



# CNO Advisory Committee Meeting

## Meeting Book

July 22, 2020

ZOOM: <https://calhospital.zoom.us/j/96187301937>

# Meeting Book - CNO Advisory Committee Meeting

CNO Advisory Committee Meeting Agenda - July 22, 2020

11:00 AM

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## I. CALL TO ORDER/INTRODUCTIONS KIGER

11:00 AM

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## II. MEMBER ROUNDTABLE

A. What capacity/surge volume issues are you experiencing?

B. Are you doing elective surgeries?

C. Have you applied for a staffing ratio waiver?

D. Are you trying to find staff? And if so, how?

E. Are you experiencing high LOA, absences, etc?

F. What do you predict a month from now?

G. Are you getting requested supplies, PPE, etc.?

H. What do you need help with?

11:45 am

## I. Staffing Issues Bartleson

1. Staffing Waivers

2. AFL 20-26.3

Page 4

3. Form 5000A

Page 7

4. CDPH Staff Waiver Process Policy

12:00 pm

## J. Workforce Blanchard-Saiger

1. CalOSHA Guidance for Respirator Shortages

Page 10

12:30 pm

## K. BRN Bartleson/Melby

1. BRN Audit Report - 1

Page 16

2. BRN Audit Report - 2

Page 70

1:00 pm

## L. HealthImpact Update Chan

1:30 pm

M. Data Collection  
Ott/Ziombra

1:45 pm

N. State of the State  
Bartleson

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III. INFORMATION

A. CNO Advisory Committee Roster

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IV. ADJOURNMENT  
KIGER



State of California—Health and Human  
Services Agency  
**California Department of  
Public Health**



**GAVIN NEWSOM**  
Governor

AFL 20-26.3

July 3, 2020

**TO:** General Acute Care Hospitals

**SUBJECT:** Suspension of Regulatory Enforcement of Hospital Requirements  
(This AFL supersedes AFL 20-26.2)

**AUTHORITY:** Proclamation of Emergency and Executive Order N-27-20

**All Facilities Letter (AFL) Summary**

- This AFL notifies hospitals of a temporary waiver of specified regulatory requirements due to the state of emergency related to the Coronavirus Disease 2019 (COVID-19) outbreak.
- This AFL has been updated to extend the waiver until March 1, 2021.
- This AFL provides clarifying changes for downgrading, changing, or eliminating services and conditions for which facilities may request a staffing waiver.

Pursuant to the Governor's declaration of a state of emergency related to COVID-19, the Director of the California Department of Public Health (CDPH) may waive any of the licensing requirements of Chapter 2 of Division 2 of the Health and Safety Code (HSC) and accompanying regulations with respect to any hospital or health facility identified in HSC section 1250. CDPH is temporarily waiving specified hospital licensing requirements and suspending regulatory enforcement of the following requirements as specified below:

**Licensing**

Hospitals seeking initial licensure or to change beds or services to their license shall submit an application online at the CDPH Health Care Facilities Online Application webpage. This shall not require approval before the hospital may provide care, although CDPH will reach out to provide technical assistance to ensure patient safety and the quality of care.

**Space**

All statutory and regulatory provisions related to the configuration and use of physical space and classification of beds in a hospital. Hospitals may reconfigure space as needed to accommodate observed or predicted patient surge, patient cohorting, modified infection and source control procedures, and other COVID-19 related mitigation strategies.

Temporary changes of use or modification to the physical environment must be restored to original conditions following expiration of a waiver. Where such temporary changes are to be made permanent, projects must be submitted for Office of Statewide Health Planning and Development's (OSHPDs) review and approval (whether the

changes involve construction or not) no later than two weeks after waiver expiration. Permanent modifications to the physical environment or changes of use must be submitted to OSHPD as projects for review and approval (whether the changes involve construction or not) immediately.

### Services

1. Detailed notifications and notification timeframes specified in HSC sections 1255.1, 1255.2, and 1255.25 that are required when a hospital plans to downgrade, change, or eliminate the level of a supplemental service. The notification procedures and timeframes may only be waived if the hospital is modifying services to address patient surge related to COVID-19. A hospital must provide notice to the public regarding the availability of supplemental services at the hospital by posting signage at the entrance of each location and on its internet website. The hospital must provide notice at least 24 hours in advance of the service change to the public and CDPH. Approval is needed if a service is being added or changed.
2. Due to the alternative arrangements available for homeless patients authorized by Executive Order N-32-20 (PDF), detailed discharge planning documentation and the provision of nonmedical services to homeless individuals specified in HSC section 1262.5 is temporarily waived.

### Staffing

Hospitals shall bring staffing levels into state ratio compliance within two weeks of this AFL issue date. Only those hospitals experiencing a COVID-19 related surge of patients or staffing shortages resulting from COVID-19 impacts including; increasing community spread, increasing need to meet demand for surge either by regional surge or incoming transfers, daycare or school closures, COVID-19 staffing absenteeism for multiple reasons, or an emergency such as a fire or public safety power shutoff, may request a waiver of minimum nurse-to-patient ratios. A hospital seeking a staffing waiver must submit a CDPH form 5000A (PDF) and provide supporting documentation to the CHCQ Duty Officer at [CHCQDutyOfficer@cdph.ca.gov](mailto:CHCQDutyOfficer@cdph.ca.gov) and copy the local district office. CHCQ is able to respond quickly to urgent requests from hospitals seeking a waiver 24/7 and should only mark urgent if needed approval within 8 hours. Pursuant to the Proclamation of Emergency (PDF), all staffing waivers will be posted on the CDPH website. Hospitals must resume mandatory staffing levels as soon as feasible during the waiver period to minimize the need for additional waivers. Temporary staffing waivers will only be approved for 90-days. A hospital may reapply for a waiver if the conditions necessitating the waiver still apply.

This statewide waiver is approved under the following conditions:

- Hospitals shall continue to comply with adverse event and unusual occurrence reporting requirements specified in HSC section 1279.1 and Title 22 California Code of Regulations section 70737(a).
- Hospitals shall report any substantial staffing or supply shortages that jeopardize patient care or disrupt operations.
- Hospitals shall continue to provide necessary care in accordance with patient needs and make all reasonable efforts to act in the best interest of patients.
- Hospitals shall follow their disaster response plan.
- Hospitals shall follow infection control guidelines from the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) related to COVID-19.
- Hospitals shall comply with directives from their local public health department, to the extent that there is no conflict with federal or state law or directives or CDPH AFLs.

CDPH understands the importance of ensuring the health and safety of all Californians and maintaining vital access to acute care services. CDPH encourages facilities to implement contingency plans to address staff absenteeism and the rapid influx of patients. CDPH will continue to promote quality healthcare, provide technical assistance and support compliance with core health and safety requirements, pursuant to Executive Order N-27-20 (PDF). CDPH is taking this unprecedented action due to the significant challenges California's health care system is facing as a result of the COVID-19 outbreak. As a result of this temporary waiver, hospitals do not need to submit individual program flexibility requests for the requirements specified above, except when seeking a staffing waiver.

This waiver is valid until March 1, 2021 and may be extended or reduced based on the conditions of the pandemic and any updated Executive Orders or guidance from CMS or the CDC.

If you have any questions about this AFL, please contact your local district office.

Sincerely,

**Original signed by Heidi W. Steinecker**

Heidi W. Steinecker  
Deputy Director

#### Resources

- Proclamation of Emergency (PDF)
- Executive Order N-27-20 (PDF)
- CDPH 5000A (PDF)
- CDPH Health Care Facilities Online Application webpage

Center for Health Care Quality, MS 0512 . P.O. Box 997377 . Sacramento, CA  
95899-7377  
(916) 324-6630 . (916) 324-4820 FAX  
Department Website ([cdph.ca.gov](http://cdph.ca.gov))



Page Last Updated : July 4, 2020

## Temporary Permission for Program Flexibility and for Emergencies

When the Medical Health Coordination Center (MHCC) is activated, Providers and District Offices (DOs) will submit requests to [CHCQDutyOfficer@cdph.ca.gov](mailto:CHCQDutyOfficer@cdph.ca.gov)

This form is to be used ONLY for program flexibility requests when providers temporarily need to comply with licensing requirements by using alternative concepts, methods, procedures, techniques, equipment, or personnel.

Providers are required to submit a program flexibility request to the California Department of Public Health (CDPH), Center for Health Care Quality for approval. This form is a mechanism to expedite the request directly to the Medical Health Coordination Center (MHCC) for approval in emergency situations.

<https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/DistrictOffices.aspx>

Facility Name	Date of Request		
License Number	Facility Phone	Facility Fax Number	
Facility Address	E-Mail Address		
City	State	Zip Code	Contact Person's Name

### Approval Request

Complete one form total per facility

Staffing	Other	Start Date
Tent use (High patient volume)	Bed Use	End Date
Space Conversion (other than tent use)	Over bedding	

### Duration of Request

### Program Flex Request

What regulation are you requesting program flexibility for?

### Justification for the Request

A disease outbreak (verifiable through sources such as the local emergency medical service agency (LEMSA), local Public Health Officer, CDPH Division of Communicable Disease Control, the Centers for Disease Control and Prevention) is present in the community where the hospital is located or in a contiguous area(s) causing a rapid influx (surge) of patients to the hospital. Examples of this type of surge include: Increased cases of seasonal influenza, onset of a severe acute respiratory syndrome-type or other highly contagious virus requiring acute care, an epidemic/pandemic, a bioterrorism agent, or a declared public health emergency.

An emergency resulting in the need for increased patient accommodations has occurred in the community where the hospital is located or in a contiguous area(s) causing a rapid influx (surge) of patients to the hospital. Examples of this type of surge include: A natural or human-caused disaster, a crime incident or transportation accident resulting in numerous mass casualties, an emergency causing the evacuation of patients or diversions from another hospital (LEMSA diversion has been implemented).

If you are seeking a staffing waiver, has your facility laid off any clinical staff within the previous 60 days?  
If so, please explain (**Note:** Attach supporting documentation if necessary)

**Justification for the Request**

Other:

**Exhausting Available Alternatives**

The provider must exhaust available alternatives before requesting increased patient accommodations. Check all that apply:

Rescheduling non-emergent surgeries and diagnostic procedures.

Transferring patients to other beds or discharge as appropriate.

Setting clinics for non-emergency cases (if possible).

Requesting ambulance diversion from LEMSA, if appropriate.

Other:

**Adequate Staff, Equipment and Space**

The provider must make arrangements for adequate staffing, equipment and space for increased patient accommodations. Check all that apply:

A plan is in place for staff if the request is for use of alternate space.

A plan is in place for equipment if the request is for use of alternative space.

The proposed space for care of patients provides sufficient square footage to ensure access for safe care.

Other:

**Additional Information**

Provide a brief description of your conditions and explain the need for program flexibility. Provide a brief description of the alternative concepts, methods, procedures, techniques, equipment or personnel to be used, and the conditions under which this program flexibility will be used. Attach additional supporting documentation as needed.

\_\_\_\_\_  
Signature of person requesting program flexibility

\_\_\_\_\_  
Title

Printed Name

**NOTE:** Approval for tent use, space conversion, bed use and over-bedding will be time limited and dependent on the facts presented that substantiate the emergency. Initial approval may be given verbally by the local DO; however, a signed written approval must be distributed (faxed) to the facility and filed in the facility's folder.

For CDPH Use Only

**Center for Health Care Quality Approval:**

Permission Granted from: \_\_\_\_\_ to \_\_\_\_\_

Permission Denied: Briefly describe why request was denied in comments / conditions below:

Comments / Conditions:

CHCQ Printed Name:

CHCQ Staff Signature: \_\_\_\_\_

Date:

\_\_\_\_\_  
L&C District Office Staff Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date



## Cal/OSHA Interim Guidance on COVID-19 for Health Care Facilities: Severe Respirator Supply Shortages

**Note: This Interim Guidance is Subject to Change as the Situation Evolves**

### Summary

This guidance is for healthcare and other employers covered by Cal/OSHA's Aerosol Transmissible Diseases (ATD) Standard (title 8 [section 5199](#)). It discusses respirator requirements for covered employers who care for suspected or confirmed COVID-19 patients when there are severe respirator shortages.

**WARNING: Respirators must always be immediately available to health care workers who may be called upon to perform emergency aerosol generating procedures on suspected or confirmed COVID-19 patients.**

### Engineering and Work Practice Controls

Regardless of respirator availability, employers must comply with all other provisions of Section 5199 at all times, including but not limited to:

- Engineering controls to minimize the number of employees exposed to suspected and confirmed COVID-19 patients and infectious aerosols. This includes using barrier enclosures that cover a patient's head and upper body that are [authorized](#) by the U.S. Food and Drug Administration.
- Source control procedures whenever employees are not using a respirator, including the masking of suspected and confirmed COVID-19 patients unless not possible for medical reasons.
- Work practices that minimize the number of employees exposed to suspected and confirmed COVID-19 patients and infectious aerosols.
- Training employees on additional precautions and changes to the ATD Plan when respirators cannot be obtained to care for suspected and confirmed COVID-19 patients.
- Informing employees and their representatives that the changes are only in effect until respirator supplies can be restored, and keeping them updated on status changes
- Full compliance with all respirator requirements in the ATD Standard, once respirator supply chains are restored

### NIOSH-Certified Respirator Requirements

In situations where there is no critical shortage, covered employers must provide to and ensure the use of NIOSH-certified particulate respirators by all employees occupationally exposed to novel pathogens such as SARS-CoV-2, the virus that causes COVID-19.

## Respiratory Protection During Severe Shortages

Where severe respirator shortages make it impossible to provide NIOSH-certified filtering facepiece respirators, employers must protect employees with the best available methods in the order listed below. A mixture of the respiratory protection methods may be used, provided higher-level protections are implemented first. Use of surgical masks cannot be used until **all** other respiratory protection options have been exhausted.

**WARNING: Elastomeric respirators should not be used in sterile fields. Other respirators with exhaust valves should normally not be used in sterile fields, but in light of shortages, use of a respirator with a valve covered by a mask would be acceptable if PAPRs or valveless respirators are not available. Discontinue if this causes any breathing difficulties.**

### 1.0 Use reusable NIOSH certified respirators instead of disposable filtering facepiece respirators

Elastomeric half-mask, full-facepiece respirators and powered air-purifying respirators (PAPRs) equipped with particulate filters can be disinfected and reused multiple times.

### 2.0 Use NIOSH certified industrial filtering facepiece respirators

On March 2, 2020, the U.S. Food and Drug Administration (FDA) issued an [Emergency Use Authorization \(EUA\)](#) allowing the use of certain industrial N95 respirators in health care settings.

### 3.0 Allow employees to wear their own respirator if it complies with Cal/OSHA requirements

Title 8 section 3380 permits employee-provided personal protective equipment (PPE) as long as the employer ensures the PPE complies with Cal/OSHA standards and is properly maintained. Employers cannot prohibit employee-provided PPE in compliance with Cal/OSHA standards when the employer fails to provide it. Disciplinary actions against employees who wear their own PPE may subject the employer to retaliation claims under Labor Code sections 1102.5 and 6310 through 6312.

### 4.0 Use certain expired NIOSH certified filtering facepiece respirators

NIOSH has approved the use of certain expired filtering facepiece respirators under specific conditions. See [Release of Stockpile N95 Filtering Facepiece Respirators Beyond the Manufacturer-Designated Shelf Life: Considerations for the COVID-19 Response](#).

### 5.0 Use methods to extend the use of existing stocks of filtering facepiece respirators.

#### 5.1 Extended use of respirators

Extended use occurs when health care employees use the same respirator during encounters with several patients without removing the respirator between patient encounters. Employers must ensure that the respirators are kept clean, sanitary, and in good working order at all times.

Extended use is practiced when multiple patients are infected with the same respiratory pathogen and patients are placed together in dedicated areas (cohorting). When patients are cohorted together:

- The maximum recommended respirator extended use period is 8–12 hours.
- Respirators should be removed and carefully stored in a clean paper bag for re-donning and worn through the remainder of the shift or processed for reuse as described below in 5.2 and 5.3 before activities such as meals, restroom breaks, and other breaks.

## 5.2 Reuse filtering facepiece respirators that have not been disinfected

Filtering facepiece respirators can be reused without disinfection only if at least seven full days pass between each respirator use. Most (greater than 99%) of the virus that may be on the respirator should become non-viable after seven days.

Employers must establish procedures and provide effective training to ensure filtering facepiece respirators are reused safely and properly. Procedures and training must include the following:

- **CDC** and **CDPH** recommendations are followed when reusing respirators.
- Employees perform a user seal check every time a respirator is put on.
- Respirators are:
  - Kept clean, sanitary and in good working order at all times.
  - Protected from contamination by a face shield or facemask.
  - Protected during storage from damage or deformation, contamination, dust, sunlight, extreme temperatures, excessive moisture and damaging chemicals.
  - Inspected prior to putting them on after storage for proper function, tightness of connections, and the condition of the facepiece, straps and valves.
  - Checked for proper fit by a user seal check each time they are put on.
  - Used by one employee only, never shared (do not write on the filtering material with a permanent marker; rather, attach a label or tag securely to the respirator strap).
  - Discarded if contaminated with a hazardous substance, blood, or bodily fluids; after use during an aerosol-generating procedure or surgery; if wet or visibly dirty; when they no longer form an effective seal to the user's face; or when breathing becomes difficult

## 5.3 Use approved methods to disinfect filtering facepiece respirators

If employers decide to reuse filtering facepiece respirators without waiting seven days, the respirator must be disinfected between uses. Employers must use a procedure authorized by the FDA and demonstrate that off-gassing of disinfectant will not occur during respirator use. Ethylene oxide cannot be used. The FDA approved procedures are:

- **Battelle Decontamination System** (hydrogen peroxide)
  - **Fact Sheet for Healthcare Providers**
  - **Instructions for Healthcare Facilities**
  - **Instructions for Healthcare Personnel**

- **STERIS Sterilization Systems for Decontamination of N95 Respirators** (hydrogen peroxide)
  - **Fact Sheet for Healthcare Providers**
  - **Instructions for Healthcare Facilities**
  - **Instructions for Healthcare Personnel**
- **Sterilucet, Inc. Sterilization System** (hydrogen peroxide)
  - **Fact Sheet for Healthcare Personnel**
  - **Instructions for Healthcare Facilities**
  - **Instructions for Healthcare Personnel**
- **Stryker STERIZONE VP4 N95 Respirator Decontamination Cycle** (hydrogen peroxide and ozone)
  - **Fact Sheet for Healthcare Personnel**
  - **Instructions for Healthcare Facilities**
  - **Instructions for Healthcare Personnel**
- **Advanced Sterilization Products STERRAD Sterilization System** (hydrogen peroxide)
  - **Fact Sheet for Healthcare Personnel**
  - **Instructions for Healthcare Facilities**
  - **Instructions for Healthcare Personnel**
- **Duke Decontamination System** (hydrogen peroxide)
  - **Fact Sheet for Healthcare Personnel**
  - **Instructions for Decontamination Facility**
  - **Instructions for Healthcare Facilities**
  - **Instructions for Healthcare Personnel**

- Writing on the filtering material of a filtering facepiece respirator with a permanent marker voids NIOSH approval. The solvents in the marker may damage the filtering material and degrade its filtering efficiency. Use a label or tag securely attached to the respirator strap.
- Disinfection must be done in accordance with title 8 [article 111 Fumigation](#).
- Filtering face piece respirators must be aerated for at least 4 hours after disinfection is complete to protect users from off-gassing of hydrogen peroxide and ozone. Employers should use real-time monitors to confirm there is no off-gassing from respirators.
- After disinfection, the respirator should only be used by the person who previously used the respirator.

## 6.0 Use filtering facepiece respirators certified to a foreign standard

The FDA issued EUAs for respirators certified to standards from other countries. Although not NIOSH certified, the following FDA authorized foreign certified respirators are allowed temporarily during the current COVID-19 crisis:

- April 14, 2020 [FDA EUA](#)

- May 7, 2020 [FDA EUA](#)

The following foreign certified respirators are not allowed regardless of FDA approval

- Respirators with ear loops. Only respirators with headbands are allowed.
- Respirators that provide less than 95 percent filtering efficiency as reported by NIOSH. See <https://www.cdc.gov/niosh/npptl/respirators/testing/NonNIOSHresults.html> for further information.

Before use, employees must be fit tested with the same make, model, style, and size of respirator that will be used.

Due to reports of counterfeit and defective respirators, employers must inspect samples from each batch of foreign standard respirators upon receipt for damage including visible holes when held up to the light, defects that limit a close seal to the face, appearance that they are counterfeit, or some other obvious problem. Provide training to employees so they can check their own respirators.

Further information on counterfeit respirators that are listed as NIOSH-approved (does not cover foreign certified respirators) is available at:

<https://www.cdc.gov/niosh/npptl/usernotices/counterfeitResp.html>.

## **7.0 Use surgical masks only when all the above attempts to provide respiratory protection have been exhausted**

For the current COVID-19 crisis, when all attempts to provide respiratory protection, including the measures listed above, are exhausted, covered employers must provide surgical masks to protect employees.

Surgical masks are not respirators. It is illegal to discipline, discharge or lay off an employee for exercising their health and safety rights. Please see Labor Code sections 1102.5, 6310 and 6311 for information on prohibited discriminatory action against employees.

When surgical masks are used by employees caring for suspect or confirmed COVID patients, the employer must also comply with all recommendations in the Centers for Disease Control and Prevention (CDC) guidelines: [Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) in Healthcare Settings](#).

Respirators, not surgical masks, must be used for the following regardless of respirator shortages:

- High-hazard tasks and aerosol generating procedures, which require use of powered air-purifying respirators whenever possible instead of a filtering facepiece respirator.
- Procedures that require close interaction with patients, such as collecting specimens by nasopharyngeal swabs or oropharyngeal swabs.

## Additional Resources

- Centers for Disease Control and Prevention. [Strategies for Optimizing the Supply of N95 Respirators: Crisis/Alternate Strategies](#)
- Centers for Disease Control and Prevention. [Decontamination and Reuse of Filtering Facepiece Respirators using Contingency and Crisis Capacity Strategies](#)
- National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention. [Respiratory Protection During Outbreaks: Respirators versus Surgical Masks](#)
- National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention. [Recommended Guidance for Extended Use and Limited Reuse of N95 Filtering Facepiece Respirators in Healthcare Settings](#)
- National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention. [Release of Stockpile N95 Filtering Facepiece Respirators Beyond the Manufacturer-Designated Shelf Life: Consideration for the COVID-19 Response](#)
- National Personal Protective Technology Laboratory, National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention. [International Assessment Results – Not NIOSH-approved](#)
- National Personal Protective Technology Laboratory, National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention. [Assessment Of Filter Penetration Performance For Non-Niosh Approved Respirators](#)
- National Personal Protective Technology Laboratory, National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention. [International Respirator Assessment Request](#)
- National Personal Protective Technology Laboratory, National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention. [Factors to Consider when Planning to Purchase Respirators from Another Country, Including KN95 Respirators from China \(Webinar, May 7, 2020\)](#)
- Cal/OSHA. Aerosol Transmissible Diseases Standard, [title 8 section 5199](#)
- U.S. Food and Drug Administration. [Protective Barrier Enclosures](#)
  - [Fact Sheet for Healthcare Providers](#)
  - [Fact Sheet for Patients](#)
- U.S. Food and Drug Administration. [Letter to Manufacturers of Imported, Non- NIOSH-Approved Disposable Filtering Facepiece Respirators](#)
- U.S. Food and Drug Administration. [Personal Protective Equipment EUAs](#)
- U.S. Food and Drug Administration. [Non-NIOSH Approved Respirator EUA FAQ](#)
- U.S. Food and Drug Administration news release. [Coronavirus \(COVID-19\) Update: FDA and CDC take action to increase access to respirators, including N95s, for health care personnel](#)



## *Board of Registered Nursing*

It Has Failed to Use Sufficient Information When Considering Enrollment Decisions for New and Existing Nursing Programs

*July 2020*

**REPORT 2019-120**





**CALIFORNIA STATE AUDITOR**

621 Capitol Mall, Suite 1200 | Sacramento | CA | 95814



**916.445.0255** | TTY 916.445.0033



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July 7, 2020  
2019-120

The Governor of California  
President pro Tempore of the Senate  
Speaker of the Assembly  
State Capitol  
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As directed by the Joint Legislative Audit Committee, my office conducted an audit of the Board of Registered Nursing (BRN) to assess its oversight of prelicensure nursing programs (nursing programs). The following report details our determination that BRN has failed to use sufficient information when considering the number of students new and existing nursing programs propose to enroll.

BRN's governing board (governing board) both approves new nursing programs in the State and makes decisions about the number of students that existing nursing programs are allowed to enroll (enrollment decisions). Two of the key factors that should influence BRN's enrollment decisions are the forecasted supply of nurses that the State will need to fulfill demand and the available number of *clinical placement* slots—placements at a health care facility for students to gain required clinical experience. BRN's 2017 forecast of the State's future nursing workforce indicated that the statewide nursing supply would meet demand; however, it failed to identify regional nursing shortages that California is currently experiencing and is expected to encounter in the future.

BRN's governing board also lacks critical information about clinical placement slots when making enrollment decisions, which hampers its ability to prevent nursing students from being displaced because other nursing programs took their clinical spots. BRN does not gather and share with the governing board information about the total number of placement slots that a clinical facility can accommodate annually or how many slots the programs that use the facility will need each year. Without this key information, BRN cannot properly gauge the risk of such student displacement—reported to have affected 2,300 students in academic year 2017–18—when its governing board makes enrollment decisions.

Finally, we found that some of BRN's requirements for nursing programs overlap with standards imposed by national nursing program accreditors (accreditors). As part of the Legislature's 2021 review of BRN, it could consider the appropriateness of restructuring BRN's oversight to leverage portions of the accreditors' review in order to reduce duplication and more efficiently use state resources.

Respectfully submitted,

A handwritten signature in black ink that reads 'Elaine M. Howle'. The signature is written in a cursive, flowing style.

ELAINE M. HOWLE, CPA  
California State Auditor

## Selected Abbreviations Used in This Report

ACC	American Career College
ACEN	Accreditation Commission for Education in Nursing
BRN	Board of Registered Nursing
CCNE	Commission on Collegiate Nursing Education
OAL	Office of Administrative Law
OSHPD	Office of Statewide Health Planning and Development
RN	Registered nurses

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## Summary

### Results in Brief

In addition to its other duties as the state agency that regulates the practice of registered nurses (RNs), the Board of Registered Nursing (BRN) oversees California's prelicensure nursing programs (nursing programs), which prepare students to practice as entry-level RNs. BRN's governing board (governing board) both approves new nursing programs in the State and makes decisions about the number of students that new and existing nursing programs are allowed to enroll (enrollment decisions). Two of the key factors that should influence BRN's enrollment decisions are the forecasted supply of nurses that the State will need to fulfill demand and the available number of *clinical placement* slots—placements at a health care facility, such as a hospital, that nursing programs must secure for students to gain required clinical experience. In this audit, we found that BRN has failed to gather and use sufficient data related to both of these factors to appropriately inform its enrollment decisions.

