

# **BACKGROUND PAPER FOR THE BOARD OF REGISTERED NURSING**

**(Oversight Hearing, March 14, 2011, Senate Committee on  
Business, Professions and Economic Development)**

## **IDENTIFIED ISSUES, BACKGROUND AND RECOMMENDATIONS REGARDING THE BOARD OF REGISTERED NURSING**

### **BRIEF OVERVIEW OF THE BOARD OF REGISTERED NURSING**

The Board of Registered Nursing (BRN) is responsible for regulating the practice of registered nurses (RNs) in California. Currently, there are almost 380,000 licensed RNs in California, with over 23,000 new licenses issued annually, and more than 170,000 licenses renewed annually. The BRN also regulated interim permittees, i.e., applicants who are pending licensure by examination, and temporary licensees, i.e., out-of-state applicants who are pending licensure by endorsement. The interim permit allows the applicant to practice while under the supervision of an RN while awaiting examination results. Similarly, the temporary license enables the applicant to practice registered nursing pending a final decision on the licensure application. The BRN also issues certificates to Clinical Nurse Specialists, Nurse Anesthetists, Nurse Practitioners, Nurse-Midwives and Public Health Nurses. These titles are those most commonly used by the California RNs and use of the titles is protected under the Business and Professions Code.

The BRN also issues furnishing numbers to nurse practitioners and nurse midwives to administer prescriptions and lists psychiatric/mental health nurses. In addition to its licensing and certification functions, the BRN also regulates and approves the following entities:

- California Pre-licensure Registered Nursing Programs.
- Nurse-Midwifery Programs.
- Nurse Practitioner Programs.
- Registered Nursing Continuing Education Providers.

The BRN is responsible for implementation and enforcement of the Nursing Practice Act; the laws and regulations related to nursing education, licensure, practice and discipline. The current BRN mission statement, as stated in its 2006 BRN Strategic Plan, is as follows:

***The mission of the Board of Registered Nursing is to protect the health and safety of the public by promoting quality registered nursing care in the State of California.***

As indicated by the BRN, it implements regulatory programs and performs a variety of activities to protect the public. These programs and activities include, setting registered nurse educational

standards for pre-licensure and advanced practice nursing programs, issuing and renewing registered nurse licenses, issuing certificates for advanced practice nurses and public health nurses, taking disciplinary action for violation of the Nursing Practice Act, and managing a Diversion Program for registered nurses whose practice may be impaired due to chemical dependency or mental illness.

The BRN also indicates that recognizing registered nursing is an integral component of the health care delivery system. The BRN affects public policy by collaborating and interacting with legislators, consumers, health care providers, health care insurers, professional organizations, and other state agencies. The BRN takes a proactive role in structuring health care and evaluating nursing trends in order to make sound policy decisions. According to the BRN, this enhances the Board's ability to interpret the Nursing Practice Act and establish policies for its regulatory programs and activities, which are then implemented by the BRN staff.

The current composition of the BRN is seven members who are appointed by the Governor, one by the Senate Rules Committee and one by the Assembly Speaker. The current make-up of the BRN includes four public members, two registered nurses in direct patient care practice, an advanced practice registered nurse, a registered nurse educator and a registered nurse administrator. (Total of 9 members, with 5 professional members from the practice of nursing and 4 public members.) The Board generally meets at least four times throughout the year to address work completed by various committees of the Board and hear disciplinary cases. The following is a listing of the current members of the BRN with a brief biography of each member, their current status, appointment and term expiration dates and the appointing authority:

Name	Appointment Date	Term Expiration Date	Appointing Authority
<p><b>Catherine M. Todero, PhD, RN</b>            Ms. Todero has served as director and a professor for the school of nursing at San Diego State University since 2006. She previously served as an associate dean for the college of nursing at the University of Nebraska Medical Center from 1989 to 2006. Prior to that, Ms. Todero held several academic appointments in the colleges of nursing at the University of Nebraska and Creighton University. She has also served as an administrative director at the Family Health Care Center from 1993 to 1998 and as a staff nurse in the intensive care units for St. Joseph Hospital in Omaha, NE in 1979 and the University of Nebraska Medical Center from 1972 to 1974. She also served as a captain and staff nurse in the U.S. Army Reserve Nurse Corps from 1979 to 1983.</p>	June 13, 2009	June 1, 2013	Governor
<p><b>Darlene Bradley, PhD, MSN, CNS, CCRN, CEN, FAEN, RN</b>            Ms. Bradley is currently the Director for Emergency and Trauma Services at UC Irvine Medical Center. She is a board-certified emergency nurse, Critical Care Nurse, and Nursing Executive. She is a Clinical Nurse Specialist in Emergency, Trauma, and Critical Care, and a Fellow in the Academy of Emergency Nursing. She holds the position of Supervisory Nurse Clinician with the National Disaster Medical Systems since 1983, and the Operations Chief and Chief Nursing Officer for Ca-1 Disaster Medical Assistance Team. She is the Director of Operations for the Center For Disaster Medical Sciences and has been on the faculty for the School of Nursing for the University of Phoenix since 1995.</p>	December 21, 2010	June 1, 2014	Governor
<p><b>Dian Harrison, MSW</b>            Ms. Harrison has dedicated over 35 years of public service to the non-profit and municipal sectors, left her position as President &amp; CEO of Planned</p>	October 2008	June 1, 2012	Speaker of the Assembly

<p>Parenthood Golden Gate after serving for over 17 years in early 2010. Prior to that Ms. Harrison served in other organizations including the San Jose Redevelopment Agency, Santa Clara and Austin Area Urban League, United Way, and Fisk University in Nashville, Tennessee. She currently serves on the boards of several organizations including the San Francisco Black Coalition on AIDS.</p>			
<p><b>Douglas Hoffner</b> Mr. Hoffner was appointed by Governor Schwarzenegger as Undersecretary of the California Labor &amp; Workforce Development Agency in February 2007. He also served as a Deputy Cabinet Secretary for Governor Schwarzenegger. From 2004-2006 he served as the Assistant Director of Legislation for the State of California Department of General Services. Before entering the executive branch, Mr. Hoffner was the Executive Director for Connerly and Associates from 1999-2004 and Legislative Director to Assemblyman Fred Aguiar from 1995-1998.</p>	December 21, 2010	June 1, 2014	Governor
<p><b>Erin Niemela</b> Ms. Niemela was Chief of Staff to former President Pro Tem Don Perata. Prior to her tenure with Senator Perata, Ms. Niemela worked for Assembly Democratic Leader Richard Katz, Speaker Willie Brown and served as an intern to former Assemblymembers Steve Peace and Tom Bates. She now owns her own lobbying and consulting firm in Sacramento.</p>	July 23, 2009	June 1, 2012	Senate Rules Committee
<p><b>Jeannine Graves, MPA, BSN, RN, OCN, CNOR</b> Ms. Graves of Sacramento, is currently employed at Sutter Medical Center, Sacramento as the Thermal Ablation and Cytoreductive Surgery Coordinator. She also serves as a Staff Nurse in the O.R. for Mercy San Juan Medical Center, Carmichael, a position she has held since 1997. She also served from 1995 - 2010, as the Thermal Ablation/Cytoreductive Surgery Coordinator for Capitol Surgical Associates in the Sutter Medical Center, Sacramento and was the Nursing Director of Surgical Services for Sutter Memorial Hospital, Sacramento from 1989-1994. Ms. Graves has served in Surgical Services since 1979.</p>	July 13, 2009	June 1, 2011	Governor
<p><b>Judy L. Corless, BSN, RN</b> Ms. Corless of Corona, has served as clinical nursing director at the Corona Outpatient Surgical Center since April 2009 and previously served as a staff nurse for labor and delivery from 2007 to 2008 and staff nurse in the emergency room from 2001 to 2007 at the Corona Regional Medical Center. Prior to that, she served as executive manager and charge nurse for Joe D. Corless, M.D. from 1979 to 2001 and a staff LVN for Cummins, Kozak and Gilman from 1977 to 1979, the UCI Medical Center from 1971 to 1972 and the Santa Ana Community Hospital from 1970 to 1971.</p>	July 13, 2009	June 1, 2011	Governor
<p><b>Kathrine Ware, MSN, RN, ANP-C</b> Ms. Ware of Davis, has served as a nurse practitioner for the Vascular Center Clinic at the University of California, Davis since 2006. She is a Vascular Nursing and Tobacco Treatment specialist. She previously worked as a nurse practitioner for internal medicine at the Sutter Medical Group in Sacramento from 2005 to 2006. Prior to that, Ms. Ware was a resource nurse for the Vascular Surgery service at UC Davis from 1996 to 2004 preceded by a position working as an RN in the Outpatient Surgery Clinic at UCD from 1992-1996. Prior to that she worked as a critical care RN for Kaiser Permanente Medical Center in San Diego and then Sacramento from 1987 to 1995 and worked in the Surgical ICU at the VA Medical Center in La Jolla from 1984-1987.</p>	July 13, 2009	June 1, 2013	Governor
<p><b>Richard Rice</b> Mr. Rice has most recently served as chair of the Unemployment Insurance Appeals Board from 2007 to 2008. Prior to that, Mr. Rice served as a member of the California Apprenticeship Council. Mr. Rice was undersecretary at the Labor and Workforce Development Agency from 2005 to 2006 and served as</p>	July 13, 2009	June 1, 2013	Governor

acting undersecretary and communications director from 2003 to 2005. Prior to that Mr. Rice was Deputy Director at the Department of Industrial Relations.			
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The total revenues anticipated by the BRN for FY 2010/11 is \$42,828,000, and for FY 2011/12, \$32,782,000. This is anticipated revenue based on a fee increase which took effect on January 1, 2011. The total expenditures anticipated for the BRN for FY 2010/11, is \$29,565,000, and for FY 2011/2012, \$28,382,000. The BRN anticipates it would have approximately 4.6 months in reserve for FY 2010/11, and 1.2 months in reserve for FY 2011/12. The BRN spends approximately 70% of its budget on its enforcement program. On July 1, 2010, the BRN was approved for 37 new positions for the Enforcement Division to be phased in over two years. However, according to the BRN, they had to reduce and re-classify some of the 37 previously approved positions because of the Governor's hiring freeze that began on August 31, 2010, as well as a 5% staff reduction directive from the Department of Finance on October 26, 2010.

(For more detailed information regarding the responsibilities, operation and functions of the BRN please refer to the BRN's "Sunset Review Report 2010." This report is available on its website at [www.rn.ca.gov](http://www.rn.ca.gov).

## **PRIOR SUNSET REVIEW: CHANGES AND IMPROVEMENTS**

The BRN was last reviewed by the former Joint Legislative Sunset Review Committee (JLSRC) six years ago (2002-2003). During the previous sunset review, the JLSRC raised 29 issues initially and then an additional 7 later in the process for a total of 36. The DCA raised 9 issues and the BRN identified 5 issues and developed a set of recommendations to address the issues. The following are actions which the BRN took over the past 6 years to address many of these issues. For those which were not addressed and which may still be of concern to the Committee, they are addressed and more fully discussed under "Current Sunset Review Issues."

On October 1, 2010, the Board submitted its required sunset report to the Committee. In this report, the BRN described actions it has taken since the Board's prior review to address the recommendations of the JLSRC. The following are some of the more important programmatic and operational changes and enhancements which the BRN has taken and other important policy decisions or regulatory changes it has adopted:

- In 2003, the composition of the BRN was changed to add one more public member and included one nurse who is in advanced practice.
- Because of a projected deficit in the BRN's budget and the need for increased staffing, the BRN recently promulgated regulations increasing specified fees effective January 1, 2011.
- The BRN enhanced its Internet capabilities adding more information to its Website and updated its Website daily and included disciplinary actions and the status of the nurses license on its Website. Licensing data and the ability to do on-line license renewals is also provided.
- To deal with the nursing workforce shortage as identified some years ago, the BRN has been in the forefront of obtaining information and data on the practice of nursing and school programs. They have also approved 52 new nursing programs since 2003, with the majority (38) being approved

within the past four years. Student completion for RN programs has almost doubled since 2003, with 11,512 graduates in 2009-2010, compared with 5,623 in 2002-2003. It also continues to support the Health Professions Education Foundation scholarship and loan repayment programs for RN students and graduates and other sources of funding. The BRN continues to recognize that the nursing shortage is a high priority for the BRN and continues to work closely with the Legislature, the Administration, nursing organizations, educational institutions, clinical agencies and health facilities in identifying nursing workforce and student needs.

