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PUBLIC SESSION MINUTES

Friday, May 18, 2012

**Department of Consumer Affairs
1625 North Market Blvd.
Sacramento, CA 95834**

Members Present: Murray Olson, RCP, RRT-NPS, RPFT, President
Charles B. Spearman, MSED, RCP, RRT, Vice President
Lupe V. Aguilera
Larry L. Renner, BS, RCP, RRT, RPFT, President
Barbara M. Stenson, RCP, RRT

Staff Present: Dianne Dobbs, Legal Counsel
Stephanie Nunez, Executive Officer
Christine Molina, Staff Services Manager
Liane Freels, Staff Services Manager

CALL TO ORDER

The Public Session was called to order at 9:50 a.m. by Vice President Spearman. Vice President Spearman stated the Board did not have a quorum, however, another board member was expected to arrive shortly. The final member, Lupe Aguilera, arrived at 9:56 a.m. and a quorum was present before any items were discussed and voted upon.

Vice President Spearman explained that public comment would be allowed on agenda items, as those items are discussed by the Board during the meeting. He added that under the Open Meeting Act, the Board may not take action on items raised by public comment that are not on the Agenda, other than to decide whether to schedule that item for a future meeting.

APPROVAL OF FEBRUARY 10, 2012 PUBLIC SESSION MINUTES

Mr. Renner moved to approve the February 10, 2012 Public Session minutes as written.

M/ Renner /S/Stenson
In favor: Aguilera, Olson, Renner, Spearman, Stenson
MOTION PASSED

1 **EXECUTIVE OFFICER'S REPORT**

2 *(Stephanie Nunez)*

3
4 **BreEZe, On-Line Application/License System**

5
6 Ms. Nunez stated the tentative rollout date for BreEZe, the on-line application license system, is
7 August/September 2012. She also indicated that staff continue to devote significant resources toward
8 the BreEZe project as implementation draws near.

9
10 **Office Relocation**

11
12 Ms. Nunez stated today was staff's first day in the new office location: 3750 Rosin Court, Suite 100,
13 Sacramento. Other than a few issues related to its server, the move was successful and staff
14 appreciate the new space.

15
16 **Status on Proposed Regulation**

17
18 Ms. Nunez advised the Board of the status of the existing rulemaking package, and explained that
19 final approval is required by May 25, 2012. She stated that following approval, the package will be
20 filed with the Secretary of State and will become effective 30 days after filing.

21
22 **Fiscal Review**

23
24 Ms. Nunez discussed the Fiscal Review covering the Board's revenue and expenditures. She
25 indicated there are no significant items of concern, but pointed out the increase in staff salaries
26 resulting from restored pay following the furloughs and personal leave program, as well as additional
27 filled positions.

28
29 **SUNSET REVIEW 2012/2013**

30 *(Stephanie Nunez)*

31
32 Mr. Olson moved to establish a Sunset Review Committee to participate in the development of the
33 Sunset Review Report and Hearings, consisting of Mr. Renner and himself.

34
35 Though his term on the Board was coming to a close, it was noted that Mr. Renner possesses a
36 wealth of information as the Board's long standing past president and would offer a unique
37 perspective in providing testimony during the Sunset Hearings.

38
39 M/ Renner /S/Spearman

40 In favor: Aguilera, Olson, Renner, Spearman, Stenson

41 MOTION PASSED

42
43 President Olson moved to pursue authority, as part of the Board's Sunset Review Report, for
44 immediate suspension for violations/arrests involving sexual misconduct.

45
46 Discussion ensued.

47
48 M/ Olson /S/Renner

49 In favor: Aguilera, Olson, Renner, Spearman, Stenson

50 MOTION PASSED

1 Ms. Nunez summarized a letter from the Los Angeles County Department of Health Services
2 requesting a permanent waiver of education for twenty individuals currently employed as Pulmonary
3 Physiology Technicians with LA County.
4

5 Discussion ensued, and it was agreed that this topic will be moved to a future agenda item for further
6 discussion.
7

8 **ENFORCEMENT UPDATE**

9 *(Charles Spearman)*

10 **Enforcement Statistics**

11
12
13
14 Vice President Spearman reviewed Enforcement Statistics stating all targets were met with the
15 exception of Formal Discipline, which was very close.
16

17 **LEGISLATION OF INTEREST – DISCUSSION/ACTION**

18 *(Christine Molina)*

19
20
21 Ms. Molina reviewed the following Legislation of Interest:
22

- 23 SB 975 – Professions and vocations: regulatory authority
- 24 SB 1575 – Professions and vocations
- 25 AB 1588 – Professions and vocations: reservist licensees: fees and continuing education
- 26 AB 1904 - Professions and vocations: military spouses: temporary licenses.
- 27 AB 1932 - United States armed services: healing arts boards
- 28 AB 1976 - Licensure and certification requirements: military experience.
- 29 HR 941 - The Medicare Respiratory Therapy Initiative Act of 2011
30

31 Mr. Renner moved to accept the following positions:
32

- 33 SB 975 – Watch
- 34 SB 1575 – Support
- 35 AB 1588 – Support
- 36 AB 1904 - Watch
- 37 AB 1932 - Watch
- 38 AB 1976 - Watch
- 39 HR 941 - Watch
40

41 M/ Renner /S/ Murray

42 Unanimous: Aguilera, Olson, Renner, Spearman, Stenson

43 MOTION PASSED
44

45 **RECOGNITION OF SERVICE: LARRY L. RENNER, BS, RCP, PAST PRESIDENT** 46 **AND BARBARA M. STENSON, RCP, RRT, PAST VICE-PRESIDENT**

47 *(Murray Olson)*
48

49
50 Past President/Member Larry Renner and Past Vice President/Member Barbara Stenson were
51 presented with plaques in recognition and appreciation for their eleven years of selfless service to the
52 Board and were thanked for their loyalty to consumer protection and dedication to the advancement of
53 the respiratory care profession.



October 26, 2012

On behalf of the American Association for Respiratory Care (AARC), representing over 53,000 respiratory therapists nationwide, I respectfully submit the following comments regarding the proposed revisions to the licensure requirements for Ohio respiratory care practitioners.

Ohio Proposed Rule Revisions

- Proposed rescission of current rule OAC 4761-5-01,
- Proposed new rule 4761-5-01, and
- Amendment of rules OAC 4761-5-04 and OAC 4761-8-01

The key proposed revision and the focus of our comments is the rescission of OAC 4761-5-01. The proposed amended rules OAC 4761-5-04 and OAC 4761-8-01 are conforming changes necessitated if proposed rule OAC 4761-5-01 were to be replaced.

Rule OAC 4761-5-01 currently allows for both the Certified Respiratory Therapist (CRT) credential and the Registered Respiratory Therapist (RRT) credential as acceptable examination requirements for Ohio respiratory care practitioners (RCP) licensure. The proposed revisions, effective after December 31, 2014, would delete the CRT credential as an accepted examination to meet Ohio licensure requirements.

Mandatory RRT Licensure Requirement is Unjustified

The AARC cannot support the proposed rule that imposes the mandatory requirement that the RRT examination will be the only accepted minimum testing requirement for Ohio respiratory care licensure.

The AARC certainly encourages all respiratory therapists to obtain the advanced level RRT credential. However, we firmly believe that professional RCP qualification requirements established by employers should and will drive the natural evolution of the profession to the RRT credential. Imposition of a new rule mandating the RRT credential that sets a ridged deadline, even one that is two years hence, we believe will have a negative effect on the RCP manpower availability on future student graduates in Ohio.