Specifically, BRN's 2017 forecast of the State's future nursing workforce needs indicated that the statewide nursing supply would meet demand; however, it failed to identify the regional nursing shortages that California is currently experiencing and is expected to encounter in the years ahead. Although BRN's methodology for determining the State's overall nursing supply and demand was reasonable, it did not measure regional variations that would have identified regional nursing shortages. Given the size and diversity of California, regional forecasts would provide critical information to inform enrollment decisions and other actions by BRN's governing board.

BRN's governing board also lacks critical information about clinical placement slots when it considers enrollment decisions. When making these decisions, the governing board should consider the available number of clinical placement slots. If the governing board's enrollment decisions allow for more enrolled students than the number of clinical placements available in the region, nursing programs end up having to compete for clinical space for their students. During the 2017–18 academic year, nursing programs reported that more than 2,300 students were affected by this *clinical displacement*—an insufficient supply of clinical placement slots. Nearly half of those programs reported that students from another program displaced their students, while many programs also reported losing clinical placements slots because facility staff workloads were too great to allow time for supervising nursing students. When displacement occurs, the nursing program

### Audit Highlights . . .

*Our audit of BRN's oversight of nursing programs highlighted the following:*

- » *BRN does not gather and use sufficient data to make decisions about the number of students nursing programs can enroll.*
  - *It determined the State's overall nursing supply and demand was balanced, but did not identify California's current regional nursing shortages.*
  - *BRN's governing board does not have needed information about clinical placement slots when making enrollment decisions—in academic year 2017–18, nursing programs reported that more than 2,300 students were affected by clinical displacement.*
  - *BRN uses inconsistent and incomplete information to assess the availability of clinical placements because it has not provided guidance to its nursing education staff about what to provide the governing board to aid it when making enrollment decisions. For example, it does not gather and share information about the total number of placement slots available at a facility.*
- » *Some of BRN's requirements for nursing programs—such as those related to approval of faculty and curriculum—overlap standards set by accreditors and, thus, some of BRN's oversight could be duplicative of what accreditors review.*

losing placement slots must find new placement slots for its displaced students in order to provide the required clinical experience to its students.

BRN uses inconsistent and incomplete information to assess the availability of clinical placements because it has not provided guidance to its nursing education consultants (nursing education staff), who are employees of BRN, about the information they should provide to the governing board to aid it in considering enrollment decisions. Our review of 15 enrollment decisions found that BRN nursing education staff did not consistently provide to the governing board the information the staff had on the availability of clinical placements, such as how a proposed increase in enrollment would affect facilities that the requesting program planned to use for clinical placements. Some of BRN's governing board members have also expressed concern that BRN's existing process for assessing clinical displacement is not clear. Additionally, BRN does not gather and share with the governing board information concerning the total number of placement slots a clinical facility can accommodate annually and how many slots the programs that use the facility will need each year. Without this key information, BRN cannot properly gauge the risk of displacement when its governing board is making enrollment decisions.

To further enhance its information about clinical placement slots, BRN should require nursing programs to annually update information about the clinical facilities they use for student placements. With this information, BRN would be able to identify the types of facilities that programs most frequently use. Compiling this information and comparing it with other publicly available information about existing clinical facilities would also allow BRN to identify clinical facilities that programs do not currently use for placements, which could help nursing programs find additional facilities with capacity for their students.

Lastly, some of the nursing programs that BRN oversees are accredited by national nursing program accreditors (accreditors). Accreditors are private educational associations that verify whether programs meet and maintain acceptable levels of quality. We found that some of BRN's requirements for nursing programs—specifically those related to approval of faculty, curriculum, and continuing compliance with state requirements—overlap with the standards imposed by accreditors. As part of the sunset review process, during which the Legislature evaluates the efficiency of certain state agencies, the Legislature should consider whether it would be appropriate to restructure any of BRN's oversight to reduce duplication with accreditors while still achieving BRN's mission to protect the public.

### **Selected Recommendations**

The Legislature should amend state law to require BRN's forecasts of the nursing workforce to incorporate regional analyses.

BRN should specify in policy the information its nursing education staff must present to the governing board for each enrollment decision it considers.

To better inform its enrollment decisions, BRN should gather information concerning the total number of placement slots a clinical facility can accommodate and how many slots the programs that use the facility will need.

As part of the sunset review process, the Legislature should consider whether it would be appropriate to restructure any of BRN's oversight of nursing programs that might overlap with accreditation.

### **Agency Comments**

BRN generally agreed with the recommendations we made to it. However, it raised concerns over the feasibility of some of the time frames for implementation.

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# Introduction

## Background

The Board of Registered Nursing (BRN) is a state regulatory entity within the Department of Consumer Affairs (Consumer Affairs). State law establishes a nine-member governing board (governing board) that serves as the governing body of BRN. It is composed of four members of the public and five registered nurses (RNs).<sup>1</sup> The governing board appoints an executive officer who has the overall responsibility for managing BRN's resources and staff, overseeing BRN's regulatory requirements, and interpreting and executing the intent of board policies for the public and other governmental agencies. In February 2020, BRN's executive officer resigned, and the governing board appointed an acting executive officer who it subsequently appointed as executive officer in June 2020. BRN had about 240 total authorized staff positions and operated with a budget of about \$55 million in fiscal year 2019–20.

## BRN's Mission and Functions

BRN's stated mission is to protect and advocate for the health and safety of the public by ensuring the highest quality of RNs in the State of California. The Legislature created BRN in order to regulate and oversee the practice of nursing by implementing and enforcing the Nursing Practice Act, which specifies that protecting the public must be BRN's highest priority in exercising its functions. Some of these functions relate to nursing education programs, and the licensure, practice, and discipline of RNs. BRN approves two types of nursing education programs: prelicensure programs and advanced practice programs. Prelicensure programs focus on preparing students to practice as entry-level RNs, while advanced practice programs are for RNs who want to advance their education by earning further certifications, such as nurse practitioner, nurse anesthetist, or clinical nurse specialist. RNs practice nursing by providing direct and indirect patient care, including administering medication and therapeutic agents necessary to implement treatments ordered by licensed physicians. Our review focused specifically on BRN's oversight of prelicensure nursing programs (nursing programs) located within the State.

<sup>1</sup> The five registered nurses include two direct patient care nurses, an advanced practice nurse, a nurse administrator, and a nurse who is an educator or administrator of a nursing education program. The Senate Committee on Rules and the Speaker of the Assembly each appoint a public member, and the Governor appoints the remaining seven board members. State law provides that all appointments are for a four-year term. Members can be reappointed, although no member can serve more than two consecutive terms.

State law requires BRN to adopt regulations that establish educational requirements for nursing programs. BRN ensures that nursing programs meet these educational requirements as part of its process for approving new nursing programs and inspecting existing programs, which includes verifying that programs provide required courses and hands-on, clinical experience. Ultimately, BRN's governing board approves nursing programs if they comply with these regulations.

### Nursing Programs in California

Students graduating from a board-approved nursing program must pass a national licensing examination in order to become licensed RNs in California. As of 2019, there were 145 board-approved nursing programs in California. Of those programs, 105 are public schools—community colleges and public universities—and 40 are private schools. Admission to a nursing program can be competitive: in academic year 2017–18 the programs received more than 38,000 qualified applications, but only about 14,000 new students were able to enroll.<sup>2</sup> All nursing programs must offer at least the minimum curriculum required by regulation, including specific numbers of coursework units in select areas, such as the science of nursing, related natural sciences, and behavioral and social sciences. Nursing programs can meet these curriculum requirements by offering a variety of degree programs: associate's, bachelor's, and entry-level master's degrees in nursing. Table 1 lists the types of nursing degrees offered by public and private schools in the State.

**Table 1**  
**Number of Nursing Programs by Type**  
**As of September 2019**

TYPE OF PROGRAM	PUBLIC	PRIVATE	TOTAL
<b>Associate's</b> —Typically takes two to three years to complete. Graduates earn an associate's degree in nursing, and are prepared to provide nursing care.	79	13	92
<b>Bachelor's</b> —Typically takes four years to complete. Graduates earn a bachelor's degree in nursing and are prepared to provide nursing care and to move to administrative and leadership positions.	21	20	41
<b>Entry-level Master's</b> —Typically takes one to two years, depending on how many nursing course prerequisites the student has completed. Graduates earn a master's degree in nursing. Designed for individuals who have a bachelor's degree in another field and wish to become registered nurses. Graduates are prepared for advanced-practice nursing careers in research, leadership, and patient care.	5	7	12
<b>Totals</b>	<b>105</b>	<b>40</b>	<b>145</b>

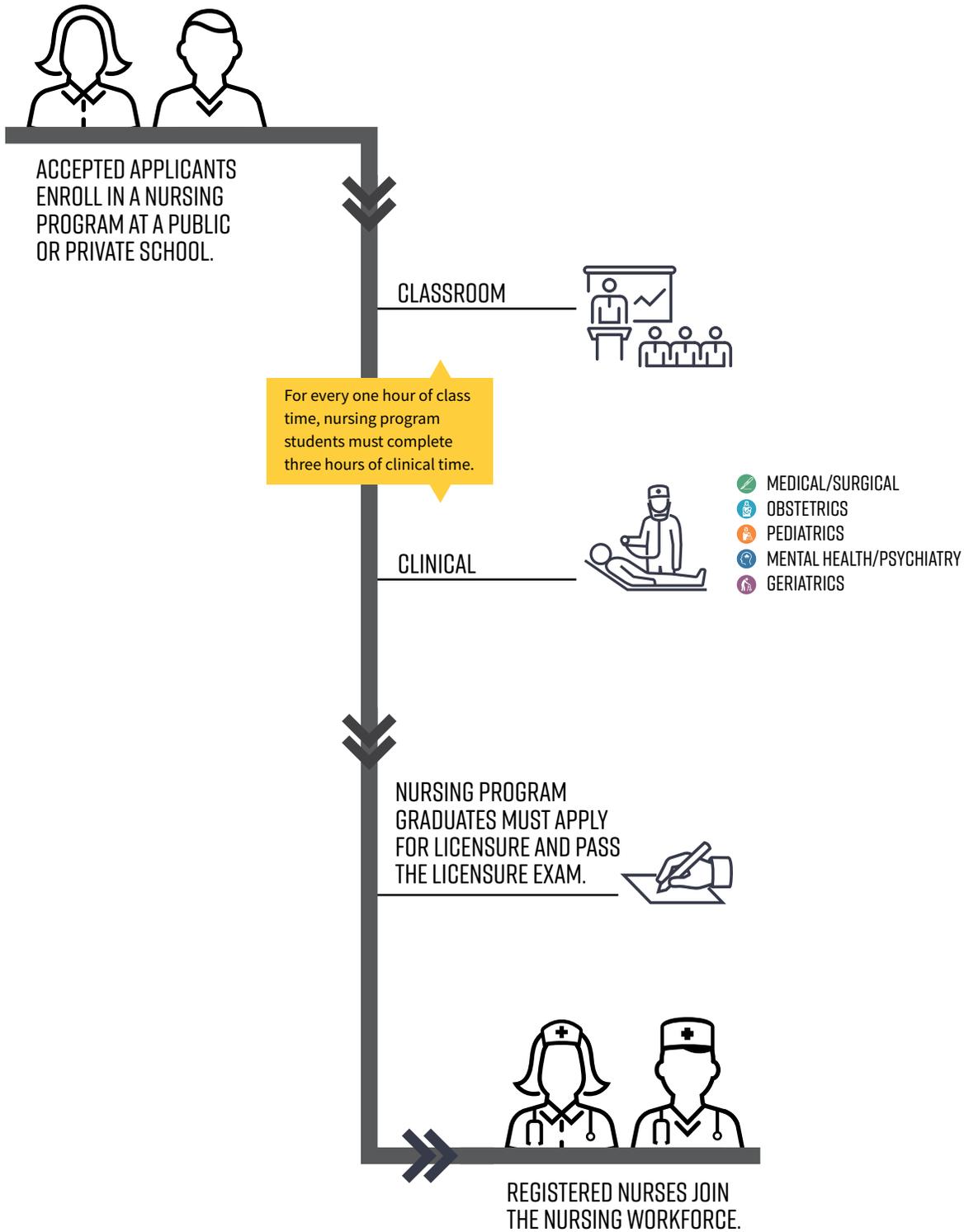
Source: BRN's website and director's handbook and nursing program websites.

<sup>2</sup> An individual can apply to multiple nursing programs, so qualified applications could be greater than the number of individuals.

To graduate from a nursing program, students must complete units in both theoretical coursework and hands-on, clinical experience in five content areas—medical/surgical, obstetrics, pediatrics, mental health/psychiatry, and geriatrics, as Figure 1 shows. To provide the required clinical experience, nursing programs must acquire placements (clinical placements) for students at clinical facilities, such as hospitals. Once a student completes the required coursework and clinical experience and graduates, she or he can apply to BRN to receive a nursing license and take the National Council Licensure Examination (licensure exam) and, upon passing, becomes an RN. Nursing programs in California must maintain a pass rate on the licensure exam of 75 percent for first-time test takers, though they generally have higher pass rates. On average, 92 percent of first-time test takers in California pass the exam.

As of November 2019, BRN had 11 staff members who are responsible for overseeing nursing programs. Nine of these were nursing education consultants and two were supervising nursing education consultants (nursing education staff). These staff members visit proposed and existing nursing programs to help ensure that they are using approved curricula to prepare competent RNs, as well as to ensure compliance with regulations. BRN generally divides staff assignments geographically into Northern California and Southern California areas, with a supervisor over each area. Each nursing education staff member oversees a group of between six and 20 nursing programs.

**Figure 1**  
Nursing Program Students in California Must Complete Both Classroom and Clinical Units to Become RNs



Source: State law and BRN's website.

## BRN’s Approval of Nursing Programs and Enrollment Levels

Nursing programs must receive approval from BRN in three circumstances: to establish a new nursing program (new program approval), to continue the nursing program following a review that takes place every five years after new program approval (continuing approval), and to make a substantive change. As a part of the new program approval process, a new nursing program must complete a feasibility study that demonstrates, among other things, a sustainable budget, evidence of availability of clinical placements for students, and information on the program’s applicant pool and sustainability of enrollment. If the governing board accepts the feasibility study, the proposed nursing program must appoint a nursing director and complete a self-study—a self-evaluation by the nursing program that demonstrates how it plans to comply with BRN rules and regulations and provides additional details about the program (self-evaluation), as the text box shows. BRN’s nursing education staff members use the self-evaluation to conduct an on-site approval visit. During this visit, nursing education staff members do an in-depth evaluation of the proposed nursing program to assess compliance with state law. When the governing board approves a new nursing program, it also approves how many students that program may enroll. New nursing programs must pay an approval fee to BRN of \$40,000.

### Key Requirements for a Self-Evaluation

A proposed nursing program must submit a self-evaluation that includes the following items:

- Application for approval of a nursing program.
- Total curriculum plan that lists all courses of the program, including general education courses.
- Documentation of curriculum BRN requires for licensure, such as courses related to nutrition and cultural diversity.
- Narrative describing how the program will comply with rules and regulations related to the following:
  - Faculty qualifications and changes to faculty.
  - Required curriculum.
  - Clinical facilities.
  - Licensing exam pass rate standard.

Source: State law and BRN forms.

In addition, nursing programs must periodically demonstrate continued compliance with state law. BRN’s policy is to conduct site visits of nursing programs every five years to determine whether they are complying with state law. Ahead of such on-site visits, a nursing program must provide another self-evaluation, similar to that required for initial approval. Nursing programs established after January 1, 2013 must pay a continuing approval fee of \$15,000 every five years to BRN.

If BRN finds that a nursing program did not comply with one or more of its rules and regulations, the program must respond to the findings at a meeting of the governing board’s Education and Licensing Committee (education committee), which consists of a subset of board members. According to BRN’s director’s handbook, in such instances, the education committee will recommend to the full governing board that it “defer action to continue approval” to give the program time to correct the violations. The program may remain in this deferred action status for no more than one year. If the school continues to be noncompliant, the governing board may place the program on “warning status, with intent to close the nursing program.”

### Information Required When Submitting a Request to Increase Enrollment

A letter of explanation on the nursing program's letterhead, including descriptions of the following:

- The proposed change.
- The reason for the change.
- How the change will improve the education of students.
- How the proposed change will affect clinical facilities.

Source: BRN's director's handbook.

Furthermore, when a nursing program desires to make a major change to its curriculum, such as changes in the program philosophy and goals or objectives, it must first receive governing board approval. BRN also considers an enrollment increase to be a major curriculum change and, therefore, a nursing program must request governing board approval before increasing its enrollment. BRN charges a processing fee of \$2,500 that must accompany a proposal for a major curriculum change. When a nursing program wants to make such a change, BRN policy requires the program to submit a letter of explanation that includes specific required information, which we list in the text box.

Generally, for enrollment increases we reviewed, this information included the number of students by which the program requested to increase its enrollment.

Our audit focused on the governing board's decisions to approve new nursing programs and enrollment increases. We refer to both new nursing program approval and the approval of an enrollment increase to an existing nursing program as *enrollment decisions* because both increase the number of enrolled nursing students. To inform these decisions, nursing education staff members review the information in the required self-evaluation or letter of explanation from the nursing program that is making the request to determine whether the program has met the applicable requirements. The nursing education staff members then present their findings to the governing board's education committee. The education committee advises and makes recommendations to the governing board regarding nursing program requests. Representatives from nursing programs requesting initial approval must appear at the education committee meeting to be available for questions. The governing board can approve, deny, or defer a nursing program's request.

### Factors Related to Enrollment Decisions

This report highlights two key factors related to the governing board's enrollment decisions. The first factor is the number of RNs working in the State—the supply of nurses. In making decisions related to the number of students nursing programs can enroll, the governing board affects the flow of new nurses into the State's nursing workforce, which can help alleviate or exacerbate shortages of nurses. In fact, state law enacted in 2002 requires BRN to collect and analyze nursing workforce data for future workforce planning. During an informational legislative hearing in 2001 on a nursing shortage—held before this law was introduced—various representatives from the nursing profession demonstrated to the Legislature that gathering

more complete data on the nursing workforce would better enable researchers and policymakers to identify, and find solutions to, nursing shortages in California. The law requires BRN to produce reports on nursing workforce data at least every two years. To meet these requirements, BRN has contracted with the University of California, San Francisco (UCSF) (contractor) since at least 2005 to publish a biennial statewide nursing workforce forecast (forecast).

The second factor we highlight that influences the governing board's enrollment decisions is the availability of clinical placement slots. When BRN evaluates a request to approve a new nursing program or increase enrollment in an existing nursing program, it considers whether the requesting program has secured sufficient clinical placement slots to accommodate the increase in students. Clinical placements are based on a written agreement with a clinical facility that has provided assurance of the facility's availability to accommodate the program's nursing students. Before a nursing program can use a facility for clinical placements—as a new program or for increased enrollment—the program must first obtain approval from BRN. The nursing program must complete and submit a clinical facility approval form (facility approval form) on which a facility representative attests that the program's use of the facility will not displace students from other nursing programs currently using the facility to gain clinical experience. BRN nursing education staff members document their approval of the facility on the facility approval form, and BRN keeps records of these forms digitally in its network drive.

State law requires all students to complete 864 hours of clinical experience to ensure that they are competent to serve the public when they become licensed nurses. Given a two-year nursing program with 16-week semesters, students might spend on average 12 to 15 hours per week meeting the State's clinical experience requirement. California is not alone in requiring clinical experience for a student's nursing education. In fact, 42 state boards of nursing require nursing programs to include clinical experience for their students. However, only 12 states have a required number of clinical hours.

Clinical placement slots are a limited resource. Not all clinical facilities have the capacity or the desire to offer placement slots. The number of clinical placement slots available to a program can constrain the number of students the governing board will allow the nursing program to enroll. *Clinical displacement* occurs when a program loses placement slots that it is currently using to provide required clinical experience to students because a clinical facility decides to discontinue those placements for some reason. Although clinical displacement can happen for several reasons, including a change in facility staffing levels or emergency situations, such as the COVID-19 pandemic in spring 2020, perhaps the reason of most

interest to BRN occurs when students are displaced because other nursing programs took their clinical spots. When displacement occurs, the nursing program losing placement slots must find new placement slots for its displaced students, either on a different shift in the same facility or at another facility, in order to provide the required clinical experience to its students. This can be disruptive to nursing students and may hinder their ability to complete their required clinical experience.

As a possible approach to alleviating some of the enrollment constraint caused by limited clinical placement slots, nursing programs and other stakeholders in health care and government have sought to increase the portion of clinical experience hours that students can fulfill through simulation labs. Simulation is an activity or event replicating clinical practice using scenarios, high-fidelity manikins, standardized patients, role playing, skills stations, and computer-based critical thinking simulations. State law allows students to meet their clinical experience requirements with up to 25 percent indirect patient care, which includes simulation labs. However, in response to the COVID-19 pandemic, Consumer Affairs issued a waiver on April 3, 2020, that allowed nursing students to complete their clinical experience with up to 50 percent indirect patient care, which could include simulation labs. Consumer Affairs set this waiver to expire after 60 days and then extended the expiration date to August 1, 2020. Although the scope of this audit did not include an evaluation of simulation labs as a reasonable substitute for in-person clinical experience, we believe it is an area that could be considered as an approach to alleviating the constraint that the requirement for in-person clinical placements might have on nursing programs' ability to enroll more students.

### **Concerns Among Nursing Programs and Other Stakeholders**

Stakeholders have called into question certain aspects of BRN's authority to make enrollment decisions and whether portions of BRN's director's handbook constitute underground regulations. For example, in October 2018 the California Association of Private Postsecondary Schools petitioned the Office of Administrative Law (OAL) asserting that BRN had no legal authority to restrain the enrollment levels of approved nursing programs, that BRN's exercise of this authority was based on certain guidelines in BRN's director's handbook that BRN had issued without complying with state law, and that these guidelines constituted an underground regulation. If a state agency issues, uses, enforces, or attempts to enforce a guideline or other rule without following the Administrative Procedure Act when it is required to do so, the rule is called an "underground regulation." State law prohibits state agencies from enforcing guidelines or rules that constitute underground regulations. If a party believes a state agency has issued

an underground regulation, that party may submit a petition to OAL seeking a determination of whether that guideline or rule is an underground regulation. Because BRN certified to OAL that it would no longer use or enforce the guidelines in question, OAL suspended the review it had initiated of the petition mentioned above.

In July 2019, West Coast University also filed a petition with OAL claiming that BRN was continuing to use and enforce some of the guidelines in question despite certifying to OAL that it would not. However, because BRN had already filed the certification stating it would not enforce the guidelines, and because a nursing program filed a lawsuit related to the guidelines in April 2019, OAL declined to take action on the matter in accordance with its regulations. OAL's director stated that OAL is considering amending its regulations to allow for it to continue its inquiry and make a determination in cases in which an agency or department has filed such a certification, but parties assert that the department or agency is continuing to use and enforce underground regulations.

In addition, American Career College (ACC), a Los Angeles private college that offers nursing associate's degrees, filed a lawsuit in April 2019 asking the court to find that BRN does not have the authority, power, or purview to determine the total number of nursing students that ACC may enroll. BRN has opposed the lawsuit because it believes it is authorized to regulate the number of students a nursing program is permitted to enroll. As the question of whether BRN has authority to make enrollment decisions regarding the number of permitted enrollments had been brought before the court, we made no such determination in this report regarding this issue because audit standards prohibit us from doing so. Instead, our report focuses on the actions BRN has taken in the recent past.

Additionally, in September and October 2018, multiple stakeholders from academia, health care providers, labor groups, and government participated in seven regional summit meetings (stakeholder summits) at different locations across California to discuss issues surrounding clinical education capacity, particularly the availability of clinical placements for nursing students. The resulting report identified six priorities for action that all seven regions agreed upon. Five of these priorities are related to clinical experience or placements:

- Seek to standardize requirements for nursing curricula, credits, and clinical hours.
- Encourage nursing programs and clinical facilities to participate in groups, consortiums, and scheduling systems related to clinical placements.

- Seek to standardize the requirements for licensing and accreditation of clinical facilities, as well as the onboarding and orientation process for students and faculty.
- Facilitate increased use of nonacute, community-based, and ambulatory clinical sites statewide.
- Seek to enable students to use simulation for up to 50 percent of their clinical practice requirements.

The sixth priority involved establishing structures to encourage communication, collaboration, cooperation, and decision making among senior-level nursing program and clinical facility staff.

### Recent Developments

Prior to the completion of this audit, the California State Auditor (State Auditor) received a whistleblower complaint alleging that BRN executives in the enforcement division intentionally manipulated data and delivered a falsified report to the State Auditor to satisfy a recommendation the State Auditor had made during a 2016 audit of the enforcement division. In response to the complaint, the State Auditor launched an investigation and substantiated that BRN executives violated state law when they carried out a plan to artificially decrease caseloads for BRN investigators before delivering a falsified report to the State Auditor. The plan involved temporarily reassigning some of the BRN investigators' cases to other employees who should not have had cases assigned to them. The investigation found that within 10 days of the State Auditor reviewing the falsified report and concluding that BRN had fully implemented the recommendation, BRN managers reversed the reassignments, increasing caseloads to their original level. A copy of investigative report I2020-0027, *Board of Registered Nursing: Executives Violated State Law When They Falsified Data to Deceive the State Auditor's Office*, can be found on our website at [www.auditor.ca.gov](http://www.auditor.ca.gov). The audit team became aware of the investigation during this audit and re-evaluated the risk assessment it conducted for the audit to ensure it could rely upon the documentation provided by BRN for this audit report. We determined that the documentation we obtained was reliable.

## Audit Results

### BRN's Forecasts of the Supply of Qualified Nurses Have Not Included Key Information

An adequate supply of nurses is critical to health care. BRN has an impact on the supply of nurses through its enrollment decisions, putting it in the unique position of being able to directly respond to and mitigate nursing shortages. BRN's contractor explains in its 2017 forecast that nursing shortages generate significant challenges because the level of nurse staffing in hospitals and other care facilities can affect patient outcomes.<sup>3</sup> As described in the Introduction, state law requires BRN to analyze data and produce reports on the nursing workforce in California to help researchers and policymakers find solutions to nursing shortages.