- Improved its approval process for nursing educational programs. According to the BRN, the nursing consultants utilized by the BRN have kept current in performing both the initial and ongoing pre-licensure nursing program reviews and continue to visit about 16 schools per semester, including new programs seeking BRN's approval and recently approved and continuing programs. The BRN recently updated their pre-licensure nursing program regulations to ensure potential program applicants are fully aware of the requirements for approval by the BRN of their nursing educational programs. The BRN indicates that the average length of time from beginning to completing the initial BRN approval process is about 18 months. The BRN also participated in efforts by the California Community Colleges (CCC), the CSU and the UC to improve student transfer from one school to the next and establish consistent prerequisite courses for admission.
- Improved the timeframe for its application and licensing process. There are currently no licensing application backlogs. In 2001/02, it took almost 6 months to obtain a license. It is now down to less than three months. When delays now occur in processing an application it is basically due to checking on the educational background and program attended by the applicant (especially if from out-of-state or a foreign country) or due to the fingerprint check by the Department of Justice (DOJ) where there may be questions as to a prior criminal background of the applicant.
- In 2002/03, the BRN was experiencing declining pass rates on its national licensing examination (NCLEX-RN) for candidates applying for licensure. The BRN took steps to improve the examination process and reach out to school programs to keep them better abreast of examination requirements. The BRN also closely monitors each programs' annual pass rates and contact programs if their pass rate falls below 70%. The current regulations of the BRN also require that nursing programs must maintain an NCLEX-RN pass rate of 75% or higher for "first-time" test takers. The BRN also took steps to also improve on the testing of international graduates since there was also a very low pass rate for foreign students. There is still a low pass rate, 37% to 47%, but improvements continue to be made.
- Increases were made to the Board's scholarship and loan repayment programs from \$579,410 in FY 2003/04 to \$1,474,975 in FY 2009/10, pursuant to Legislation supported by the BRN.
- Although improvements have been made in the BRN's enforcement program, there are still extreme delays in the handling of disciplinary cases. To deal with this problem, the BRN worked closely with the Department of Consumer Affairs (DCA) and its Division of Investigation (DOI) and with the Attorney General's Office (AG) to work on handling the backlogs of cases, prioritizing cases, drafting pleadings, creating a case management system for tracking cases, and accessing state and national data bases for criminal and disciplinary information. It also requested and had Budget approval for increased staffing levels. It is the goal of the BRN with all of these changes to eventually improve discipline case processing timeframes so that cases are completed in an average of 12 to 18 months.

- The Board also proposed a number of legislative and regulatory changes to improve its overall operations and functions of both its licensing and enforcement programs and to deal with nursing shortages and workforce issues for the nursing profession.

## **CURRENT SUNSET REVIEW ISSUES**

The following are unresolved issues pertaining to the BRN, or those which were not previously addressed by the BRN, and other areas of concern for the Committee to consider along with background information concerning the particular issue. There are also recommendations the Committee staff have made regarding particular issues or problem areas which need to be addressed. The Board and other interested parties, including the professions, have been provided with this Background Paper and can respond to the issues presented and the recommendations of staff.

### **BOARD ADMINISTRATION ISSUES**

**ISSUE #1: (IS BRN MEETING THE GOALS AND OBJECTIVES OF ITS STRATEGIC PLAN?) Is the BRN meeting the goals and objectives of its Strategic Plan developed in 2006, and should the strategic plan for the Board be updated?**

**Background:** Back in July 2009, *Pro Publica* and the *Los Angeles Times (Times)* reported that there were serious problems with the BRN, and how the BRN was unaware in many instances of nurses who were incompetent, who had committed crimes, or had problems with drug abuse; and even if the BRN was aware, it was taking much too long to take action against its licensees who continued to keep treating patients. At that time, this Committee began its own investigation into what *Pro Publica* and the *Times* had uncovered and found that it was not only the BRN, but other health care boards which had serious deficiencies. Moreover, aside from the boards, the DOI and the AG's Office, upon which these boards rely, had difficulties as well in the length of time it took to investigate and prosecute disciplinary cases. Additionally, the Legislature and the Governor had not committed the resources and staffing necessary for the boards to effectively do their jobs of protecting consumers. The specific problems identified by the Committee included the following:

- Serious delays in the disciplinary process of up to 3 years.
- Protracted process to immediately suspend the license of a health care practitioner who poses an immediate threat to patients or committed a crime.
- Lax reporting of crimes committed by health care practitioners and of civil judgments or settlements.
- Little reporting by health care facilities of practitioners with serious deficiencies or who are a potential danger to patients.
- Effectiveness of drug diversion programs called into question.
- Lack of staffing and funding resources for the boards and the DCA.
- Inability to Track Disciplinary Cases and Lack of Information Sharing.
- Inconsistent Reporting of Information to the Public Regarding Licensees.

After the investigation and an Informational Hearing conducted by this Committee on August 17, 2009, this Committee began working with the DCA to come up with changes to address the delays in the disciplinary process and to give the boards the enforcement tools they needed to deal with all of the

aforementioned problems. In August, many of the changes were put into a bill, SB 294 (Negrete McLeod of 2009), which was referred to the Assembly Business and Professions Committee. However, because of the complexity of these changes and concerns raised by the health professions that more time was needed to review this proposal, agreement was reached to introduce a measure in 2010, and in the meantime the DCA and this Committee would continue to meet and work with all health professions affected by this measure. SB 1111 (Negrete McLeod) was introduced and sponsored by the DCA in an attempt to address many of the concerns raised regarding the enforcement programs of the health care boards under the DCA and to standardize the disciplinary process for the state's one million licensed health care professionals, including physicians, dentists, psychologists, chiropractors and others. This measure, however, was unsuccessful because of concerns raised about some of the changes proposed by the DCA.

The BRN's most current Strategic Plan was updated in June 2006. The BRN managers met in 2007 and 2008 to review the plan. They determined it was still current and effective and that the BRN was meeting its strategic goals and objectives. However, in light of the concerns which have been raised over the past year, and with the current lack of staffing and other resources needed by the BRN, does the BRN still believe that they will be able to meet their strategic goals and objectives?

***Staff Recommendation:*** *The BRN should explain to the Committee whether it believes it is meeting the goals and objectives of its Strategic Plan of 2006 and briefly what efforts it is taking to address the concerns and changes which have been proposed by this Committee and the DCA pursuant to the particular problems identified last year. The BRN should also complete an update of their Strategic Plan as soon as possible.*

**ISSUE #2: (THE NEED FOR THE CONTINUED WORK OF THE BRN'S ADVISORY COMMITTEES ON EDUCATION AND WORKFORCE ISSUES.) Should the Education Advisory Committee and the Nursing Workforce Advisory Committee of the BRN be combined and meet concurrently with the BRN to address common issues regarding both nursing education, nursing shortages, disparities in the nursing profession and make recommendations to the BRN, the Administration and the Legislature?**

**Background:** In April of 2002, the BRN approved appointment of the Education Advisory Committee (EAC) to support the goals of former Governor Davis' Nurse Workforce Initiative. According to the BRN, the Committee provides expert input on education issues related to reforming nursing education to assist in alleviating the nursing shortage. The EAC meets annually to review the *Annual School Survey*. The survey is completed by all approved nursing programs to obtain enrollment, graduation, student and faculty demographic data, and other information related to nursing programs and students. The EAC has representation from different educational degree programs (both public and private), nursing organizations, and other state agencies with work related to nursing.

The Nursing Workforce Advisory Committee (NWAC) is a nine member advisory committee which was created by the BRN in November 2001, to provide guidance to the BRN on the content of surveys regarding RN workforce issues, recommend strategies to address disparities in workforce projections, and identify factors in the workplace that positively and negatively affect the health and safety of consumers and nursing staff. The NWAC includes members from nursing education, nursing associations, and other state agencies. Initially, the NWAC worked closely with the California Strategic Planning Committee for Nursing (CSPCN). The CSPCN was part of a national effort of forming state regional collaboratives for nursing workforce development. In 1994, the national

program supported 23 statewide and multi-county consortiums or collaboratives that worked on a regional basis to: (1) give nurses greater educational and career mobility; (2) align the supply of nurses more closely with the marketplace demand; (3) develop programs to recruit and retain nurses; and (4) affect public policy on nursing education and workforce issues. The national program, along with the work of the collaboratives, was somewhat successful in obtaining these stated goals. However, much was left undone and when the program ended in 2003, it was hopeful that states would assume this responsibility. When the CSPCN ceased its operation it transferred its data functions to the newly created NWAC under the BRN.

As indicated, the BRN compiles the *Annual School Survey* which the EAC of the Board reviews. (The most recent *School Survey* was completed in February 9, 2011.) The BRN also compiles the *Survey of Registered Nursing* every two, pursuant to Section 2717 of the Business and Professions Code, which provides demographic information about working nurses, and data is compared with results from surveys. (The BRN anticipates that it will complete an updated version of its *Survey of Registered Nursing* by spring of 2011.) Another report conducted for the BRN is the *Forecasts of Registered Nurse Workforce in California*, completed in September of 2009 by Joanne Spetz, PhD, Center for the Health Professions. There are also some more recent reports, studies, surveys and information which are available regarding both the education and workforce issues of the nursing profession which should be reviewed and considered. They include:

- ***“Falling Behind: California Community Colleges Unable to Train Enough Allied Health Workers,”*** Survey conducted by Goodwin Simon Strategic Research, California Watch reports, January 31, 2011.
- ***“Profiting From Health Care: The Role of For-Profit Schools in Training the Health-Care Workforce,”*** Center for American Progress, prepared by Julie Margetta Morgon and Ellen-Marie Whelan, January 2011.
- ***“Implementation of the Affordable Care Act in California: A Window of Opportunity for State Policy Makers,”*** Paper published by the California Health and Human Services Agency, December 2010.
- ***“California Nurses Facts and Figures,”*** prepared by the California Health Foundation, November 2010.
- ***“Impact of National Health Care Reform on California’s Health Workforce,”*** University of California Berkeley School of Public Health, prepared by Janet Coffman, MA, MPP, PhD, and Gil Ojeda, Director, October 2010.
- ***Regional Planning to Diversify the Healthcare Workforce: A Guide for Workforce Investment Boards,”*** prepared by the California Workforce Association, October 2010.
- ***“Men of Color in California’s Health Professions Education Programs,”*** Center for the Health Professions, by Tim Bates, MPP; Susan Chapman, PhD, RN; Catherine Dower, JD, October 2010.
- ***“The Future of Nursing: Leading Change, Advancing Health,”*** Institute of Medicine, October 2010.
- ***“For-Profits Schools: Large Schools and Schools that Specialize in Healthcare are more Likely to Rely Heavily on Federal Student Aid,”*** Report Prepared by the Government Accountability Office, October 2010.
- ***“Rx for a New Health Care Workforce: Promising Practices and Their Implications for State and Federal Policy,”*** Report prepared by Randall Wilson, Jobs for the Future, April 2010.
- ***Help Wanted: Will Californians Miss Out on a Billion-Dollar Industry?,*** Study conducted by Beacon Economics and funded by a grant to Fenton Communications from the California Wellness Foundation, September 2009.
- ***“Master Plan for the California Nursing Workforce: Increasing Diversity in California’s Nursing Workforce,”*** Submitted by the California Institute for Nursing & Health Care, prepared by Bonnie Adams, RN, MSN, Ed.D and Barbara Napper, RN, MSN, June 2007.



In carrying out its role and responsibilities regarding review and evaluation of current nursing education programs and future trends or needs in education, and in looking at future trends and needs for nurses in the workplace and in workforce planning, it would seem as if both the EAC and the NWAC of the BRN should work together as advisory committees, and meet more often to better inform the BRN, the Administration and the Legislature on future policy decisions which need to be made for the future of the nursing profession in California. For example, recent information shows that over the past nine years the number of nursing programs has almost doubled, and that graduation of nurses has almost doubled as well, but that currently nurses are having problems finding work. What implications this has for future nursing programs, and their growth, and the impact on nursing shortages should be examined more closely. There is still a significant disparity between the Latino and the African American population and the RN workforce. Targets were suggested in 2007 (*Master Plan for the California Nursing Workforce*) to increase the number of graduates of RN programs, but a recent report highlighted the severe lack of representation of African American and Latino men in nursing training programs and consequently in the nursing profession. What steps should be taken to improve this situation could be more fully explored by these advisory committees working in tandem with each other. Based on the work of these two committees, there seems to be common issues that members of these committees could address and which would provide a more comprehensive approach to the education of nurses and nursing workforce development issues. Education and workforce issues should not be examined separately or in isolation by these two committees. Members of these committees, or other representatives of the BRN should also continue to meet, collaborate and partner with other state and local agencies such as the Chancellor's Office for Community Colleges, the Office of Statewide Health Planning and Development (OSHPD) and its Healthcare Workforce Diversity Advisory Council, the Workforce Investment Board and its newly created Health Workforce Development Council.

***Staff Recommendation:*** *The BRN should combine both these committees, the EAC and NWAC, and begin to address some of the more critical issues regarding both the education of nurses and workforce planning development for the nursing profession. Recommendations and policy direction should be forthcoming from the BRN to the Administration, the Legislature and other state and local agencies pursuant to the work of what would now be a single committee dealing with education and workforce issues. The BRN should also consider if more current information and data is necessary. For example, the last RN Employer Survey was conducted in December 2004. This Survey provided key information regarding the recruiting and retention of RNs and the needs of health care employers. Also, determining where there may be communities in need and lack of nurses in certain geographic locations should also be examined.*

## **NURSING EDUCATION AND PROGRAM APPROVAL ISSUES**

**ISSUE #3:** (ADDITIONAL IMPROVEMENTS NEEDED TO THE APPROVAL PROCESS FOR NURSING SCHOOLS/PROGRAMS.) Are there ways in which the BRN could improve and streamline its approval process for pre-licensure nursing programs and thereby facilitate the approval of more programs and increase access to nursing education?