No Documentation that CRT Respiratory Therapists have Harmed Ohio Citizens

Before proceeding with this unprecedented rule change we would ask that evidence be provided that documents respiratory therapists credentialed as CRTs, because they do not hold the RRT credential, have been deficient in their clinical evaluation and assessment skills and, thereby, have rendered poor quality patient care or have harmed patients. We would request further elaboration on the competency issues and concerns that we conclude must be a key rationale for mandating in 2014 licensure only for those who hold the RRT credential. There is no documented evidence from any state, including Ohio that supports the contention that those holding only the CRT credential pose any risk to the health and safety of the public.

Nationwide CRT Credential is by Statute Accepted as Licensure Requirement

In addition to Ohio, the 48 contiguous United States and the District of Columbia have by statute universally set the CRT credential as the accepted competency examination for respiratory therapist licensure. The stated purpose of enacting state regulation of any profession and those who practice said profession is to protect the health and safety of the public by mandating documentation of *minimum* competencies, including education and examination. Ohio will become an “outlier” in effect establishing a barrier to employment in Ohio of out of state licensed respiratory therapists.

Ohio Border States and Labor Pool are Negatively Impacted

Ohio shares a border with five states: Indiana, Michigan, Pennsylvania, West Virginia and Kentucky. According to the most recent respiratory therapy licensure board data collectively there are 22,177 licensed respiratory therapists in these bordering states. One could make the assumption that in these border regions a certain number of respiratory therapists live in one state and the cross state line to work in Ohio. A certain percentage of these RTs hold dual licenses with Ohio and their home state, providing employment flexibility. Mandating the RRT credential only in Ohio will cause a negative ripple effect on many future border based respiratory therapists where additional Ohio requirements will be imposed where none existed before, thus diminishing the potential labor pool of respiratory therapists.

Negative Impact on Ohio RT Manpower

The AARC understands the theoretical intent of establishing the advanced RRT credential as a licensure minimum and may be viewed as a laudable effort. However, after December 31, 2014 the practical impact on Ohio health care entities employing licensed RCPs will, in practice, result in the barring of excellent and experienced licensed CRT credentialed respiratory therapists from other states and those graduating in other states from being employed in Ohio as licensed respiratory care practitioners.

Moreover, Ohio law permits students and recent graduates to obtain a limited permit to practice respiratory care. The limited permit is valid for one year and in certain circumstances may be extended. Ohio law also requires those who hold a limited permit to be supervised by a licensed respiratory therapist. The impending rule change will have a negative impact on employers who might consider hiring a limited permit holder as they will have to assure that their supervising respiratory therapist will also hold the RRT credential.

We continue to have concerns regarding the validity of the Survey results that have been used as the cornerstone to support these revisions.

However, despite questions over the accuracy of the Survey results even the Fiscal Impact Statement findings from the Survey (Item 9) state the following:

Of the 379 surveyed, 220 complete surveys were returned. These respondents show that 55% do not currently require the RRT credential for initial employment, (emphasis added).

More than one half of Ohio employers do not require the RRT credential for employment. We understand the rule change will not be implemented until 2015 and that hiring practices will change. Nevertheless, we believe that there will still be numerous employers who will assess or reassess their need to hire recent respiratory graduates or students if only the more costly RRT, the advanced practitioner, must be their supervisor.

Ultimately, we believe once implemented the restriction to only RRTs qualifying for licensure will have a severe and negative impact on manpower availability.

No Evidence Exists the CRT Credential has Jeopardized Ohio Patient Safety or Health

The AARC is unaware of documentation that provides evidence of any quality, safety or clinical outcome differences between those licensed RCPS holding the CRT credential and those that hold the RRT credential. Stating this in colloquial terms, is the proposed rule change requiring a minimum of the RRT credential for Ohio RCP Licensure a “solution in search of a problem”?

Conclusion:

Given the above enumerated areas of concern, the AARC would urge the Ohio Board for Respiratory Care to reconsider taking any further action towards finalizing the proposed changes.

Sincerely,



Karen J. Stewart, MSc, RRT, FAARC
President

HORIZONS

CREDENTIALING FOR THE RESPIRATORY CARE PROFESSION



ICE Membership and
NCCA Accreditation 6



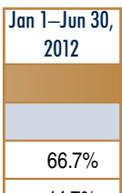
AARC International
Congress to be
Held in New Orleans 7



ACCS Examination
Update 8



Annual Renewal
Reminder 8



Examination Statistics
for the First Half of
2012 9

2012 JIMMY A. YOUNG MEMORIAL LECTURE: EVOLUTION OF CRT AND RRT CREDENTIALING PROGRAMS

*By Robert C. Shaw, Jr., PhD, RRT, FAARC, NBRC Assistant Executive Director
Kerry E. George, RRT, MEd, FAARC, 2012 NBRC President*

INTRODUCTION

This article explains changes the NBRC plans to implement regarding examinations for the Certified Respiratory Therapist (CRT) and Registered Respiratory Therapist (RRT) credentials that were presented at the 2012 AARC Summer Forum. One effect of these changes will be to remove one examination from the hierarchical system through which individuals achieve the RRT credential. Another effect will be to require those achieving the RRT credential to demonstrate strong abilities in both gathering information and making decisions about the care of patients while taking the Clinical Simulation Examination.

HISTORICAL MILESTONES

The April 2012 AARC Times celebrated 1947 as the year in which the professional association began. The NBRC was incorporated as the credentialing organization for respiratory therapists in 1960. The following milestones also are worth noting to provide context for the evolutionary changes planned for the CRT and RRT credentialing programs:

- The first credential the NBRC awarded after it was incorporated was the RRT
 - Successful RRT candidates passed an examination in the multiple-choice format (the Therapist Written Examination) and an examination in the oral format (the Oral Examination) starting in 1961
 - After the AARC started the certification program in 1969, the NBRC agreed to take over the program in 1975
 - The RRT examination system transitioned from oral to clinical simulation examinations in 1979 while also retaining the multiple-choice examination

CONTINUED ON PAGE 2

EVOLUTION ...
 CONTINUED FROM PAGE 1

- Because of evidence there were tasks in common among entry-level and advanced-level therapists, starting in 1983 a candidate was required to achieve the Certification level of credential before attempting to achieve the Registry level
- There were few schools for respiratory therapists in the early years
 - The demand for respiratory care grew rapidly after World War II as a result of advancing technologies
 - The emphasis for credentialing was to assess competence **by whatever means competence was acquired** including (1) training on the job, (2) short, intensive courses, (3) technical schools, (4) community college programs, and eventually (5) bachelors degree programs
 - The only route for new therapists to become credentialed today is by completing formal education through accredited college-level programs

Of the 50 states within the United States, all but one have come to rely on achievement of the CRT credential to contribute to the regulation of respiratory care practice. There are other elements of regulation that belong to the states alone. The power to conduct investigations and subpoena witnesses come to mind. Therefore, respiratory care regulation involves partnerships between states and the NBRC that has relied on faith in a system that confers both the CRT and RRT credentials.

Within the respiratory therapy profession there are many levels of proficiency; the national leadership for respiratory therapists incrementally and purposefully built the current two-tiered system. Because other health professions choose to regulate one level of practice does not mean that there are not multiple proficiency levels among its practitioners.