However, the conclusion from BRN's 2017 forecast that supply is adequate is inconsistent with other similar studies. This inconsistency has caused some confusion about whether the State will experience a nursing shortage. BRN's forecast includes high and low estimates of supply and demand, but it indicates that the supply of and demand for RNs will be fairly well balanced across the State over the next 10 years, if current enrollment patterns and migration patterns of nurses into and out of the State remain stable. In contrast, various other studies and reports on the nursing workforce in California project a nursing shortage in the State or in areas within the State, although the studies differ as to the magnitude of the projected shortages. In particular, the projected statewide shortages range from none at all, according to BRN's 2017 forecast, to a shortage of approximately 141,000 nurses by 2030, according to "United States Registered Nurse Workforce Report Card and Shortage Forecast: A Revisit" (RN Workforce Report Card), a study published in the May/June 2018 issue of the *American Journal of Medical Quality*. Table 2 shows five recent studies we identified and the key differences among them, such as their scope and how they measured supply and demand, that likely contributed to the different projections.

The methodology that BRN's contractor used in its 2017 forecast is reasonable, but BRN could have asked for a more robust analysis. The contractor measured the supply of nurses statewide by reviewing the number of RNs entering, departing, and choosing to participate in the workforce. Specifically, the contractor considered factors such as the number of newly graduated nurses, the

<sup>3</sup> BRN published its more recent 2019 forecast in May 2020, near the completion of our audit. Therefore we refer to conclusions cited in the 2017 forecast. The 2017 and 2019 forecasts are largely similar in their scope and methodology. The 2019 forecast projected that a small surplus of RNs statewide could emerge in the future.

migration of nurses to and from other states, and the number of RNs with active licenses in the State. In fact, the model that BRN's contractor used to measure supply is similar to those used in other health care studies that we identified.

**Table 2**  
BRN's Workforce Study Does Not Account for Regional Differences

STUDY	PUBLISHING ENTITY	DATE RELEASED	TIME FRAME	SCOPE	SUPPLY MODEL	DEMAND MODEL	CONCLUSION
Forecasts of the Registered Nurse Workforce in California*	UCSF for BRN	June 2017	2017 to 2035	Statewide	Estimated the number of RNs entering, departing, and choosing to participate in the workforce	Estimated future demand based on current hospital utilization and staffing patterns <sup>†</sup>	Supply and demand are balanced
Regional Forecasts of the Registered Nurse Workforce in California	Healthforce Center at UCSF	December 2018	2018 to 2035	Regional	Estimated the number of RNs entering, departing, and choosing to participate in the workforce	Estimated future demand based on current hospital utilization and staffing patterns <sup>†</sup>	Large differences across regions of the State.
United States Registered Nurse Workforce Report Card and Shortage Forecast: A Revisit	<i>American Journal of Medical Quality</i>	May 2018	2016 to 2030	National study that provided statewide information	Estimated the number of individuals in a region or state who are likely to work as a nurse based on estimated populations over a 10-year period (2006 to 2015)	Estimated number of jobs needed to meet population needs based on the 2015 national mean average of jobs per 100,000 people	Shortage of 141,348 nurses
Supply and Demand Projections of the Nursing Workforce	U.S. Department of Health and Human Services	July 2017	2014 to 2030	National study that provided statewide information	Estimated the number of RNs entering, departing, and choosing to participate in the workforce and other factors, such as wage rates	Estimated number of jobs needed to provide a level of care consistent with the baseline year—2014—based on hospital utilization and staffing patterns	Shortage of 44,500 nurses
Registered Nurse Shortage Areas Update	California's Office of Statewide Health Planning and Development (OSHPD)	June 2019	2017	County	Actual number of registered nurses in a county	Actual current hospital and long-term care facility utilization	28 counties are RN shortage areas

Source: Studies as listed in table.

\* BRN published its 2019 forecast in May 2020, near the completion of our audit. The 2017 and 2019 forecasts are largely similar. In its 2019 version, BRN again reported a forecast of the nursing workforce on a statewide basis that did not include a regional analysis. It also generally used the same methodology as its 2017 forecast and projected that a small surplus of RNs statewide could emerge in the future.

<sup>†</sup> OSHPD data was used to create these demand models.

Similarly, the contractor's method for measuring demand is generally reasonable. Specifically, it identified the demand for nurses at hospitals and other health care facilities in California by reviewing the staffing patterns of RNs—in particular, the number of RN hours worked per day that a patient was in the hospital (patient day)—and data on hospital usage. BRN's contractor also

considered information that state law requires BRN to analyze, such as the number of RN hours worked, age-specific demographics, and number of patient days. These factors are different from those used in the RN Workforce Report Card study, which defines RN demand as the estimated number of RN jobs needed to meet population needs. The section of law that requires BRN to analyze workforce data does not require BRN to collect and analyze information on the health care needs of California residents or the number of health care facilities that exist in California.

The 2017 forecast has a limitation that it acknowledged: it represents the State as a whole and does not reflect the fact that one region of California may experience a shortage while another faces a surplus of RNs. Because BRN's forecast does not measure regional variations in supply and demand, it obscures regional shortages that currently exist and those projected to exist in the future. Thus, BRN's forecast does not provide information that would help it respond to and mitigate regional nursing shortages.

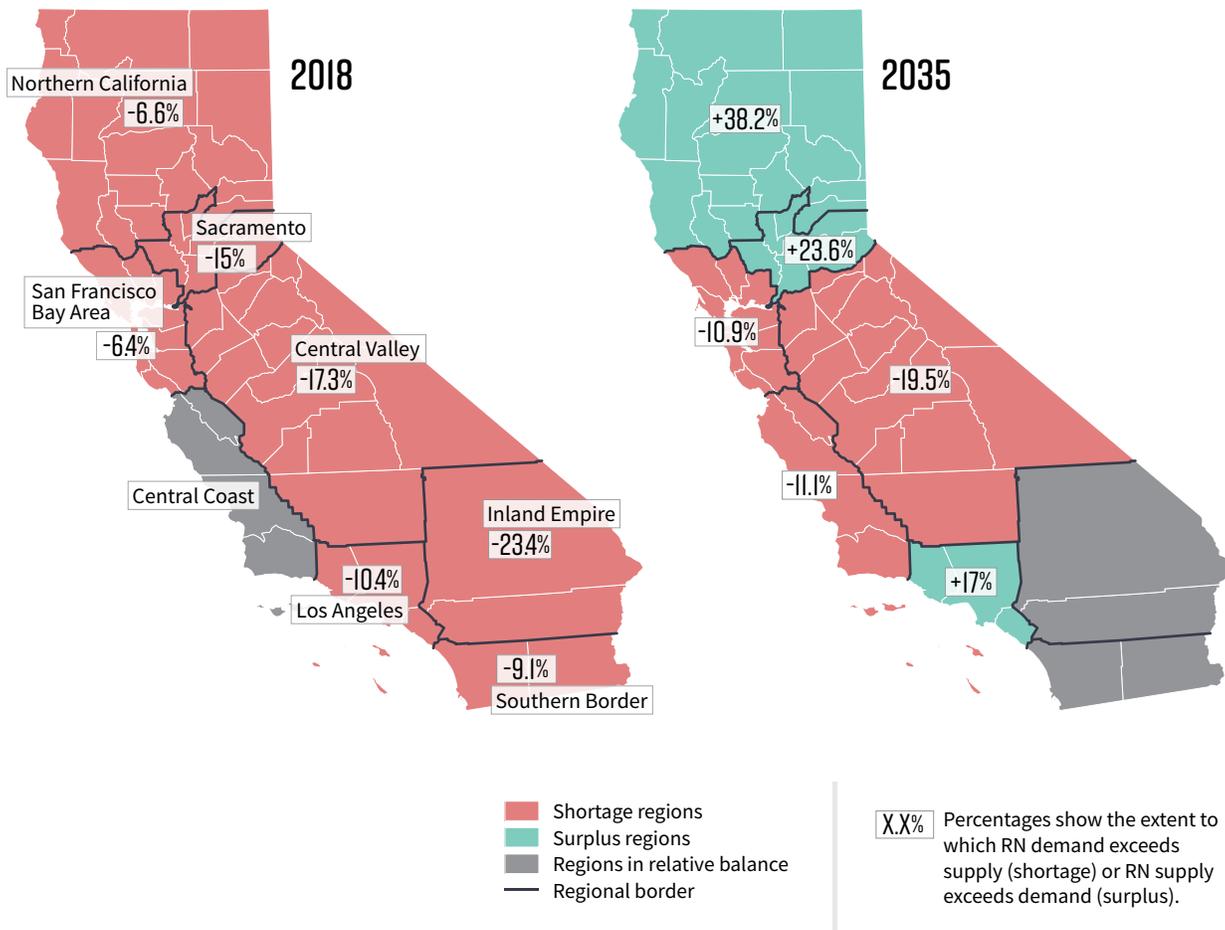
BRN can influence the supply of nurses through its enrollment decisions. In fact, BRN's contractor recommends in its 2017 forecast that policymakers continuously monitor factors that could influence regional shortages, such as the number of graduates from RN education programs and the interstate migration of nurses. According to BRN's 2017 forecast, the solution to a nursing shortage in 2005 was in part to increase the number of graduates from California nursing programs, which led to a stable workforce. Additionally, the forecast indicates that if future numbers of student enrollments and graduates decline, a shortage could reemerge. Given the size and diversity of California, we believe a regional forecast would provide critical information to inform the governing board's enrollment decisions and other actions to address identified shortages. BRN officials agreed that a regional analysis would provide valuable information.

Only two of the five studies we reviewed measured shortages on a more local level. Specifically, the 2018 *Regional Forecasts of the Registered Nurse Workforce in California* (2018 regional forecast) by the Healthforce Center at UCSE, and a 2019 report by OSHPD titled *Registered Nurse Shortage Area Update* (OSHPD report) employ a more localized analysis. In fact, the 2018 regional forecast, which was prepared by the same entity with which BRN contracts for its forecast and, using generally the same method for measuring supply and demand, identified and measured regional differences in the need for RNs within California. The 2018 regional forecast concludes that all regions except the Central Coast appear to have had nursing shortages that year and that by 2035 the Central Valley, Central Coast, and San Francisco Bay Area will experience or continue to experience nursing shortages. Figure 2 shows the counties that are

***Because BRN's forecast does not measure regional variations in supply and demand, it obscures regional shortages that currently exist and those projected to exist in the future.***

included in each of the eight regions defined in the 2018 regional forecast and indicates whether the regional forecast projects a shortage, a surplus, or balanced supply and demand for each region in 2035. Similarly, the OSHPD report used patient day data and BRN’s active nurse licensee data from 2017 to classify 28 counties as having had a shortage of RNs in that year.

**Figure 2**  
Some Regional Nursing Shortages Are Projected to Continue Within California



Source: Analysis of UCSF’s 2018 *Regional Forecasts of the Registered Nurse Workforce in California*.

Note: The supply and demand numbers for the regions include adjustments to account for RNs commuting between regions, advanced-practice RNs not working in RN jobs, and the number of RN hours worked by contract staff at hospitals.

If BRN’s forecast identified regional shortages and surpluses, it would be able to provide the governing board better information to consider the reasons that nursing programs assert for expanding their programs. We reviewed governing board meeting minutes and corresponding materials between 2017 and 2019 and found that

18 of the 35 requests from nursing programs to increase enrollment or open a new nursing program cited nursing shortages as a reason for requesting an enrollment increase. For example, in a June 2019 letter to BRN, Unitek College provided additional information to BRN about its proposal to start a registered nursing program at its Bakersfield campus. Unitek College cited community nursing workforce shortages and data from the 2018 regional forecast on the migration of RNs out of the Central Valley region as causes for concern. However, BRN's forecast did not include relevant regional information that would allow its nursing education staff to verify those assertions. BRN officials stated that if BRN's forecast identified more specific and concrete data on regional shortages, it would give the governing board better information to consider the assertions that nursing programs make for expanding their programs, such as nursing shortages that exist in their areas.

Regularly collecting information on California's regional nursing workforce would also give BRN the information it needs to identify shortage areas and take action to mitigate those shortages. The Nursing Practice Act does not require BRN to address any identified shortages. However, BRN's mission, in part, is to advocate for the health and safety of the public. As part of this advocacy, BRN should develop a plan to support increases in enrollment at existing nursing programs or new programs in areas with shortages, such as providing programs with information that they could use to identify additional clinical placements, as we discuss later.

### **BRN's Process for Assessing the Availability of Clinical Placements Is Inadequate**

The number of available clinical placement slots affects the number of student enrollments the governing board should approve and the eventual supply of nurses in the State. This information is also crucial to understanding the risk of clinical displacement. However, BRN does not track or consistently report this information to its governing board. In fact, it has not established what information its nursing education staff must provide to the governing board when it is considering enrollment decisions. We found that nursing education staff provided inconsistent information to the governing board, hampering its ability to properly gauge the risk that its decisions might displace students from their clinical placement slots. If BRN augmented information it collects about the number of clinical placement slots at facilities and stored that information in a database, it could better analyze the data and present to the governing board more robust and objective information to consider in making its enrollment decisions. Additionally, BRN could

*Regularly collecting information on California's regional nursing workforce would also give BRN the information it needs to identify shortage areas and take action to mitigate those shortages.*

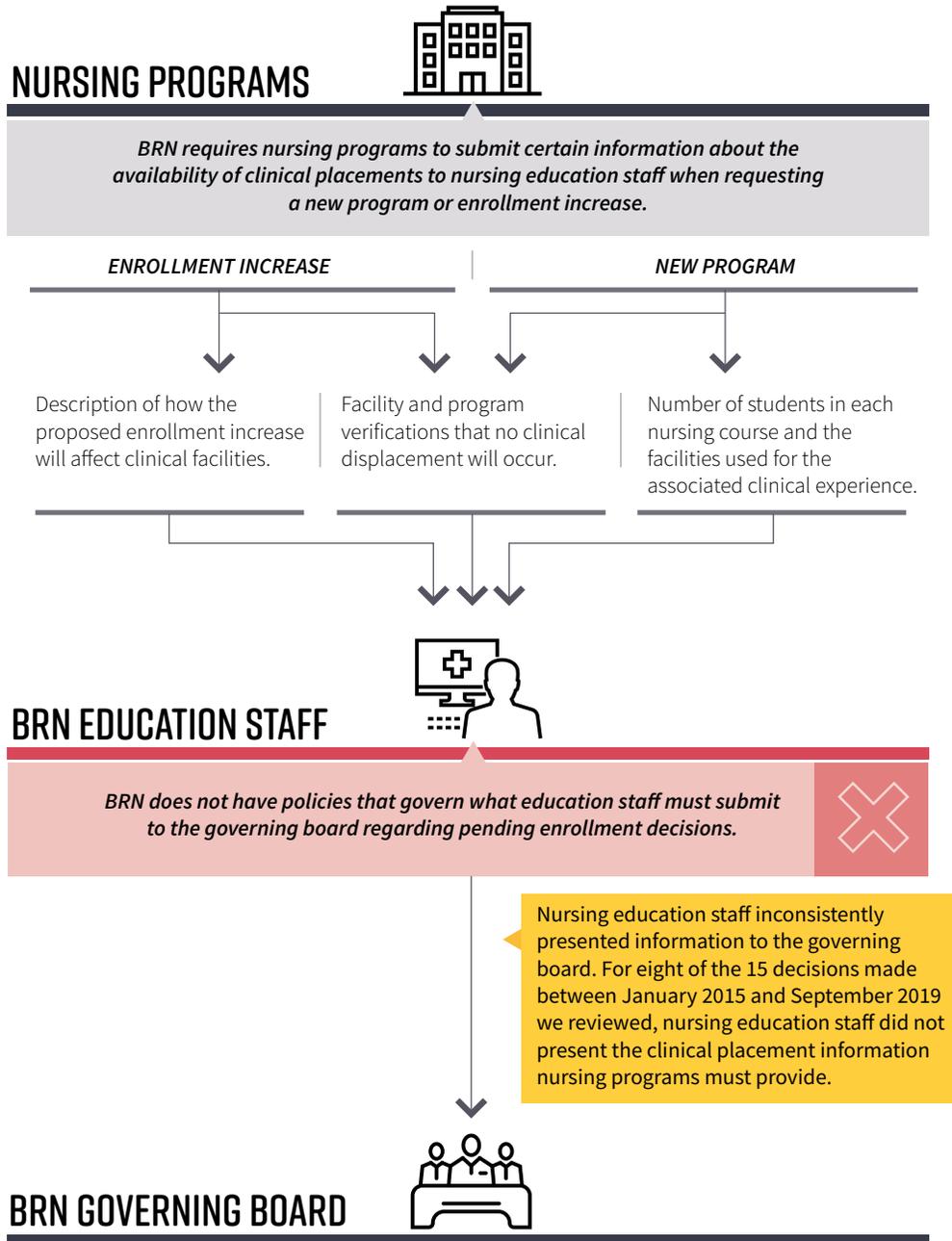
compare the facility information in its database with OSHPD's health care facility data to identify additional facilities with potential clinical placement slots.

***BRN Uses Inconsistent and Incomplete Information to Assess Whether an Adequate Number of Clinical Placement Slots Is Available***

Another key factor that should influence the governing board's enrollment decisions is the availability of clinical placement slots. Because the availability of clinical placement slots has an impact on the number of student enrollments the governing board should approve for a nursing program and the eventual supply of nurses in the State, having this key information is crucial for the board. However, BRN has not established a policy for its nursing education staff members that specifies the information they must provide to the governing board for each enrollment decision, such as the number of available clinical placement slots in a facility where a program plans to place students. We found that, for the 15 enrollment decisions made between January 2015 and September 2019 we reviewed (five requests for new nursing programs and 10 requests for enrollment increases at existing programs), nursing education staff did not consistently present to the governing board the information that nursing programs must submit regarding clinical placements, as Figure 3 shows. Specifically, for eight of the 15 decisions, nursing education staff did not present all the clinical placement information that nursing programs must provide. For example, for the five requests for new programs, nursing education staff did not present information about the number of students the programs intended to have in classroom nursing courses or the facilities they planned to use for the associated clinical experiences. Consequently, the governing board could not properly assess the risk of clinical displacement for these programs. Nevertheless, the governing board approved all but one of the requests. To help ensure that the governing board bases enrollment decisions on complete and consistent information in the future, BRN should establish a uniform format and structure for information that nursing education staff must provide to the governing board for each enrollment decision.

***Nursing education staff did not present information about the number of students the programs intended to have in classroom nursing courses or the facilities they planned to use for the associated clinical experiences.***

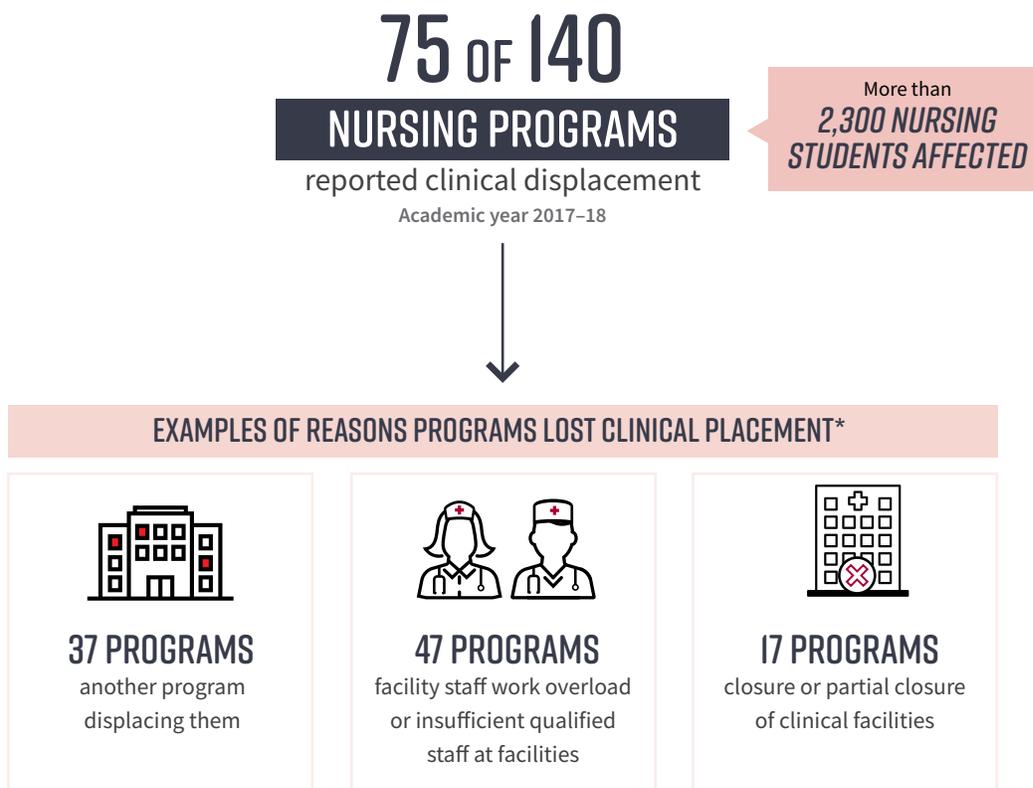
**Figure 3**  
BRN's Lack of Guidance Results in Staff Presenting Inconsistent Information to the Governing Board



Source: Analysis of state law, governing board meeting minutes, materials, and BRN's director's handbook.

One possible unintended consequence of BRN’s enrollment decisions is the clinical displacement of students. Since at least 2009, BRN has been performing an annual survey of schools with nursing programs, a portion of which relates to clinical displacement. It asks responding nursing programs whether in the past year they lost clinical placement slots, how many students were affected, and the perceived reason that clinical placement slots were not available. BRN publishes the annual survey report on its website. As Figure 4 demonstrates, nursing programs reported in the most recent survey that more than 2,300 students were affected by a loss of clinical placement slots in academic year 2017–18—an amount generally similar to previous years. Most notably, nearly half of the nursing programs that lost a clinical placement reported that it occurred because other nursing programs took their clinical spots.

**Figure 4**  
Summary of Survey Responses Related to Clinical Displacement



Source: BRN’s 2017–18 Annual School Report.

\* Nursing programs can report more than one reason for clinical displacement.

To identify potential clinical displacement, BRN asks programs that are seeking initial approval or enrollment increases to contact nearby nursing programs and obtain statements indicating their support or opposition to the proposed change. BRN does this despite the fact that it requires the clinical facilities to assert, on the facility approval form that programs are required to submit to BRN, that a program's use of a facility will not displace the students of other programs. The nursing education staff members then generally provide a summary of the statements to the governing board. According to BRN's assistant executive officer, this practice first occurred in October 2016, when the education committee requested that Azusa Pacific University obtain statements from nursing programs potentially affected by its proposed enrollment increase. Since 2016 programs have continued to provide these statements to BRN. However, BRN has never established a process for handling these statements, such as promulgating a regulation to govern this process. For instance, the governing board approved requests for new programs and increased enrollment for several nursing programs despite existing statements of opposition.

BRN does not require its nursing education staff to independently verify the nearby nursing programs' assertions in these statements. For example, when the statements present significant disagreement, such as the seven statements of opposition and five statements of support provided to BRN regarding a proposed enrollment increase, BRN policy does not require nursing education staff to contact the programs and investigate the discrepancy. Nearby nursing programs might compete with the new nursing programs for clinical placement slots, and thus they have no clear incentive to support increasing enrollment for another nursing program. Further, the nearby nursing programs do not always provide responses to the requesting program. For example, according to the governing board meeting materials, 25 of 38 programs did not respond to Concordia University Irvine's June 2017 enrollment increase request. All of these factors call into question the validity and usefulness of the practice of soliciting the statements, and thus BRN should immediately discontinue its practice of asking nursing programs to seek statements of support or opposition from neighboring nursing programs.

Some governing board members and stakeholders agree that the existing process for assessing clinical displacement lacks clear direction and robust information. During the September 2019 board meeting, some governing board members echoed this sentiment as they made decisions involving enrollment increases. During this meeting, two governing board members acknowledged that the governing board had not provided its staff with clear direction on what information it needs when assessing clinical displacement. Stakeholders also voiced their displeasure with

*Some governing board members and stakeholders agree that the existing process for assessing clinical displacement lacks clear direction and robust information.*

BRN's current method of assessing clinical displacement during the stakeholder summit meetings in the fall of 2018. For example, the resulting summit report describes an interest in replacing BRN's existing approval process with "reliable processes that provide sufficient evidence of clinical capacity/clinical placement." BRN's executive officer stated that gathering more information about clinical placement slots would help the governing board and BRN education staff better understand clinical capacity. Without accurate clinical placement information, BRN cannot consistently and confidently prevent current nursing students from being displaced.

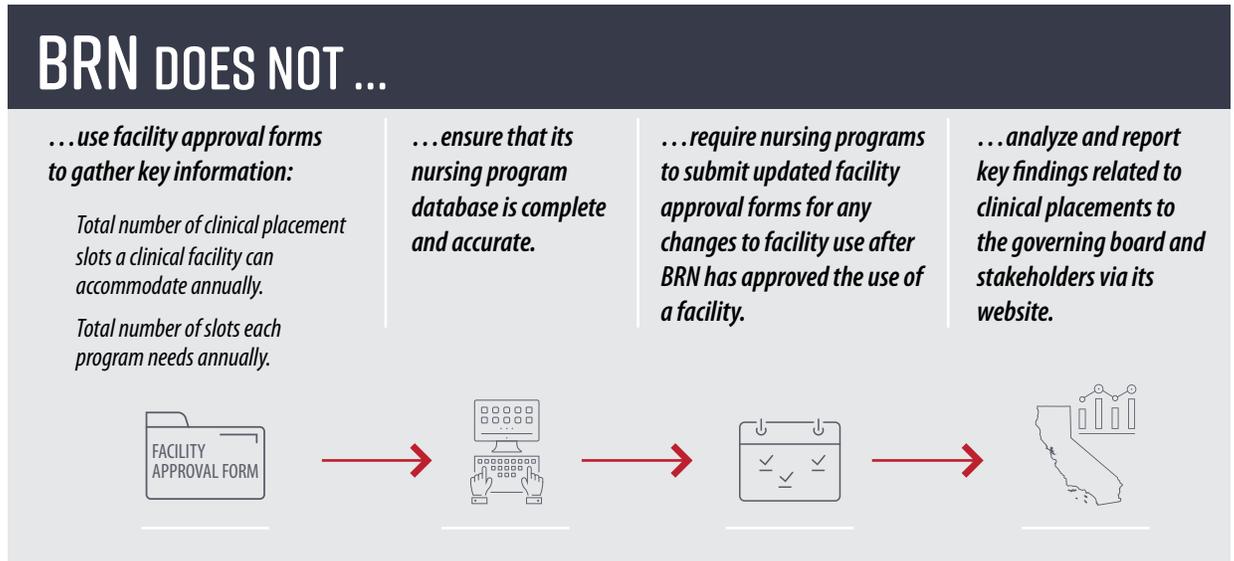
***BRN Is Not Collecting and Analyzing Useful Information Regarding Clinical Placement Slots and Capacity***

Although BRN has a database with some information about the clinical facilities that nursing programs use (nursing program database), it does not track the number of available clinical placement slots or the total number of students placed at a clinical facility. Consequently, BRN cannot effectively analyze and report the risk of displacement to its governing board when it is considering enrollment decisions. As we mention in the Introduction, nursing programs must get BRN approval before using a clinical facility. BRN documents its approval on a facility approval form, on which the facility and program attest that the program's clinical placements at the facility will not displace students from other nursing programs. The form also includes the program location and the content area for which the program is using the facility. Therefore, BRN should have a record of all facilities that nursing programs are using for clinical placement slots. BRN compiles some of the information captured in the facility approval form in its nursing program database. According to BRN, the database is intended as a tool for nursing education staff to hold information on nursing programs.