**Background:** Approval of pre-licensure nursing programs is an integral component of the BRN's operation. The purpose of approval is to ensure the program's compliance with statutory and regulatory requirements. Approval of advanced practice nursing (i.e., nurse practitioner and nurse-

midwifery) programs is voluntary and at the request of the program. BRN approval of advanced practice programs is advantageous to program graduates because it facilitates their obtaining BRN certification as a nurse practitioner or nurse-midwife. Currently, there are 148 approved pre-licensure nursing programs and 26 approved advanced practice nursing programs, as follows:

### **Pre-licensure Programs**

- 90 associate degree (ADN)
- 39 baccalaureate degree programs (BSN)
- 19 entry-level master's degree programs (ELM)
- 110 Public Programs
- 38 Private Programs

### **Advanced Practice Nursing Programs**

- 22 nurse practitioner programs
- 4 nurse-midwifery programs

The approval process begins with a Letter of Intent from the school or institution of higher education which is trying to establish and offer a nursing program and must be submitted at least one year in advance of the anticipated date for admission of students. It is required that the program applicant be an institution of higher education or affiliated with an institution of higher education (referred to as "affiliated institution"). Affiliated institutions must make an agreement with an institution of higher education in California in the same general location, i.e., within 50 miles, to grant degrees to students who complete the RN programs. This requirement exists because the BRN is not able to grant the applicant nursing program the authority to grant a degree because the BRN does not have authority to approve a degree program. After a Letter of Intent is submitted, the applicant must submit a Feasibility Study to the BRN documenting the need for the program and the program applicant's ability to develop, implement, and sustain a viable pre-licensure RN program. The feasibility study is rather extensive and usually requires the applicant to seek the assistance of a consultant familiar with providing the information needed by the BRN in determining the feasibility of the program. One of the primary requirements of the feasibility study, among other things, is evidence of the availability of clinical placements for students of the proposed program. Once the feasibility study is completed and is submitted to the BRN for consideration, a BRN staff member will review the feasibility study and will work with the applicant to assure it is complete. The feasibility study will then be submitted to the BRN's Education/Licensing Committee (ELC) for consideration. There are more procedures to be followed by the applicant if the ELC deems the study as incomplete, however, once it is deemed complete by the ELC, the ELC will then recommend to the full Board the acceptance or non-acceptance of the feasibility study. The BRN may then either accept or reject the feasibility study, or defer action on the study to provide the program applicant an opportunity to provide additional information. If the feasibility study is rejected, the process starts all over again with the submission of a Letter of Intent by the applicant. If the feasibility study is accepted by the BRN, the program applicant must then appoint a Program Director. The Program Director will have responsibility for preparing a Self-Study for the proposed program and coordinate any site visits by the BRN. The Self-Study describes how the proposed program plans to comply with all BRN nursing program related rules and regulations. The BRN will assign a Nursing Education Consultant (NEC) who will verify that the Self-Study satisfactorily addresses the rules and regulations regarding a nursing program and will also make on-site visits where the program will be maintained and the selected clinical sites. Once the self-study is completed, the NEC will then complete a report to be submitted to the ELC and then the ELC may recommend that the BRN either grant or deny approval, or defer action to grant the

program additional time to resolve areas of noncompliance. Once the program is approved by the BRN, it receives a certificate of approval. The applicant is then required to receive approval from the Bureau of Private Postsecondary Education (BPPE) if they are not accredited by the Western Association of Schools and Colleges (WASC) or by a Regional accreditor. This approval process can also take some time to complete and it is not clear what advantage it provides in performing similar requirements for feasibility and self-study which are already required by the BRN. It should be noted that currently both the Medical Board of California and the Dental Board are the only agencies that respectively approve either medical schools or dental schools in California, as well as other states and in foreign countries.

The BRN indicated that the average length of time from beginning to completing the initial BRN approval process is about 18 months, but there have been instances in which this approval process has taken almost four to five years for particular programs, especially if they are “for-profit” schools. It is unknown why the BRN continues to have difficulties in approving the private school sector. Some of the criticism directed at the BRN’s approval process is that the rules and regulations and requirements for approval have not always been clear and applied consistently. The approval by the BRN of recent rules and regulations regarding nursing program approvals seem to more clearly specify the criteria and requirements for program approval. However, the BRN may need to assure that its staff and NECs are applying those rules and regulations consistently. The for-profit schools are a growing sector in the training of health care workers. From 2001 to 2009, the percentage of nursing degrees awarded by for-profit schools throughout the U.S. grew from 4 % to 11 % of the national total, while nursing awards from public colleges shrank from 78 to 70 %. In California, the share of public nursing programs has decreased from its high of 85.6% to its current share of 76.1%. It is anticipated that this growth of private nursing programs will continue, particularly in California. Private programs in California grew from just 14 programs in 2001, to now over 38 in 2010. Also, student enrollment grew from 951 students in 2001, to 4,607 in 2010. The BRN information, however, does not show the graduation rates (student completions) of these private programs. With over 41,500 qualified applicants in 2009-2010, and the ability of both public and private programs to only admit about 14,200 applicants in 2009-2010, the BRN must find ways to improve its approval process so that private for-profit schools at least have an equal chance of meeting the requirements to provide nursing programs in California. The BRN also needs to consider whether there are other ways to streamline its approval process for all potential nursing program applicants. For example, could the requirements for the feasibility study and the Self-Study be considered and worked upon at a staff level, and that both move forward for consideration by the ELC and then the BRN together rather than separately? In other words, is it really necessary for the ELC and BRN to approve the feasibility study and then again approve the Self-Study? For example, the BPPE staff currently works with schools in meeting all of the requirements for approval before they receive final approval by the DCA.

**Staff Recommendation:** *The BRN should explore any opportunity to streamline their current nursing program approval process to decrease the amount of time it takes for program approval and to work more closely with those private for-profit programs also seeking approval of their programs to meet the current rules and regulations of the BRN regarding these programs. The BRN should also consider providing training to its staff and NECs involved in program approval so the new rules and regulations are applied consistently to these programs. The involvement of the BPPE in the approval of nursing school programs seems unnecessary and therefore the BRN should assume all responsibility regarding approval of these programs. In doing so, the BRN should be given authority to charge an appropriate fee to cover their costs for reviewing documents, consulting with the program and conducting site visits. This fee should be similar to fees currently assessed by the*

*BPPE for approval of school programs. It should be noted that current student protections provided under the BPPE Act should continue to apply to those nursing programs which are currently approved by BPPE and that the BRN would now assume the responsibility of responding to student complaints regarding a nursing program.*

**ISSUE #4: (APPROPRIATE OVERSIGHT OF CURRENT NURSING PROGRAMS.)**

**Does the BRN provide appropriate oversight of those schools approved and those which may have potential problems, and take immediate action against those which do not meet the requirements of the BRN or are considered unapproved/unaccredited?**

**Background:** The BRN changed its school review to every eight years from a five-year cycle in 2004. Therefore, each approved nursing program, pre-licensure and advanced practice, is reviewed every eight years. The pre-licensure programs, however, are visited four years following the eight-year review visit. Although the standards for review are different, the same process is used for both. The on-site review of the nursing program includes meetings with administrators, students, and health care agency personnel to ensure continued statutory/regulatory compliance and consumer (student) satisfaction. The BRN grants continued approval to the program if it is in compliance with all applicable rules and regulations. When programs are found to be in noncompliance, the programs are placed on deferred action and are allowed a specified time to correct area(s) of noncompliance. NECs work closely with program directors to assist with their efforts to be granted continued approval. When a program is unable to correct the area(s) of noncompliance, or demonstrates a lack of progress toward correcting the noncompliance, the program is placed on warning status. Being placed on warning status is a rare and serious Board action in that the Board is warning the school of its intent to close the nursing program.

During the last eight-year period, no pre-licensure or advanced practice nursing program was placed on warning status by the BRN. Although the BRN voted to defer action on a total of thirteen pre-licensure nursing programs and one advanced nursing program during this time period for programs that were found in noncompliance, each of the programs responded quickly to correct identified areas of noncompliance and received subsequent approval. During the last eight years, the BRN reviewed 98 pre-licensure programs; 34 (35%) of the programs were in noncompliance. The two primary reasons of noncompliance were program evaluation and adequacy of resources. Of the 20 advanced practice nursing programs reviewed, four (20%) were in noncompliance. All four advanced practice programs in noncompliance were nurse practitioner programs. The primary area of noncompliance related to curriculum and curricular content.

A recent case illustrates the BRN's commitment to work out problems and issues of noncompliance with a school rather than shutting the program down. Humboldt State University announced in December 2010, that it had suspended spring admission into its nursing program. According to a newspaper article, it appeared as if the school administration was letting the struggling department sink. At the same time the nursing school lost its program director. The BRN stepped in to work with the school administration to assure that the program could still meet regulatory requirements for continuation of the program. The BRN explained that with a projected nursing shortage in the state, the Board wanted to see the program succeed.

As indicated, the BRN has primary responsibility for approval of pre-licensure nursing programs and when a program is not approved it is not permitted to operate in California or shouldn't be able to open its doors to potential nursing students. The BRN provides on its website a notice about the increasing

number of “unaccredited” nursing programs within California. The BRN’s notice indicates that they will not qualify an applicant to take the National Council Licensing Examination (NCLEX), or to be licensed, after completion from an “unaccredited” nursing program. “If any portion of the instruction is completed at or through an unapproved program, it is considered unaccredited,” as stated by the BRN. The BRN goes on to explain some of the indicators of a program that may be unaccredited and to caution students to verify whether such a program is accredited by seeing the listing of the BRN’s website of approved nursing programs. The BRN also specifically lists those programs which are “approved,” however, it does not appear as if it lists those programs which may have been “disapproved” by the BRN.

The efforts of the BRN, however, in only informing students of “unaccredited” programs may not be sufficient. Recently there was a nursing program that continued to operate for over two years even though the BRN did not grant approval and in 2007 had ordered the school to close (three years ago). As many as 300 students paid \$20,000 each to enroll and attend classes at this school; some attending for over two years. If potential students had checked the BRN Website they would not have found it listed as an approved program, but sadly many potential students do not know that the BRN provides this information and warning. The Attorney General (AG) was able to assure that the institution was finally shut down and reached a settlement agreement with the owner and operators of the school for \$500,000 as restitution to the former students. According to the then Attorney General Edmund G. Brown, Jr., this sham nursing school created “the illusion it was training future nurses by pretending to offer an accredited nursing program and tricking graduates into believing they had qualified to become nurses.” Something must be done to assure that once the BRN has decided that a program should not operate in California that it does not then find a way to open its doors to students who then spend two to three years of their lives in a school they think will qualify them to be a nurse, but sadly will not. Better communication between the BRN and the AG’s Office and re-visiting the school site by the BRN may be an option. The BRN should also consider ways in which it can better inform potential nursing students of the information it provides regarding nursing programs in California.

***Staff Recommendation:*** *Even though the BRN has not placed a warning status on a nursing program over the past eight years, the BRN should assure that if such a status is accorded a program that it should be reflected on the Board’s Website regarding that program. The BRN should continue its active role in trying to assure that troubled nursing programs can continue to meet both the rules and regulations of the BRN to maintain approval of their programs. The BRN must also work more closely with the AG’s Office and perform site-visits to assure that a nursing program which is not approved somehow continues to operate in California. In other words, there must be an IMMEDIATE shut down of this program if the BRN or AG becomes aware of its continued operation so that students are not ultimately deceived and waste precious years of their lives attending a bogus program. The BRN should also consider other ways in which it can continue to better inform students about the information it has available regarding nursing programs; those approved and disapproved, the graduation rates of these programs, and potential employment from these programs. It is also not clear if use of the term “unaccredited” is clear when the BRN is also discussing those programs which may be “unapproved.” There are nursing programs in California which may not have institutional or program accreditation, which are considered as “unaccredited” but do have approval status from the BRN to operate in California.*

**ISSUE #5: (REQUIRE ACCREDITATION FOR ALL NURSING PROGRAMS?) Should accreditation be required for all pre-licensure nursing programs to be approved by the BRN?**

**Background:** A recent report of the Center for American Progress (CAP) indicates that there are about 19 institutional accrediting organizations in the United States that accredit around 7,000 institutions, both for-profit and nonprofit. These private organizations stress a voluntary system of quality control. The idea that higher education institutions should be primarily responsible for their own quality is a core principle of institutional accreditation, according to the Council for Higher Education Accreditation, the leading voice for voluntary accreditation. The accreditation process is built around the idea that an institution's mission should be the touchstone for judging academic quality. For instance, accreditors ask whether the academic programs are of sufficient quality and integrity to achieve the institution's mission and similarly whether the institution maintains a faculty to fulfill the mission in terms of qualification, numbers, and performance. However, the fact that an institution is accredited does not guarantee the quality of the individual programs, course, or graduates. The CAP explains that program accreditation differs from institutional accreditation in that it looks more closely at the delivery of education within the discipline. The U.S. Department of Education recognizes more than 40 program accrediting agencies, including at least 25 agencies that accredit health-related programs. The Council for Higher Education Accreditation recognizes at least 61 agencies. The Commission on Collegiate Nursing Education and the National League for Nursing Accrediting are two of the independent accreditors for nursing programs. They both require programs to meet requirements related to mission, administrative capacity, faculty and staff, students, curriculum, clinical training, resources and outcomes. The CAP states that institutional and program accreditation certainly ensures some basic level of quality in educational institutions. However, the relationship between program accreditation and institutional accreditation is complicated and it is not often clear to students. Nursing students can find themselves at a serious disadvantage if they are enrolled in a program which is not accredited or has accreditation which is not readily recognized by other schools. The critical factor for students attending accredited institutions is the ability to transfer academic credits from one nursing program to another to complete their pre-licensure education, and for registered nurses who wish to pursue additional education/degrees. In addition to impeding students' academic progress, the inability to transfer academic credits also creates a financial burden for students by requiring that they pay twice for the same courses.