The door is not closed to continued evolution of the credentialing system in respiratory care. As the system evolves, the NBRC will continue to support both the CRT and RRT credentialing programs and those who have achieved those credentials.

MULTIPLE-CHOICE EXAMINATION CONCEPTUAL CHANGES

Changes to the new multiple-choice examination for respiratory therapists are related to an evolution in concept about what CRT and RRT credentials have and will mean. The current concept is illustrated in Figure 1. The scope of practice for CRTs has been conceived as a subset of the scope of an RRT. The NBRC, the AARC, and the CoARC have jointly stated that the RRT represents the standard of excellence for respiratory therapists. There are more than two scopes of competence represented in Figure 1. Some scopes of competence can be less than is expected for someone who has achieved the CRT credential while others may exceed expectations for the RRT credential.

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Published Quarterly by the
**NATIONAL BOARD FOR
 RESPIRATORY CARE, INC.**
 18000 W. 105th St.
 Olathe, Kansas 66061-7543
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 Website: www.nbrc.org

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NBRC Horizons is published Quarterly to communicate information about the admission policies and procedures, the day-to-day activities, and the short-term and long-range plans of the National Board for Respiratory Care, the national certifying board for the respiratory care profession. The NBRC is sponsored by the American Association for Respiratory Care, the American Society of Anesthesiologists, the American Thoracic Society and the American College of Chest Physicians. Subscriptions to NBRC Horizons are free for active credentialed practitioners and \$24 for inactive practitioners and others. Subscription forms can be obtained by contacting the NBRC Executive Office.



EVOLUTION ...
CONTINUED FROM PAGE 2

The future concept, which the NBRC expects to implement in 2015, is illustrated by Figure 2. The critical difference between original and modern concepts is that the content over which candidates for CRT and RRT credentials will be assessed will be the same. Figure 1 illustrates content differences between the CRT and RRT scopes. Figure 2 illustrates CRTs and RRTs will be separated based on proficiency. Increased proficiency while providing care is expected to result in higher accuracy, more effective interventions, reduced costs, and greater speed. Increased proficiency while taking a test over respiratory care content is expected to manifest in a higher score.

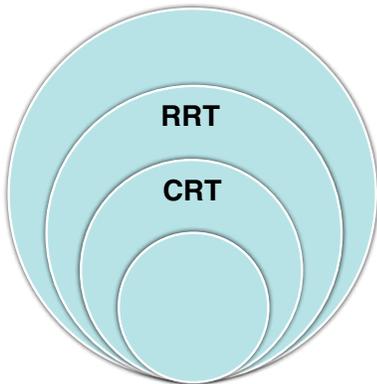


FIGURE 1. CURRENT CONCEPT

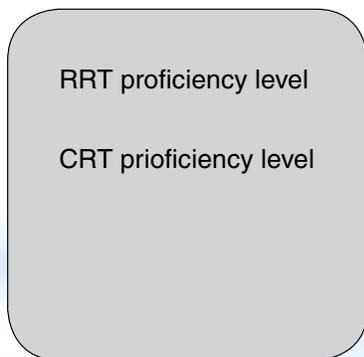


FIGURE 2. FUTURE CONCEPT

Application of Importance Criterion

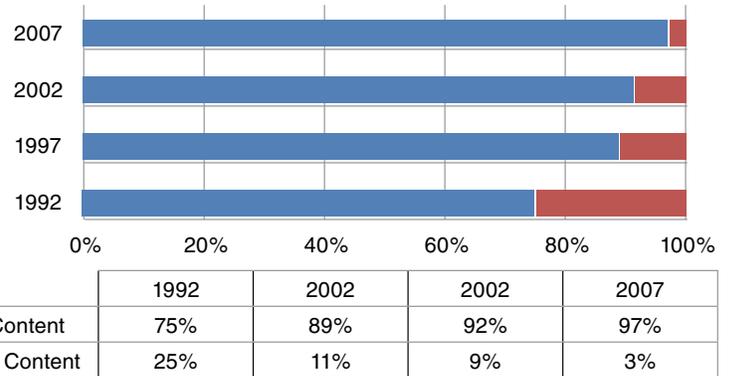


FIGURE 3. TREND IN CONVERGENCE BASED ON IMPORTANCE TO PRACTICE

Application of Extent Criterion

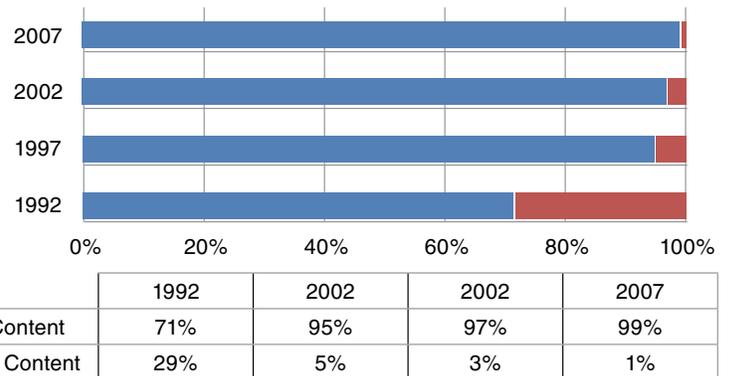


FIGURE 4. TREND IN CONVERGENCE BASED ON EXTENT IN PRACTICE

The change in concept is justified in part because educational preparation is more similar today than it used to be. The fact that CoARC now accredits programs to one standard is an important change that helps justify the future concept about CRT and RRT credentialing programs. In addition, internal research conducted by the NBRC has demonstrated convergence of the scope of practice.

As Figures 3 and 4 illustrate,¹ job analysis survey responses indicated a CRT was expected to function within a substantial subset of content that was done by an RRT in 1992. As subsequent studies were done, CRT and

¹Two groups of respondents rated tasks based on expectations for entry level and advanced level therapists. Information in Figure 3 shows percentages of converged and independent examination content when extent-in-practice and importance-to-practice thresholds were applied. The extent threshold was 50% of survey respondents and the importance threshold was 2.5 out of 4.0.

EVOLUTION ...
CONTINUED FROM PAGE 3

RRT scopes of competence converged to the point that very little difference remained in 2007.

There were three RRT tasks excluded from the examination for the CRT credential in 2007. Those three tasks nearly met the extent-in-practice criterion for CRT examination content. Nine additional RRT tasks were excluded from the examination for the CRT credential. Here again, these tasks nearly met the importance-to-practice criterion for CRT examination content. Results about these few tasks and information in Figures 3 and 4 convinced the NBRC trustees that prospective CRTs and RRTs should be assessed over the same content at the point of entry starting in 2015.

RRT is the standard for excellence for respiratory therapists and CRT is the standard for licensure in 49 states. This convergence evidence indicated to the NBRC that a new concept for the credentialing system was justified. While Figure 2 is not the only potential new concept on which the NBRC could have settled, it does respect precedent.

EVOLUTION OF MULTIPLE-CHOICE EXAMINATIONS

In 1988, the NBRC reduced the number of items on the examination for the CRT from 200 to 140 because a study indicated that using fewer items would not diminish the accuracy of competence measurements. In 1994, the number of options for each test item were reduced from five to four. Nothing will fundamentally change about the test-candidate interaction when the new multiple-choice examination for therapists is implemented. Hence, CRT examination scores will continue to be based on 140 items.