Yet, BRN does not gather certain critical information about available clinical placement slots in its nursing program database. In particular, BRN does not collect on its facility approval form or track the total number of students—or clinical placement slots—a clinical facility can accommodate annually or how many slots the programs that use the facility will need each year, as Figure 5 shows. As a result, BRN's governing board lacks key information it needs to make enrollment decisions. For example, knowing the number of placement slots that a facility can accommodate would allow the governing board to determine whether a program's request to increase enrollment by using that facility would exceed that capacity and risk displacing students.

***BRN does not track the total number of students a clinical facility can accommodate annually or how many slots the programs that use the facility will need each year.***

**Figure 5**  
**BRN Is Not Taking Full Advantage of Its Nursing Program Database**



Source: Analysis of state law and BRN's data and documents.

As it is, the database is incomplete and unreliable because BRN has not added information for all the facilities where nursing programs have clinical placements. Some of the facility approval forms on file, as well as entries in the database, are over a decade old and include outdated and incomplete information because BRN does not require nursing programs to submit updated facility approval forms once a facility is approved. Consequently, if a nursing program does not submit an updated facility approval form, BRN may be unaware of changes to facility use, and therefore the governing board may not have current and complete information to assess how any changes could affect its enrollment decisions concerning that facility. To ensure that it maintains up-to-date information on the number of available clinical placement slots at facilities, BRN should revise its regulations to require nursing programs to report to it, using a facility approval form, anytime they make changes to their use of clinical facilities, as well as to report annually if they have made no changes. BRN should use these forms to update the information contained in its database.

If BRN's database were complete and up to date, it could have used the data to analyze the risk of displacement related to a program's request for an enrollment decision and informed the governing board of the results of its analysis. In fact, we tested this idea for the 16 nursing programs located in five Bay Area counties (Alameda, Contra Costa, Marin, San Francisco, and San Mateo). For these

***Although the survey gathers valuable information, it does not capture statewide or regional information on clinical capacity.***

programs, we compiled the data from hundreds of facility approval forms BRN had in its files into a list, and we analyzed the data by program, facility, and content area. We found that, according to BRN's records, the 16 programs reported using certain facilities for clinical placement slots far more frequently than others. For example, 11 of the 16 nursing programs we reviewed reported using UCSF Children's Hospital in Oakland for their students to get their pediatric clinical experience.

According to the executive officer, BRN agrees that it should compile and analyze data related to clinical placement slots, and she indicated that BRN would be able to assign administrative staff or a data expert to do so. The executive officer also asserted that although BRN does not track clinical capacity and displacement on a statewide systematic basis, it has been gathering information related to clinical displacements through its annual school survey for several years. Although the survey gathers valuable information, such as the number of students that nursing programs reported had lost clinical placement slots and the nursing program's perceived reason that clinical placement slots were not available, it does not capture statewide or regional information on clinical capacity.

Capturing in its database the total number of placement slots a clinical facility can accommodate and how many slots the programs that use the facility utilize and then publishing this information on its website, would allow BRN and other key stakeholders to begin to understand the capacity for clinical placement slots on a regional and statewide basis. We acknowledge that the number of available clinical placement slots changes over time, and multiple factors can affect a facility's ability to predict the exact number of its annual placements. However, even if there are changes throughout the year, collecting annual estimates of clinical slots from facilities across the State will allow BRN to make better informed enrollment decisions that affect the State's nursing supply. BRN should revise its facility approval form to collect the total number of students that a clinical facility can accommodate annually as well as the number of students the program needs to place annually.

***BRN Is Forgoing Opportunities to Help Nursing Programs Identify Facilities With Potential Clinical Placement Slots***

BRN could also analyze and share information that could foster additional clinical placement opportunities, which in turn could enable some nursing programs to increase enrollment and educate new nurses. Specifically, OSHPD has a downloadable list on its

website of state health care facilities.<sup>4</sup> If BRN had a complete and up-to-date database with information related to the facilities each nursing program is using, it could compare this information to OSHPD's list of health care facilities and publish its comparison on its website. This comparison could assist nursing programs in identifying clinical facilities that other nursing programs are not using at all for clinical placement slots or that only a few are using.

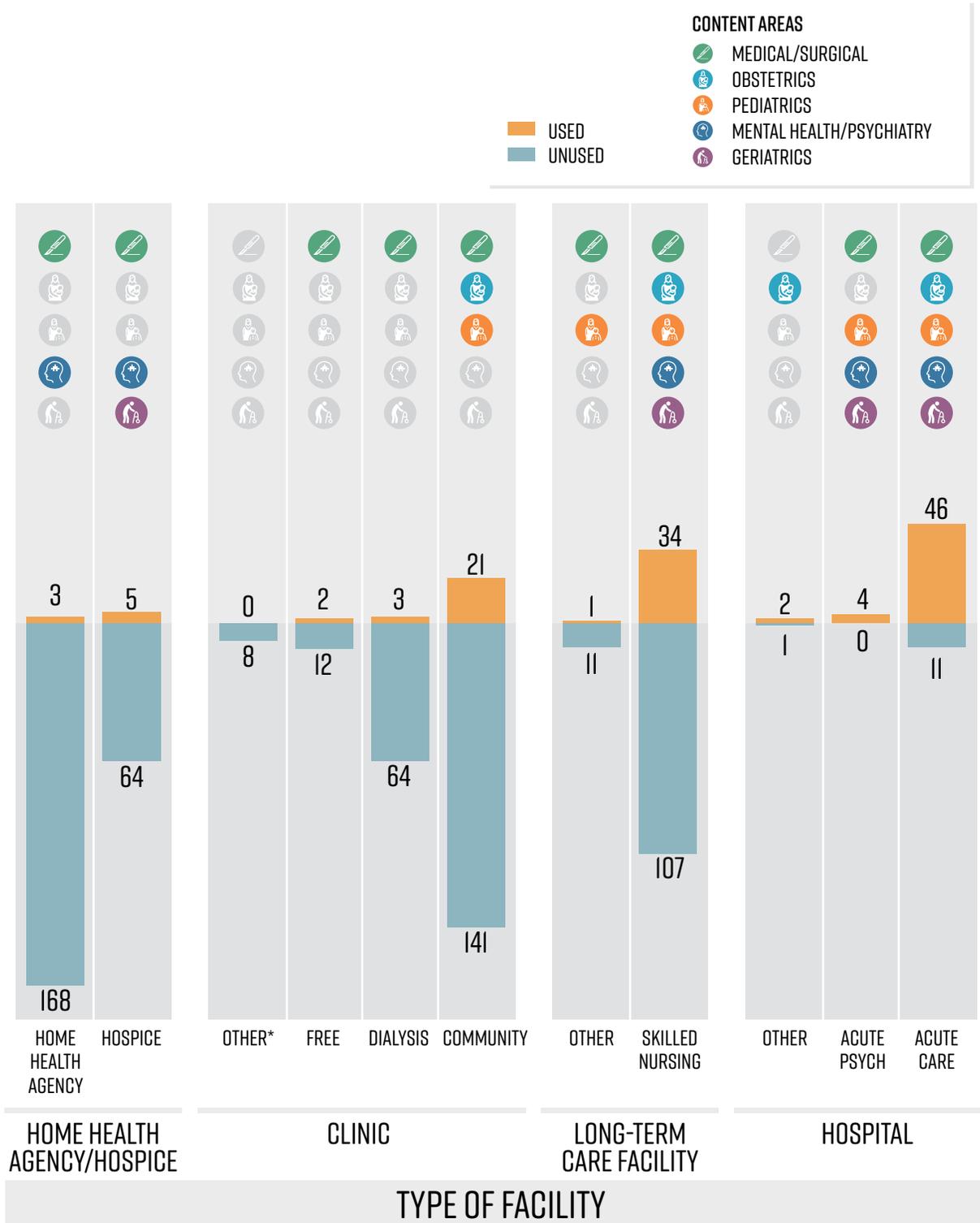
In fact, using OSHPD's information, we identified many facilities that, according to BRN's records, are not currently placing students, and some of these facilities potentially could be sources for clinical placement slots. Using the information we compiled from BRN's facility approval forms for the 16 nursing programs in five Bay Area counties we described earlier, we compared the facilities these programs used with OSHPD's list of health care facilities in those same counties.<sup>5</sup> We found that the 16 nursing programs were using 121 of the 708 facilities on OSHPD's list, or 17 percent. This means that there are hundreds of clinical facilities in those five counties that nursing programs are not currently using for clinical placement slots, representing a possible untapped source of additional clinical placement slots.

We also found from this analysis that nursing programs have clinical placements at most acute-care hospitals but are not currently using nonacute facilities, such as home health agencies, hospice facilities, and clinics nearly as much. Specifically, the programs in the Bay Area we reviewed are using 82 percent of the acute-care hospitals in OSHPD's list, but are using only 10 percent of the clinics. In fact, this analysis helps identify possible additional nonacute facilities for placements, which was a priority for action from the stakeholder summits. Figure 6 illustrates the number of used and unused facilities in the five counties by facility type. In addition, we determined the content areas for which nursing programs were using each type of facility, as Figure 6 also shows. For example, skilled nursing facilities can accommodate several content areas and, while 34 of those facilities are currently being used, 107 are currently unused.

<sup>4</sup> According OSHPD's website, this is a listing of facilities that are licensed by California Department of Public Health.

<sup>5</sup> The counties are Alameda, Contra Costa, Marin, San Francisco, and San Mateo.

**Figure 6**  
Facilities Not Used by Nursing Programs for Clinical Placements Could Be a Source of Additional Placements



Source: Analysis of BRN's documents and OSHPD's data for programs in the Bay Area.

\* Because no programs currently use other clinical facilities, we could not determine the content areas that would apply.

It is important to note that just because a nursing program is not using a facility does not necessarily mean the facility is available for use or willing to provide clinical placement slots for nursing students. For example, a facility might not have enough staff to support student learning or might have other concerns. BRN and nursing programs would need to do additional work to contact currently unused facilities to gauge their interest in providing clinical placement slots. However, we believe such a comparison and the necessary follow-up would provide valuable information to help identify additional clinical placement slots and alleviate some of the possible constraints on enrollment for nursing programs in areas experiencing a nursing shortage. BRN agreed that comparing its data from the facility approval forms with OSHPD data could be helpful in identifying facilities that might provide additional clinical placement slots.

#### **BRN's Process for Approving Nursing Programs Partially Overlaps With the Work of Accreditors**

Some of BRN's requirements for approving nursing programs are similar to accreditation standards. National Nursing Program Accreditors (accreditors) are private educational associations that assess whether nursing programs meet and maintain acceptable levels of quality. As part of their evaluation of nursing programs, accreditors verify that course content is consistent with contemporary nursing practices, instructors are using teaching methods that support expected student outcomes, and schools are meeting the needs of nursing students by providing adequate resources and support services. Although BRN approval is required for nursing programs in California, accreditation is optional. BRN reported that roughly half of the nursing programs in the State were accredited as of fiscal year 2017–18. Of those that are accredited, nearly all are accredited by the Commission on Collegiate Nursing Education (CCNE) or the Accreditation Commission for Education in Nursing (ACEN). Both of these accreditors are recognized by the U.S. Department of Education as reliable authorities on the quality of nursing education.

BRN's approval of nursing programs has similarities to accreditation in both its approval process and the standards it requires nursing programs to meet. For instance, both review processes involve an initial approval in which accreditors and BRN verify that nursing programs meet their standards; a cycle of periodic continuing approvals; and the requirement that nursing programs report substantive changes, such as enrollment increases or curriculum changes. For continuing approval, both processes require a program to conduct a self-evaluation that provides similar information, such as licensure exam pass rates and faculty

qualifications. BRN requirements for nursing program approval are found in state law. These requirements are similar to accreditation standards in many categories. For example, as shown in Table 3, the accreditors’ standards overlap with BRN’s requirements in each of the following areas: administrator and faculty qualifications and responsibilities, program resources, curriculum requirements, and testing standards. For certain areas, one accreditor verifies that nursing programs are meeting the same state requirements that BRN verifies. In fact, eight ACEN accreditation standards specifically require accreditors to verify that nursing programs are in compliance with state requirements or policies for the applicable area under review.

**Table 3**  
**Accreditors’ Standards Are Similar to Some of BRN’s Requirements**

SELECTION OF BRN’S REQUIREMENTS FOR NURSING PROGRAM APPROVAL	ACCREDITORS	
	ACEN	CCNE
Nursing program faculty and administrators are qualified and have relevant experience.	✓	✓
Nursing program has sufficient resources for students and faculty.	✓	✓
Curriculum is comprehensive and includes concurrent clinical experience.	✓	✓
Nursing program maintains a minimum pass rate for the licensure exam.	✓	✓
The majority of clinical hours are completed in direct patient care.	X	X
Nursing program considers clinical displacement when selecting a new clinical facility to use.	X	X

Source: Analysis of state law and accreditors’ documents.  
 ■ The requirement is present in the accreditor’s standard.  
 ■ The requirement is not present in the accreditor’s standard.

However, there are some important differences between BRN oversight and accreditation. According to the National Council of State Boards of Nursing (National Council), a state board’s mission is protecting the public and ensuring that nursing programs meet state requirements, whereas accreditors focus on quality and program effectiveness.<sup>6</sup> The National Council points out that boards of nursing also understand nursing education issues in their specific jurisdictions. Accreditors do not have statutory authority

<sup>6</sup> The National Council is a nonprofit organization whose members consist of the nursing regulatory bodies in the 50 states, the District of Columbia, and four U.S. territories. Its mission is to empower and support nursing regulators in their mandate to protect the public.

to close nursing programs that do not meet standards, while boards of nursing do have that authority. The National Council also states that boards of nursing can act right away when they identify problems with nursing programs; accreditors cannot act as quickly. Additionally, continuing approval visits by ACEN and CCNE may occur less frequently than BRN's—up to every eight to 10 years for the accreditors compared to every five years for BRN. Also, BRN approves nursing program faculty prior to employment, whereas accreditors do not.

BRN's executive officer strongly opposes the prospect of reducing BRN's involvement in reviewing and approving nursing programs. She stated that accreditation reviews are too infrequent and are not focused on ensuring that nursing programs comply with BRN regulations. She added that BRN has identified noncompliance even at accredited programs, such as unapproved curriculum changes and insufficient resources. She also echoed the point made by the National Council that accreditors do not have statutory authority over nursing programs. She believes that maintaining BRN's oversight and implementation of the review process is the only way to ensure consistent program review for all prelicensure nursing programs and that relying on accreditation does not enable BRN to achieve its mission of protecting the public and nursing students. Finally, she stated that reducing BRN oversight could result in registered nursing students and graduates not having sufficient educational preparation and opportunities to obtain the requisite knowledge, skills, and abilities needed to safely and competently perform required nursing functions.

Nevertheless, aligning state review with accreditation is not uncommon. We identified several California healing arts boards that rely on accreditation in place of or in conjunction with state review: the Medical Board of California, the Osteopathic Medical Board of California, the Physician Assistant Board, and the Dental Hygiene Board of California. This is not the case for California nursing programs: the State does not require accreditation for these nursing programs, and only half of them have chosen to become accredited. However, the State does require accreditation for nurse practitioner programs located in California, which are advanced-practice programs. The National Council recommended in 2012 that all state boards of nursing require nursing programs to be accredited by 2020. As of March 2020, a total of 26 U.S. states and territories require accreditation, according to the National Council.

Additionally, collaboration between states and accreditors is encouraged. Although BRN specifically states that it will not accept reports prepared for accrediting bodies, ACEN indicated that it welcomes the opportunity to cooperate with state regulatory agencies for nursing with the goal of increasing efficiency and

*Although the State requires accreditation for nurse practitioner programs located in California, it does not require it for prelicensure nursing programs.*

***We believe policymakers should consider whether it would be appropriate to restructure any of BRN's oversight to reduce duplication with accreditation agencies while still achieving its mission to protect the public.***

decreasing workload while maximizing outcomes. In addition, the National Council recommends that boards of nursing work toward harmonizing their approval process with accreditors.

Given the differences in the purposes of BRN's approval and national accreditation, we are not suggesting that accreditation is an exact replacement for BRN's oversight. Rather, we believe policymakers should consider, as part of their sunset review, whether it would be appropriate to restructure any of BRN's oversight to reduce duplication with accreditation agencies while still achieving its mission to protect the public. *Sunset review* is a process intended to identify and eliminate waste, duplication, and inefficiency in government agencies. The purpose of sunset review is for a legislative committee to conduct a comprehensive analysis on a periodic basis to determine whether the subject agency is still necessary and cost-effective. As a part of this process, the committee considers recommendations for changes and reorganization to help the agency better fulfill its purpose. Given that some of BRN's oversight of nursing programs might be duplicated by accreditors, we believe the upcoming sunset review in 2021 would be an appropriate setting to consider whether the State would be better served by having BRN revise its regulations to leverage portions of the accreditors' reviews in order to reduce duplication and more efficiently use state resources. For example, it could consider restructuring continuing approval requirements for nursing programs that are accredited and maintain certain high performance standards for consecutive years (for example, licensure exam pass rates, program completion rates, and job placement rates).

### **Other Areas We Reviewed**

#### ***BRN's Conflict-of-Interest Code Is Adequate, and Members of the Governing Board Recused Themselves Appropriately***

BRN's conflict-of-interest code (code) incorporates the terms of the Fair Political Practices Commission's standard code and appropriately identifies positions within BRN that must report economic interests. State law requires that every agency adopt and promulgate a code. It also requires that, in their codes, agencies must specifically designate positions that involve the making of or participation in the making of decisions that may have a foreseeable effect on any financial interest for individuals in those positions, and the types of financial interests that those individuals must report. Additionally, agencies' codes must contain provisions that outline circumstances under which designated employees must recuse themselves from participation in decision making.

To report their economic interests, designated BRN employees file a Statement of Economic Interests—known as a *Form 700*—that the Fair Political Practices Commission publishes. Based on our review, every individual at BRN who is significantly involved in the approval process for nursing programs filed a Form 700 for each year from 2017 to 2019. However, two people filed two of their forms late after we found that they were missing and discussed it with a filing officer at Consumer Affairs. We found that governing board members appropriately recused themselves from decisions regarding nursing programs in which they had reported an economic interest during the audit period.

***Nursing Education Staff Members Responsible for Reviewing Nursing Programs Are Adequately Qualified***

BRN's nursing education staff members are appropriately qualified to perform their oversight responsibilities. To assess their expertise, we reviewed the minimum qualifications of nursing education staff members as defined by their job classifications and compared each staff member's most recent application file to those minimum qualifications. We also determined that the minimum qualifications appeared appropriate for the type of oversight work that nursing education staff perform. Nursing education staff members must have an active, valid California license as an RN and at least five years of nursing experience, which must include three years as a teaching nurse faculty member; or three years as a clinical specialist, nurse practitioner, or in-service educator in a hospital, clinic, or private-practice setting, and a master's degree in nursing or a related field. Supervising nursing education staff members must have two years of experience performing the duties of staff-level nursing education staff or five years of nursing experience, including three years as a teaching nurse faculty member and two years of experience in nursing administration. All of the 11 currently employed nursing education staff members meet or exceed the minimum education qualifications; in fact, six of the staff have a doctoral degree.

## Recommendations

### *Legislature*

To better inform stakeholders and the governing board's decision making, the Legislature should amend state law to do the following:

- Require BRN to incorporate regional forecasts into its biennial analyses of the nursing workforce.
- Require BRN to develop a plan to address regional areas of shortage identified by its nursing workforce forecast. BRN's plan should include identifying additional facilities that might offer clinical placement slots.

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

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

### *BRN*

To better ensure that California has an appropriate number of nurses in the future, BRN should do the following by January 1, 2021:

- Revise the scope of work of its contract for workforce forecasting services to direct the contractor to incorporate regional analyses.
- Ensure that the governing board's enrollment decisions and other actions adequately take into consideration the regional analyses in BRN's future workforce forecasts. Specifically, it should amend its policies to require that when its staff present information to

the education committee and the governing board to inform them on pending enrollment decisions, staff should include relevant information related to BRN's most recent forecast of the nursing workforce.

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

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

- Update its clinical facility approval form to capture annual capacity estimates from clinical facilities, as well as annual clinical placement needs of programs.
- Revise its regulations to require nursing programs to report any changes they make to their use of clinical facilities within 90 days of making a change and report annually if the program has made no changes.
- Compile and aggregate the information from the facility approval forms into a database and take reasonable steps to ensure that the information is accurate and current.
- Annually publish clinical capacity information on its website for public use.
- Immediately discontinue its practice of having nursing programs seek statements of support or opposition from neighboring nursing programs when considering requests for new programs or increased enrollment at existing programs.

To identify additional facilities that might offer clinical placement slots, by October 1, 2021, and annually thereafter, BRN should compare its nursing program database with OSHPD's list of health care facilities. BRN should share the results of its comparison with nursing programs by publishing this information on its website.

We conducted this performance audit in accordance with generally accepted government auditing standards and under the authority vested in the California State Auditor by Government Code 8543 et seq. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on the audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,



ELAINE M. HOWLE, CPA  
California State Auditor

July 7, 2020

# Appendix

## Scope and Methodology

The Joint Legislative Audit Committee (Audit Committee) directed the State Auditor to examine BRN’s oversight of nursing programs. Specifically, we reviewed BRN’s process for approving new nursing programs or programs seeking to expand and its efforts to analyze the nursing workforce in California. The Table lists the objectives that the Audit Committee approved and the methods we used to address them.

### Audit Objectives and the Methods Used to Address Them

AUDIT OBJECTIVE	METHOD
<p>1 Review and evaluate the laws, rules, and regulations significant to the audit objectives.</p>	<p>Reviewed relevant laws, rules, and regulations.</p>
<p>2 Determine whether BRN is appropriately reviewing and approving nursing programs, including the following:</p> <ul style="list-style-type: none"> <li>a. Whether BRN’s policies and procedures for approving, denying, deferring, or revoking its approval of nursing programs comply with laws and regulations.</li> <li>b. Whether the factors that BRN uses when considering a request from a school to expand its nursing program are reasonable.</li> <li>c. Whether BRN consistently and objectively applied these factors as a part of its decision-making process for a selection of requests.</li> </ul>	<ul style="list-style-type: none"> <li>• Objective 2 asked us to assess whether BRN’s policies and procedures comply with state law. We found that in matters not related to enrollment, BRN’s policies and procedures were in compliance with the Nursing Practice Act and BRN’s regulations. We made no determination as to whether BRN has authority to determine the total number of students a nursing program may enroll or whether any of BRN’s policies and procedures constitute underground regulations in violation of the Administrative Procedures Act as these issues were in litigation during our fieldwork and audit standards prohibit us from interfering with litigation. With respect to these issues, our report simply focuses on the actions BRN has taken in the recent past.</li> <li>• Reviewed BRN’s director’s handbook, which describes the information nursing programs must provide to BRN when requesting to expand the program.</li> <li>• Identified governing board decisions approving new programs and expanding existing programs from January 2015 through September 2019, and reviewed related governing board meeting minutes and materials.</li> <li>• Reviewed five requests for new programs and 10 requests to expand existing programs that the governing board decided between January 2015 and September 2019 to determine if the governing board’s decision making was objective and consistent.</li> </ul>
<p>3 Review petitions of regulatory violations related to nursing programs filed against BRN with OAL over the last three years and summarize the outcomes of the complaint process.</p>	<p>Obtained and reviewed OAL’s list of petitions for regulatory violations regarding BRN and summarized outcomes.</p>

*continued on next page...*

AUDIT OBJECTIVE	METHOD
<p>4 Determine whether there are adequate conflict-of-interest rules or policies for governing board members, executive management, and nursing education staff who work on the oversight of nursing programs. Further, to the extent possible, identify whether BRN's staff or governing board members appropriately recused themselves from decisions regarding nursing programs with which they may have had a conflict of interest.</p>	<ul style="list-style-type: none"> <li>• Interviewed key staff at BRN and Consumer Affairs to identify relevant laws, regulations, policies, and documentation related to Consumer Affairs' conflict-of-interest code and statements of economic interest.</li> <li>• Identified and assessed whether Consumer Affairs' conflict-of-interest code that applies to BRN is sufficient and appropriate.</li> <li>• Identified governing board members, executive management, and nursing education staff required to file a Form 700, collected and reviewed each of those Form 700s for 2017 through 2019, and determined whether those individuals had any pertinent economic interests.</li> <li>• Reviewed meeting minutes for each governing board meeting from January 2015 through September 2019 to determine whether governing board members recused themselves appropriately if their reported economic interests were the subject of board action.</li> </ul>
<p>5 Identify the process BRN uses to evaluate clinical displacement and whether it consistently and objectively uses that process across all nursing programs. For a selection of requests for increased enrollment or new nursing programs, assess the factors BRN evaluated in making its decisions and the resulting clinical displacement.</p>	<ul style="list-style-type: none"> <li>• Interviewed key staff at BRN and determined that BRN does not evaluate clinical placements across the State. We could not assess the clinical displacement that might have resulted from BRN's enrollment decisions because it does not track this information at that level.</li> <li>• Reviewed BRN's annual school survey and the stakeholder summit report to determine the extent of clinical displacement.</li> <li>• Assessed the factors BRN evaluated as part of our review under Objective 2, including when applicable, information about clinical displacement.</li> <li>• Reviewed BRN's database to identify the clinical facility information it has. Determined BRN's database to be incomplete and unreliable.</li> </ul>
<p>6 Determine whether BRN's oversight of nursing programs is appropriate, including the following:</p> <p>a. Whether BRN is duplicating oversight of nursing programs conducted by other entities, including state and federal entities, as well as nursing school accreditors.</p> <p>b. An assessment of the expertise BRN relies on when it evaluates the curricula of nursing programs.</p>	<ul style="list-style-type: none"> <li>• Compared BRN's oversight requirements to national accreditation standards and processes. Reviewed National Council documents related to state boards of nursing and national accreditation.</li> <li>• Interviewed key nursing education staff about documentation and processes related to their review of nursing programs.</li> <li>• Determined that nursing education staff are primarily responsible for evaluating the curricula of nursing programs.</li> <li>• Compared the hiring applications for each nursing education staff member hired after December 2014 with California Department of Human Resources' minimum qualifications for those positions.</li> <li>• Assessed the type of oversight nursing education staff perform and available documentation of the various processes related to BRN's approval of nursing curricula.</li> </ul>
<p>7 Determine whether BRN's analysis of California's nursing workforce is reasonable and consistent with the scope and breadth of current and future health care workforce needs as identified by similar analyses.</p>	<ul style="list-style-type: none"> <li>• Interviewed key staff at BRN to understand the process BRN uses to develop and publish studies on California's nursing workforce forecast.</li> <li>• Identified recent studies related to the nursing workforce in California.</li> <li>• Reviewed key elements of the studies, including their methodologies and conclusions.</li> <li>• Compared the methodology and findings of BRN's nursing workforce forecast to those of other studies.</li> </ul>
<p>8 To the extent possible, identify the time spent and resources used by BRN on each of its programs.</p>	<ul style="list-style-type: none"> <li>• Interviewed key staff at BRN and Consumer Affairs to identify and understand BRN's budgeting practices. We could not identify the time spent and resources used by BRN on each of its programs because BRN is a single payroll reporting unit, which means it budgets and reports expenditures as a single unit. It does not track time and resources by program or organizational units. For example, its expenditures for salaries are recorded as one amount, even though BRN has staff dedicated to different units.</li> <li>• Reviewed documentation related to BRN's budget, including its latest budget augmentation.</li> </ul>

AUDIT OBJECTIVE	METHOD
<p>9 Review and assess any other issues that are significant to the audit.</p>	<ul style="list-style-type: none"> <li>Reviewed facility approval forms for 16 nursing programs in five counties in the San Francisco Bay Area and compared the clinical facilities associated with the 16 nursing programs with OSHPD data of registered health care facilities from the same five counties to identify facilities not currently used by the 16 nursing programs.</li> <li>Prior to the completion of this audit, the State Auditor received a whistleblower complaint alleging that BRN executives in the enforcement division intentionally manipulated data and delivered a falsified report to the State Auditor to satisfy a recommendation the State Auditor had made during a 2016 audit of the enforcement division. In response to the complaint, the State Auditor launched an investigation and substantiated that BRN executives violated state law when they carried out a plan to artificially decrease caseloads for BRN investigators before delivering a falsified report to the State Auditor. The plan involved temporarily reassigning some of the BRN investigators' cases to other employees who should not have had cases assigned to them. The investigation found that within 10 days of the State Auditor reviewing the falsified report and concluding that BRN had fully implemented the recommendation, BRN managers reversed the reassignments, increasing caseloads to their original level. A copy of investigative report I2020-0027, <i>Board of Registered Nursing: Executives Violated State Law When They Falsified Data to Deceive the State Auditor's Office</i>, can be found at <a href="http://www.auditor.ca.gov">www.auditor.ca.gov</a>. The audit team became aware of the investigation during this audit and re-evaluated the risk assessment it conducted for the audit to ensure it could rely upon the documentation provided by BRN for this audit report. We determined that the documentation we obtained was reliable.</li> </ul>

Source: Analysis of the Audit Committee's audit request number 2019-120, and information and documentation identified in the column titled Method.