The BRN has indicated an interest in exploring the issue of requiring accreditation for nursing programs provided in California pursuant to a proposal presented at the Education/Licensing Committee of the BRN. The reasons stated in the proposal are:

- 1) Accreditation is in the public interest.
- 2) Is a requirement for other types of health care professionals' education.
- 3) Assures the quality of the institution.
- 4) Provides consistent standards.
- 5) Increases the potential for transferability of units.
- 6) Ensures that the institution provides an environment that supports broad education and intellectual stimulation.
- 7) Facilitates students' access to financial aid.

The BRN has indicated it will take into consideration the reasonable/feasible timeframe for compliance by existing programs that do not meet the accreditation requirement, and alternative proposals to the accreditation requirement with rationale for the proposal. The major problem with this proposal,

however, is that it asks the BRN to only consider accreditation by the Junior/Community College or Senior College Division of the Western Association of College and Schools (WASC accredited schools) or a regional counterpart. Recent case law has made it clear that California can no longer discriminate between accreditors for purposes of approving a school program. Restricting accreditation to those WASC accredited schools would be inconsistent with other state boards which have considered such requirements and with recent attempts to exempt schools only approved by WASC from the state's approval requirements under the BPPE, which approves both degree-granting and non-degree granting schools and programs. The most recent consideration made regarding accreditation by a licensing board was that of the California Board of Accountancy. Their initial proposal was to only approve schools of accountancy or Certified Public Accountant programs which had regional accreditation only. This proposal was rejected by the Legislature, and the Board of Accountancy instead adopted language which recognized all accreditors approved by the U.S. Department of Education.

***Staff Recommendation:*** *The BRN should carefully consider a requirement for all nursing programs to be accredited in light of recent legal decisions and actions taken by other nursing boards, and by the Legislature, in dealing with the issue of which accrediting organizations would be recognized. It should also carefully consider a timeline for implementing such a requirement so as to not severely impact existing programs or those programs which may be approved by the BRN in the near future.*

**ISSUE #6:** (ADDITIONAL INFORMATION NEEDED REGARDING PROGRAM/SCHOOL PERFORMANCE.) What additional information could be made available by the BRN to students of pre-licensure nursing programs to evaluate the quality of nursing educational programs?

**Background:** Accreditation of the school/program; graduation rates of each of the school/programs in California and each type of school/program whether public or private; licensure examination pass rates for graduates of all nursing programs; and success in entering into the nursing workforce. These are just some of the indicators which could provide useful information for students in selecting a particular program and in avoiding those programs which potentially will not provide the education and clinical training necessary for the graduate to pass the licensing examination and to succeed in obtaining work in the nursing profession. The BRN provides the following information on its Website: The NCLEX-RN examination pass rates for students who have taken the examination for the first time within the last five years for each of the nursing schools/programs in California, a listing of approved pre-licensure nursing programs and advanced nursing programs, and, its *Annual School Report*.

**Staff Recommendation:** *The BRN should continue to expand on ways to make this type of school/program data relevant and readily available to potential students of pre-licensure nursing programs. The BRN should consider whether they can provide a breakdown on individual pre-licensure programs and provide the additional following information for each program:*

- *Whether a Public or Private Program*
- *If Program is Accredited and by Whom*
- *Possible Transfer for Accreditation Purposes*
- *Student Completion Rates*
- *Student Retention and Attrition Rates*
- *Attrition Rate for Graduates to Employment*

## **NURSING WORKFORCE AND DIVERSITY ISSUES**

**ISSUE #7: (NURSING GRADUATES ARE HAVING DIFFICULTY IN FINDING EMPLOYMENT.)** There is currently an unexpected difficulty of new nursing graduates finding employment in California and this hiring dilemma threatens to undermine the progress that has been made, according to the BRN.

**Background:** To better understand how many newly licensed RNs are experiencing difficulties, a statewide survey was recently conducted through the efforts of the California Institute of Nursing & Health Care (CINHC), the BRN, the California Student Nurses Association, Association of California Nurse Leaders, the California Community Colleges Chancellor's Office and the UCLA School of Nursing. According to the *New Graduate Hiring Opportunity Survey Report 2009*, there is not a shortage of nursing positions in California but a shortage of those hiring RNs. It was reported that 37% of California hospitals have 5,462 unfilled RN positions, where new graduates commonly work, but are only actively recruiting to fill fewer than half of these positions. It was estimated that 40% of new graduates would not be hired in hospitals in 2009. Hospitals also reported that they are expecting to hire half as many RNs in 2009 and 2010, as were hired in 2008. Employers reported the following reasons for not hiring new RN graduates:

- Less employee turnover.
- Delayed retirements of existing RNs.
- Hiring freeze or budget constraints.
- Decrease in patient census.
- Current staff working more shifts or converting from part time to full time.

The high cost of hiring new graduates to prepare them to practice safely and competently after their academic studies, a cost which is absorbed by the employer, has further limited employment opportunities. Most California hospitals are employing experienced RNs. As a result of all of these factors, a number of new RNs are unemployed and are opting for non-nursing employment or moving to seek employment opportunities out of state. According to the BRN, it is of benefit to California to consider potential solutions/alternatives which have been discussed by professional nursing organizations, employers, educators, and state agencies. They include the following:

- Support non-acute settings in hiring new graduates.
- Encourage new graduates to continue their education.
- Identify where jobs are outside of the region (but still within California) and share this information with new graduates.
- Develop community-based "RN Transition Programs" (residencies.)

**Staff Recommendation:** *The BRN should continue to serve on the Committee of the CINHC, and with other organizations and agencies to find ways to improve new RN graduates employability and their continued practice in the nursing profession. The BRN should also work with nursing programs, employers, health care facilities, and other agencies and organizations to ensure the availability of clinical training for nursing students and to enhance the employability of RN graduates; this includes promoting the use of transition or residency programs for RN graduates.*



**ISSUE #8: (IS THERE STILL, OR WILL THERE CONTINUE TO BE, A NURSING WORKFORCE SHORTAGE?) Will California continue to experience a critical shortage of registered nurses and what can the BRN do to address this shortage?**

**Background:** In 2002, the BRN and this Committee discussed in depth the increased demand and decreased supply of RNs in California. The BRN stated that, “the well-documented and publicized shortage of registered nurses in the workforce is the most critical issue impacting nursing.” The BRN projected that California would need approximately 67,500 more registered nurses by 2006, and that we were rapidly approaching a shortfall of 25,000 nurses to meet the current health care needs of Californians. As explained by the BRN, such a shortfall would create a public health crisis, place consumers at risk, and have a crippling effect on healthcare delivery. The BRN indicated that it had been at the forefront of researching and strategizing to resolve this issue. BRN efforts included: identification and elimination of barriers to licensing; approval of new pre-licensure nursing programs; and active involvement with the Governor’s Nurse Workforce Initiative, other nursing organizations and educational institutions providing nursing programs to specifically deal with student matriculation. Significant efforts and expense were also invested since 2002 to address the nursing shortage. They included:

- Governor’s Nurse Education Task Force led a \$165 million dollar initiative to build educational capacity over 10 years, anchored by public-private partnerships.
- Increased funding for scholarship and loan repayment program by additional assessment on nurses licensing fees.
- Working with the community colleges and CSUs to provide more efficient transfer agreements and matriculation of students from one institution to the next.
- Focus on remediation programs and hiring of counselors to improve retention and graduation rates of nursing students.

Since 2002, the BRN approved 52 new nursing programs and increased their enrollment capacity by a 92% increase (from 13,401 to 25,719), with over a 100% increase in student graduations (from 5,623 to 11,512). There has also been a 10% increase in student retentions.

Although there may currently be difficulty for new RN graduates finding employment, the BRN argues that the current economic recession is distorting or masking the long term nursing shortage. The BRN explains that as the economy improves, and the current nursing workforce continues to age, there will be an exodus of the current RN workforce that expanded during the recession and took the jobs that new graduates expected to fill. This will result in a major shortage of nurses, which will be further compounded by the federal health care reform and expectations by the federal administration that nurses will help fill the gap for primary care and chronic care management as the population continues to age. The increases in health care coverage provided by the federal health care programs and incentives for patients to seek routine and preventative care will surely increase the need for more RNs. A memo recently sent to all executive officers by the DCA Director indicated that all the healing arts boards should prepare for increased activity over the next several years. An example of the federal reform encouraging and facilitating the growth of the health care workforce is a commitment to increase funds available for nursing programs and student scholarships and loans. The CINHC has also pointed out that “the nursing shortage is not over; the current situation is temporary.” The CINHC states that California must not lose sight of the future and the looming nursing shortage and the impact it would have on the health status of millions of Californians. “We cannot afford to go backwards.” California still has one of the lowest number of RNs per capita at 638 RNs per 100,000 population. It

is estimated that California will have a shortfall of 116,000 RNs by 2020, meeting only 65% of the state's demand for RNs and a need for 108,000 more RNs to meet the benchmark of the national average of RNs per capita by 2020.

The fact remains that interest in nursing as a career also remains strong, but educational capacity is still not keeping up. There was a total of 41,105 qualified applicants to nursing programs in 2009-2010. California schools of nursing turned away 26,877 qualified applicants, denying about 65% of potential nursing students. A recent survey of 33 deans of the nearly 100 health programs at California community colleges pointed out that they continue to be unable to keep up with student demand for their allied health programs. About 72% of deans reported that health training programs are their school's most sought after, and 97 % report that those graduates are usually successful in finding employment in the health field. Yet only 6% of colleges are able to accept all qualified applicants for programs in 2009 and 2010, and only one in four accepted all or most. In fact, one in four community colleges had to eliminate one or more of their health training programs during the past two years, while one out of five reduced the number of slots in their programs. The deans indicated that while they recognize that there is a demand for both students and the economy to increase the number of health professionals, they believe that this will not be easy. Most deans cite a lack of funding, in addition to the specific lack of clinical space to help students finish their coursework, and lack of funds to hire instructors.

Continuing to increase the number of nursing programs and available funding will obviously be necessary, but also assuring that clinical space and access is available for these programs will also be an important consideration in providing for expanded programs. The BRN indicated that it is aware of instances where nursing programs have had difficulty obtaining clinical placements or have been terminated or replaced at clinical sites where their students complete clinical experiences as part of their nursing education. In addition, there have been reports of RN students being denied access to medication administration systems, equipment, or other required duties while completing their clinical experiences. The BRN is also beginning to collect more data on the frequency and extent of this issue.

***Staff Recommendation:*** *The BRN should continue its efforts in increasing the number of RN graduates by not only improving on its approval process for nursing programs, but also working with schools, colleges and universities to promote, create or expand nursing programs, provide for more timely matriculation for students, alleviate course repetition through standardized course requirements and find ways to increase access to nursing programs especially for socio-economically disadvantaged students.*

**ISSUE #9: (IS THERE STILL A SEVERE LACK OF DIVERSITY IN THE NURSING PROFESSION?) Is there more that the BRN can do to further diversity in the nursing profession by utilizing its advisory committees, the data it receives, and in its participation and collaboration with other schools, universities, colleges, and nursing programs and with other local and state agencies, nursing associations, groups and nursing research organizations?**

**Background:** As indicated by the Center for the Health Professions (Center), it has long been known that certain ethnic and racial groups are underrepresented in the health professions. "The subject of racial and ethnic underrepresentation in California's health professions training programs and workforce has come to occupy a central role in the effort to develop better models of health care practice and better systems for health care delivery," as stated by the Center. The reasons for this are varied, as explained by the Center:

- The practice of linguistically and culturally competent health care of a diverse health professions workforce is critical to addressing health disparities.
- Student experiences in health professions training programs are enriched by the presence of fellow students with diverse social and cultural experiences.
- Economic development in communities is another reason to promote greater diversity in the health professions. The health industry is one of the few economic sectors in California that continues to create jobs and most jobs in health care are well paid, and many of them offer opportunities for professional development.

A recent study by the Center, for example, found that in the nursing profession men of color still represent a very small share of the total of RN's in the profession, and that Latino men are profoundly underrepresented in this profession as well as in other health professions education programs. This is in spite of the fact that the capacity of training programs for nurses around the state have greatly expanded and there have been some concerted efforts to broaden student diversity and that the nursing profession is still a very significant source of health care employment.