The examination will differ from the current CRT examination by having two passing points. In keeping with what Figure 2 proposes, meeting or exceeding the low passing point will result in achievement of the CRT credential. Achieving a test score equal to, or greater than, the high passing point will result in eligibility to take the Clinical Simulation Examination. Persons who subsequently pass the Clinical Simulation Examination will achieve the RRT credential.

Although the new multiple-choice examination will contain the same number of items as the current CRT Examination, we expect the new examination will contain a higher proportion of items at the application and

analysis levels of cognition compared to what Table 1 shows for the current CRT Examination. A job analysis study was underway, but not completed when this article was written, so specific information about this change will be released about this time next year.

Table 1. Comparison of Current Cognitive Level Distributions by Examination

Cognitive Level	Percentages of Items for Each Multiple-Choice Examination	
	CRT	RRT
Recall	25	6
Application	53	15
Analysis	22	79
Total	100	100

EVOLUTION OF THE CLINICAL SIMULATION EXAMINATION

The start of computer-based testing in the year 2000 has been associated with several benefits.

- Candidates may schedule testing appointments on any of about 300 days each year
- Most candidates may test at centers closer to home
- Final results from each test administration are given to candidates as soon as they finish
- Opportunities for candidates to collaborate while testing are reduced
- Each new item is evaluated during pretesting among large, randomly assigned samples from the candidate population before use as a scored item on future tests

Providing instant scoring of simulation examinations administered by computer created a new challenge. The examination committee increasingly struggled to keep the content of problems current. When Clinical Simulation Examinations were administered in paper format and results were delayed by several weeks, it was possible to modify option scoring before scores were released. Subsequently, the content of problems could be readily revised before they were used again. In other words, the delayed scoring model created an environment that was conducive to updating problem content.

After instant results reporting began in 2000, a test form (10 active and 1 pretest simulations) was administered

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EVOLUTION ...
 CONTINUED FROM PAGE 4

for several months. When the form was retired, some of the problems already had been selected for forms that had been, or soon would be, released. Taking a problem out of play to update content meant a multiyear commitment to pretesting the revised problem before assessing whether the changes were valid. These factors discouraged content updates enough for the content of some problems to lag behind practice.

THE SIMULATION SOLUTION

After an ad hoc committee considered alternative test formats to address this issue, the NBRC trustees accepted a proposal for a new examination that retains current simulation characteristics. The solution the trustees approved was to halve the length of each problem while doubling the number of problems. Candidates will continue to have four hours to complete the examination, which will contain 20 problems each of which will be half the length of the current simulation problems.

These changes presented the NBRC an opportunity to enhance the psychometric properties of the Clinical Simulation Examination. First, the NBRC will standardize each test form more thoroughly. Table 2 presents a comparison of current and future specifications. The current specifications permit some variability in test form assembly; variability has been removed from the 20-problem specifications.

Table 2. Comparison of Test Specifications

Type of Problem	Specifications	
	Current 10-Problem	Future 20-Problem
A1. COPD Conservative Care	1 or 2	2
A2. COPD Critical Care	1 or 2	2
B. Trauma	1 or 2	3
C. Cardiovascular	1 or 2	3
D. Neurological / Neurosurgical	1 or 2	2
E. Pediatric	1	2
F. Neonatal	1	2
G. General Medical / Surgical	optional	4

NBRC Trustees also decided to change the way in which simulation examination scores and passing points are determined. Currently the Clinical Simulation

Examination really contains two short tests. A candidate must clear two hurdles, one for competence in gathering information, and one for making decisions. Test score accuracy should increase when based on one long test compared with two short tests. The way the Trustees will lengthen the Clinical Simulation Examination is to combine information-gathering and decision-making scores into one total score.

The future examination will produce one total score with one passing point. Simulation examinations will continue to contain sections devoted to information-gathering and sections devoted to decision-making. By combining all problem responses into one score, the NBRC expects the precision of test scores to increase. To ensure that mistakes in candidates' decision making cannot be offset by points from information gathering sections, the passing level for information gathering sections will increase.

SUMMARY

Changes described in this article are substantial, but they respect precedent and are next steps to an evolving examination system that began in 1961.

Candidates for CRT and RRT credentials initially will be assessed over the same scope of competence. Two passing points will differentiate CRTs from those who become eligible to take the Clinical Simulation Examination and potentially achieve the RRT credential.

Within the same four-hour test administration period, Clinical Simulation Examination candidates in the future will be tested on information-gathering and decision-making sections within twice as many patient scenarios. Each scenario will contain half the number of sections as current problems. Candidates will achieve a single score that will determine the pass or fail outcome.

Candidates have had to schedule three testing appointments on at least two different days while attempting to achieve the RRT credential. In the future candidates may achieve the RRT credential by scheduling two testing appointments on two different days.

ICE MEMBERSHIP AND NCCA ACCREDITATION— VALUABLE RELATIONSHIPS FOR THE NBRC

The NBRC is a member of the Institute for Credentialing Excellence (formerly the National Organization for Competency Assurance [NOCA]) and its examinations are accredited by the National Commission for Certifying Agencies (NCCA). ICE is a professional membership association for organizations, testing companies, and individuals interested in assessment. The NCCA functions as an independent commission under the auspices of ICE, sets standards for credible certifying agencies, and accredits those that voluntarily apply. The NBRC and its subsidiary, Applied Measurement Professionals, Inc. (AMP) have been active in ICE from its inception. AMP is a “Sustaining Member” that contributes significantly to the organization from a financial standpoint as well as exhibiting at the annual ICE meeting.

In almost every field, there exists a measure of excellence or a benchmark that signifies leadership and unsurpassed quality. This is certainly true of the certification arena, where accreditation by NCCA is the recognized measure for meaningful credentialing programs. The NBRC was one of the first four organizations to achieve NCCA accreditation and is proud to be the only organization that has maintained continuous accreditation since the Commission was formed in 1977.

Accreditation by the NCCA began due to initiatives in the mid-1970s by the Federal government to set standards for the many professional credentialing agencies that serve numerous occupations. In essence, certifying organizations elected to voluntarily support the formation of the NCCA and submit to accreditation according to standards that were universally recognized and accepted, rather than have the Federal government establish a law requiring participation. Accreditation by the NCCA was previously granted on an organizational basis, rather than to the individual credentialing programs offered by the accredited organizations. However, the Commission now grants accreditation to individual certification programs, such as the CRT or RRT Examinations, without requiring all certification examinations offered by an organization meet the Commission’s standards. The NBRC has been granted accreditation for six of its national



examination programs, including the Sleep Disorders Specialty Examination. Each of the examination programs are developed according to the same measurement standards.

Why is NCCA accreditation of the NBRC’s examination programs important for the respiratory care profession? In short, it represents the “Good Housekeeping Seal of Approval” on the profession’s credentialing process. This enables credentialed individuals, examination candidates, and the public to know that a nationally credentialed respiratory therapist or pulmonary function technologist has completed a credentialing process that has been reviewed in detail by an independent, external agency and found to unconditionally comply with current assessment standards and principles. These include the requirements that examination content be based on job analysis research, that examination candidates receive detailed information about the material to be tested, and that score reports enable examinees who do not pass to have information useful for remedial study efforts. NCCA accreditation must be renewed every five years. To comply with this process, the NBRC submits detailed information regarding the development of all of its examinations, including reliability and validity statistics, as well as the test administration and scoring process. In addition, an annual report is submitted that includes examination statistics and details any changes in the examination programs.