### Assessment of Data Reliability

In performing this audit, we relied on electronic data files that we obtained from OAL related to petitions it received and from OSHPD's website related to health care facilities. The U.S. Government Accountability Office, whose standards we are statutorily obligated to follow, requires us to assess the sufficiency and appropriateness of computer-processed information we use to support our findings, conclusions, and recommendations. We used the data from OAL to verify that it had received two petitions related to BRN over the last three years. OAL performed for us multiple queries of its system to identify petitions related to BRN, and each query identified the same two petitions; therefore, we determined that the data were sufficiently reliable for our purpose. We also downloaded from OSHPD's website the list of health care facilities. We used the data to identify clinical facilities that nursing programs are not currently using for clinical placements. We verified that the data included logical information; however, we did not perform completeness testing because the supporting documentation is maintained at the facilities, making such testing impractical. We concluded that the data are of undetermined reliability. Although we recognize that this limitation may affect the precision of the numbers we present, there is sufficient evidence in total to support our audit findings, conclusions, and recommendations.

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July 2020



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June 11, 2020

Elaine M. Howle, State Auditor\*  
 California State Auditor's Office  
 621 Capitol Mall, Suite 1200  
 Sacramento, CA 95814

RE: Response from California Board of Registered Nursing to Audit 2019-120 -  
 Oversight of Pre-Licensure Nursing School Programs

Dear Ms. Howle,

The California Board of Registered Nursing (Board) appreciates the time and effort you and your staff have dedicated to evaluating our oversight of pre-licensure nursing school programs and making recommendations to refine and improve the Board's processes. The Board sets a high standard for itself and is always interested in identifying opportunities to better fulfill its mission of protecting California consumers. We are keenly aware of the critical role of registered nurses in maintaining the health and safety of Californians. Thus, we are committed to ensuring that our nurses receive a quality education that prepares them for the incredibly important jobs that they have in our communities. We thank you for your recommendations in the audit report, and respectfully submit the attached responses.

Should you have any questions or require anything else, please do not hesitate to contact the Board's Assistant Executive Officer, Evon Lenerd Tapps at (916) 574-7610.

Sincerely,

Michael D. Jackson, MSN, RN, CEN  
 President  
 California Board of Registered Nursing

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

Attachment

\* California State Auditor's comments begin on page 47.

**The California Board of Registered Nursing (BRN) Responses  
to the California Bureau of State Audits (BSA) Findings  
June 11, 2020**

**Audit Name**

Board of Registered Nursing – Oversight of Pre-Licensure Nursing School Programs

**Audit Number**

2019-120

**BSA Recommendations to BRN and BRN Responses**

**Recommendation 1:** To better ensure that California has an appropriate number of nurses in the future, BRN should do the following by January 1, 2021:

- Revise the scope of work of its contract for workforce forecasting services to direct the contractor to incorporate regional analyses.
- Ensure that the governing board's enrollment decisions and other actions adequately take into consideration the regional analyses in BRN's future workforce forecasts. Specifically, it should amend its policies to require that when its staff present information to the education committee and the governing board to inform it on pending enrollment decisions, they include relevant information related to BRN's most recent forecast of the nursing workforce.

**BRN Response 1:**

- ① BRN collects data which assists in determining if California has the appropriate number of nurses in the future. This includes, but is not limited to, information gained from the 2018 Regional Nursing Summits (Summit)<sup>1</sup>, the raw data which the University of California, San Francisco (UCSF) collects on behalf of BRN, and information collected from pre-licensure nursing programs through their "written plan for evaluation of the total program" that includes, among other things, evaluation of the performance of the school's graduates in meeting community needs. (16 CCR §1424(b)(1).)<sup>2</sup>

On or about January 1, 2021, to better ensure California has an appropriate number of nurses in the future, BRN will:

- BRN has a current contract for workforce forecasting services in place with an end date of June 30, 2021, and work has already been performed for this contract period. BRN will request the contractor to include a regional analysis within the report 'Forecasts of Registered Nurse Workforce in California' that is published on the BRN website. BRN will ensure that the scope of work for future

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<sup>1</sup> The goal of these Summits was to examine clinical capacity in more detail with the intent to address clinical capacity issues and associated factors in a collaborative and transparent manner. The data collected during the Summits included regional workforce differences and other regional data. Although this data is not typically presented by NECs, it is used by the governing board when making enrollment decisions. If future Summits occur, BRN will seek to participate in these Summits to address ongoing clinical capacity and collaborate with other stakeholders, as appropriate.

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<sup>2</sup> This data is typically collected and evaluated during the five-year Continuing Approval Visit. BRN does not have regulatory authority to require a plan for evaluation of the total program on an annual basis, and to require that it include regional nursing workforce forecast data. Therefore, in order for BRN to require nursing programs to submit their written plan for evaluation on an annual basis, BRN would need to pursue a change to regulations, which would not feasibly be promulgated on or before January 1, 2021. However, BRN will consider revising its regulations to require nursing programs to submit their written plan for evaluation on an annual basis on or before October 1, 2021. On or before January 1, 2021, BRN will request nursing programs to submit their written plan for evaluation for their total program on an annual basis. BRN will also provide training to all impacted staff.

②

contracts for workforce forecasting services will incorporate regional data and analysis, in alignment with the data in the 2018 Summit report currently relied upon by the governing board. ①

- Amend its policies, as appropriate, to require that relevant information related to BRN's most recent forecast of the nursing workforce, and other relevant regional data, be included in Agenda Item Summaries (AIS), presentations by Nursing Education Consultants (NEC; referred to as nursing education staff in the audit report), and supporting documentation, so that they may be taken into consideration when making enrollment decisions. These items may also include, but will not necessarily be limited to, the school's report on how their graduates will be meeting community needs, which sometimes includes regional nursing workforce data.

**Recommendation 2:** To ensure that nursing education staff provide complete information to the governing board when it is considering enrollment decisions, by January 1, 2021, BRN should establish in policy the specific information that its staff should present to the education committee and governing board, including data about clinical facilities that nursing programs use for placements, the content areas for which the programs use those facilities, and the total number of available placement slots and the risk of clinical displacements at the facilities.

**BRN Response 2:**

Through discussions with BSA during the audit process, BRN initiated meetings and process improvement efforts to ensure consistency and uniformity with AIS and supporting documentation requirements when presenting to the ELC and governing board. BRN will continue to work with the ELC, the governing board, and the NECs to establish and implement a uniform format and reporting structure which informs the ELC and the governing board of appropriate information for enrollment decisions for pre-licensure nursing programs. On or before January 1, 2021, the information will include data about clinical facilities that nursing programs use for placements and the content areas for which the programs use those facilities. However, BRN can only include data relating to the total number of available placement slots and the risk of clinical displacements at the facilities once that information can be collected and analyzed, which will be after January 1, 2021. ③

BRN agrees that the available data on clinical placements can be enhanced; therefore, BRN has researched and discussed regional consortiums as a way to identify every student placement in all clinical settings, provide a transparent system for resolving clinical placement conflicts, and document problem areas. There are currently limited consortiums available in California and they are not uniform nor are they located in every region, and participation in the consortiums is voluntary. Without legislative and regulatory authority, BRN cannot implement a statewide consortium with a regional focus and require all clinical settings and academic institutions to participate. Such a system could ensure that data relating to the total number of available placement slots and the risk of clinical displacements at the facilities will be collected and analyzed. A statewide consortium with regional focus would provide a complete and accurate representation of available clinical placement slots. ④

**Recommendation 3:** To ensure that BRN is using up-to-date, accurate, and objective information to inform the governing board's enrollment decisions and to assess clinical capacity for student placements, by April 1, 2021, BRN should:

- Update its clinical facility approval form to capture annual capacity estimates from clinical facilities, as well as annual clinical placement needs of programs.
- Require nursing programs to report any changes they make to their use of clinical facilities within 90 days of making a change and report annually if the program has made no changes.
- Compile and aggregate the information from the facility approval forms into a database and take reasonable steps to ensure that the information is accurate and current.
- Annually publish clinical capacity information on its website for public use.

- Immediately discontinue its practice of having nursing programs seek statements of support or opposition from neighboring nursing programs when considering requests for new programs or increased enrollment at existing programs.

BRN Response 3:

As mentioned in the responses for recommendations one and two, effective March 2020, BRN initiated meetings and process improvement efforts to amend its policies related to the AIS, the NEC presentation, and supporting documentation, which will ensure that the information presented to the ELC and the governing board is up-to-date, accurate, and objective, and provides sufficient information for the ELC and the governing board to assess clinical capacity for student placements in connection with enrollment decisions; additionally, BRN will take the following actions:

- On or before April 1, 2021, BRN will update the clinical facility approval form to capture annual capacity estimates from clinical facilities as well as annual clinical placement needs of programs.
- In order for BRN to require nursing programs to report any changes they make to their use of clinical facilities within 90 days of making the change and report annually if the program has made no changes, regulation sections including, but not limited to, CCR sections 1427 and 1432 will need to be revised. It is not feasible that a regulatory change could be promulgated on or before April 1, 2021. However, ⑤ BRN will consider revising its regulations to require nursing programs to report any changes they make to their use of clinical facilities within 90 days of making the change and report annually if the program has made no changes.
- In order for BRN to require nursing programs to submit the facility approval form, a regulatory change will need to be promulgated. It is not feasible that a regulation package could be promulgated on or before April 1, 2021. However, BRN will consider revising its regulations to require nursing programs to submit a facility approval form on or before October 1, 2021. On or before April 1, 2021, BRN will develop a policy to compile and aggregate the information from the facility approval forms into a database and take steps to ensure it is accurate and current.<sup>3</sup> This information will be used to assess the risk of clinical displacement when gathering information related to enrollment decisions and will be reported to the ELC and the governing board in its newly developed uniform reporting format and structure. BRN will also provide training to all impacted staff. ⑤
- On or before April 1, 2021, BRN will commence the process to analyze clinical capacity information that is available to BRN for the purpose of publishing it on the BRN website for public use on an annual basis.
- As of March 11, 2020, BRN discontinued its practice of requiring nursing programs to seek statements of support or opposition from neighboring nursing programs when considering requests for new programs or increased enrollment at existing programs. BRN will update the 2020 Director's Handbook with this information.

Recommendation 4: To identify additional facilities that might offer clinical placement slots, by October 1, 2021, and annually thereafter, BRN should compare its nursing program database with OSHPD's

④ <sup>3</sup> BRN agrees that collecting and analyzing clinical information is necessary; therefore, BRN has researched and discussed regional consortiums as a way to identify every student placement in all clinical settings, provide a transparent system for resolving clinical placement conflicts, and document problem areas. There are currently limited consortiums available in California and they are not uniform nor are they located in every region, and participation in the consortiums is voluntary. Without legislative and regulatory authority, BRN cannot implement a statewide consortium with a regional focus and require all clinical settings and academic institutions to participate. Such a system could provide a complete and accurate representation of available clinical placement slots and ensure that information presented to the ELC and the governing board to assess clinical capacity for student placements is up-to-date, accurate, and objective.

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

BRN Response 4:

To identify additional facilities that might offer clinical placement slots, on or before October 1, 2021, and annually thereafter, BRN will compare its aggregated data in its nursing program database with OSHPD's list of health care facilities and will share the results of the comparison by publishing to the BRN website. As stated by BSA in the audit report, OSHPD data will not show the clinical settings that do not have the capacity or the desire to offer placement slots; therefore, such a comparison might produce information that could be used to locate unused clinical sites, however it would not be an accurate representation of available clinical placement slots for nursing students. As previously stated, a statewide consortium with a regional focus would provide a complete and accurate representation of available clinical placement slots for nursing students. BRN needs legislative and regulatory authority to develop and implement a statewide consortium with a regional focus and require health care facilities and academic institutions to participate in the statewide consortium, which will ensure that BRN has accurate and current data on clinical placement slots.

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**BSA Recommendations to the Legislature and BRN Responses**

Legislative Recommendation 1: To better inform the governing board's decision making and stakeholders, the Legislature should amend state law to do the following:

- Require BRN to incorporate regional forecasts into its biennial analyses of the nursing workforce.
- Require BRN to develop a plan to address regional areas of shortage identified by its nursing workforce forecast. BRN's plan should include identifying additional facilities that might offer clinical placement slots.

BRN Response to Legislative Recommendation 1:

Business and Professions Code section 2717 requires BRN to collect and analyze workforce data from its licensees for future workforce planning. BRN collects and analyzes this data via its contractor, the University of California, San Francisco (UCSF). However, BRN has not requested the regional information from UCSF for purposes of publishing to its website. BRN does not oppose the development of a plan to identify regional areas that are underserved and collaborating to identify options to address those underserved areas, including but not limited to finding additional facilities that may offer clinical placements to students.

Legislative Recommendation 2: As a part of BRN's sunset review in 2021, the Legislature should consider whether the State would be better served by having BRN revise its regulations to leverage portions of the accretor's review to reduce duplication and more efficiently use state resources. For example, it could consider restructuring continuing approval requirements for nursing programs that are accredited and maintain certain high performance standards for consecutive years (for example, licensure exam pass rates, program completion rates, and job placement rates). Additionally, the Legislature should consider whether and how BRN could coordinate its review with accretors to increase efficiency.

BRN Response to Legislative Recommendation 2:

BRN is not opposed to identifying and addressing any duplicative efforts involving third party accreditation entities and BRN's statutory and regulatory oversight of pre-licensure nursing programs. However, this recommendation being addressed to the Legislature does not consider BRN's ability and willingness to address any concerns regarding duplicative efforts. BRN is in the unique position to take the lead and 1) assess the roles of the accreditation entities and its current processes; 2) identify areas of overlap and areas of improvement; 3) incorporate feedback of the Deans and Directors of currently accredited ADN and/or BSN pre-licensure nursing programs; 4) implement enhancements to its processes; and 5) conduct continuous quality

⑦

improvement assessments and implement revisions based on the data. BRN could report the progress and accomplishments of reducing these duplicative efforts during its sunset review for evaluation and additional input. BRN affirms its interest in ensuring that its processes are evidence based and that we continue to offer the highest level of protection to consumers, patients, nursing students, and licensees.

Legislative Recommendation 3: To ensure that BRN and stakeholders have an understanding of clinical placement capacity in California, the Legislature should amend state law to require BRN to annually collect, analyze, and report information related to the number of clinical placement slots available and the location of those clinical placement slots within the State.

BRN Response to Legislative Recommendation 3:

- BRN supports advancing the understanding of clinical placement capacity and supports working in collaboration with other stakeholders, including but not limited to, hospitals and other health care facilities eligible to offer clinical placements to nursing students, for the purpose of collecting, analyzing and reporting information related to the number and location of clinical placement slots available in California. BRN believes that a statewide consortium with a regional focus could accomplish this. In order to implement such a statewide consortium and require health care facilities and academic institutions to participate, BRN needs legislative and regulatory authority. Such a system could ensure that data relating to the total number of available placement slots and the risk of clinical displacements at the facilities can be collected and analyzed. This would allow for identification of every student placement in all clinical settings, provide a transparent system for resolving clinical placement conflicts, and allow for documentation of problem areas. In the absence of legislative authority for a statewide consortium, BRN believes that OSHPD and/or the California Department of Public Health (CDPH) are in a better position to annually collect information on clinical placement slots, as they have statutory authority over health care facilities. BRN will analyze and report clinical placement slots for nursing students based on the data that OSHPD and/or CDPH collect.

## Comments

### CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE BOARD OF REGISTERED NURSING

To provide clarity and perspective, we are commenting on BRN's response to our audit. The numbers below correspond to the numbers we have placed in the margin of BRN's response.

Notwithstanding the other information that BRN asserts its governing board members consider, the nursing education staff do not typically present regional workforce data to the governing board. Further, as we note on page 19, nursing programs have cited nursing shortages as a reason for requesting an enrollment increase and referenced other forecasts to support their requests. However, BRN's forecasts do not include relevant regional information that would allow its nursing education staff to verify those assertions. Thus, BRN should ensure that the forecasts it is paying its contractor to develop every two years include regional variations in the projected supply and demand of nurses, to better inform the governing board's enrollment decisions.

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We recommended that BRN revise the scope of its contract for workforce forecasting services to incorporate regional analyses and ensure that the governing board's enrollment decisions and other actions adequately take into consideration those regional analyses in future forecasts. We did not recommend that BRN require nursing programs to provide a plan for evaluation of the total program on an annual basis.

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BRN misunderstands the time frames of our recommendations. We recommended that by January 1, 2021 BRN establish in policy the specific information its staff should present. As for the time frame for collecting the information, we recommended that BRN compile and aggregate the information by April 1, 2021. Although BRN expressed some concern in its response about promulgating regulations by April 1, 2021, we expect BRN to take actions to implement our recommendations and provide us documentation of its progress as part of its 60-day, 6-month, and 1-year responses.

③

BRN does not describe how the consortium—a group of nursing programs and health care facilities that work together to address clinical placement issues—it mentions in its response would function to address our recommendations. Moreover, we believe BRN can implement our recommendation without using a consortium to identify clinical placements as BRN suggests. Specifically, BRN is well-positioned to gather and analyze data regarding clinical placements. As we state on page 24 of our report, nursing programs must get BRN approval before using a clinical

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facility and BRN documents that approval on a facility approval form. Therefore, BRN should already have a record of all facilities that nursing programs are using for clinical placement slots. We believe that BRN can and should collect on the facility approval form the total number of clinical placement slots a clinical facility can accommodate annually and how many slots the programs that use the facilities will need each year.

- ⑤ We believe that it is imperative that BRN implement our recommendations to ensure its governing board has complete information about clinical placements when it is considering enrollment decisions. We look forward to BRN's 60-day, six month, and one-year response to our audit report, which should include documentation demonstrating the actions it is taking to implement our recommendations.
- ⑥ To clarify, we note on page 29 of our report that just because a nursing program is not using a facility does not necessarily mean the facility is available for use or willing to provide clinical placement slots for nursing students. However, we believe such a comparison and the necessary follow-up could identify additional clinical placement slots, thereby alleviating potential constraints on enrollment for nursing programs in areas with nursing shortages.
- ⑦ Nothing in our recommendation to the Legislature precludes BRN from taking the actions it identifies in its response. In fact, we believe these actions, if taken, would facilitate the Legislature's implementation of our recommendation.



## ***Board of Registered Nursing***

Executives Violated State Law When They Falsified Data  
to Deceive the State Auditor's Office

*June 2020*

**INVESTIGATIVE REPORT I2020-0027**





**CALIFORNIA STATE AUDITOR**

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June 30, 2020  
*Investigative Report I2020-0027*

The Governor of California  
President pro Tempore of the Senate  
Speaker of the Assembly  
State Capitol  
Sacramento, California 95814

Dear Governor and Legislative Leaders:

The California State Auditor (State Auditor), as authorized by the California Whistleblower Protection Act, conducted an investigation into allegations that executives within the Board of Registered Nursing (BRN) intentionally manipulated data and delivered a falsified report to my office in 2018 to satisfy a recommendation we had made during a 2016 audit of BRN's enforcement program.

The investigation substantiated that BRN executives violated state law when they carried out a plan to artificially decrease caseloads for BRN investigators before delivering a falsified report to my office. The plan involved temporarily reassigning some of BRN investigators' cases to other employees who should not have had the cases assigned to them. Within 10 days of my office reviewing the falsified report and concluding that BRN had fully implemented the audit recommendation, BRN managers reversed the reassignments, which increased caseloads to their original levels. The executives' deceitful actions obstructed our required follow-up to the audit recommendation and constituted gross misconduct.

The executives' behavior also undermined the trust that our office had with BRN. When we received the whistleblower complaint that precipitated this investigation, we were midway through fieldwork for a separate audit of BRN's oversight of prelicensure nursing school programs, audit 2019-120, which we anticipate publishing in July 2020. Consequently, that audit team closely reviewed the data it obtained from BRN and confirmed the reliability of the evidence the auditors used in readying their findings and recommendations for the forthcoming audit report.

We recommend that BRN take appropriate corrective action against the executives involved and that it take steps to address investigator caseloads and fully implement the recommendation from the 2016 audit. BRN must report to my office any corrective or disciplinary action it takes in response to recommendations we have made. Its first report is due August 12, 2020, which is 60 days after we notified it of the improper activity. It must continue to report monthly thereafter until it has completed corrective action.

Respectfully submitted,

A handwritten signature in black ink that reads "Elaine M. Howle". The signature is written in a cursive, flowing style.

ELAINE M. HOWLE, CPA  
California State Auditor

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## Investigative Results

### Results in Brief

After we received a whistleblower complaint alleging that Board of Registered Nursing (BRN) executives intentionally manipulated the data used to create a report, we initiated an investigation and found that three executives at BRN conceived and carried out a plan in late 2018 to manipulate data and provide a deliberately misleading report to the California State Auditor (State Auditor). The report falsely showed that BRN had decreased its investigators' caseloads enough to satisfy a recommendation the State Auditor had made to BRN in an audit report titled *Board of Registered Nursing: Significant Delays and Inadequate Oversight of the Complaint Resolution Process Have Allowed Some Nurses Who May Pose a Risk to Patient Safety to Continue Practicing*, 2016-046, December 2016.

Furthermore, our investigation revealed that one of those executives directed his subordinate managers to carry out the plan to deliberately change the caseload distribution information. Specifically, in November 2018, as the executive prepared documentation for the State Auditor's required follow-up to the 2016 audit recommendations, he directed two managers to reassign cases within BRN's case tracking system so that a caseload report would indicate that each BRN investigator had a caseload of 20 or fewer investigations. This threshold was based on statements by BRN's chief of investigations during the 2016 audit that a full caseload for BRN's investigators was 20 cases.

Knowing that the data misrepresented BRN investigators' actual caseloads, one of the BRN executives submitted the falsified report to the State Auditor's Office with the intent of convincing the State Auditor that it had fully implemented the recommendation. As BRN executives anticipated, the State Auditor's audit team (audit team) relied on BRN's manipulated data and declared the recommendation to have been fully implemented. The executives' actions obstructed the State Auditor from making a correct assessment regarding the status of the audit recommendation. The executives also demonstrated dishonesty by intentionally misrepresenting known facts, and their misdeeds brought discredit to BRN. The serious and egregious nature of the executives' overall behavior regarding this matter constituted gross misconduct.

### Relevant Criteria

Government Code section 8545.6 states that any officer or employee who, with intent to deceive or defraud, obstructs the California State Auditor in the performance of his or her official duties relating to a statutorily required audit is subject to a fine not to exceed five thousand dollars (\$5,000).

Government Code section 8547.2 provides that an improper governmental activity includes actions of gross misconduct undertaken by any state employee in the performance of the employee's duties. In general, gross misconduct is unacceptable behavior of the sort that typically results in dismissal of the offending employee.

Government Code section 19572 specifies that employee dishonesty constitutes a cause for discipline, and an employee who engages in "other failure of good behavior that causes discredit to the employee's agency or employment" is also subject to discipline.

## Background

BRN is responsible for implementing and enforcing the Nursing Practice Act, which establishes the laws related to the licensure, practice, and discipline of nurses. In its mission to protect the public, BRN regulates more than 430,000 licensed nurses who provide health care services to the public. It receives an average of about 8,500 complaints annually regarding licensed nurses and prospective nurse applicants.

To help ensure that BRN fulfills its mission and legal obligations, the State enacted a statute in 2015 that required the State Auditor to conduct an audit of BRN. In December 2016, the State Auditor's Office published report 2016-046, *Board of Registered Nursing: Significant Delays and Inadequate Oversight of the Complaint Resolution Process Have Allowed Some Nurses Who May Pose a Risk to Patient Safety to Continue Practicing*, which summarized the mandatory audit it conducted of BRN's enforcement program. In particular, the audit team found that BRN consistently failed to process complaints within the 18-month goal that its oversight agency, the Department of Consumer Affairs, had established. This failure to process complaints in a timely manner contributed to a backlog of more than 180 complaints against registered nurses as of July 2016. The audit team concluded that unnecessary delays in the complaint resolution process enabled nurses who were the subject of serious allegations to continue practicing and may have posed a risk to patient safety.