The California Workforce Association (CWA) recently provided a Regional Planning Guide to Diversify the Workforce for use by the Workforce Investment Boards (WIBs). CWA currently represents the 49 WIBs, over 200 One-Stop Career Centers and other workforce development partners in California. The purpose of the guide is to assist WIBs in their strategic planning efforts to increase the diversity of the allied health care workforce, and in developing strategies to help recruit, train and retain a diverse, culturally competent workforce. It was anticipated that this guide could also be used by any other set of stakeholders in health care workforce development. In looking at the overall picture of the nursing profession and its diversity, the CWA found that with a Latino population of over 36% in California only 5.7% of that population are nurses. It was suggested that WIBs could serve in varying roles in bringing about greater diversity in the health care profession.

In 2007, the California Institute for Nursing and Health Care as part of its Master Plan for the California Nursing Workforce, set as its primary goal to increase diversity in the nursing workforce. Specific targets were set for 5, 10, and 15 years, consistent with population projections and the shifting demographics of the aging RN workforce, and to develop a strategically focused plan that describes interventions to meet the targets. Since availability of data was a weakness of the project, only targets for the Latino nursing workforce for Los Angeles County were set. It was anticipated that as more data became available that targets could be set for other regions.

***Staff Recommendation: The BRN should continue to focus its efforts on diversity issues, both through its collaboration and participation with a number of state and local agencies, health facilities/employers, educational institutions, nursing programs, nursing associations and groups, and research organizations.***

**ISSUE #10: (SHOULD THE FUNDING FOR THE NURSES SCHOLARSHIP PROGRAM BE INCREASED?) It is unclear how well the Board's scholarship and loan repayment program, which is managed by the OSHPD, is functioning and if moneys available are being fully utilized, and whether the funding should be increased based on the number of potential applicants. Should the BRN be the central source for information regarding available funding for students or at least the first point of contact for students?**

**Background:** Obviously, the ability of students to receive scholarships to attend nursing programs (or for advanced degrees in nursing), or to receive loan repayment funds, provides a strong incentive for students to choose a career in the nursing profession. Currently, the BRN funds, through a \$10.00 assessment of its license renewal fees, several different scholarship and loan repayment programs to nursing students and graduates who will agree to practice in medically underserved areas. The Health Professions Education Foundation (HPEF), which is under the OSHPD, administers the scholarship and loan repayment programs for aspiring and practicing nurses, as well as physicians and other health professions. The HPEF awards scholarships and loan repayments through five special funds including that of the BRN (the "Registered Nurse Education Fund" (RNEF)). These programs are governed by a thirteen-member Board of Trustees, appointed by the Governor, Speaker of the Assembly, the Senate Committee on Rules, and the Medical Board of California (MBC). The MBC is allowed to make two appointments to the Board of Trustees. The BRN currently has two appointments on the Board of Trustees but they are not required appointments. In 2004, pursuant to a recommendation of the JLSRC, the assessment fee for RNs was increased from \$5 to \$10 for the RNEF. According to BRN, in 2003/04, \$579,410 was transferred to the RNEF and in 2009/10 the amount more than doubled to \$1,474,975. With the money received from the BRN, the OSHPD provides for two separate scholarship programs for nursing students, one is for an Associate Degree in Nursing (ADN) and one is for a Bachelor of Science Degree in Nursing (BSN). In OSHPD Report to their Board of Trustees on January 13, 2011, it showed that in September 2009 and March 2010, the ADN awarded \$685,000 to 71 nursing students dedicated to work in medically underserved areas. In September 2009 and March 2010 cycles, the BSN awarded \$1,254,500 to 98 nursing students. It is difficult to determine whether OSHPD is fully utilizing the dollars it receives from the BRN, since the amounts distributed by the BRN to OSHPD do not match with the award cycle of the OSHPD.

The HPEF is not alone in providing scholarship and loan repayment programs. The Healthcare Workforce Development Division of OSHPD provides for a "State Loan Repayment Program (SLRP) for nurse practitioners and certified nurse midwives who practice in defined health professional shortage areas. The SLRP has approximately \$4 million to award in 2011. The California Student Aid Commission provides a loan assumption program for nursing students committed to becoming nursing instructors (faculty) for nursing programs. The California Nurse Education Initiative adopted in 2005 was anchored by a \$90 million, five-year public-private partnership commitment that was to focus on expansion of nurse education capacity, faculty development, student support services, including loan forgiveness, and additional funding for nursing schools. This initiative has assisted in the expansion of nursing programs by California colleges and universities which provided increased graduation of nursing students over the past five years. (It is unknown at this time whether the yearly \$6 million may be committed to programs which would provide scholarships and loan forgiveness for nursing students. It has been recommended that the Chancellor's Office for Community Colleges, the Labor and Workforce Development Agency and the Workforce Development Board work in concert to further the Nursing Initiative's intent to maintain the expansion of nursing students within California.)

Funds made available by the “American Recovery and Reinvestment Act” (ARRA) are also targeting nursing training programs and possible student loan and repayment programs. In September of 2010, the U.S. Department of Health and Human Services (HHS) announced an award of \$130.8 million in grants to strengthen and expand the health professions workforce. Six areas are targeted including loan repayments for health professionals (\$8.3 million) and health career opportunity programs for disadvantaged students (\$2.1 million).

**Staff Recommendation:** *It is not clear what commitment will be made to scholarship programs for nursing students in the future. However, it does appear that there will be more dollars available for repayment of loan programs, especially for those students who commit to serve in medically underserved areas or who want to become nursing instructors and faculty members for nursing programs. The BRN should consider increasing the amount of licensing fee committed to its scholarship program by \$5 to at least increase the availability of funds for those students wishing to attend nursing programs. Prior to any increase, however, the BRN should report to the Legislature on how the moneys are being expended by OSHPD. Since these are licensing fees they must be expended only for those purposes which would further the nursing profession and not be diverted for other purposes. The BRN should also meet and collaborate with OSHPD, Labor and Workforce Development Agency, California Workforce Development Board and other agencies which may be involved in providing scholarship and loan repayment programs for students, and assure that potential and current nursing students have information and access to information regarding these programs.*

## **NURSING SCOPE OF PRACTICE ISSUES**

**ISSUE #11: (SCHOOL PERSONNEL PROVIDING NURSING SERVICES.)** The BRN is concerned that school personnel may be providing nursing services that in other settings would be prohibited.

**Background:** As explained in the BRN’s Report, California’s public school children are being placed at risk due to inappropriate use of unlicensed school personnel to provide nursing care. The major contributing factor, as the BRN argues, is a conflict between the Nursing Practice Act and the Education Code that permits unlicensed personnel to perform nursing tasks that in other settings they would be prohibited from performing. For the past several years, the BRN has worked collaboratively with the California Department of Education on school health-related issues. However, in spite of these efforts, issues pertaining to nursing care in schools continue to increase. Given the existing statutes and the shortage of registered nurses in schools, it is anticipated that the situation will only worsen. The most recent controversies have revolved around administration of insulin to students with diabetes and diastat for students having seizures. This issue has ended up in the courts and a recent decision on June 2010, by the 3<sup>rd</sup> District Court of Appeal, held that school personnel may not administer insulin to students with diabetes. The BRN has consistently affirmed its position that students should receive all health care services to which they are entitled and which are necessary for them to receive maximum benefit from the education program. At the same time, however, such services must be provided by individuals legally authorized to provide the services. Business and Professions Code 2725(b)(2) defines medication administration as a nursing function, which cannot be performed by unlicensed persons without express statutory authority. With the exception of glucagon and epinephrine, there is no statutory authority for unlicensed school personnel to administer

medications. Thus far, as indicated by the BRN, the approach to resolving student health-related issues has been on an issue by issue, medication by medication basis. Hence, the Education Code has been amended to permit unlicensed personnel to administer glucagon and epinephrine, and to permit students with asthma to carry inhalers at school. Legislation has been introduced, but failed passage, or was vetoed, to permit unlicensed personnel to administer insulin and diastat. The BRN believes that such a fragmented approach to school health services is not in the best interest of students, and fails to ensure that each district/school maintains health care services at a level that ensures every student receives safe and appropriate care.

***Staff Recommendation:*** *This issue will have to be resolved through the Legislature. Special consideration should be given to the nurse’s scope of practice and potentially allowing others to perform those procedures which have been traditionally restricted to the practice of nursing. The BRN should continue to provide input and participate in discussions regarding this very important issue.*

**ISSUE #12: (PROVIDE PRESCRIPTIVE AUTHORITY TO ADVANCED PRACTICE NURSES?)** Should the current terms “furnishing or ordering drugs or devices,” as authorized by Section 2746.51 of the Business and Professions Code for certified nurse-midwives and Section 2836.1 for nurse practitioners, be changed to “prescribing drugs or devices,” clarifying in effect the prescriptive authority for these advanced practice nurses?

**Background:** A furnishing number enables nurse-midwives and nurse practitioners, under standardized procedures, to write a medication order on a transmittal slip (similar to a physician’s prescription form) for a pharmacist to fill; thereby, the advanced practice nurse “furnishes” a drug to a patient. As argued by the BRN, two major problems exist with the terms “furnishing” and “transmittal orders.” The public and other health care providers do not understand what the terms mean. Medication orders and prescription are synonymous. Furnishing and transmittal orders are confusing. The second problem, however, is more serious. In some instances, pharmacists refuse to fill a medication order on transmittal slips on the basis it is not a prescription. As a result, the patient does not obtain needed medication. The BRN is very concerned about this practice and strongly recommends change. Deletion of the word furnishing eliminates the ongoing confusion regarding this word and facilitates the filling of medication orders by pharmacists. Legislation enacted in 1999 and 2001 resulted in nurse practitioners and nurse-midwives being eligible for Drug Enforcement Administration numbers, which facilitated their furnishing of controlled substances. However, the new laws did not resolve the underlying problems of consumer access to medications and consumer confusion created by use of the term “furnishing.”

***Staff Recommendation:*** *The BRN continues to recommend that the Nursing Practice Act be changed so that the term “furnishing” is replaced with “prescriptive authority.” The Legislature should review this issue to determine whether such a change is necessary and to determine if confusion still exists with pharmacists filling medication orders.*

**ISSUE #13: (DEFINE “ADVANCED PRACTICE NURSE?”)** Should a separate statutory definition for “advanced practice nurse” be created?

**Background:** Nationally, the term “advanced practice nurse” refers to four categories of registered nurses with education and expertise beyond basic registered nurse education. The four categories are

nurse anesthetists, nurse-midwives, nurse practitioners, and clinical nurse specialists. In discussions with the public, consumer groups, other professional organizations, and the Legislature, the phrase “advanced practice nursing” helps identify these groups of certificated nurses and helps identify their special expertise and knowledge, as stated by the BRN. In this era of health care reform, the BRN is finding increasing need to be able to identify these categories of registered nurses with advanced skills and knowledge through one phrase, and to protect this phrase from use by individuals who do not understand that the advanced practice nurse is a registered nurse with advanced training. Once this phrase is defined in statute, there is some indication that the BRN would be able to consolidate some of the advanced practice regulations under this over-riding phrase, rather than individually changing each body of regulations for each category of advanced practice nursing.

**Staff Recommendation:** *The BRN should consider whether a separate statutory definition for “advanced practice nurse” should be created similar to other states.*

### **CONTINUING COMPETENCY ISSUES**

**ISSUE #14: (INCREASE CONTINUING EDUCATION AUDIT OF RNs AND PROVIDERS?) Should the BRN increase the random audits it performs per year on both RNs and Continuing Education Providers (CEPs)?**

**Background:** The BRN requires RNs to complete a total of 30 hours of continuing education (CE) biennially in order to renew their RN licenses in the active status. The BRN conducts random audits of RNs to check for CE compliance. The BRN also approves and conducts random audits of CEPs. In the past, the BRN completed an average of 2,700 RN and 282 CEP random audits per year. However, due to lack of staff because of workload demands, random CEP audits have not been completed since January 2001, and RN random audits have been reduced to approximately 350 per year in the past four years. *California Watch* (the Center for Investigative Reporting) recently reported on an article written by the *Committee for Skeptical Inquiry* (CSI) which was titled, “*State-Sponsored Quackery: Feng Shui and Snake Oil for California Nurses.*” This article detailed the problems with the BRN’s approval of questionable CE providers and even evidenced creation of a sham CE provider by the CSI to prove that the BRN would almost approve any type of CE provider no matter what the coursework provided. The *California Watch* article pointed out that the BRN’s Sunset Review Report expressed little urgency about improving the quality of CE courses or ensuring that the state’s 3,300 certified providers are running a legitimate operation.

Assessment of continued competence is a national issue facing all professional healing arts licensing boards. A BRN staff member served as chair and participated on the National Council of State Boards of Nursing’s Continue Competence Committee. The Committee developed research questions related to the study of continued competence. Even so, the BRN must develop a way to provide better oversight of its CE providers, in particular those that it continues to approve. The BRN should also investigate whether the current method for CE really provides the best way to assure continuing competence for nurses. The House of Delegates for the Federation of State Medical Boards (FSMB), which represents all of the nation’s state medical and osteopathic boards, recently adopted a framework by which licensed physicians would be required to periodically demonstrate ongoing clinical competence as required for licensure renewal. As pointed out by FSMB, this approach is both proactive and consistent with the FSMB’s mission to promote policies and procedure that protect the public through quality health care practices, promote patient safety, and demonstrate the value of the

earned license to the practice of medicine. Obviously this approach is in its early stages but it is one that the BRN should consider as a way of looking at performance-based CE with a focus on the nurses keeping abreast of their clinical practices rather than taking courses which may have no bearing on their day-to-day practice. Consideration could be given to initiating a pilot program in California modeled after the FSMB approach.