Participation by the NBRC and AMP in ICE and the NCCA has also provided opportunities to contribute to the leadership and direction of both agencies. The NBRC Chief Executive Officer Gary A. Smith has served as Chairman of the NCCA and President of NOCA, and Dr. Lawrence J. Fabrey, AMP’s Senior Vice President of Psychometrics, was the 2007 NCCA Chairman and has also served as the accrediting agency’s Psychometrician, or measurement expert.



AARC INTERNATIONAL CONGRESS TO BE HELD IN NEW ORLEANS

Respiratory therapists, physicians, nurses, and other healthcare providers and leaders from all over the world will gather November 10-13, 2012 for the AARC's 58th International Respiratory Congress at the Ernest N. Morial Convention Center in **New Orleans, Louisiana**. Participating in four full days of educational programs with the ability to interact with faculty and other professionals in the field ensuring a great time and learning experience at the convention.

Connect with us at the NBRC booth at the largest respiratory care meeting in the world. Meet NBRC staff and have your questions answered regarding online examination scheduling, the Adult Critical Care Specialty Examination, the RRT Three-Year Time Limit for Eligibility, compliance with the Continuing Competency Program requirements and more. Exhibitors, including the NBRC and the Lambda Beta Honor Society, will be representing all aspects of the respiratory care industry and will be available on the convention floor. For those who have never participated, this event is a must. We expect the 2012 AARC International Congress will be the best to date!

Don't miss this important event in respiratory care! We look forward to your participation in the 58th International Congress and hope to see you at the NBRC booth. Online registration is available at www.aarc.org.



VALUABLE RELATIONSHIPS...

CONTINUED FROM PAGE 6

The NBRC's ICE membership enables us to share and learn about the latest in testing innovations, including advancement in technology, examination methods, and security procedures. In addition, representatives from the NBRC and AMP frequently present at ICE meetings regarding the respiratory care credentialing process and ideas that might be of value to other certifying agencies. The NBRC believes that accreditation of the respiratory care credentialing examinations by NCCA is an important benefit that adds value and meaning to the national

credentials. Many Federal and state agencies rely on the NCCA standards and look to the Commission, as well as ICE, for guidance when evaluating quality credentialing programs. Through its continuous NCCA accreditation and ICE membership, the NBRC makes sure that its examinations are up to date with respect to contemporary processes and are in compliance with leading assessment principles. This helps assure the public and the respiratory care communities of interest that the credentials awarded by the NBRC reflect competence in respiratory care. ○



STUDENT SURVIVOR HOUR TO BE HELD AT THE AARC INTERNATIONAL CONGRESS

Students are once again invited to attend the popular Student Survivor Hour at the 58th AARC International Congress in New Orleans, Louisiana. The NBRC will co-host this valuable meeting for respiratory care students on Saturday, November 10, at 5 pm at the JW Marriott, New Orleans.

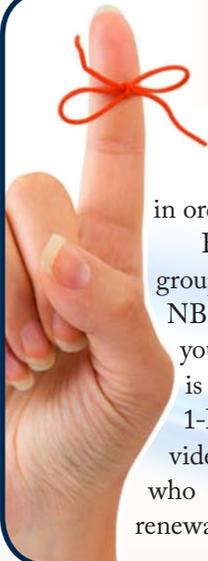
This meeting will feature speakers representing the NBRC, AARC, CoARC and Lambda Beta, and gives students an opportunity to find out what is in store for them as graduates of respiratory care programs. Navigating the road from student to a credentialed practitioner active in the field of respiratory care can be challenging. Interacting with speakers representing the education, credentialing, and professional association areas of respiratory care will be an invaluable experience for students during this critical time of their professional development.

For students who have never participated, **Student Survivor Hour** is a must. We hope to see you at Student Survivor Hour and the 58th International Congress!

INSTANT SCORING NOW AVAILABLE FOR THE NEW ADULT CRITICAL CARE SPECIALTY EXAMINATION

The scoring process has been completed for the Adult Critical Care Specialty Examination and instant scores are now being provided at the Assessment Center Network locations. For more information on this new specialty examination, please visit the NBRC website at www.nbrc.org.

ANNUAL RENEWAL REMINDER



Have you completed your 2013 annual renewal? Be sure to renew early in order to receive the benefits all year long!

Being an active member in the national groups of practitioners credentialed by the NBRC means you care about protecting your professional future. The renewal cycle is based on a calendar year, from January 1-December 31 each year. The Board provides an annual gift of appreciation to those who support the NBRC through the annual renewal process. The 2013 gift will be mailed

out approximately 4-6 weeks after your renewal is processed.

If you have not maintained active status in the past, please reconsider activating your status to demonstrate support for your credentialing organization and to help ensure that your NBRC credentials continue to have value and meaning. Part of being a professional is to continue to recognize the value of your national credentials and support the organization that stands behind them. Your support will be greatly appreciated and used by the NBRC to accomplish our mission for years to come.

You can renew online at www.nbrc.org under the 'Credentialed Practitioners' link or by clicking [here](#).

EXAMINATION STATISTICS FOR THE FIRST HALF OF 2012

During the first six months of 2012, the NBRC administered 20,572 credentialing examinations and awarded a total of 12,357 new CRT, RRT, CPFT, RPFT, Neonatal/Pediatric Specialist and Sleep Disorders Specialist credentials. Following are the examination statistics for each respective NBRC examination program.

CRT Examination

Seven thousand three hundred and forty-two (7,342) candidates attempted the CRT Examination in the first half of 2012. A total of 4,752 individuals earned the CRT credential January 1 through June 30, 2012. As of publication, the total number of CRTs is 215,594.

RRT Examinations

The RRT Examination consists of the Written Registry and Clinical Simulation Examinations (CSE). In the first half of 2012, 6,862 individuals attempted the Written Registry Examination and 5,762 candidates attempted the CSE. Three thousand four hundred and forty-six (3,446) individuals earned the Registered Respiratory Therapist (RRT) credential by successfully completing both portions of the Examination. A total of 126,984 practitioners have earned the RRT designation.

Pulmonary Function Technologist Examinations

One hundred fifty-one (151) candidates attempted the CPFT Examination during the first half of 2012, with 96 individuals earning the entry-level pulmonary function technologist credential. From January 1 through June 30, 2012, 35 CPFTs achieved the advanced RPFT credential. To date, there have been 12,604 CPFTs and 4,278 RPFTs credentialed.

Neonatal/Pediatric Specialty Examination

Three hundred and eighty (380) CRTs and/or RRTs attempted the Neonatal/Pediatric Specialty Examination during the first half of 2012. Two hundred and thirty-five (235) individuals earned the RRT-NPS or CRT-NPS designations. Since this specialty examination began, 10,975 practitioners have achieved the CRT-NPS or RRT-NPS credentials.

Sleep Disorders Specialty Examination

Twenty-seven (27) individuals attempted the Sleep Disorders Specialty Examination during the first half of 2012, and 24 practitioners earned the CRT-SDS or RRT-SDS credential. This new specialty credential has been earned by 202 practitioners who may now use RRT-SDS or CRT-SDS designations.