To enhance public safety, the State Auditor's report made several recommendations to BRN, including that it establish a plan to eliminate its backlog of complaints awaiting assignment to a BRN investigator. In BRN's required 60-day response to the audit, BRN claimed to have eliminated the backlog of cases, in part, by increasing the number of cases it assigned to its investigators from 20 to 25. However, the audit team concluded that this approach did not fully satisfy the recommendation because BRN's chief of investigations had confirmed during the initial audit that a full caseload for BRN's investigators was 20 cases. Therefore, the audit team determined that BRN had simply shifted—not eliminated—its backlog of complaints and that BRN had not yet fully implemented this recommendation. For the next year and a half, BRN continued to claim that it had fully implemented the recommendation, but because BRN never provided evidence that it had reduced investigator caseloads, the audit team did not agree.

State law compels the State Auditor to solicit responses from statutorily audited entities within 60 days, six months, and one year of an audit report's publication and annually thereafter until the audit team determines that each recommendation has

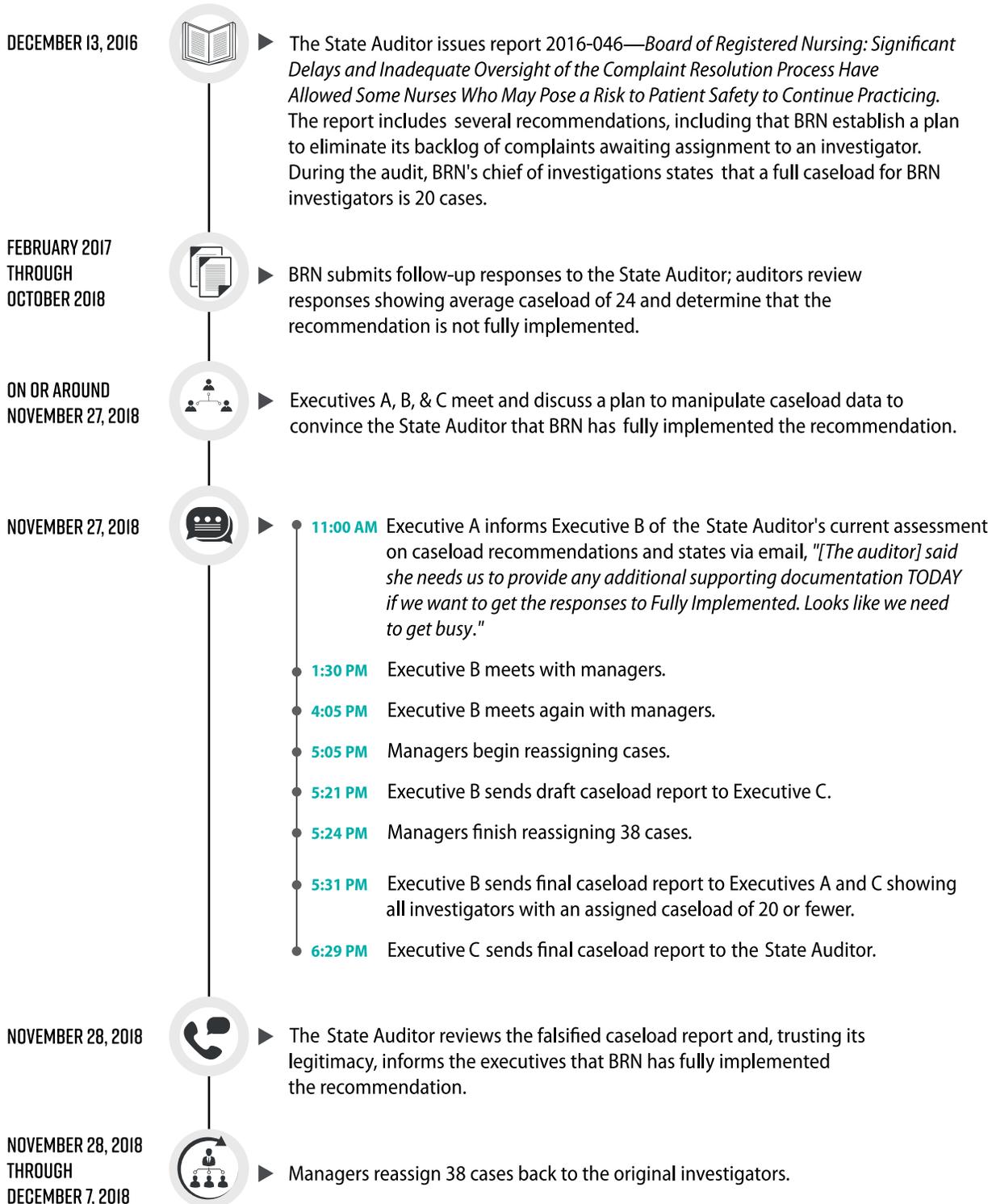
been fully implemented. Furthermore, the State Auditor must report to the Legislature the progress on any recommendations that agencies have not fully implemented within one year. In order to verify that an audited entity has fully implemented a recommendation, the State Auditor relies not only on the entity's claims, but it also requires that the entity supply the necessary data and documentation to substantiate any claims of progress or completion.

In its November 2018 annual update about progress toward implementing recommendations, BRN provided the caseload report that is the subject of this investigation and that demonstrated investigator caseloads of 20 or fewer for each member of its investigative team. The audit team reviewed the report and concluded that BRN had fully implemented the recommendation. As a result, the State Auditor's January 2019 report to the Legislature, *Recommendations Not Fully Implemented After One Year: The Omnibus Audit Accountability Act of 2006*, report 2018-041, reflected that BRN had fully implemented the recommendation in question from the original 2016 audit.

### **Executives Intentionally Manipulated Investigator Caseload Data Before Providing a Report to the State Auditor**

The investigation revealed that three BRN executives devised a plan to manipulate BRN's investigator caseload data to convince the State Auditor that it had fully implemented the recommendation from the 2016 audit about clearing its backlog of outstanding complaints. In November 2018, the State Auditor's Office reminded BRN that its annual update about its progress toward implementing recommendations from the 2016 audit would be due by the 27<sup>th</sup> of that month. When we interviewed Executive B and Executive C, they confirmed that they met with Executive A and discussed a plan to temporarily reassign investigations from investigators who carried more than 20 cases to managers and another employee who did not carry a caseload at the time. Executive B stated that other executives and managers were also present at this meeting as well. The plan involved producing a report for the audit team that showed that all investigators had a caseload of 20 or fewer and then shortly thereafter reshuffling the cases back to the original investigators. Figure 1 provides a timeline that describes when and how BRN executives carried out this plan.

*The plan to deceive the State Auditor involved producing a report for the audit team that showed that all investigators had a caseload of 20 or fewer and then shortly thereafter reshuffling the cases back to the original investigators.*

**Figure 1****Timeline of Events Leading Up to Submission of Falsified Caseload Report**

Source: Analysis of submitted responses, BRN's emails, BRN's case tracking system data, and interviews.

Executive B acknowledged that, following the meeting with Executives A and C, he put the plan into action. On the afternoon of November 27, 2018—the due date for providing an update to the State Auditor—he met with two managers who reported to him. They discussed the plan and he directed them to begin reassigning cases in BRN’s case tracking system. Then, shortly after 5 p.m., the managers engaged in what they later described to us as a hurried process of reassigning a total of 38 cases, sometimes reassigning cases multiple times, so that no investigator’s individual caseload exceeded 20 cases. To accomplish the goal of 20 cases or fewer per investigator, the managers reassigned 20 cases to one BRN investigator who was out on extended leave and was not anticipated to be back for more than a month. They also temporarily reassigned cases to one of the managers, even though managers do not typically carry their own caseloads. Shortly before 5:30 p.m., the managers finished the task and notified Executive B, who had been updating Executive A and Executive C on the reassignments. At some point, the managers notified BRN’s investigators that some of their cases would be or had been temporarily reassigned, but that they were still responsible for them.

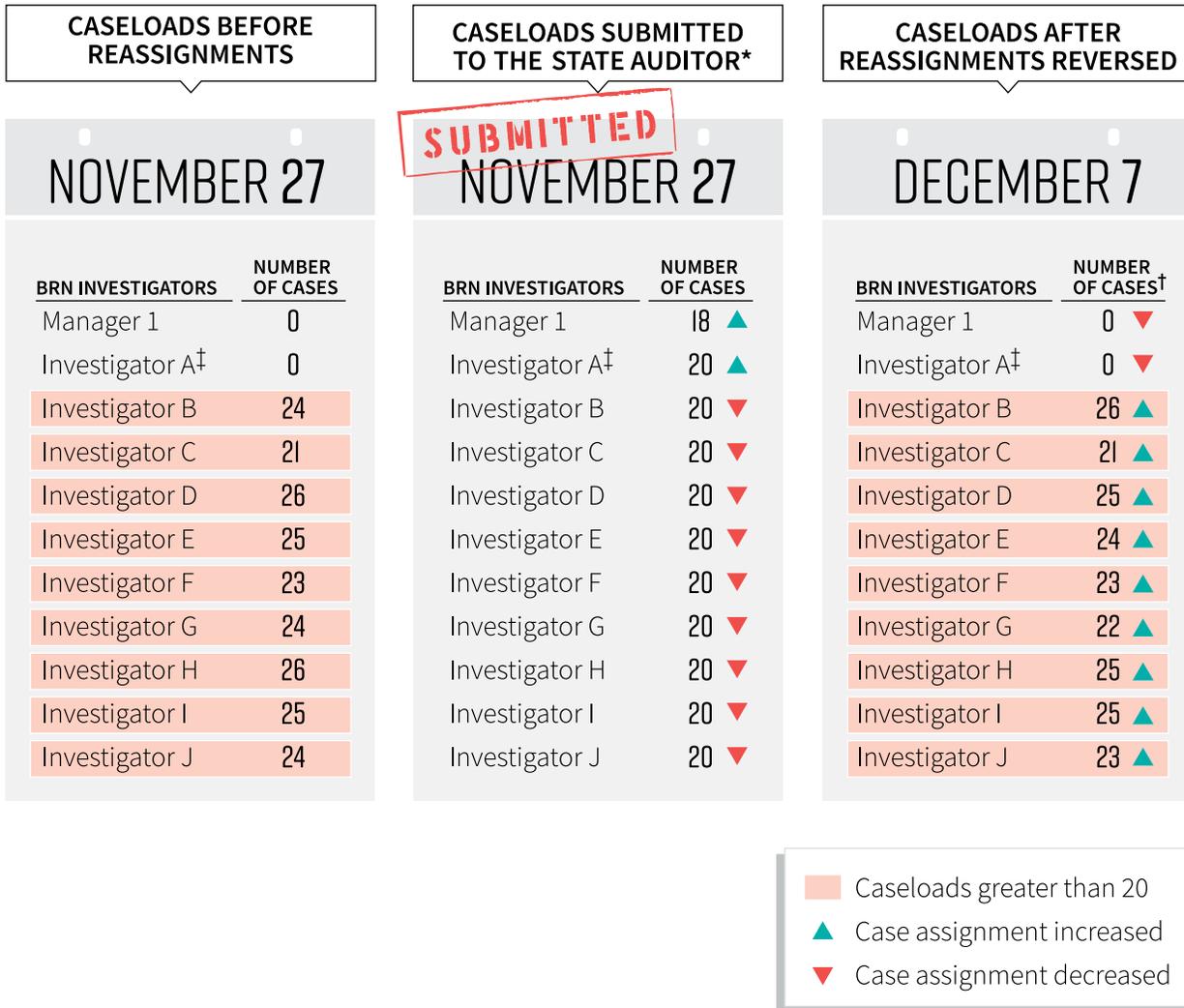
Although the two managers certainly played a key role in producing the manipulated report, their actions appear to have been at the direction of Executive B. Both managers acknowledged that the numbers in the caseload report were either “fudged” or “inaccurate” and that they either knew or assumed the report was intended for the State Auditor. They claimed to have objected to the plan and only proceeded after Executive B disregarded their concerns and provided a clear directive to move forward with the plan.

Once the managers finished their task, Executive B emailed to Executive C and Executive A the caseload report showing all investigators with caseloads of 20 or fewer. Executive C reviewed the documentation and an hour later emailed the caseload report, along with documentation related to other recommendations, to a member of the audit team.

The next day on November 28, the audit team reviewed the report—which it assumed was legitimate and truthful—and informed the executives that it would now credit BRN with having fully implemented the recommendation. That same day, the managers at BRN began reversing many of the assignments they had made fewer than 24 hours earlier to assist the executives with the falsified report for the State Auditor. Within 10 days of making the initial changes, the managers had reassigned all 38 cases back to the original investigators, and many had, yet again, caseloads in excess of 20 cases. Figure 2 demonstrates how managers shifted cases during the 10-day span in question. Since November 2018, many BRN investigators have continued to carry caseloads of as many as 26 cases.

***Both managers acknowledged that the numbers in the caseload report were either “fudged” or “inaccurate” and that they either knew or assumed the report was intended for the State Auditor.***

**Figure 2**  
Comparison of Caseload Report Manipulation



Source: Analysis of BRN’s case tracking system data.

\* Figure 2 displays a selection of the caseloads included in the report BRN submitted to the State Auditor.

<sup>†</sup> The managers reassigned the cases back to the original investigators between November 28, 2018, and December 7, 2018. During this time period, BRN closed some of the investigators’ cases and managers assigned new cases to some investigators, which affected their caseload totals.

<sup>‡</sup> Investigator A was out on extended leave during this time.

## The Executives' Obstruction Violated State Law and Constituted Gross Misconduct

The investigation revealed that the executives sought to deliberately obstruct the State Auditor from making an accurate determination of BRN's implementation of the recommendation, and that they achieved that obstruction with dishonest behavior. Both of these actions are violations of state law and, together, brought discredit to BRN and constituted gross misconduct.

When interviewed, both Executive B and Executive C admitted that they knew the caseload report they prepared and provided to the State Auditor was not an accurate reflection of the investigators' workloads. They also both acknowledged that the intent behind their plan was to appease the audit team so it would conclude that BRN had fully implemented the recommendation. They both expressed regret for having participated in the plan and said that they knew it was problematic or not the right approach. We were unable to interview Executive A, who is no longer employed by BRN, but the other executives credibly described that Executive A either came up with the idea to reassign cases or pushed to implement the plan. Executive B explained how he had one-on-one conversations with Executive A to provide updates about how the case reassignments were progressing.

All three executives' actions to intentionally send false data to the audit team obstructed the State Auditor from making an accurate determination of BRN's progress in implementing the recommendation—an official duty imposed on the State Auditor by state law. Therefore, in accordance with the law, the State Auditor will seek to impose a fine not to exceed \$5,000 on each of the executives involved.

Taken as a whole, the executives' behavior that led to and included the submission of the falsified report constituted gross misconduct: they violated several laws, including the obstruction statute, by presenting intentionally manipulated data to deceive the State Auditor—and ultimately the Legislature. Such deceit demonstrates dishonesty and a lack of integrity, and not only undermines the State Auditor's trust in the agency, but also brings discredit to BRN as a whole. For those reasons, the executives are subject to discipline for dishonesty and "other failure of good behavior."

During our investigation, we did not uncover any evidence that the executives provided any other false, incomplete, or inaccurate information with respect to the other 2016 audit recommendations. However, due to the nature of the misconduct

*All three executives' actions to intentionally send false data to the audit team obstructed the State Auditor from making an accurate determination of BRN's progress in implementing the recommendation.*

we discovered, the State Auditor will likely have to spend additional resources on future engagements with BRN to mitigate the risk that BRN might provide further incomplete or inaccurate information.

### Recommendations

To remedy the effects of the improper governmental activities identified by this investigation and to prevent those activities from recurring, we recommend that BRN take the following actions:

- Within 90 days, take appropriate corrective action against Executives B and C, and consider placing a notice of the investigation in Executive A's personnel file, as that individual has left BRN.
- Within 30 days, reassess investigator caseloads and determine the maximum number of cases that investigators should be assigned based on clear criteria.
- Within 90 days, work with the audit team to develop a satisfactory approach for fully implementing the 2016 audit recommendation.

### Summary of Agency Response

BRN stated that it takes the investigative findings and recommendations very seriously. It informed us that it initiated its own investigation and will take the appropriate corrective action based on the results of its investigation and that it plans to place a notice of the investigation in Executive A's personnel file. It also stated that it will begin reassessing investigator caseloads and establishing clear criteria for the maximum number of cases that investigators should be assigned. Finally, it is committed to working with the audit team to develop a satisfactory approach for fully implementing the audit recommendation.

Respectfully submitted,



ELAINE M. HOWLE, CPA  
California State Auditor

June 30, 2020



# California Newly Licensed RN Employment Survey Report

Fall 2019

June 9, 2020

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## INTRODUCTION

To better understand the employment landscape for newly licensed RNs in California, along with the prevalence of social determinants of health experienced by nursing students and RNs as they enter practice, a statewide study conducted annually by HealthImpact since 2010 was replicated again in fall 2019. The employment landscape for newly licensed RNs in California was relatively strong as of fall 2019, with 84.5% of new graduates licensed within the prior 12 months employed and working in their first RN position; 92.4% of which obtained employment within 6 months of RN licensure.

Following a slight decline seen in each of the prior two years, this most recent period indicates an improved job market for new graduate RNs entering the workforce. Acute care hospitals continue to be the largest type of employer hiring newly licensed RNs overall, with 59.3% of nurses reported to be working in Inpatient settings, 11.0% in Emergency Departments and Urgent Care, and 5.1% working in other types of hospital areas. Beyond acute care hospitals, 24.6% of newly licensed RNs are employed in various types of health care organizations and practice settings with diverse populations including ambulatory care services and community health. Employment patterns are comparable to the prior year, when 26.0% reported employment outside of acute care hospitals. The wide range of practice settings that employ newly licensed RNs provides evidence of the type of career options and opportunities available to nurses as they first enter practice.

Preparing the emerging nursing workforce with sufficient knowledge, skills, and attributes to perform competently in diverse practice settings, also presents challenges considering the complex health care needs of the population, and evolving health care systems. Providing transition to practice programs designed to support newly licensed RNs as they enter practice while developing skills and competencies performing in an RN role remains important. Of the RNs working in their first job, 53.1% reported participating in a new graduate transition to practice program.

California is an ideal greenhouse for nurturing new pathways to prosperity in America given its long history of technical innovation, cultural creativity, and civic optimism. However, anecdotal reports reveal students in higher education also experience challenges that threaten successful progression and completion, resulting in program attrition rates. To better understand the prevalence of social determinants of health that can impact education and student success, including factors that may impact well-being once employed, a set of new questions were included for the first time in this fall 2019 study.

POST STUDY NOTATION: This statewide employment survey conducted in late fall 2019 reflects education and employment patterns in the 12-month period prior to the COVID-19 pandemic. The state of emergency and response underway as this report was being prepared poses challenges to nursing programs with uncertain impact to the timely completion, graduation, licensure, and employment for some nursing students. Academic-practice collaboration remains essential to assure the preparation and supply of the emerging workforce will be able to meet evolving workforce demand in the near term.

## KEY FINDINGS

RNs newly licensed by exam in California in the prior 12-month period between September 2018 and August 2019 were invited to participate in the fall 2019 study. A total of 2,968 nurses completed the survey for a 24.3% survey response rate.

- 84.5% of RNs reported being employed and working in their first registered nursing job; an increase of 5.1% from the prior year indicating an improved job market for new graduate RNs entering the workforce.

- 92.4% of those employed found jobs within 6 months (67.0% in 3 months, 25.4% in 3-6 months).
- Percent of RNs employed by nursing degree: 84.0% ADN, 84.4% BSN, 93.2% Masters Entry (MEPN).
- Regional differences in employment rates were reported, ranging from areas with the highest percent of newly licensed RNs employed in the San Joaquin Valley (93.8%) and the Central Coast (92.9%) to areas with the lowest percent of newly licensed RNs employed in the Greater Sacramento (71.4%) and San Francisco Bay (76.6%) areas.
- Most frequently reported employment settings where greater than 2% of newly licensed RNs reported to be working include: Hospital Inpatient areas (59.3%) followed by Emergency Department/Urgent Care (11.0%), Nursing Home/Extended Care/Skilled Nursing or Group Home (5.1%), Rehabilitation/Long-Term Care (3.6%), other types of Hospital Departments (3.0%), Inpatient Mental Health/Sub-Acute Abuse (2.3%), and Home Health/Hospice (2.3%).
- 53.1% of RNs employed and working in their first job report participating in a new graduate transition to practice program; a slight increase of 0.6% from the prior year.
- The prevalence of social determinants experienced by students that can impact health, well-being and education during their nursing program, and once employed were evident; 25.1% of RNs reported experiencing a lack of resources to obtain or provide for basic needs such as food, clothing, housing, medical care, child or dependent care, or transportation during the time they were students, with some challenges continuing after graduation during their first year in practice.

## SURVEY REPORT – EMPLOYMENT EXPERIENCES OF NEWLY LICENSED RNS

### 1. DESIGN AND SAMPLE

All RNs newly licensed for the first time by exam in California between September 2018 and August 2019 were identified by the BRN and invited to participate in the survey. This was an increase from prior years when only 50% of those licensed in the prior year were randomly selected and invited to participate in the study. Each nurse received an invitation email addressed from Dr. Joseph Morris, Executive Officer of the BRN, in early November 2019, requesting they participate in the study by completing an online survey. Of the 12,583 RNs in the BRN database that met criteria, 12,249 survey invitations were disseminated to those with an email address on file, and 52 others with email reported as “undelivered”. A total of 2,968 nurses completed the survey, for a 24.3% survey response rate. Initial review identified and removed 96 records from the database from respondents indicating they either resided out of state (66) or reported obtaining their RN license before or after the 12-month period included in the study. A final total of 2,873 respondents that met criteria were analyzed in this report. No personal identification information was requested, and results were reported only in aggregate. The margin of error rate for this survey of 1.6% was calculated at a 95% level of confidence. This should be kept in mind when interpreting findings throughout this report as small changes from the prior year that fall within this margin of error rate may not be statistically significant.

### 2. RESPONDENT PROFILE

The profile of RNs newly licensed within the prior 12-month period and residing in California participating in this survey included 93.6% (n=2,688) who completed their nursing program in California, and 6.0% (n=171) in another state, and 0.4% (n=14) in another country. All RNs were newly licensed by exam in California between September 2018 and August 2019 in the 12 months prior to the survey. Peak months when RN licenses were obtained typically followed graduation twice a year as anticipated, in summer between July (25.9%) and August 2019 (19.3%), followed next in frequency in spring in either February (11.2%) or March (9.6%) 2019. The

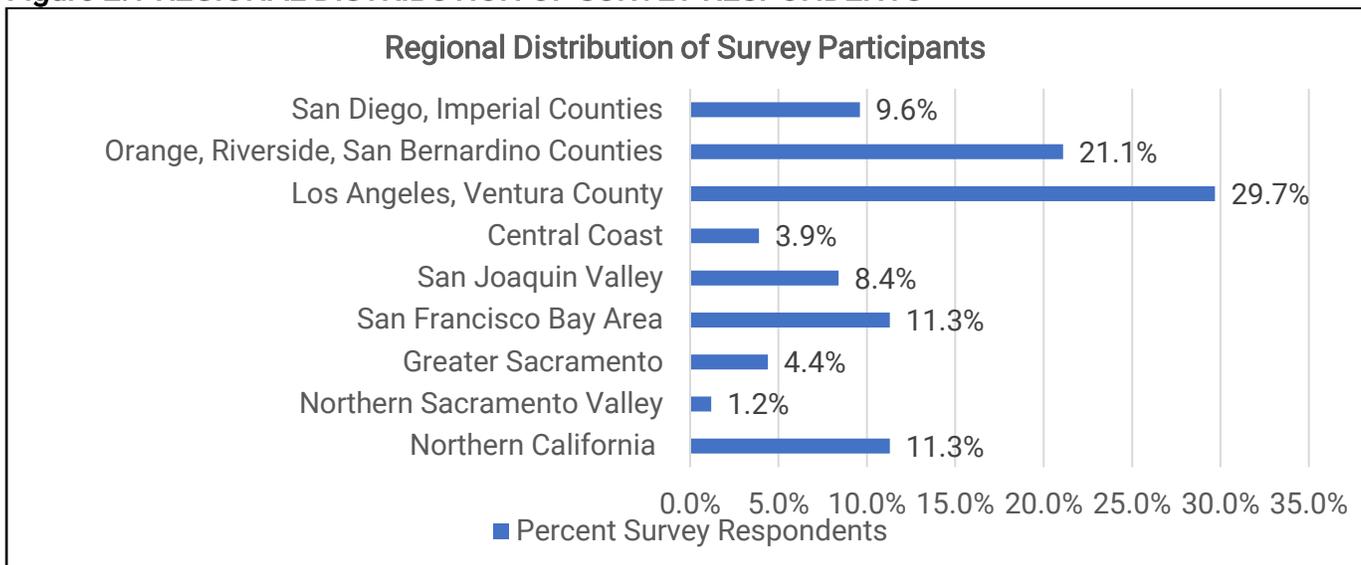
balance of nurses (33.0%) reported obtaining their RN license fairly evenly distributed across each of the remaining 8 months across the survey period.

Of the 2,873 RN respondents, 51.9% (n=1,489) graduated with an associate degree in nursing (ADN), 44.5% (n=1,276) with a baccalaureate degree in nursing (BSN), and 3.6% (n=103) from an entry level master’s program in nursing (ELM or MEPN). The distribution of survey respondents closely approximates the pattern of RN pre-licensure students reported to have completed their RN program by type of degree in the most recent 2017-2018 California BRN Annual School Report, with 47.8% ADN, 42.8% BSN, and 6.7% ELM respectively.<sup>1</sup>

The geographic distribution where survey respondents reside is representative of and consistent with patterns of population density in each area, with 29.7% residing in the Los Angeles/Ventura area; 21.1% in Orange, Riverside, and San Bernardino counties; 11.3% in the San Francisco Bay Area; 11.3% in Northern California; 9.6% in the San Diego/Imperial County area; 8.4% in the San Joaquin Valley; 4.4% in the Greater Sacramento area; 3.9% in the Central Coast, and 1.2% in the Northern Sacramento Valley, as displayed in Figure 2.1.

With greater numbers of new graduates participating from the more densely populated areas, aggregate statewide survey findings are similarly influenced, thus results largely represent the employment experiences within these large metropolitan regions. Notable employment patterns and differences unique to each of 9 regions were analyzed and discussed in the employment section later in this report.

