNP, RN, CNL, PHN
President, CACN

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1/27/2025

RE: Concerns Regarding BRN Processes for Nursing Program Leadership

Dear Dr. Chan and Members of the Nursing Education and Workforce Advisory Council,

I am reaching out to express significant concerns regarding the processes and fairness of the California Board of Registered Nursing (BRN) in the recruitment, selection, and approval of RN Program Directors at the college level. As previously discussed in the September 12, 2024, NEWAC meeting (Agenda Item 7.0), these concerns—also raised by the QUAD Council—highlight systemic challenges, that inhibit program management such including the absence of a remediation process for Director candidates deemed ineligible. Also noted in the QUAD Council letter, we continue to see ongoing issues related to rule interpretation, communication, and professionalism between Nursing Education Consultants (NECs) and educational institutions.

The Urgency of Rural Nursing Education

California's nursing shortage remains a pressing issue, particularly in rural areas like Joshua Tree, where Copper Mountain College (CMC) serves as a vital hub for RN and VN education. Many of our graduates remain in these underserved communities, helping to fill critical healthcare gaps. However, rural colleges face unique challenges in recruiting qualified faculty and administrators. The ability to act swiftly in hiring is crucial, yet current BRN practices create unnecessary barriers that hinder our efforts.

The passage of AB 2015 was a step in the right direction. By establishing a faculty database and allowing temporary faculty approvals with remediation plans, it streamlines faculty recruitment. However, it does not extend the same provisions to Nursing Directors and Assistant Directors. There remains no master list of qualified candidates, no equivalency process, no appeal mechanism, and no temporary approvals with remediation—critical elements that would help colleges like ours recruit qualified leadership.

Concern 1: Lack of Consistency and Remediation for Program Director Approvals

CMC was placed on deferred status by the BRN's Education and Licensing Committee last year, requiring quarterly reports to reach full compliance—primarily related to staffing. Since then, we have hired two tenure-track faculty members and transitioned our Nursing Director position to management, as recommended. However, we continue to face unnecessary roadblocks in obtaining BRN approval for our selected Director of Nursing and Health Sciences, as well as for an existing faculty member to serve as Assistant Director.

In rural areas, where the candidate pool is often small, and local elected governing boards, such as CMC's Board of Trustees, and the Human Resource Department that support them, must make reasonable hiring decisions based on California Code of Regulations, Title 16 § 1425. Our chosen candidate meets the intent of these qualifications, yet was denied approval. Notably, in my 10+ years of executive experience overseeing RN programs, I have never encountered a hire being denied until now.

The lack of a remediation pathway for Program Directors is especially troubling. Despite conflicting messages from the BRN, our NEC stated that remediation was not an option—yet later communication from the BRN Executive Director suggested otherwise. If remediation is indeed an option, it should be clear, standardized, and accessible.

We respectfully request that the BRN:

Establish a centralized database of pre-approved Nursing Directors and Assistant Directors.

Implement a transparent appeals process for denied approvals.

Clarify and codify a remediation pathway—just as AB 2015 did for faculty—so qualified often local candidate administrators are not arbitrarily excluded.

Concern 2: Communication, Professionalism, and a Culture of Fear

Attempts to seek clarity from the NEC regarding our situation have been met with delays, frustration, and a refusal to engage with senior college leadership. When our Vice President of Academic Services, Dr. Michael Reese, reached out for guidance, he received no response. In a later meeting, the NEC expressed visible frustration, stating that only the Nursing Director or Assistant Director should contact her—disregarding the delegated authority of college administration, from the publicly elected Copper Mountain Board of Trustees.

Further compounding the issue, my outreach to the BRN Executive Director initially went unanswered for three weeks. During this time, I began hearing disturbing rumors that questioning BRN processes could jeopardize our program and even impact our new hire's RN

license. These kinds of punitive implications—whether intentional or not—create a culture of fear and hinder open, constructive dialogue.

To ensure better collaboration, we urge the BRN to:

Require NECs to engage directly with campus leadership, including Deans and Vice Presidents.

Improve response times and transparency in decision-making.

Foster a culture of support, not intimidation, when colleges seek clarity on regulations and processes.

Closing:

I want to acknowledge that since raising these concerns, BRN leadership has been more responsive and willing to engage in productive discussions. I truly appreciate this shift and hope it leads to meaningful, long-term improvements in how we work together to support nursing education in California though updated regulation and if needed legislation.

I welcome the opportunity to further discuss these issues and collaborate on solutions that serve both the integrity of nursing education, and the urgent workforce needs of our communities.

Thank you for your time and consideration.

Sincerely,

Daren Otten

Daren M. Otten, Ed.D

Superintendent/President

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Cc: CCC Chancellor, Sonya Christian

CCC Vice Chancellor Workforce and Economic Development, Anthony Cordova

CCCCEO Chair, Roger Schultz

CCLC CEO, Larry Galizio

Policy Committee Consultant, Assembly Committee on Business and Professions, Vincent Chee

Agenda Item 5.0

Discussion and possible action: Regarding assigning replacement member(s) to the Clinical Placement and Impaction subcommittee

Nursing Education and Workforce Advisory Committee (NEWAC) Meeting | June 25, 2025

BOARD OF REGISTERED NURSING
Nursing Education and Workforce Advisory Committee Meeting
Agenda Item Summary

AGENDA ITEM: 5.0
DATE: June 25, 2025

ACTION REQUESTED: **Discussion and possible action:** Regarding assigning replacement member(s) to the Clinical Placement and Impaction subcommittee

REQUESTED BY: Garrett Chan, PhD, RN, APRN, FAEN, FPCN, FCNS, FNAP, FAAN
Chair of the Nursing Education and Workforce Advisory Committee

BACKGROUND:

The advisory committee will discuss the vacancy to the Clinical Placement and Impaction subcommittee and vote to fill this vacancy which may include reassignments of current members of other subcommittees.

RESOURCES:

NEXT STEPS:

FISCAL IMPACT, IF ANY: None

PERSON(S) TO CONTACT:
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