The Board of Trustees extends congratulations to the respiratory care professionals earning the 12,357 new credentials awarded by the NBRC during the first half of 2012. The NBRC has now awarded 370,637 credentials since its formation in 1960. ○

PASS RATES COMPARED

Below are the passing percentages for NBRC credentialing examinations given January 1 through June 30 of 2010, 2011, and 2012. As the pass rates reflect, the percentages of first-time candidates passing the NBRC credentialing examinations have remained relatively stable.

	Jan 1–Jun 30, 2010	Jan 1–Jun 30, 2011	Jan 1–Jun 30, 2012
CRT Examination			
Entry Level Graduates:			
New Candidates	70.9%	72.8%	66.7%
Repeat Candidates	25.5%	20.3%	14.7%
Advanced Level Graduates:			
New Candidates	81.3%	80.9%	82.7%
Repeat Candidates	24.4%	26.4%	26.5%
RRT Therapist Written Examination			
New Candidates	66.0%	66.6%	68.2%
Repeat Candidates	30.8%	29.2%	32.2%
RRT Clinical Simulation Examination			
New Candidates	57.0%	61.0%	66.7%
Repeat Candidates	47.8%	52.5%	52.8%
CPFT Examination			
New Candidates	59.0%	72.7%	77.4%
Repeat Candidates	31.0%	42.5%	31.1%
RPFT Examination			
New Candidates	93.5%	85.7%	85.4%
Repeat Candidates	30.0%	69.2%	40.0%
Neonatal/Pediatric Specialty Examination			
New Candidates	74.3%	76.2%	67.4%
Repeat Candidates	52.6%	47.9%	44.6%
Sleep Disorders Specialty Examination			
New Candidates	90.5%	100%	88.9%
Repeat Candidates	00.0%	100%	00.0%

Consideration to Require Passage of RRT Examination as Part of State Licensure

Prepared April 19, 2011

Issue

The California Respiratory Care Board (Board) is considering whether to modify respiratory care practitioner (RCP) licensure requirements to require the passage of both the entry-level Certified Respiratory Therapist (CRT) and advanced-level Registered Respiratory Therapist (RRT) examinations.

Background

The Board believes the respiratory care practice has evolved significantly over the last 25 years, and several members have expressed that the requirement to pass the advanced RRT examination is long over due. The Board has considered requiring the RRT examination as the entry level examination for nearly a decade; However, several years ago, upon further inquiry, the Board found that the national exam provider prohibited the passage of the RRT examination, without first passing the CRT examination.

Currently, there are no other states that require the advanced level examination for licensure. However, increasing education and examination standards has been a high priority nationally, and much discussion has ensued.

The Commission on Accreditation for Respiratory Care (CoARC), is the nationally-recognized organization, responsible for accrediting respiratory therapy education programs. The CoARC is currently phasing out all entry-level educational programs providing, "As of July 1, 2010, no new students shall be admitted into [entry]-level programs. Students enrolled in a [entry]- level program must graduate by December 31, 2012, to be recognized as graduates of a CoARC-accredited program. All [entry]-level programs that remain non-compliant with the new standards must voluntarily withdraw effective December 31, 2012. Failure to do so by this date will result in a CoARC action to withdraw accreditation."

At this time, California has 34 institutions and a total of 37 respiratory therapy programs. Of the 34 institutions, 33 offer an Associate Degree and one offers a baccalaureate degree (**Attachment A**). Of the 37 programs, 34 are advanced and 3 are entry level programs (the three schools with entry-level programs also have advanced-level programs). Graduation from an advanced level program qualifies a student to sit for the advanced-level RRT examination.

The American Association for Respiratory Care (AARC) established a task force in late 2007 to identify likely new roles and responsibilities of respiratory therapists (RTs) in the year 2015 and beyond. A series of three conferences was held between 2008 and 2010. The first task force conference affirmed that the healthcare system is in the process of dramatic change, driven by the need to improve health while decreasing costs and improving quality. This will be facilitated by application of evidence-based care, prevention and management of disease, and closely integrated interdisciplinary care teams. The second task force conference identified specific

competencies needed to assure safe and effective execution of RT roles and responsibilities in the future. The third task force conference was charged with creating plans to change the professional education process so that RTs are able to achieve the needed skills, attitudes, and competencies identified in the previous conferences.

The AARC issued a report of the recommendations of the third task force held in July 2010 (**Attachment B**). The participants, who represented groups concerned with RT education, licensure, and practice, proposed, discussed, and accepted that to be successful in the future a baccalaureate degree must be the minimum entry level for respiratory care practice (by 2021). Also accepted was the recommendation that the Certified Respiratory Therapist examination be retired, and instead, passing of the Registered Respiratory Therapist examination would be required for beginning clinical practice (by 2015).

Following are excerpts from the attached report:

“A majority of Conference three participants believe that the scope of practice in 2015 will require the level of knowledge and critical thinking tested by the RRT examination. They were confident that the knowledge, skills, and attributes tested on the CRT examination, but not currently on the RRT examination, could be easily incorporated into the two RRT examinations. The vast majority felt that educators prepare students for the RRT examinations and 2015 was the right time to require the RRT credential for entry into practice.”

“The American public should feel assured that patient care is given by the most competent and highly trained therapist possible. Many RT educators and department directors surveyed prior to the conference stated that having two credentials (CRT and RRT) confuses the public, patients and other healthcare colleagues who are not aware of the difference. This is primarily the result of CRTs and RRTs being assigned to the same job responsibilities. The majority of conference participants believe that the respiratory therapy profession needs one level of credential (RRT), one educational goal, and one expectation for competency of graduate therapists entering the workforce in 2015 and beyond.”

“Of great concern to conference participants was the fact that the CRT credential was developed for 12 month training programs that will no longer exist in 2015. Any change in the credentialing system may require changes in some state regulations controlling who may deliver respiratory care. Participants at the conference recognized the need to prepare for changes in state legislation and regulations regarding licensure of RTs to practice if the CRT examination was retired...Accordingly,...the conference recommended that the AARC establish on July 1, 2011 a commission to assist state regulatory board transition to a RRT license.”

In December 2010, the AARC board of directors approved the transition plan with attributes of additional research and planning prior to implementation (**Attachment C**). The board of directors stated, “These attributes will provide assurance to all stakeholders that as we move forward, we will not create new problems to solve old ones. We must not create a new system which cannot adequately provide adequate numbers of graduates. By adhering to these attributes we will consider virtually all tactics and strategies put forth while providing assurance of goal-directed change which will not only move the profession forward but also address the many challenges [which] manifest in such a transition.”

Proposed Alternative Interim Resolution

While there are several alternative approaches to require the passage of the RRT examination as part of State licensure, staff are proposing an alternative that is believed to be most efficient, requiring the least personnel resources, as well as, provide for a relatively smooth transition should the RRT examination become the sole entry level examination in the future as recommended by the AARC task force.

The attached proposed legislative and regulatory language provides that effective January 1, 2014, all applicants shall be required to pass both the CRT written examination and the RRT written and clinical simulation examinations prior to licensure (***Attachment D***). It also provides an exemption from the RRT examination for out-of-state applicants who hold a valid and current license in another state, free from *any* discipline, that was issued prior to January 1, 2014.

Contingencies

NBRC

The proposed alternative is contingent upon conferring with the National Board for Respiratory Care, Inc. (NBRC) and its acceptance to waive all eligibility requirements to sit for the RRT examination.