***Staff Recommendation:*** *The BRN should submit a Budget Change Proposal to obtain staff dedicated to conducting increased RN audits and begin again audits of CEPs. The BRN should only be required to increase audits of RNs of CEPs if it receives sufficient staffing to conduct such audits. The BRN should also continue to review and evaluate national continued competence research and possible clinical competence based CE and make recommendations for changes, as appropriate.*

## **ENFORCEMENT ISSUES**

**ISSUE #15: (DISCIPLINARY CASE MANAGEMENT TIMEFRAME STILL TAKING ON AVERAGE THREE YEARS OR MORE.) Will the BRN be able to meet its goal of reducing the average disciplinary case timeframe from three years or more, to 12-18 months?**

**Background:** The average number of years it takes from receipt of a complaint to the final disposition of a case, where disciplinary action is taken, has not changed to any significant degree for several years. It takes on average 16 months to complete an investigation, 7.5 months for the AG to file an accusation and another 12 months for the AG to prosecute a case or reach a stipulated settlement; a little over 3 years. This does not take into account cases which may go well over three years to complete. There are a number of reasons for the extremely lengthy process for taking disciplinary action against a nurse who may have violated the Nursing Practice Act or been involved in criminal activity.

The BRN is not alone in its problems related to its lengthy disciplinary process; all other health boards under DCA are affected as well. The process begins generally with a complaint from a consumer, or information provided possibly by another health care licensee or facility (hospital), a public agency or local law enforcement. Complaints often take a circuitous route through several clogged bureaucracies; from the health care boards for initial assessment to the DOI of the DCA for investigation, to the AG's Office for filing of an accusation and prosecution, to the State Office of Administrative Hearings (OAH) for a disciplinary hearing. Lastly, the case goes back to the board for a final decision. On August 17, 2009, this Committee held an informational hearing entitled, "Creating a Seamless Enforcement Program for Consumer Boards." The hearing revealed that the biggest bottleneck occurs at the investigation and prosecution stages of the process, as the DOI investigators and the AG's Office prosecutors struggle to handle complaints against a variety of health care practitioners, as well as those against cosmetologists, accountants, engineers, shorthand reporters, funeral directors, private investigators and others. Some of the reasons given for delays of almost three years in the investigation and prosecution of cases by boards are as follows:

- DOI has high caseloads and lacks adequate staffing.
- Lack of management and prioritization of cases by DOI and training and specialization of investigators.



- Inability to obtain important medical records and other documents in a timely manner
- Delay in obtaining needed outside expert or consultant evaluations of complaints
- Lack of communication and coordination with the client board by the DOI and AG in its handling of cases.
- Lack of accountability, such as reporting of performance measures both for the DOI and the AG's Office
- Complicated budgeting mechanism for use of the DOI and the AG's Office services.
- Deputy AGs within its Licensing Section handle both licensing and health care cases in a similar fashion without any expertise devoted to the prosecution of those cases involving serious health care quality issues.

It takes, as indicated, on average, about 7.5 months for the AG's Office to prepare an accusation, petition to revoke probation, or statement of issues for the BRN. Moreover, the AG's staff often allows respondents to file a notice of defense long after the 15-day time limit has ended, which lengthens the time a case is processed by the AG's Office. The practice of the AG's Office of not requesting a hearing date when notice of defense is received is also contributing to the delays. The AG's Office often waits for settlement negotiations to break down before requesting a hearing date with OAH. It can then take one to two years to prosecute the case and for a disciplinary decision to be reached. Finally, OAH provides services to over 950 different governmental agencies. The DCA's cases are not given a higher priority and are calendared according to available hearing dates and Administrative Law Judges (ALJs) assigned. Cases on average can take up to 12 months or more to be heard. Also, the DCA's boards and bureaus have over 40 different laws and regulations with which ALJs must be familiar. This lack of specialization and training for the cases referred by the other health care boards creates a situation in which judges are issuing inconsistent decisions. The board is then placed in a position of non-adopting the decision of the ALJ and providing for a hearing of its own to make a different determination regarding the disciplinary action which should be taken against the nurse.

Possibly the most critical issue which must be addressed to improve the disciplinary case timeframe is the shortage of investigators for the BRN. The BRN received 7,483 complaints in 2009-2010, over 1,689 more complaints than it received in 2008-2009 (5,794), and has steadily increased over the past four years when in 2006-2007 it received less than half as many cases (3,361). The primary reason for the substantial increase is that all nurses are now fingerprinted and the BRN receives criminal history information on the applicant for an RN license and the current licensee upon renewal of their license. This was not the case prior to 2009. In 1990, the BRN began to fingerprint applicants, but the law was not retroactive so about 146,000 RNs were never fingerprinted and it was not required that an RN be fingerprinted upon renewal of their license. In the fall of 2008, as mentioned, the *Times* published several articles which focused on nurses who had prior criminal convictions and were still licensed by the BRN. The *Times* investigation was a joint effort with the nonprofit investigative reporting agency *Pro Publica*, which reviewed nursing board files and court pleadings, consulted on-line databases, newspaper clippings, and conducted interviews with nurses and experts in several states. The articles reported finding 115 cases in which the BRN didn't seek to revoke or restrict licenses until nurses had three or more criminal convictions. Twenty-five nurses had at least five convictions. In some cases, nurses with felony records continued to have spotless licenses, even while jailed or imprisoned. The BRN believed that if it was able to fingerprint all nurses, and to fingerprint upon renewal of their license, then any criminal activity by a California licensed RN would be captured. The BRN pursued emergency regulations to require fingerprinting and the regulations were adopted in 2009. The largest

number of complaints now filed by the BRN, are those related to convictions against both applicants and licensees (71% in 2009-2010) with DUI convictions being the most frequent.

There is also an increase, and will continue to be an increase, in the information that the BRN also receives regarding nurses who may have violated the law or been disciplined by a licensing authority in another state. In March 2010, the BRN contracted with the National Council of State Board of Nursing (NCSBN) to complete a comparison of the BRN's licensing data base with that of the NURSIS database, which provides information on prior disciplinary action of state boards. The BRN is also requesting that it be able to participate with the Department of Justice and with the FBI to participate in a program that will provide subsequent arrest/conviction information for nurses from other states who may now be practicing in California.

With the increased complaint activity, the BRN is still doing a good job of moving complaints along expeditiously without any additional staffing. Complaint processing time on average has dropped from 100 days in 2006-2007, to 40 days in 2009-2010. Delays in moving the case forward begin to occur once the case moves to investigation, either by BRN staff or the DOI. Because of a severe lack of investigators within the BRN, the backlog of cases and the timeframe for investigating cases will only increase, and substantially increase because of the large number of complaints the BRN is now receiving. The BRN originally requested 63 positions but was granted 37 new positions in the current budget year. However, these new positions are now in jeopardy because of the recent hiring freeze and a \$15 million loan which will be taken from the BRN's reserve funds for the General Fund purposes. One of the goals of BRN in obtaining its own investigative staff was to handle more investigations by their own staff and not rely on DOI for many of its investigations. For example, out of the 7,864 cases handled by BRN staff investigation, 6,453 or 82% were closed within one year by. The DOI has also had problems in pursuing its cases. DOI has seen increased caseloads but a decrease in staffing levels. DOI also had problems with lack of management and prioritization of cases and communication with client boards regarding the status of their case. Although the circumstances for DOI have improved somewhat, thanks to the efforts of the DCA's California's Protection Enforcement Initiative (CPEI) from last year, the DOI is still taking on average about 20 months to investigate BRN cases. Providing the opportunity for the BRN to assume major responsibility for investigating cases should have a significant impact on the overall time it is taking to complete investigations.

For cases which move forward to investigation, delays also occur because of problems investigators confront in obtaining documents and other relevant records; in particular medical records. The BRN does not have a specific provision of law that deals with the proper procedures for obtaining medical records. In some instances, health facilities will not cooperate with investigators of the BRN or DOI in obtaining the necessary documents or medical records they need. As stated by the BRN, "investigators need to be able to inspect and copy any documents related to any investigation of a licensee or applicant, and [health facilities] and licensees and applicants need to be compelled to cooperate during an investigation."

Once investigation is completed and the case is turned over to the AG's Office for prosecution and possible settlement or hearing, delays still continue. The Licensing Section of the AG's Office handles cases for the BRN and many of the other boards and bureaus under the DCA. In 2009-2010, the average case took 7 months from the referral of the case to the AG until an accusation (pleading) was filed, and then on average almost 12 months before a settlement was reached or disciplinary action was taken. Although some of the delay occurs with the AG, the OAH is currently backlogged with cases and it is taking almost 6-9 months before a case can be calendared for hearing. Disciplinary action

may be further delayed if the decision made by the ALJ does not comport with the action which the BRN may believe is necessary. In other words, there has been some issue raised about the lack of specialization and training for ALJs who handle health care cases and this has created a situation where ALJs issue inconsistent decisions. In doing so, the BRN is forced to non-adopt the decision of the ALJ, re-review the case, and issue a different disciplinary order.

***Staff Recommendation:*** *It does not appear as if the BRN will be able to meet its goal of reducing the timeframe for the handling of its disciplinary cases for some time. Lack of adequate staffing, reliance on DOI and delays at the AG's Office in prosecuting cases, and OAH in hearing cases, and the inability to obtain necessary records, all contribute to the current average of three years to complete a disciplinary action. The Committee should consider communicating with the Senate and Assembly Budget Committees, with the Department of Finance and with the Governor's Office on the unique circumstances which exist regarding the funding and staffing of the BRN. It was the intent of both Budget Committees last year to assure that the BRN had sufficient staffing and funding to provide for the increased staffing levels it needed. Without this additional staffing, the investigation and prosecution of BRN disciplinary cases and the overall administration of its other programs, including licensing of nurses in an expeditious manner, will be in jeopardy. Backlogs of licensing applications and disciplinary cases will increase and any action on the part of the BRN against a nurse, who has either violated the law or the Nursing Practice Act, will be severely delayed. The BRN should also be granted statutory authority to deal with its need to obtain documents and records it needs pursuant to their investigations, including the need for medical records. The authority currently granted to the Medical Board of California in obtaining medical records should also be granted to the BRN. Provide that failure to furnish information in a timely manner to the BRN or cooperate in any disciplinary investigation constitutes unprofessional conduct. The Committee should also give consideration to auditing both DOI and the Licensing Section of the AG's Office to determine whether improvements could be made to the investigation and prosecution of BRN's disciplinary cases and coordination between all three agencies.*

**ISSUE #16: (DOES THE BRN RECEIVE SUFFICIENT INFORMATION ON NURSES WHO VIOLATED THE LAW OR HAVE ISSUES REGARDING THEIR COMPETENCY?)**

**Does the BRN receive sufficient information from the courts, other agencies, health facilities, and from the licensee if there is reason to believe they have been involved in criminal activity, violated the Nursing Practices Act, or have issues regarding their competency or ability to continue practice.**

**Background:** One of the primary concerns raised by the *Times* articles was that the BRN was unaware of nurses practicing in California who had been charged with violating a crime or who practiced in one facility where serious harm or abuse had occurred with a patient(s) under their care, or if there were substance abuse problems, and the nurse was terminated and then moved on to work in another health facility where there was subsequent harm or abuse of a patient or abuse of drugs. Both the BRN and the other health facility were unaware of problems with the nurse who worked in the facility which terminated or suspended his or her practice. This raised three areas of concern:

(1) *Reporting of arrests or convictions.* The *Times* revealed that nurses convicted of crimes, including sex offenses and attempted murder, continued to be licensed by the BRN. This was primarily the result of over half of the health care licensees being grandfathered into the fingerprinting requirement (without having to be fingerprinted) when it went into effect several years ago. With the requirement for all health care licensees to be fingerprinted, boards will now receive information regarding any

arrests or convictions regarding the individual licensees. In addition to fingerprinting, however, several of the health care boards also require the reporting by the courts and by the licensee of any arrest or conviction information, or any disciplinary action taken against them by another agency or state, to assure that this information is received as soon as possible so that appropriate action may be taken by the boards. However, there are several health care boards including the BRN which do not have such a reporting requirement and this could delay action on the part of the BRN especially if a serious crime has been committed or the practitioner's license in another jurisdiction has been suspended or revoked. Some health boards also require the self-reporting of the licensee of any crimes committed. The BRN does not have a self-reporting requirement in statute. Another problem is that the BRN only has access to DOJ files which are updated periodically, but the more sophisticated system used by law enforcement is the "California Law Enforcement Telecommunications System, or better known as the "CLETS." The CLETS provides law enforcement and criminal justice agencies access to various databases and the ability to transmit and receive point-to-point messages to other agencies within California or via the National Law Enforcement Telecommunications System (NLETS) to other states and Canada. Eligibility and access to CLETS is limited to non-law enforcement public agencies which performs the duties of a law enforcement agency (such as the BRN), but only if they employ peace officers to retrieve information from CLETS. The BRN would need to employ investigators classified as peace officers like the Dental Board and the Medical Board, otherwise they would have to rely on the DOJ to obtain such information.