**Figure 2.1 REGIONAL DISTRIBUTION OF SURVEY RESPONDENTS**



The age distribution of survey respondents in order of frequency indicates 35.9% are between 25-30 years of age; 24.6% less than 25 years; 18.3% are between 31-35 years of age; 10.4% age 36-40; 6.2% age 41-45; 2.9% age 46-50; and 1.8% over 50 years of age. The age range for entry into nursing practice is consistent with historical and national trends, with nursing attracting a younger age group of career-oriented professionals. Survey respondents were 83.1% female and 16.6% male, 0.2% non-binary, with 0.1% preferring no response.

California’s nursing workforce diversity is demonstrated by the wide range of ethnicities reported by survey respondents, including: 38.5% Caucasian/White, followed by 22.9% Latino/Hispanic, 13.1% Native Hawaiian/Pacific Islander, 12.9% Asian, 4.9% African American/Black/African, and 0.5% American Indian/Native American/Alaskan Native. A detailed listing of specific ethnicities included within each category is displayed in Table 2.1.

<sup>1</sup> Blash, T., Spetz, J. 2017-2018 Annual School Report: Data Summary and Historical Trend Analysis. Sacramento, CA: California Board of Registered Nursing, July 2019.

**Table 2.1 ETHNIC DISTRIBUTION OF SURVEY RESPONDENTS**

Category	Percent	Ethnic Groups Included
<b>Caucasian</b>	38.5%	Caucasian, White, European, Middle Eastern
<b>Latino/Hispanic</b>	22.9%	Central American, South American, Cuban, Mexican, Other Hispanic
<b>Native Hawaiian/ Pacific Islander</b>	13.1%	Fijian, Filipino, Guamanian, Hawaiian, Samoan, Tongan
<b>Asian</b>	12.8%	Cambodian, Chinese, Indian, Indonesian, Japanese, Korean, Laotian/Hmong, Pakistani, Thai, Vietnamese
<b>African American</b>	4.9%	African American, African, Black
<b>Native American</b>	0.5%	American Indian, Alaskan Native
<b>Other/Mixed</b>	6.0%	Other/Mixed
<b>Prefer to Not Answer</b>	1.3%	Not Reported

While English was reported to be the only language spoken by 53.5% of respondents, a total of 67 other languages were reported to be spoken fluently. Data were obtained for each of the 16 most commonly spoken languages, with other languages invited to be written in through an open answer option.

**Table 2.2 LANGUAGES SPOKEN FLUENTLY**

Language	Percent
Arabic	0.4%
Armenian	1.0%
Cambodian	0.6%
Chinese	3.3%
Farsi	0.8%
Hindi	1.5%
Hmong	0.7%
Japanese	0.5%
Korean	2.0%
Laotian	0.1%
Punjabi	1.4%
Russian	1.5%
Spanish	22.8%
Tagalog	7.7%
Thai	0.3%
Vietnamese	2.0%
<u>Other languages:</u> American Sign Language, Assyrian, Bisaya, Bosnian, Burmese, Cantonese Chinese, Chamorro, Creole, Croatian, Dutch, Ethiopian, French, German, Gujarati, Igbo, Hebrew, Hiligaynon, Igbo, Ilocano, Italian, Indonesian, Kapampangan, Kiswahili, Lithuanian, Luganda, Malaysian, Mien, Navaho, Nigerian, Mien, Norwegian, Pashto, Patois, Polish, Portuguese, Romanian, Shanghainese, Sinhalese, Siswati,	5.5%

### 3.SOCIAL DETERMINANTS OF HEALTH AND EDUCATION

This statewide study provides evidence of the prevalence of social determinants as reported by the population of RNs who successfully completed their RN prelicensure nursing program as newly licensed RNs and when the respondents were nursing students. These findings should be considered a minimum rate for nursing students in prelicensure RN programs considering the prevalence and/or impact of social determinants are thought to be greater in the population of students who did not complete their nursing program and were not part of this study. Student attrition rates provide an indication of the need to identify and effectively address factors that impact student success and program completion. In the prior year, attrition rates reported by 136 California RN Prelicensure programs<sup>2</sup> ranged from less than 5% (n=50), to 5-10% (n=38), 11-15% (n=13), 16-20% (n=18), and greater than 20% (n=17).

A social determinants framework is helpful to identify the social, economic, educational, and environmental barriers that can impede a student’s success from enrollment through graduation, and into employment. Students from economically and educationally disadvantaged backgrounds can experience some of the greatest challenges stemming from a lack of resources. Evidence suggests that a diverse healthcare workforce that is racially, ethnically, and socioeconomically aligned are more likely to practice in communities with similar populations, improving access to culturally competent care, health equity, and improved health outcomes. Key factors experienced by students and self-reported in this study that most often present challenges are displayed in Tables 3.1, 3.2, 3.3 and 3.4.

**Table 3.1 FAMILY BACKGROUND**

Family Background		
<b>Family Economic Status</b>		<b>N=2,241</b>
Long-term poverty		7.1%
Working class		27.4%
Lower middle class		19.9%
Middle class		31.6%
Upper middle class		12.1%
Wealthy		0.6%
<b>Highest Level of Parent Education</b>		<b>N=2,858</b>
<b>Degree</b>	<b>Mother or Parent/Guardian #1</b>	<b>Father or Parent/Guardian #2</b>
Do not know	6.5%	8.6%
Grade School	9.9%	8.9%
Some High School (did not complete)	7.2%	7.0%
High School Diploma or GED	19.2%	20.2%
Some College (did not complete)	17.6%	17.4%
Associate degree	10.2%	8.7%
Bachelor’s Degree	20.7%	18.5%
Some Graduate School (did not complete)	0.8%	0.7%
Master’s Degree	6.3%	6.8%
Doctoral Degree	1.6%	3.2%

<sup>2</sup> California Board of Registered Nursing, RN Accreditation, Attrition, and on Time Completion Rates Report, 2018-2019.

**Table 3.2 BASIC NEEDS**

<b>Basic Needs</b>			
<b>During Time in School N=2,301</b>	<b>Living Situation/Housing</b>		<b>Now N=1,622</b>
5.0%	Did/do not have a steady place to live		3.2%
16.3%	Worried about losing a steady place to live		7.8%
78.7%	Had/have a steady place to live		89.0%
<b>During Time in School N=721</b>	<b>Unable to Get or Provide What Was Needed N=721 (25.1%) of all RN respondents (option to select more than 1 answer)</b>		<b>Now N=721</b>
56.3%	Health care or medicine		19.0%
33.1%	Clothing		5.4%
31.1%	Food		5.8%
30.9%	Utilities		6.1%
27.6%	Childcare		7.1%
15.3%	Dependent adult or sibling care		3.9%
30.9%	Transportation		6.7%
<b>1-Way Commute Time During School (shortest average) N=1,822</b>	<b>1-Way Commute Time During School (longest average) N=1,427</b>	<b>One Way Commute Time</b>	<b>1-Way Commute Time to Work N=1,490</b>
67.3%	28.0%	1-30 minutes	60.4%
23.8%	36.2%	31-59 minutes	26.6%
6.8%	22.6%	60-89 minutes	9.2%
2.1%	13.2%	90 minutes or more	3.8%

**Table 3.3 FINANCIAL RESOURCES**

<b>Financial Resources</b>	
<b>Funding Sources Used to Pay for Education (option to select more than 1 answer)</b>	<b>N=2,240</b>
Student's own savings or income	61.1%
Federal or state loans	53.8%
Grants	34.8%
Scholarships	32.0%
Student's personal credit card	30.7%
Parent savings or income	27.7%
Private loans	26.5%
Parent loans or credit card	10.2%
<b>Amount of Student Debt at Time of Academic Program Completion</b>	<b>N=1,935</b>
Maximum	\$200,000
Median	\$29,000
Mean	\$42,000
<b>Level of Confidence to Pay Back Student Loans or Education Debt</b>	<b>N=2,188</b>
Very Concerned	9.7%
Some Concern	19.3%
Confident	21.1%
Very Confident	23.1%
Not Applicable/No Student Loans or Education Debt	26.8%

**Table 3.4 PHYSICAL AND MENTAL HEALTH**

<b>Physical Health Status</b>			
<b>During Time in School N=1,999</b>	<b>Overall Health</b>		<b>Now N=1,934</b>
2.6%	Poor		0.8%
9.7%	Quite Poor		3.2%
31.8%	Fair		24.1%
34.3%	Quite Good		43.7%
21.6%	Very Good		28.2%
<b>Mental Health Status</b>			
<b>During Time in School N=2,242</b>	<b>Level of Stress</b>		<b>Now N=1,775</b>
46.1%	Very much		16.3%
32.7%	Quite a bit		24.0%
14.4%	Somewhat		31.9%
5.0%	A little bit		22.2%
1.8%	Not at all		3.6%
<b>During Time in School N=2,067</b>	<b>Feeling Down, Depressed, or Hopeless</b>		<b>Now N=1,831</b>
6.1%	Nearly every day		3.7%
15.6%	More than half the time		9.6%
39.1%	Several days a month		32.3%
39.2%	Not at all		54.5%
<b>During Time in School N=2,202</b>	<b>Feeling Lonely or Isolated</b>		<b>Now N=1,686</b>
11.2%	Always		4.5%
29.6%	Often		15.2%
28.9%	Sometimes		31.0%
16.5%	Rarely		30.4%
13.7%	Never		19.0%
<b>Feeling Talked Down To</b>	<b>Personal Family or Friends N=2,145</b>	<b>During Time in School N=2,145</b>	<b>Now N=2,072</b>
Frequently	2.2%	2.3%	1.4%
Often	4.2%	5.1%	3.5%
Sometimes	16.5%	17.4%	15.3%
Rarely	18.2%	17.9%	17.3%
Never	58.9%	57.3%	62.4%
<b>Physical Harm or Threat</b>			
<b>Physically Hurt</b>	<b>Personal Family or Friends N=2,153</b>	<b>During Time in Nursing Program N=2,150</b>	<b>Work Environment N=2,079</b>
Frequently	0.3%	0.2%	0.1%
Often	0.6%	0.3%	0.4%
Sometimes	3.1%	2.0%	1.8%
Rarely	7.5%	3.1%	3.7%
Never	88.5%	94.5%	94.0%
<b>Threatened with Harm</b>	<b>Personal Family or Friends N=2,140</b>	<b>During Time in Nursing Program N=2,138</b>	<b>Work Environment N=2,072</b>
Frequently	0.2%	0.1%	0.4%
Often	0.6%	0.4%	0.5%

Sometimes	2.7%	1.8%	2.3%
Rarely	6.8%	3.8%	3.6%
Never	89.7%	93.9%	93.1%
Experienced Bias or Discrimination			
During Time in School N=2,149	Race		Now N=2,124
1.1%	Always		0.8%
2.8%	Often		2.0%
14.5%	Sometimes		11.9%
16.5%	Rarely		16.6%
65.1%	Never		68.7%
N=2,131	Ethnicity		N=2,107
1.1%	Always		0.9%
2.6%	Often		1.8%
13.2%	Sometimes		11.9%
15.8%	Rarely		16.1%
67.3%	Never		69.2%
N=2,106	National Origin		N=2,083
0.9%	Always		0.8%
1.6%	Often		1.1%
9.0%	Sometimes		6.9%
11.7%	Rarely		11.8%
76.9%	Never		79.4%
N=2,117	Gender Identity or Sexual Orientation		N=2,086
0.2%	Always		0.2%
1.6%	Often		1.2%
6.2%	Sometimes		5.5%
9.6%	Rarely		9.6%
82.3%	Never		83.5%
N=2,114	Religious Belief		N=2,079
0.4%	Always		0.2%
1.0%	Often		0.8%
4.8%	Sometimes		3.4%
7.9%	Rarely		8.7%
86.8%	Never		86.9%
N=2,136	Age		N=2,104
1.5%	Always		1.5%
5.2%	Often		4.4%
16.2%	Sometimes		14.5%
15.7%	Rarely		17.4%
61.2%	Never		62.3%
N=2,103	Political Affiliation		N=2,073
0.8%	Always		0.4%
1.2%	Often		0.8%
4.3%	Sometimes		3.5%
7.6%	Rarely		8.7%
86.2%	Never		86.7%
N=2,085	Pregnancy Status		N=2,060
0.1%	Always		0.0%
0.4%	Often		0.1%

1.3%	Sometimes	1.1%
2.4%	Rarely	2.0%
95.8%	Never or Not Applicable	96.7%
<b>N=2,172</b>	<b>Military or Veteran</b>	<b>N=2,061</b>
0.0%	Always	0.0%
0.1%	Often	0.0%
0.5%	Sometimes	0.4%
1.4%	Rarely	1.6%
98.1%	Never or Not Applicable	98.0%
<b>N=2,071</b>	<b>Disability</b>	<b>N=2,051</b>
0.3%	Always	0.1%
0.6%	Often	0.2%
1.6%	Sometimes	1.0%
2.0%	Rarely	2.0%
95.5%	Never or Not Applicable	96.6%

While all of the RNs in this survey completed their RN prelicensure programs, 5.6% reported experiencing challenges that temporarily interrupted or delayed on-time completion for a combination of personal, health, or financial reasons, as well as academic performance issues. The primary reasons for delay are displayed in Table 3.5. The population of nurses invited to participate in this survey were all licensed RNs, however 5.0% reported not passing the NCLEX RN licensing exam the first time, and taking it a second time (4.1%), a third time (0.8%), or more (0.1%). Special accommodations were made for 1.0% students while taking the NCLEX RN licensing examination that had limitations or disabilities that impacted test taking including: extra time 0.8%, a separate room 0.7%, or special equipment 0.2%.

**Table 3.5 FACTORS CAUSING DELAY IN ACADEMIC COMPLETION**

Factors		
Reasons		N=2,869
No, did not "step out" or take a leave		94.4%
Personal reasons		2.9%
Health related concern		1.6%
Academic performance (failed, repeated one or more courses)		0.7%
Financial need		0.4%

#### 4. EMPLOYMENT AND TYPE OF JOBS RNS OBTAINED

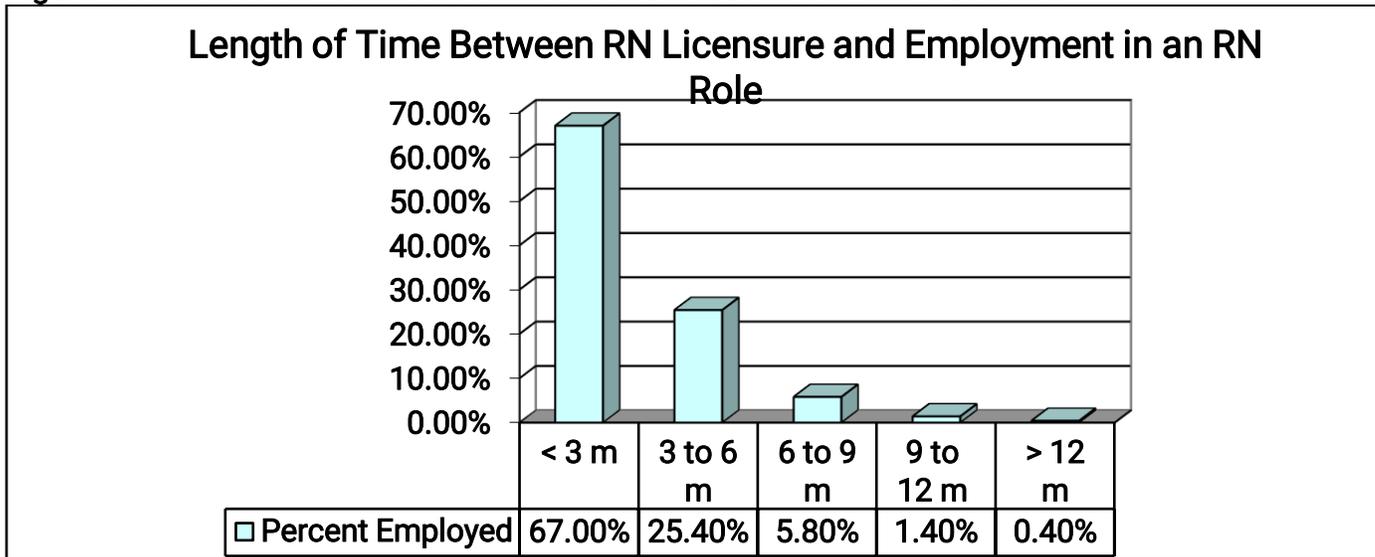
The majority of newly licensed RNs responding to the survey reported being employed as an RN, with 84.6% working in their first registered nursing job, and 15.4% not yet working as a registered nurse. These results show marked improvement in the rate of new graduate employment compared with the past two years and indicate a relatively strong employment landscape. (Table 4.1) The change in employment rate reported from the prior year given the calculated margin of error rate of 1.6% can be considered statistically significant. Monitoring employment trends over time provides evidence of employment opportunities and potential challenges aligned with workforce demand.

**Table 4.1 EMPLOYMENT OF NEWLY LICENSED RNS**

Survey Year	2013	2014	2015	2016	2017	2018	2019
Percent RNs Employed	59.3%	65.1%	74.2%	84.7%	81.1%	79.5%	84.5%

Those employed at the time of the survey were asked how long it was from the time they were licensed as an RN to when they begin working as an RN. The pattern of employment intervals reported is consistent with prior years, with less than 1% variation found year to year. As of fall 2019, 67.0% of respondents reported being employed within three months; 25.4% between 3-6 months, 5.8% between 6-9 months, 1.4% in 9-12 months, and 0.4% more than 12 months as displayed in Figure 4.1. Employment within 6 months of licensure reported to be 92.4% as of fall 2019, was 0.3% higher than the prior year.

**Figure 4.1 LENGTH OF TIME BETWEEN RN LICENSURE AND EMPLOYMENT**



Employment rate by type of nursing degree is an indicator of workforce needs, hiring trends and employer preferences. Of the nurses employed in their first job, 84.0% of ADN nurses were working, 84.4% of BSN nurses, and 93.2% of RNs graduating from a master’s Entry Program in Nursing. While no appreciable differences were found in the employment rate of ADN and BSN RNs, the employment rate for ELM RNs was reported to be higher by comparison as displayed in Table 4.2.

**Table 4.2: EMPLOYMENT OF RNS BY LEVEL OF EDUCATION**

Survey Respondents N=2,868	Employment of RNs by Type of Nursing Degree		
	ADN 51.9% (N=1,489)	BSN 44.5% (N=1,276)	ELM 3.6% (N=103)
<b>Employed as RN 84.5% (N=2,424)</b>	84.0%	84.4%	93.2%
<b>Not Employed as RN 15.5% (N=444)</b>	16.0%	15.6%	6.8%

Notable differences in new graduate employment rates are reported by newly licensed RNs residing in different regions of the states (Table 4.3) from a low of 71.4% in the Greater Sacramento Valley, followed by the San Francisco Bay Area with 78.6% employed, to a high of 93.8% in the San Joaquin Valley, followed closely by the Central Coast with 92.9%. While the overall patterns of employment reported between regions have been fairly consistent with prior years, all areas reported an increase in the employment rate as of fall 2019 except for the

Greater Sacramento and Orange/Riverside/San Bernardino Counties areas. The supply of newly licensed RNs is currently meeting employer demand overall. During this same period, California hospital chief nursing officers indicated demand for new RN graduates was generally weak across the state on average, with only the Central California region indicating a perception of moderate demand, as reported in the fall 2018-2019 Survey of Nurse Employers.<sup>3</sup>

**Table 4.3: EMPLOYMENT RATES BY GEOGRAPHIC AREA OF CALIFORNIA**

Geographic Area	Employed as an RN	Not Employed as an RN	Number of Respondents*
Northern California	87.4% (285)	12.9% (41)	226
Northern Sacramento Valley	89.5% (34)	10.5% (4)	38
Greater Sacramento	71.4% (90)	28.6% (36)	126
San Francisco Bay Area	76.6% (249)	23.4% (76)	325
San Joaquin Valley	93.8% (227)	6.2% (15)	242
Central Coast	92.9% (104)	7.1% (8)	112
Los Angeles/Ventura Counties	84.2% (692)	15.9% (131)	823
Orange/Riverside/San Bernardino Counties	89.5% (511)	15.5% (94)	605
San Diego/Imperial County	85.9% (237)	14.1% (39)	276

\* Regional results of local interest are provided; however, areas with small sample sizes may limit findings from being representative of the region overall.

Respondents reported working in their first RN role across various types of facilities, in different clinical practice settings and specialties during the 12-month period surveyed. A majority (75.4%) of those employed report working in acute care hospitals, most often in an inpatient care setting (59.3%), or in an emergency department or urgent care setting (11.0%) as reported in Tables 4.4 and 4.5, respectively. Patterns of practice settings and types of specialties are consistent with prior years, found to be preferred career choices for newly licensed nurses, as well as indicating where employers typically hire large numbers of new graduates.

The percent of newly licensed RNs newly employed in hospital-based settings this past year is slightly greater than the percent of all RNs in California reported to be working in hospital-based employment settings, reported to be 66.3% in the prior survey of all RNs in California 2016.<sup>4</sup> Small but consistent trends year to year reflect an ongoing shift, with new graduates also employed in a broader range of non-acute and community health settings, along with employment trends for experienced RNs moving from acute care to diverse non-acute care roles throughout their nursing careers.

**Table 4.4 TYPES OF FACILITIES NEW GRADUATE NURSES ARE EMPLOYED**

Type of Facility	Percent Employed (N=2,251)
Hospital	75.4%
• Inpatient Care	59.3%
• Emergency/Urgent Care	11.0%
• Other Type of Department	3.0%
• Ambulatory Care (Outpatient Surgery, Clinic etc.)	1.0%
• Nursing Home Unit	0.8%

<sup>3</sup> Bates, T., Chu, L., Spetz, J. Survey of Nursing Employers in California, fall 2018-2019: Philip R. Lee Institute for Health Policy Studies, University of California San Francisco. April 2020.

<sup>4</sup> Spetz, J., Chu, L., Jura, M., Miller, J. 2016 Survey of Registered Nurses. (biannual) Sacramento, CA: California Board of Registered Nursing, September 2017.

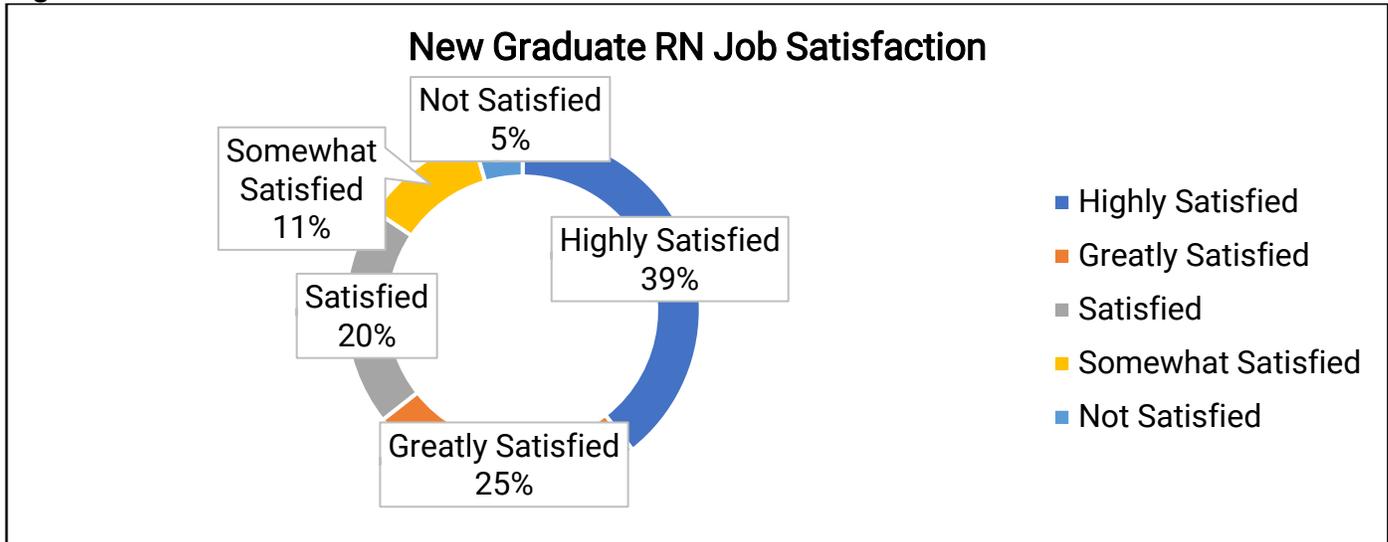
• Home Health	0.2%
• Ancillary Unit	0.1%
Nursing Home/Extended Care/Skilled Nursing/Group Home	5.1%
Rehabilitation Facility/Long-Term Acute Care	3.6%
Inpatient Mental Health/Sub-Acute Abuse	2.3%
Home Health Agency (including hospice)	2.3%
Ambulatory Surgery Center (free-standing)	1.3%
Correctional Facility/Prison/Jail	1.2%
School Health (K-12 or college)	1.2%
Public Health or Community Health Agency (not a clinic)	1.1%
Public or Community Clinic, Rural Health Center	1.0%
Private Medical Practice, Physician Office, Clinic	0.8%
Urgent Care (non-hospital)	0.5%
Outpatient Mental Health/Substance Abuse	0.4%
Inpatient Hospice (not hospital-based)	0.3%
Occupational Health or Employee Health Service	0.2%
Government Agency (other than public/community health or corrections)	0.2%
Self-Employed	0.2%
Call Center/Telemedicine	0.1%
University/College Academic Department	0.0%

**Table 4.5 CLINICAL AREAS NEW GRADUATE NURSES PRACTICE**

Percent Employed (N=2,251)			
General Medical-Surgical	21.0%	Oncology	2.2%
Critical Care/Intensive Care	10.7%	Ambulatory Care/Specialty	1.8%
Telemetry	9.9%	Mother-Baby/Newborn	1.7%
Emergency Care/Trauma	9.4%	Home Health	1.7%
Geriatrics	4.4%	Work in Multiple Areas	1.3%
Psychiatry/Mental Health	4.2%	Orthopedics	1.3%
Pediatrics	3.5%	Primary Care	1.2%
Labor and Delivery	3.3%	Dialysis	1.2%
Rehabilitation	3.3%	Hospice	1.1%
Step-Down or Transitional Care	3.0%	Community/Public Health	0.9%
Surgery/Pre-Op/Post-Op/PACU	2.8%	School Health K-12, Post-Secondary Education	0.8%
Cardiology	2.7%	Corrections	0.7%
Neonatal Care	2.3%	Obstetrics/Gynecology	0.5%

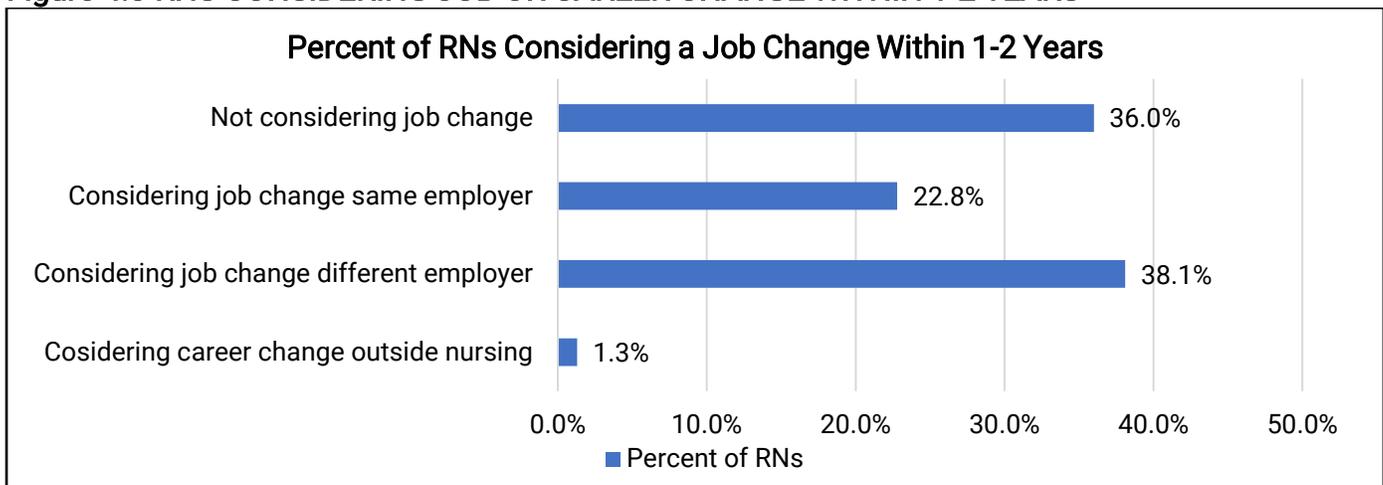
Nurses were asked about their level of job satisfaction in their first RN position, and whether they were considering a job change in the next 1-2 years. A majority of respondents (84%) report being highly satisfied, greatly satisfied, or satisfied with their first RN position as shown in Figure 4.2.