Currently, the NBRC has several policies to be eligible to sit for the RRT examination that are not compatible with state licensure including:

- Requirement to pass the RRT examination within three years from graduation or recertification as a CRT. A new graduate who passes the CRT but then fails to pass the RRT examination within three years would be required to retake the CRT examination.
- Requirement to hold a current CRT credential. In order to maintain a CRT credential, holders must pay an annual \$25 fee.
- Several other eligibility requirements that could pose a conflict with other respiratory care statutes.

The philosophy to retake an examination or pay annual fees to qualify for a required licensure examination, has not been shared by the California legislature in the past, and is inconsistent with California licensure laws in general. Additional legislative changes would be required to accommodate NBRC's existing policies and it is unlikely the legislature would approve such changes.

The NBRC has a history of being cooperative with the Board in contract negotiations. So long as the Board is not attempting to completely bypass the requirement to take and pass the CRT examination, the NBRC may be open to waiving all other eligibility requirements to sit for the RRT examination.

Legislature & Office of Administrative Law

The proposed alternative is contingent upon approval of legislation by the California Legislature and Governor Edmund G. Brown, Jr., and regulations by the California Office of Administrative Law.

Proposed Alternative Interim Resolution Timetable

September 2011 - Submit proposed legislation package.

February 2012 - Secure bill author.

Feb.-Sept. 2012 - Actively support legislation.

Sept./Oct. 2012 - Presume legislation chaptered.

Sept. 2012-April 2013 - Amend NBRC contract.

Sept. 2012-Nov. 2013 - Process regulation package; modify ATS database.

January 2014 - Change in effect.

Considerations

Database Requirements - Staff will need to work with the Department of Consumers Affairs to make minor changes to the ATS database.

Staff Resources - Should the NBRC agree to waive RRT eligibility requirements for the purposes of California licensure, staff will need to explore the method in which that will be used to schedule candidates for the examination. Currently, 99% of all applicants may apply for the CRT exam directly through NBRC. However, NBRC's electronic scheduling system may not accommodate departures from the NBRC's eligibility requirements. It will need to be determined how many candidates may have to be scheduled by Board staff.

In addition, staff will need to explore additional workload associated with extending work permits or issue permits for a greater period of time. Work permits are currently issued for a period of 90 days for new graduates and for all others (upon receipt of certain background clearances). In most instances, this time period allows a candidate to pass the entry level examination and ensure all required documentation is submitted; A work permit extension is rarely necessary. However, by requiring the passage of an additional examination, staff will need to explore whether or not a work permit should be issued for a greater period of time or determine the workload that would be associated with extending work permits.

Additional workload will likely result in the need for an additional staff person. In order to obtain an additional staff person, staff must submit a request 18 months in advance, and for the past several years, requests to increase staffing have been largely denied.

**Graduates from Entry Level Programs*

The last group of students to graduate from an entry-level educational program will be in December 2012. However, should these applicants not become licensed by December 31, 2013, they will be required to take and pass the RRT examination. These candidates will have much more difficulty in passing the RRT examination and most will not be equipped with the education and/or training needed to pass the examination. Is one-year sufficient time to require licensure? If an applicant had a personal crisis or situation that prevented them from passing the examination in this one-year period, it would virtually eliminate or make it very difficult for them to obtain licensure without further education.

**Out-of-State Applicants*

While the proposal provides an exemption for out-of-state applicants who hold a current and valid license in another state that was issued prior to January 1, 2014, there will undoubtedly be qualified applicants without current licensure in another state or who were licensed after January 1, 2014 who will be required to take the RRT examination. Should additional exemptions be considered for out-of-state applicants, as well as, previously California licensed RCPs who may have inadvertently allowed their license to cancel?

Fees

Considering the most recent proposed regulatory changes to the Board's fee schedule, an applicant will pay the following fees prior to licensure (not taking into account the need to retake the examination, if applicable):

Application Fee (to Board):	\$300
Examination Fee (to NBRC):	\$190
Fingerprint Fees:	\$ 71
Other Document Fees:	\$ 20
<u>Total:</u>	<u>\$581</u>

This proposal would tack on addition \$390 in fees paid to the NBRC (\$190 for the RRT written exam and \$200 for the RRT clinical simulation exam). The total fees would then be \$971 (not including fees associated with retaking any examinations).

*Shortage of RCPs

Will the impact of requiring the advanced level exam be a temporary shortage of licensees or could the requirement have a permanent impact? Would any permanent shortage of licensees outweigh the need for advanced level competency requirements given the advancements in the profession and the need for public safety?

* Issues indicated with an astrick are part of the planning and research that AARC has recommended be performed prior to implementing these changes.

Recommendation

Given the immediate shortcomings and the efforts underway to explore alternatives and the impact of such a change, staff recommend that the Board take no action at this time, though revisit this issue at each Board meeting. Consideration to take action on the proposal is better suited next year at this same time, with an implementation date, no sooner than January 1, 2015. The Board would have the opportunity to evaluate new findings that could alter its course of action.

At this time, staff recommend exploring the willingness of NBRC to enter a contractual agreement to allow the Board to use both the CRT and RRT examinations for licensure, waiving all RRT eligibility requirements and report back to the Board in October.

California Respiratory Therapy Education Programs as of April 19, 2011

(Data pulled from www.coarc.com)

	Institution	Entry Level	Advanced Level	Satellite	Associate Degree	Baccalaureate Degree
1	American Career College (Ontario)		200566		X	
2	American River College (Sacramento)		200194		X	
3	Antelope Valley College (Lancaster)		200523		X	
4	Butte College (Oroville)		200142		X	
5	California College San Diego		200276		X	
6	Carrington College California (Bay Area)		200542		X	
7	Concorde Career College - Garden Grove		200472		X	
8	Concorde Career College - North Hollywood	100092	200440		X	
9	Concorde Career College - San Bernardino		200498		X	
10	Concorde Career College - San Diego		200525		X	
11	Crafton Hills College (Yucaipa)		200132		X	
12	East LA College/Santa Monica		200102		X	
13	El Camino Community College (Torrance)	100400	200584		X	
14	Foothill College (Los Altos)		200017		X	
15	Fresno City College		200083		X	
16	Grossmont College (El Cajon)		200085		X	
17	Kaplan College - Modesto		200433		X	
18	Loma Linda University		200161	300161		X
19	Los Angeles Valley College		200210		X	
20	Modesto Jr. College		200360		X	
21	Mt. San Antonio College (Walnut)		200022		X	
22	Napa Valley College		200157		X	
23	Ohlone College (Newark)		200289		X	
24	Orange Coast College (Costa Mesa)		200136		X	
25	Pima Medical Institute - Chula Vista		200494		X	
26	Platt College - Alhambra		200596		X	
27	Platt College - Ontario		20588		X	
28	San Joaquin Valley College - Bakersfield		200425		X	
29	San Joaquin Valley College - Rancho Cordova		200518		X	
30	San Joaquin Valley College - Rancho Cucamonga		200495		X	
31	San Joaquin Valley College - Visalia		200389		X	
32	Simi Valley Adult School/Excelsior	100120	200586		X	
33	Skyline College (San Bruno)		200147		X	
34	Victor Valley Community College (Victorville)		200207		X	
	Totals	3	34	1	33	1

Draft- Editorial [This is an editorial by Sam Giordano with AARC, it will be published along with the paper in the May 2011 issue of the RC Journal (which should be out in the second week of May)

Building a Bridge to the Future: Some Points to Ponder

Since 1947 respiratory care professionals have provided clinical services to tens of millions of patients with pulmonary diseases in North America. In the United States, we, as respiratory therapists, evolved as a profession because of external factors, such as the health care environment and clinical needs of our patients; as well as the internal factors that built our current education system, program accreditation, and competency documentation/credentialing systems. The latter includes both legal credentialing (licensure) and voluntary credentialing (eg, certified [CRT] and registered [RRT] respiratory therapist). External factors are generally the first to trigger change in health care systems. It is easier to identify unmet patient and health system needs than it is to reach agreement on precisely how we are to meet those needs.