(2) *Reporting and retrieving enforcement action from other states.* It is currently a federal requirement for state health care licensing boards to report specific enforcement actions taken against health care practitioners to the following national data banks: the National Practitioner Data Bank (NPDP) and the Healthcare Integrity and Protection Data Bank (HIPDB). Federal law requires hospitals to query the national data banks before they hire a practitioner. However, it does not require state health care boards to query either the NPDB or the HIPDB prior to licensing a practitioner to determine if there were enforcement actions taken in another state against the practitioner. As indicated earlier, the BRN is about to enter into a contract with the Nursys which will report disciplinary actions of the BRN to both NPDP and HIPDB and will also link with the BRN to provide disciplinary actions compiled by the NPDP and HIPDB to the BRN.

(3) *Use of "gag clauses" in civil dispute settlement agreements.* Health care licensees are also permitted to include as part of a civil settlement agreement a provision which would prohibit a person (former patient) from contacting, cooperating with or filing a complaint with the appropriate board based on any action arising from his or her practice. However, physicians and surgeons are prohibited from including such a "gag clause" in a civil dispute settlement agreement. There was no reason why this prohibition should not apply to other practitioners as well, since it prevents the boards from receiving information about a practitioner who may have violated the law. The use of gag clauses still persists. Gag clauses are sometimes used to intimidate injured victims so they refuse to testify against a licensee in investigations. Gag clauses can cause delays and thwart a board's effort to investigate possible cases of misconduct, thereby preventing the board from performing its most basic function – protection of the public. Gag clauses increase costs to taxpayers, delay action by regulators, and tarnish the reputation of competent and reputable licensed health professionals. California should not allow repeat offenders who injure patients to hide their illegal acts from the authority that grants them their license to practice as a health care professional.

(4) *Reporting by health care facilities of nurses with serious deficiencies or who may be a danger to patients.* There are 36 other states that currently require health care facilities to report nurses and other

health care practitioners who have been fired or suspended for harming a patient or other serious misconduct. There are also a number of health care boards under the DCA that also require this type of reporting. Currently, employers of vocational nurses, psychiatric technicians, pharmacists and respiratory care therapists are required to report to the respective boards the suspension or termination for cause of these health care practitioners. The Medical Board, Board of Podiatric Medicine, Board of Behavioral Sciences, Board of Psychology and the Dental Board also have more extensive reporting requirements for peer review bodies and hospitals which are specified in Section 805 et seq. of the B&P Code. The Board of Pharmacy also requires its licensed pharmacies to report their own employees (pharmacists or pharmacy technicians) if there is evidence of theft, diversion or misuse of drugs and they are terminated from employment for any of those reasons. However, the BRN does not have any similar requirement. Practitioners who may have serious problems continue to work in facilities, or move from one facility to another, with no action taken against them by the Board (since the BRN is unaware that such problems exist). The *Times* found that there were nurses who were fired or suspended for patient harm or other serious wrongdoing yet had a blemish-free record with the BRN. It should be recognized, however, that unlike many of the other health professions which have an opportunity to appear before peer review bodies before any subsequent action is taken against the health practitioner by a health care facility; nurses are not afforded this opportunity before they may be terminated or suspended from practice. (It should be noted that there may be some facilities which provide for nursing peer review, but it is not the standard throughout the state.) Currently, there are some states which provide for statutorily required nursing peer review in their health facilities before termination or suspension from employment can occur. Texas is the most notable which provides for nursing peer review in all of its health facilities, “safe-harbor” for nurses who act as whistleblowers against facilities, and reporting to the nurses licensing board by the peer review body if there are serious competency issues or questions about the ability of the nurse to continue their practice without harming patients.

***Staff Recommendation:*** *Require courts to report if there is a judgment for a crime committed or any civil judgment against the licensee for any death or personal injury in excess of \$3,000, or any filings of a felony. The DOJ should also report within 30 days to the BRN any arrests, convictions or other updates on licensees pursuant to their fingerprint file. The BRN should also be allowed to employ a sufficient number of investigators classified as peace officers to receive important criminal justice information regarding their licensees rather than relying on DOI. RNs should also be required to self-report any serious crimes committed. The BRN shall also be required to report any of its enforcement actions against its licensees to the NPDB and the HIPDB and to also query these data banks for those licensed in another state. The BRN should be able to contract with the NURSYS to meet this requirement, and report and retrieve enforcement actions provided on the NPDB and the HIPDB. Prohibit “gag clauses” against patients pursuant to a civil dispute settle agreement. The BRN should begin to explore the use of nursing peer review and mandatory reporting for all health care facilities within California, possibly modeled after the Texas law.*

**ISSUE #17: (PROTRACTED PROCESS TO SUSPEND LICENSE OF RN.)** The BRN must go through a cumbersome process to suspend the license of an RN who may pose an immediate threat to patients or who have committed a serious crime and may even be incarcerated.

**Background:** Currently in California, even if a health care provider is thought to be a serious risk to the public, the boards must go through a cumbersome legal process to get permission to stop the provider from practicing, even temporarily. As pointed out by the *Times*, the BRN for example had only obtained immediate suspension of nurses just 29 times within 5 years, while Florida which

oversees 40 percent fewer nurses takes such action more than 70 times per year. Under existing law, the Interim Suspension Order (ISO) process (Section 494 of the B&P Code) provides boards with an avenue for expedited suspension of a license when action must be taken swiftly to protect public health, safety, or welfare. However, the ISO process currently takes weeks to months to achieve, allowing licensees who pose a serious risk to the public to continue to practice for an unacceptable amount of time. Also the timeframes in which a future action against the licensee must be taken, where there is only 15 days to investigate and file an accusation, are unreasonable and prevents most boards from utilizing the ISO process to immediately suspend the license of a health care practitioner. Also, there are no uniform requirements for health care boards to automatically suspend the license of a practitioner who has been incarcerated after the conviction of a felony. Existing law allows for physicians and podiatrists to be suspended while incarcerated but not for other health care professionals. According to the *Times*, nurses with felony records continued to have spotless licenses even while serving time behind bars. Some of the other health care boards which license physicians, podiatrists, osteopaths, psychologists, respiratory care therapists, marriage and family therapists, clinical social workers also provides for revocation of a license if there is a judgment that the practitioner was involved in a serious sex offense or a registered sex offender.

***Staff Recommendation:*** *Extend the time constraints placed on the AG to file an accusation thus allowing the AG to utilize the ISO process without having to have their accusation prepared within a very limited time frame (15 days). Pursuant to Section 494 of the B&P Code, the BRN does not have to always rely on an ALJ to conduct the ISO hearing, the BRN also has authority to conduct the hearing and could do so more expeditiously where serious circumstances exist regarding the suspension of the nurses' license. Provide for automatic suspension of a nurses' license if the nurse is incarcerated and mandatory revocation of their license if they are found to be convicted of acts of sexual exploitation of a patient or if they must register as a sex offender.*

**ISSUE #18: (DIFFICULTY IN TRACKING DISCIPLINARY CASES.)** The BRN along with other health boards have to rely upon an outdated, limited and cumbersome tracking system called the "Consumer Affairs System" (CAS) that is managed by the DCA.

**Background:** For over a decade the DCA has struggled to update its licensing and enforcement information system. Due to limitations of the automated information system, boards have created duplicative systems that do not interact with DCA system, therefore, staff are required to make multiple entries or forced to track some information manually or with additional small data bases. Also, information sharing between boards is almost non-existent. For example, the BRN cannot access the licensing or disciplinary records of the Board of Vocational Nursing. In 2010, the DCA developed a reporting tool in its current CAS system to capture date and time measures for complaint intake, desk investigations, sworn and non-sworn investigations, as well as information related to disciplinary actions. This new reporting tool has required significant data clean-up in order to capture data. Most recently, a BCP for FY 2010/11, was approved by the Legislature. It will provide the ability and resources for the DCA to create or adapt an integrated computer data system, known as the BreEZe Project, sometime in 2010/13. The goal of the system is to handle online licensing applications and renewals, electronic document handling, enforcement data, cashiering, and a variety of other department-wide processes. BRN staff have been recruited as subject matter experts in many areas of this new system. According to the BRN, if the computer system provides all that is planned, it should be an efficient, user-friendly tool that can be customized for each board and bureau's use. It is anticipated that the BRN will have the ability to create reports and gather data much easier, faster, and with more reliability than with the antiquated CAS system.

**Staff Recommendation:** *With the recent concerns raised by the State Auditor regarding a case management system for California’s courts, called the “California Court Case Management System, or CCMS, and its cost overruns and questions about the quality of the system, the DCA should be closely monitored in its efforts to implement an integrated licensing and case management system that could have significant impact on its 40 boards and bureaus. The DCA and the boards and bureaus together manage more than 2.5 million licenses, certificates and approvals in more than 100 businesses and 200 professional categories. The failure of such a new program for DCA could have vast impact on professional licensing and consumer enforcement efforts throughout the state and for those trying to enter the state to practice. There is no doubt that a new system is needed. The DCA over several years has made other attempts to implement a new computer system, but for varying reasons have not been able to move forward. The BRN should continue in its role to work collaboratively with the DCA’s Office of Information Services project staff, as well as with any vendor, to assist in creating an efficient and user-friendly integrated computer system.*

## **SUBSTANCE ABUSE AND DIVERSION PROGRAM ISSUES**

**ISSUE #19:** (EFFECTIVENESS OF DRUG DIVERSION PROGRAMS CALLED INTO QUESTION.) **It is unknown how successful the BRN’s Drug Diversion Program is in preventing recidivism of those nurses who may abuse drugs or alcohol, and if the Diversion Program is effectively monitoring and testing those who participate in the program.**

**Background:** The BRN Diversion Program was created in 1985 as an alternative to disciplinary action for RNs whose practice may be impaired due to chemical dependency or mental illness. The BRN relies on a contractor (MAXIMUS) to provide the necessary oversight and treatment of its licensees. There are several other state-run recovery programs for substance abusing health care professionals which also rely on MAXIMUS. Those who have substance abuse problems can avoid license sanctions by taking part in a confidential “diversion” program of drug testing, treatment and restrictions on their practice. The success and effectiveness of these programs has been called into question. For example, the *Times* detailed how the program for nurses with drug abuse problems was largely unsuccessful and had failed to quickly take action when nurses flunked out and were internally labeled “public safety threats.” Moreover, it was pointed out that because the program is confidential, it is impossible to know how many enrollees relapse or harm patients and that the necessary oversight of programs like this is lacking. In July of 2008, the diversion program for the Medical Board was eliminated because of its continued failures to provide the appropriate oversight and treatment of physicians who participated in this program. In 2010, MAXIMUS was audited by the DCA and it was indicated that they were complying with all of the requirements of their contract; however, Committee staff had serious concerns about the completeness of this audit and the serious deficiencies which may still exist with this program. This came to light when it was found that MAXIMUS was recently testing those participants in the health boards Diversion Programs and using inexact standards (i.e., participants were tested at a higher standard and tested negative when they should have been tested at a lower standard and may have potentially tested positive). The DCA took immediate steps to rectify this problem, but it still raises questions about the effectiveness and efficiency of MAXIMUS and those diversion programs which rely on this contractor. Also, none of the individual health board programs have been audited, so the success or failure of these programs is unknown. (It should be noted the Medical Board’s Diversion Program was audited 5 times, before the Medical Board decided to call it quits and end the program.) The BRN does point out that there have been over 1,500 RNs

who have successfully completed their Diversion Program out of the 4,000 who have entered the program since 1985, but it is unable to accurately determine if nurses relapse. They rely instead on “self-reporting” of prior participants. The BRN indicates that since 1985, there are 40 known instances of relapse or a 4.9% recidivism rate. It should also be noted that the administrative costs for the Diversion Program are borne mainly by the BRN. Participants pay \$25 a month and pay for the cost of random drug testing. Total costs for the Division Program have risen from \$1,064,962 in FY 2006/07 to \$1,436,324 in FY 2009/10.

In an attempt to at least provide uniform standards for these programs in the way they operate, the DCA was mandated by legislation (SB 1441 (Ridley-Thomas) Chapter 548, Statutes of 2008) to put forth “Uniform Standards Regarding Substance-Abusing Healing Arts Licensees” (Uniform Standards). Although this may provide these health care boards with consistent standards in dealing with substance-abusing licensees, there is still the issue of the overall effectiveness, efficiency and performance of these programs to assure that participants are appropriately monitored, and that the public is protected from health care practitioners who are impaired due to substance abuse. There is also a question as to how the BRN is implementing the Uniform Standards and especially as to the drug testing requirements.

***Staff Recommendation:*** *The Committee should consider requiring an audit of the BRN’s Diversion Program in 2012, along with the other health boards which have Diversion Programs, to assure that these programs are appropriately monitoring and treating participants and to determine whether these programs are effective in preventing further substance abuse. The BRN should also indicate to the Committee how the Uniform Standards are being implemented and if all Uniform Standards are being followed, and if not, why not.*

### **DISCLOSURE POLICY ISSUE**

**ISSUE #20: (INCONSISTENT REPORTING OF PRIOR DISCIPLINARY OR CRIMINAL CONVICTIONS OF NURSES.)** The BRN was criticized by the Media for not providing information on the correct status of the licensee, or if they had a prior disciplinary action or criminal conviction.