**Figure 4.2 JOB SATISFACTION**



While a majority reports being satisfied with their first job, 62.2% of RNs also indicated they are or would consider a job change in the next 1-2 years. Of those, 22.8% interested in a job change plan to stay with the same employer, 38.1% are considering working for a different employer, and 1.3% indicate a career change outside of nursing is an option, as displayed in Figure 4.3. These findings illustrate the need to understand why newly licensed RNs consider changing jobs within the same employer or migration from one organization to another. Additionally, further investigation is needed to understand why 1.3% of nurses are considering a career change given the time and resources spent thus far on a nursing career. Employers are encouraged to evaluate RN interest in and satisfaction with their current position, as well as the work environment itself and engagement within the organization overall, taking steps to address key drivers of dissatisfaction and options for professional growth.

**Figure 4.3 RNS CONSIDERING JOB OR CAREER CHANGE WITHIN 1-2 YEARS**



Percent's do not add up to 100% due to rounding

These findings highlight the importance for employers to anticipate RN turnover from those that are satisfied with their current role in the short term, explore what motivates them to learn and grow professionally, and provide opportunities within the overall organization for nurses to advance in their careers. In addition to professional satisfaction, employers are encouraged to evaluate the work environment itself and provide options for RN contribution, involvement, engagement, and leadership in changes and improvements, taking steps to address key drivers of dissatisfaction that may lead to dissatisfaction and turnover.

Interest in changing jobs arising from job dissatisfaction can be an indication of nursing burnout that influences turnover, and/or may lead to the decision to abandon the practice of nursing. A combination of factors arising from the work environment itself involving role expectations and workload, along with individual capability, interpersonal relationships and social determinants that may contribute to nursing burnout are important implications for practice and further research. Of the RNs responding to this study, 16.5% reported experiencing feelings of burnout within their first year of employment as shown in Table 4.6.

**Table 4.6 BURNOUT WITHIN THE FIRST YEAR OF EMPLOYMENT**

Level of Burnout	Percent (N=2,243)
I enjoy my work, and have no symptoms of burnout	34.3%
Occasionally I am under stress and do not always have as much energy as I once did, but do not feel burned out	49.2%
I am definitely burning out, and have one or more symptoms of burnout, such as physical and emotional exhaustion	13.9%
The symptoms of burnout that I am experiencing will not go away. I think about frustration at work a lot.	1.7%
I feel completely burned out and often wonder if I can go on. I am at a point where I may need some changes or may need to seek some sort of help.	0.9%

Among respondents that indicated they were not yet working as an RN, 23.3% reported looking for a job fewer than 3 months, 52.0% 3-6 months; 16.4% 6-9 months; 6.7% 9-12 months and 1.7% longer than 12 months. Nurses not yet employed as an RN indicated the two most frequently reported reasons given by potential employers for not extending a job offer were lack of experience for the position (77.0%) and BSN degree either preferred or required (34.1%) as displayed in Table 4.7.

**Table 4.7 REASONS FOR DIFFICULTY FINDING EMPLOYMENT REPORTED BY RNs**

Reported by Newly Licensed RNs Not Yet Employed	2017	2018	2019
No RN experience	79.1%	72.9%	77.0%
Lack of a (minimum) of a BSN degree	39.5%	21.1%	34.1%
Reported by California Hospitals <sup>5</sup>			
Require a minimum amount of experience prior to hire (usually 12 months)	51.9%	41.7%	48.3%
Prefer a minimum of a BSN degree upon hire	53.8%	54.9%	54.3%
Require a minimum of a BSN degree upon hire	3.8%	9.0%	18.0%

RN perception or understanding of employer preference for RNs to have a minimum of a BSN degree upon hire increased compared with the prior year and is consistent with trends also reported by California employers. While a majority of hospitals (54.3%) responding to the most recent Survey of Nursing Employers in California report a preference for hiring bachelor’s-trained RNs consistent with the previous three years, 18% report a bachelor’s degree in nursing to be required for employment, which is twice what was reported in fall 2017. Nursing programs providing collaborative ADN to BSN academic progression models that offer streamlined pathways for ADN students to also obtain a BSN within a year after ADN program completion are strategically positioned to address evolving trends.

Of the RNs who were not yet employed, 15.3% indicated reasons they were not offered a job was a limited resume lacking activities, experience or skills that may have distinguished them further as candidates for employment, or where their experience was not related to the setting or applicable to the position; 2.4% reported being told they’d been out of school too long; 1.2% reported their academic preparation was

<sup>5</sup> Bates, T., Chu, L., Spetz, J. Survey of Nursing Employers in California fall 2018-2019. San Francisco, CA: Philip R. Lee Institute for Health Policy Studies, University of California, San Francisco. April 2020.

insufficient for the scope of the position or specialty; and 0.2% indicated not getting a job offer related to having a low GPA.

Newly licensed RNs are interested in academic progression that also supports career advancement, with 32.3% reporting they are currently enrolled and continuing their education to obtain a higher degree, 66.9% indicating plans to do so in the next 1-3 years, or 31.9% indicating a higher degree as a long-term goal as displayed in Table 4.8.

**Table 4.8 PLAN TO ADVANCE NURSING EDUCATION**

N=2,068	Currently Enrolled 32.3%	1-3 Years 66.9%	4-6 Years 39.5%	7-10 Years 13.3%	>10 years 31.9%
BSN	576	509	36	2	5
MSN	90	683	488	82	104
MPH	1	39	38	13	87
MBA	0	23	29	11	74
DNP	1	119	194	128	198
PhD	0	10	31	39	139

Nurses not working as RNs were asked what they were doing at this time. Findings indicated 34.7% were working in non-nursing/non-health-care jobs (30.8% part time, and 3.9% full time), and 29.5% indicated working in health care although not as an RN. Just over a third (37.4%) reported they were currently continuing their education in nursing. RNs also indicated they were volunteering in a health-related service (14.1%) while looking for a job. Beyond these primary response categories, a few respondents described activities they are currently involved in while looking for employment, including continuing to work as an LVN, participating in an RN transition program or unpaid internship, waiting to start a new position, spending time with family, caring for a new baby, or traveling.

## 5. PARTICIPATION IN TRANSITION TO PRACTICE PROGRAMS FOR NEWLY LICENSED RNs

Transition to practice programs were broadly defined in the survey questionnaire as programs provided for newly licensed nurses, conducted either by a school of nursing following completion of their academic program and prior to employment, or by an employer upon hire. RNs employed at the time of this survey provided information regarding their participation in a new graduate transition program, with 53.1% indicating they had participated in some type of program. This was slightly more than the prior year, when 52.5% of RNs reported completing a program in 2018, however less than reported in 2017 when 56.9% indicated completing a program. Transition to Practice programs for newly licensed RNs more typically found in mid- to large size hospitals are less prevalent or not provided in smaller hospitals, or other types of health care organizations, who cite limitations with cost, capability, lack of resources within their setting, and to some extent, the lower volume of RNs hired.

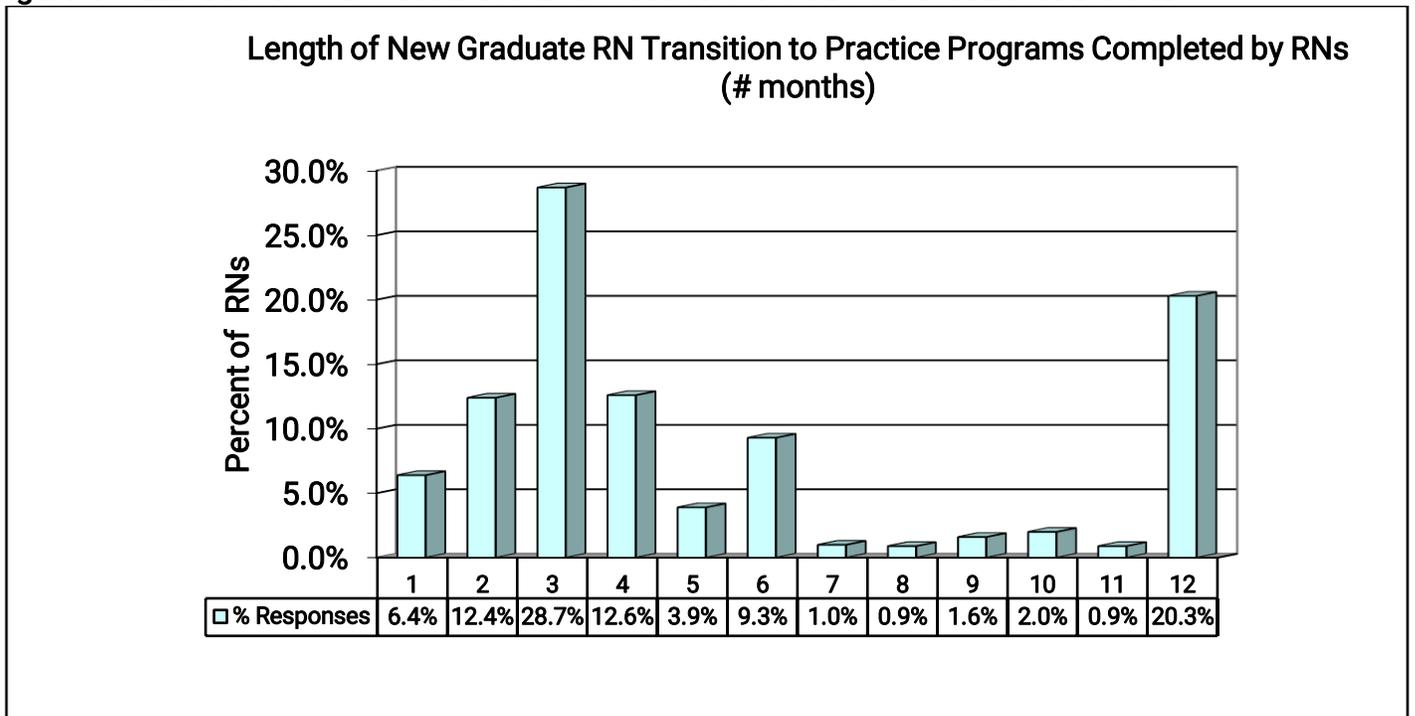
Findings reported by RNs regarding their participating in transition to practice programs provides evidence that the number of programs or access new graduates have to them is relatively limited and unchanged from prior years, helping illuminate the need for California to develop and expand such programs aligned with the 2020 IOM Future of Nursing Report goal that all newly licensed RNs complete a transition to practice program as they enter practice. Programs more typically provided by large hospitals and those within large health care systems are often limited in scope or length, or not offered at all in mid to small organizations and community-based healthcare settings that may lack the resources and capability needed to provide these programs.

The length of programs that are provided by employers upon hire including both classroom and supervised clinical components were reported to vary significantly, from one to twelve months, with 3 months most

frequently reported by 28.7% of RNs, followed by twelve months with 20.3%, and six months reported by 9.3% of RNs. As in prior years, program lengths were most often reported to be clustered between two to four months as depicted in Figure 5.1. While this overall pattern remains consistent with prior years, it was noted that 8.0% fewer RNs reported participating in programs that were a full year, with a shift to programs conducted over four months or less.

Distinct differences in the length of programs reported reflect wide variation in program models and design, with potential for different outcomes. Programs conducted based on national standards and those that are also nationally accredited are twelve months in length. Further examination of the scope and composition of various types of employer-provided transition to practice programs and evidence-based outcomes remains a priority to guide program improvement and adoption of effective practices that support the professional development and retention of the emerging nursing workforce.

**Figure 5.1 LENGTH OF NEW GRADUATE RN TRANSITION TO PRACTICE PROGRAMS**



Of the 754 nurses who reported participating in a transition to practice program provided by a school of nursing prior to employment, a majority indicated the program was helpful in gaining:

- Confidence in practice (89.5%)
- Skills and increasing competencies (89.2%)
- Experience in a licensed RN role (88.6%)
- Employment (82.6%)

There is further opportunity to more directly and purposefully connect RNs enrolled in transition to practice programs with employers as intended pipelines to employment. Newly licensed RNs were asked about their interest in participating in a transition to practice or new graduate residency program following graduation and prior to employment. The percent of respondents indicating they were either interested or very interested has increased when compared with prior years, regardless of whether it was structured as an unpaid program or required tuition to be paid. This change in interest provides evidence of the importance and value these programs have for RNs as they enter the workforce, their willingness or ability to invest time and resources to support their transition into practice, as well as a growing interest in career pathways outside of traditional acute care settings as shown in Table 6.1.

**Table 6.1 RN INTEREST IN TRANSITION TO PRACTICE PROGRAMS**

RN Interest	FALL 2015	FALL 2016	FALL 2017	FALL 2018	FALL 2019
Interest in a program if payment of tuition was required	30.8%	20.5%	19.4%	19.8%	26.0%
Interest in a program if it was an unpaid internship	47.8%	32.4%	33.5%	33.9%	38.1%
Interest in a program to gain experience in a non-acute health care setting	56.7%	44.8%	47.6%	50.8%	67.8%

All respondents, regardless of employment status or participation in a transition to practice program, were asked to rank various incentives that engaged or would engage their participation in a program. Those identified as providing the greatest incentive in were:

1. Opportunity to increase skills, competencies, and confidence
2. Opportunity to gain experience as a licensed RN
3. Opportunity for potential employment with a specific employer
4. Deferment of student loans
5. Obtaining college credit applicable to BSN or MSN degree
6. Opportunity to practice in a specific specialty area
7. Improving resume and employability

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## 7. STATEWIDE SURVEY COMPARISON OF FINDINGS

This survey provides evidence of the employment experiences reported by newly licensed RNs in California over the 12-month period between September 2018 and August 2019, with comparison of trends noted in recent years. These findings and employment patterns provide valuable information for nurse leaders and educators working together to assure the academic preparation of students is aligned with patterns of employment as indicators of emerging workforce needs. While the calculated margin of error rate of 1.6% is relatively low overall, caution is advised when interpreting results applied to individual sub-regions of the state as findings with lower responses may not fully reflect the unique variables in each area. It is possible that nurses who were not yet employed at the time of the survey may have been more motivated to complete it, and if so, the actual employment rate in the overall population of newly licensed nurses may be higher than reported. The survey methods have been consistent each of the ten years the study has been conducted, and the survey instrument has included standard questions to support comparison and inform trends over time.

These results reflect the demographic pattern and regional distribution of new graduates reported in the annual BRN school survey, and mirror data obtained from other sources, including employer surveys of nurses and surveys fielded by schools of nursing. Data from this current California survey indicate a relatively stable and strong employment landscape for newly licensed RNs. Data indicate 92.4% of newly licensed RNs residing in California are employed within 6 months, which is slightly higher than findings reported by the American Association of Colleges of Nursing (AACN)<sup>6</sup> in its annual survey of nursing schools offering baccalaureate and graduate programs in the U.S. In their assessment of new graduates finding employment, the national AACN

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<sup>6</sup> American Association of Colleges of Nursing, AACN Research Brief (February 2019). Employment of New Nurse Graduates and Employer Preferences for Baccalaureate-Prepared Nurses Report.

survey found 94% of entry level BSN and 95% of entry level MSN graduates had been offered a job within 4-6 months of graduation, noting employment rates vary across the country by region, with the lowest rates consistently reported in the West, with 87% BSN and 86% MSN, respectively.

California employment trends are relatively consistent when also compared with findings reported by the National Student Nurses' Association (NSNA) study of new graduate employment trends obtained through a post-graduate RN survey conducted of RN graduates annually since 2008. Their national fall 2018 survey findings reported in summer 2019 indicated employment of entry level RNs exhibited upward trends with 89.0% of new graduates reported to be employed, compared with 88.1% in the prior year.<sup>7</sup> The NSNA analysis of new graduate RN employment data continues to indicate regional differences across the country, with a slight increase in employment from the prior year reported across two of the four regions. Their findings consistently indicate the Western region has the lowest rate of employment of 84%, this was up from 82% in the prior year. Differences in national employment rates by type of RN degree were found to be the same as the prior year, with 87% ADN and 91% BSN. Data were not provided from master's Entry Programs.

While various state and national surveys show some notable differences in survey populations, questions, and measures from this California Newly Licensed RN Employment Survey, there are consistencies in findings and trends comparing employment experiences supported with evidence-based results across various studies. National, statewide, and regional trends reflect evolving workforce needs and the progressive emergence of new roles and varied practice settings, providing broad opportunity within a dynamic job market for newly licensed RNs embarking on a nursing career. The employment rate reported by newly licensed RNs indicates job opportunities were slightly greater than the prior two years.

According to the most recently reported projections in the *Forecasts of the Registered Nurse Workforce in California*,<sup>8</sup> the state's supply of RNs through 2035 is predicted to be slightly higher than projected demand. The model relies on a number of factors monitored over time including nursing program enrollment and completion rates, state-to-state RN migration patterns, and changes in health care delivery and work force demand. The composition of the states' overall nursing workforce and employment findings reported in the prior *California Board of Registered Nursing (BRN) Survey of Registered Nurses (2016)*, along with the *2018-2019 BRN Annual School Report of RN Pre-Licensure Programs in California*, and other state and national data sources provide further detail and evidence of specific trends. Projections by the Health Resources and Services Administration (HRSA) National Center for Health Workforce Analysis indicate California's RN supply will be 11.5% (44,500 RNs) lower than demand in 2030.<sup>9</sup> Considering various forecasting models utilized in different studies, the collective evidence reported from these sources indicates California must maintain and should position to increase the number of nursing graduates to meet long-term health care needs.

The recent *Survey of Nurse Employers in California*<sup>10</sup> reports over 90% of hospitals hired new RN graduates in fall 2019, with over half of those also indicating they had increased their employment of new RN graduates in the prior year. Fewer hospitals report having a minimum experience requirement, from 68% in 2015 down to 48.3% in 2018-19, partially influenced by a continued shortage of experienced RN candidates, and the availability of newly licensed RNs to fill vacant positions. The 2019 report found 54.3% of hospitals preferred hiring baccalaureate prepared RNs, which is consistent with prior years; however, the percent that require newly hired RNs to hold a bachelor's degree upon hire has doubled to 18.1% over the past two years.

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<sup>7</sup> V. Feeg, D. Mancino, National Student Nurses' Association, Dean's Notes Volume 41, No.1 (summer, 2019). Loan Debt for New Graduates in Nursing: How Employment Post Graduation and Student Loan Debt are Affected Over Time.

<sup>8</sup> Spetz, J., *Forecasts of the Registered Nurse Workforce in California*, California Board of Registered Nursing, May 2020.

<sup>9</sup> U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. *The Future of the Nursing Workforce: National- and State-Level Projections, 2014-2030*. Rockville, Maryland.

<sup>10</sup> Chu, L., Spetz, J. *Survey of Nursing Employers in California, fall-winter 2018-2019*. San Francisco, CA: Philip R. Lee Institute for Health Policy Studies, University of California, San Francisco, April 2020.

Trends in healthcare delivery and payment models continue to shift, supporting greater emphasis and utilization of resources on value-based care, including health maintenance and prevention, providing further opportunity uniquely suited for nurses to impact health outcomes. These factors will continue to influence greater demand for nurses to be well prepared to practice in a range of employment settings and new roles. Tracking pathways to employment of new graduate RNs informs workforce planning and indicates the type of settings students need to be prepared for upon entry into practice.

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## 8. CONCLUSIONS

California needs to prepare newly licensed RNs for practice in acute care settings and emerging new roles to include diverse ambulatory care settings to meet evolving healthcare needs, assuring the state has the supply of future nurses prepared with the knowledge, skills, and competencies needed. Interest in nursing as a career and enrollment of new students in RN programs remains strong, with slight increases in the number of students completing RN pre-licensure programs annually over the past few years. With 11,890 new graduates in California completing RN programs in the 2017-2018 academic year, current workforce demand and nursing education supply are in balance in the near term; however the Health Resources and Services Administration (HRSA) National Center for Health Workforce Analysis projects the demand for RNs in California will be 11.5% (44,500 RNs) greater than the supply by 2030. The California Employment Development Department forecasts there will be 327,800 registered nurse jobs in California or an increase of 16.2% or 45,800 jobs over the next 10 years. (California Employment Development Department, September 2019).<sup>11</sup> These indications are reminders of the importance that California continue monitoring workforce changes and position to support future growth where needed in nursing pre-licensure programs. The future nursing workforce also needs to be prepared to fill more diverse roles in varied practice settings, respond to employer expectations for RNs to be prepared with at least a BSN degree, and address the growing demand for nurses to be prepared to practice in specialty areas.

It is evident from the survey that newly licensed nurses are eager to obtain employment, often working a combination of temporary or part-time jobs, with engagement and growing interest in career options outside traditional acute care hospital settings. With a strong economy this past year, and an increased number of experienced nurses now retiring, the demand for new nurses is anticipated to remain healthy. The stabilization and slight increase in the employment rates for newly licensed RNs is consistent with current and future demand predictions and should be monitored for early indications of change in emerging workforce supply and demand, considering an aging population, a greater proportion of insured individuals now having more access to care, and associated growth or shift in services and settings. Acute care hospitals have historically been the largest employer of nurses and new graduates. With an average RN vacancy rate of 4.3% reported by California's hospitals at the time of this study,<sup>12</sup> employers also indicate a growing need and greater demand for open positions to be filled with RN applicants experienced in specialty areas. Nurse leaders from both academia and practice should continue to share best practices and innovative strategies to ensure that new RNs gain and expand essential competencies to meet emerging health care needs across diverse practice settings, and high-demand specialty areas.

This survey also indicates transition to practice programs and residencies have been important and effective ways for new nurses to obtain further skills and competencies needed to increase employability. Lack of experience as an RN continues to be reported as the primary reason new graduates are not offered available jobs. Addressing academic practice gaps through active collaboration between nursing programs and employers, along with strategies and programs that support effective transition to practice and provide mentoring during the first year of practice remain important to progressive competency attainment. Transition to practice programs have provided options for specialty training and guided experience as newly licensed RNs enter the workforce, yet findings indicate these programs could be more prevalent and

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<sup>11</sup> California Employment Development Department, EDD Data Library, September 2019.

<sup>12</sup> Healthcare Workforce Survey Report, Third Quarter 2019, Hospital Association of Southern California.

accessible while supporting the attainment of key competencies over a longer period of time. Resources and strategies to expand, improve, and strengthen transition to practice programs across all types of organizations and practice settings remain a strategic priority.

This study also provides important evidence of the prevalence of social determinants of health in California's emerging nursing workforce that can impact education and employment. Social determinants that shape health and well-being can influence student experiences, and positively or negatively impact learning, academic progression, and success. Health and well-being dimensions encompass physical, social, mental, and financial factors that can continue to influence an individual's potential, including employee engagement.<sup>13</sup> Establishing systems, providing support services and allocating resources that address social determinants of health and well-being are integral to effective recruitment, development, retention, and workforce outcomes.

These results will be reviewed by nursing leaders, employers, schools of nursing, policy makers and others concerned about the challenges students experience and new graduates face in finding RN jobs and transitioning to practice as licensed RNs. The importance of preparing future nurses aligned with evolving workforce needs recognizes the value of expanding access to effective transition to practice programs as a strategic priority. Results from this annual survey continue to inform strategies that support and improve collaborative academic practice pathways to employment for newly licensed nurses, and opportunities to strengthen their success in practice.

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## 9. ACKNOWLEDGEMENTS

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## POST STUDY NOTICE – IMPACT OF COVID-19 PANDEMIC ON RN EDUCATION AND EMPLOYMENT

This statewide employment survey conducted in late fall 2019 reflects education and employment patterns in the prior 12-month period, a few months before the COVID-19 pandemic. The state of emergency and response underway at the time this report was being prepared is requiring modification in nursing program teaching methods, and presenting limitations to and postponements of clinical education, that may delay nursing program completion, graduation, and licensure for some nursing students. Employment patterns are also impacted, with workforce needs shifting to expedite focused hiring in the short term to accommodate COVID-19 response, as well as some reduction or closure of elective services, limiting employment options. It will be

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<sup>13</sup> A. Blacker, J. Grossmeier, L. Meyer, N. VanderHorst, and E. Wolfe, Social Determinants of Health – An Employer Priority, American Journal of Health Professions 34(2).

important to monitor the short- to mid-term impact the COVID-19 pandemic will have on nursing education and employment in the months ahead. Academic-practice collaboration remains important for nursing programs and employers implementing changes and adopting strategies to assure the preparation and supply of the emerging workforce in meeting evolving workforce needs.

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The report is available at the HealthImpact website: [www.healthimpact.org](http://www.healthimpact.org)



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