**Background:** The Board currently has a Complaint Disclosure Policy which was last revised and adopted by the Board on September 7, 2001. The BRN posts citations for unlicensed activity, accusations, statements of issue, petitions to revoke probation, petitions for interim suspension orders, criminal court orders pursuant to Penal Code Section 23, license suspensions, and final decisions which result in a BRN order for public reprimand, probation, suspension, voluntary surrender, and/or license revocation. Some of the reason that the BRN was unable to post prior disciplinary action, especially if it occurred out-of-state or criminal conviction information is because it basically did not have access to the information. With all licensees fingerprinted and with the sharing of information with national data bases this may improve. However, there still is not a consistent policy for the type of information that should be disclosed to the public over the internet (on the BRN’s Website). Some of the other health boards have a statutory requirement regarding the disclosure of licensee information over the internet. The policy should be the same for the BRN.



**Staff Recommendation:** *Statutory authorization should be granted to the BRN, similar to that of the Medical Board and other health boards, to disclose all of the above information which it currently provides on its Website, and also provide whether the status of the license of the RN is in good standing, and/or they have been subject to one of the above disciplinary actions or convicted of a crime in California or in another jurisdiction.*

## **BUDGETARY ISSUES**

**ISSUE #21: (ARE RECENT INCREASES IN LICENSING FEES SUFFICIENT TO COVER BRN COSTS?) Is the BRN adequately funded to cover its administrative, licensing and enforcement costs and to make major improvements to its enforcement program?**

**Background:** The BRN is a self-supporting, special fund agency that obtains its revenues from licensing fees. The fees are currently set close to the maximum level of the range provided in statute due to a recent fee increase. The BRN's fee had remained at the same level for 19 years, but over the past decade the BRN had faced many impediments to obtaining adequate staffing levels to provide the most effective public protection and consumer services, and accomplish the many tasks which it is required to perform. The BRN has had significant increase in workload over the past decade as more nurses were educated and licensed, more pre-licensure nursing programs to approve, expanded enforcement responsibilities and more disciplinary cases to handle. During its last sunset review in 2002, there were indications that the BRN was struggling to keep up. The Committee identified backlogs in its licensing of applicants and in pursuing disciplinary action against nurses who had violated the Nursing Practice Act, or who were incompetent or negligent in their practice. Disciplinary cases of the BRN were also taking an inordinate amount of time to be resolved, in other words to either revoke a license or take other appropriate action against the licensee; it was sometimes taking up to 4 to 6 years from the original complaint until final action was taken against the licensee. In the summer of 2009, the *Times*, as indicated, did several articles and highlighted the problems surrounding the BRN's enforcement program. The *Times* indicated that it was taking too long to take action against its licensees who continued to keep treating patients, on average about 3 years, and that the Legislature and the Governor had not committed the resources necessary for the BRN to effectively do its job of protecting consumers. This Committee further investigated the problems surrounding the BRN and identified a number of areas for improvement especially in increasing the staffing levels of the BRN to improve its overall enforcement program. This of course meant that the BRN would need additional funds to cover increased staffing costs.

On January, 2011, the BRN, by regulation, increased its licensing fees so that it can remain financially stable, cover increased staffing costs and improve its enforcement program. For example, the application fee went from \$75 to \$150, and the renewal fee went from \$75 to \$130. If this fee increase had not gone into effect it would also have meant that the BRN would have been in the red by this fiscal year and would have had no reserves in its fund. There also would not have been sufficient funds to increase staffing to rectify the problems with its enforcement program and pay the increased enforcement costs for investigation and prosecution of its disciplinary cases.

**Staff Recommendation:** *The BRN should assure the Committee that with the recent fee increase it will have sufficient funds to cover its administrative, licensing and enforcement costs and to provide for adequate staffing levels for critical program areas if appropriate staffing is provided.*

**ISSUE #22: (THERE IS STILL A SEVERE LACK OF STAFFING FOR BRN'S ENFORCEMENT PROGRAM.)** The BRN is still suffering from backlogs in critical program areas and is still having difficulty shortening its time frame for pursuing disciplinary action against licensees because of the lack of staffing and the inability to hire for any new positions, even though additional staffing was granted to the BRN (but put on hiring freeze) and it appears to have sufficient funding to cover any additional staffing needs.

**Background:** According to the BRN, over the past decade, multiple hiring freezes, denial at different departmental levels for staff positions requested in Budget Change Proposals (BCPs), mandatory staff reductions, and furloughs have all impeded the BRN efforts in obtaining adequate staffing to provide the most effective public protection and consumer services and meet program needs. Even though the BRN was granted 37 new positions for FY 2010/2011, it is now under a recent order by the Governor to continue with the former hiring freeze that began on August 31, 2010, as well as to continue with a 5% staff reduction. This effectively means that the BRN will be unable to hire anyone for the new positions which were granted to deal with the severe lack of resources and staffing from which the BRN suffers. The BRN also now indicates that it has been forced to reduce and reclassify some of the 37 previously approved positions in the Budget, which will now reduce the number of enforcement positions available to the BRN. The BRN has also provided the Committee with a detailed analysis of current staffing needs and current workload and staffing resources in seven critical program areas as follows: Administration Services, Continuing Education, Nursing Education and Consultation, Legislation/Regulations, Licensing, Enforcement and Diversion. Without the ability to hire new staff the BRN will continue with the downward spiral of its enforcement program, and it will prevent the BRN from handling complaints and disciplinary cases more effectively and expeditiously.

**Staff Recommendation:** *The BRN should express to the Committee its frustration in being unable to meet the staffing needs of its various critical programs, especially that of its enforcement program, and the impact that it will have on its ability to address the problems identified by this Committee, especially as it concerns its goal to reduce the timeframe for the investigation and prosecution of disciplinary cases.*

**ISSUE #23: (IMPACT OF THE RECENT PROPOSED BRN LOAN TO THE GENERAL FUND.)** Will the Governor's recent proposed borrowing of \$15 million from the BRN's reserve account have an impact on the ability of the BRN to deal with some of the serious issues raised in this Paper?

**Background:** The Governor recently proposed borrowing \$830 million from 48 special funds to be transferred to the General Fund as a way to replace the bulk of the \$1.2 billion in one-time revenue lost by the cancellation of the former Administration's proposed sale of state office buildings. Also tapped are more than 15 of the regulatory boards and bureaus under the DCA. At \$15 million the BRN gives up the most. It is proposed that this amount will be paid back during the FY 2013/2014. For the BRN, this may be too late. In FY 2002/03, \$12 million was taken from the BRN's reserve funds and in FY 2008/09, \$2 million was taken, and the BRN is still owed \$2 million. This means that there will be over \$17 million owing to the BRN. In an effort to hire more staff and investigators, the BRN almost doubled the licensing fees charged to RNs on January 1, 2011, as indicated. This means that even if the BRN was granted authority to hire the 37 positions granted to the BRN in FY 2010/11 (because of the current hiring freeze), it is questionable whether there will be sufficient funds available to hire the investigative staff the BRN so badly needs.

This has been a constant problem for the Committee and the Legislature in regards to the boards and bureaus under the DCA. This Committee along with the Assembly Business and Professions Committee has over the years reviewed all boards (through the process of sunset review) and any anticipated problems in the appropriate funding of their programs has been considered and efforts have been made to either reduce their budget or program requirements, or increase their level of funding through license fee increases. The boards over the years have been placed in a position of not being able to spend the revenue which has been made available to them for purposes of properly running their enforcement programs. They have either been denied spending authority for their increased revenue by denial of BCPs or by other directives, which has had the effect of increasing their reserve funds, and then find that rather than having any chance of using these funds in the future to deal with increased enforcement costs, the money reverts back to the General Fund by way of a “loan.” Unless there is a strong mandate that licensing fees should only be used for purposes of properly operating the boards this vicious cycle will continue. One of the outcomes of budget changes and cutbacks to boards has been the slow-down of cases or actual holding off on pursuing cases by DOI and the AG’s Office because the board(s) ran out of money at some point later in the fiscal year. For example, it appears as if BRN had to tell the AG to slow down or stop working on its cases for a certain amount of months for fiscal years 2003-2004, 2004-2005, 2006-2007, 2007-2008 and 2008-2009.

***Staff Recommendation:*** *No more loans from the reserve funds of the BRN to the General Fund, especially in light of the recent fee increase which the RN profession must now absorb. The RN profession will see little if any return on its investment to improve the operation of the BRN, especially in its enforcement program and in providing the resources and staffing it so sorely needs. The BRN should explain to the Committee what the impact will be to its overall Budget and the ability to hire new staff if the loan of \$15 million is made from its reserve fund. This of course is if the BRN is granted an exemption from the hiring freeze, otherwise new expenditures will not be necessary.*

### **CONTINUED REGULATION OF THE PROFESSION BY THE CURRENT MEMBERS OF THE BOARD OF REGISTERED NURSING**

**ISSUE #24.** (CONSUMER SATISFACTION WITH BRN IS LOW.) A Consumer Satisfaction Survey performed by the BRN over the past four years, shows that on average about 65% of consumers were satisfied with the overall service provided by the BRN. There was a higher satisfaction, almost 70%, if some disciplinary action was taken by the BRN.

**Background:** According to the BRN, the low level of consumer satisfaction regarding consumer complaint handling is still an issue being addressed. Consumers are still dissatisfied with the time it takes to resolve a complaint and the lax information the BRN provides to the consumer about the status of their cases as they move through the process. The excessive delay as indicated in this Paper is something that needs to be addressed. Although the BRN tries to provide a “Frequently Asked Questions” portion on its Website and an online complaint submission option, and sends a notice of the procedures, steps and timelines of the enforcement process, it does not seem as if the BRN provides timely updates regarding the status of the consumer’s complaint. It should be noted, however, that there has been steady improvement by the BRN both in being keeping consumers informed, a low of around 35% in 2006/07, to 60% in 2009/10; and, in terms of satisfaction with the overall service provided by the BRN, a low of around 55% in 2006/07, to 69% in 2009/2010. (It should be noted that

the sampling is usually small in terms of consumers who respond to the BRN's survey. The survey of 2009/10 had the highest sampling with a total of 62 surveys returned to the BRN.)

As indicated by the BRN, if there is resolution and possible disciplinary action taken by the BRN then the satisfaction rate increases, but not to any significant degree. This is a shortcoming of many of the boards under the DCA; some have satisfaction rates much lower than the BRN's 65%. The most prominent reason for dissatisfaction with boards is that consumers do not feel as if they are being kept updated about the status of their complaint and case, and the outcome takes so long that they see the board as not really having any real interest in their case as it moves slowly through the process. And the only satisfaction the complainant gets is usually to either see the licensee placed on probation (with conditions) or to have their license revoked. Waiting three years or more for some resolution to their case is extremely frustrating for consumers and is probably something they don't clearly understand, and while the final result may be taking the practitioners license or placing them on probation, one wonders whether there could be a better result for the original complainant. The Contractor's Board seems to enjoy a better satisfaction rate in resolving a complaint because it tries under certain circumstances to try and mediate disputes first to hopefully bring quicker resolution to the matter and possibly provide some form of restitution to the consumer who has been harmed by the licensee. If there is an issue of competency or violation of law(s) then the Contractor's Board will still proceed with licensing action against the contractor even though the complainants issue has been settled. This Committee should begin to explore the use of mediation or what is called "alternative dispute resolution" (ADR) for health boards and whether they could utilize those trained in ADR or current ADR programs to resolve complaints. Consideration could be made of possibly expanding on the current "Complaint Medication Program" (CMP) of DCA to also include consumers who have problems with health professionals. The CMP under DCA now only deals with difficulties by consumers in purchasing products or business services, but there are certainly instances where ADR could be utilized when disputes arise (in the form of a complaint to the board) regarding services provided by health professionals.

***Recommendation:*** *The BRN should explain to the Committee why it believes consumer satisfaction regarding the service of the BRN is still so low and what other efforts the BRN could take to improve its general service to the consumer. Does BRN believe that mediation could be used in certain circumstances to help resolve complaints from the general public regarding health care practitioners?*

**ISSUE #25. (CONTINUED REGULATION OF RNs BY THE BRN.) Should the licensing and regulation of the nursing profession be continued and be regulated by the current board membership?**

**Background:** The health and safety of consumers are protected by a well-regulated nursing profession. In August 2009, because of the media attention the BRN received which highlighted some serious problems with the BRN, which have been referred to in this Paper, Governor Schwarzenegger reconstituted the BRN and replaced it with new members. The Executive Officer of the BRN resigned shortly thereafter. Since the reconstitution of the BRN, the new members of the Board and its staff have made a strong commitment to improve the BRN's overall efficiency and effectiveness. As indicated by this Paper, there are still many changes which need to be made and providing the proper resources and staffing are key, but the BRN has committed to work cooperatively with the Legislature and this Committee to bring about the necessary changes. The BRN should be continued with a four-

year extension of its sunset date so that the Committee may review once again if the issues and recommendations in this Paper and others of the Committee have been addressed.

**Recommendation:** *Recommend that the nursing profession should continue to be regulated by the current BRN members in order to protect the interests of the public and be reviewed once again in four years.*