Reacting to challenges is good, but anticipating challenges is even better. That is why the Board of Directors of the American Association for Respiratory Care (AARC) authorized a project to begin the process of thoughtful planning for the future of respiratory care, and anticipate the future roles of those persons providing respiratory care services. Once that first step was taken, we then needed to identify the competencies, knowledge, skills, and attributes that future providers must own in order to execute their future roles successfully in order to meet the needs of our patients.

Of course, if we stopped at this point, our task would still be incomplete. It is not enough to anticipate our role in future years. Indeed, to assure success, it is not enough to only identify the competencies and skills that will be needed. If our profession is unable to transition from where we are today to where we will need to be tomorrow, we will fail. It reminds me of a slogan I have seen over the years. It goes something like: “The road ahead is never a dead end unless you fail to make the turn.” To take this analogy a bit further, it does not matter if we know how to drive the car, and it does not matter if we have built the right car. Neither matters unless we are able to add that third ingredient, “making the turn.” Thoughtful transition is what is required if respiratory therapists (RTs) are going to be at the top of their game when caring for patients in the future.

The AARC’s *2015 and Beyond* project was launched in 2007 to set future directions for the respiratory care profession in the United States. In my capacity as Executive Director of the AARC, I was asked to organize a series of 3 conferences to answer the previously posed questions regarding our future. Thus we invited representatives from all stakeholder groups, including not only RTs, but also physicians, payers, government officials, credentialers, accreditors, patients, and employers. As you might imagine, there was a high degree of interest in the conferences. And, certainly, as you will read, at every conference there was no shortage of diversity of opinion. This was encouraging.

I would like to offer a few points for you to consider as you read the third paper that was written after the third and final conference that targeted transition was convened last July.(1) My first suggestion is to review the 2 conference papers previously published: “*Creating a Vision for Respiratory Care in 2015 and Beyond.*”(2) Do you want to see our future? Read this paper. Since it was published in 2009, we have not received one letter stating disagreement with that

vision. The second conference focused on the identification of competencies and the knowledge, skills, and attributes s required to fulfill those future roles, and the proceedings were published in the 2010 paper, “Competencies Needed by Graduate Respiratory Therapists in 2015 and Beyond.”(3) There was fairly broad consensus with regard to the competencies and the knowledge, skills, and attributes. But, when it came to attempting to parse the entry level and advanced level, there was less consensus. Do you want to know about the future competencies you’ll need? Read this paper.

The third and final conference focused purely on transition issues. It attempted to answer the following question: How do we take the profession from where we are today to where we need to be in the future, to optimize our role and value for our patients and our employers? As you will see, the paper contains recommendations that were developed from opinions expressed during the conference. The recommendations run the gamut from mandating a minimum baccalaureate educational level to exploring the utilization and creation of an RT assistant. Please bear in mind as you read through this that the recommendations did not originate from the AARC, or the other organizations mentioned in many of the recommendations, but rather from those attending the conference. And please note that conferees were invited to represent the diverse perspectives of different members of our community, rather than the position of any one organization.

There were also opinions and recommendations from conferees related to our current examination system. Those of you who have been around the profession for a long time will see few surprises here. What you will see is what has been discussed over the last 20 years in other meetings of our colleagues. Some conferees had biases and convictions, but they also had the courage to express those convictions. There is nothing wrong with such an exchange of ideas and

remedies. We wanted diverse opinions because we wanted consideration of all ideas for a transition plan.

The AARC leadership, working with the respiratory care community, will continue to plan for the future of our profession in a way that is consistent with the values of our American health system and the needs of our patients. While the recommendations, at least in some cases, may not seem practical (and some might argue that they even impinge upon our ability to generate adequate numbers of RTs in future years), it was important to list every possible option and to investigate not just the desirability, but the practicality, of implementing these recommendations. We would like to learn from the evolution of other professions as they evolved and to avoid unintended consequences that could prove negative for our patients, such as an inadequate number of RTs to care for our patients.

The 2015 planning committee developed a list of attributes that any transition plan must possess if it is to be supported by the AARC Board of Directors. I won't recite them all here, but as you will see from Table 1 in the paper, most of the recommendations are straightforward common sense. I do want to point out that the AARC Board of Directors eliminated one attribute from this table: that related to not reporting recommendations that did not receive a plurality of votes from conferees. This point was eliminated to ensure that the AARC Board of Directors considered all recommendations, and, more importantly, maintained process transparency.

The attributes discussed in the paper will be key to our success. The AARC will not create a future system that fails to produce adequate numbers of RTs in the United States. It will not undertake any changes unless the case has been established that our future roles, skill sets, and

education are consistent with the values of our patients, our employers, and our health care system.

The AARC is far from finished with this project. Indeed, it has just begun. The 3-conference series was the first phase to frame the issues, regardless of whether they be pro change, anti-change; more education, less education; or more testing, less testing. It reminds me of that commercial for a spaghetti sauce: “It’s in there!” Indeed, everything is on the table. That is as it should be, since we are considering the future direction of our profession. No idea was, or is, out of bounds. As as you read this final paper from the series and you come up with an idea that we should consider, please send it in to the AARC President.

As we move our profession forward, we face some difficult questions. Particularly thorny is the question of whether or not our current education system is able to prepare graduates with the expanded skills inventory identified in the second conference. Understandably, some of our colleagues feel threatened. Others who want to increase education are dealing with the challenge of the current system to produce adequate numbers of RTs at that higher level of education.

These are just some of the reasons that the AARC Board of Directors is investigating each and every recommendation contained in this paper. The Board’s first action is to conduct a crosswalk between all of the recommendations from the third conference and the transition plan attributes. Remember, these must be followed in order to assure avoidance of negative consequences for the patients and our profession. Thus far, the AARC Board of Directors has approved only the transition plan attributes, after eliminating the previously mentioned point from Table 1 in order to maintain transparency.

The Board of Directors is performing due diligence in order to responsibly consider all recommendations. This includes gathering input from stakeholder organizations and our community before addressing the recommendations themselves. This process is proving long and arduous. However, given the importance of this project, how can we do less than our very best? We are facing tremendous challenges and opportunities in the future. And, now that we have the beginnings of a plan to prepare for that future, the continued evolution of the profession of respiratory therapy is guaranteed.

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Transitioning the Respiratory Therapy Workforce for 2015 and Beyond

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Abstract

The American Association for Respiratory Care established a task force in late 2007 to identify likely new roles and responsibilities of respiratory therapists (RTs) in the year 2015 and beyond. A series of three conferences was held between 2008 and 2010. The first task force conference affirmed that the healthcare system is in the process of dramatic change, driven by the need to improve health while decreasing costs and improving quality. This will be facilitated by application of evidence-based care, prevention and management of disease, and closely integrated interdisciplinary care teams. The second task force conference identified specific competencies needed to assure safe and effective execution of RT roles and responsibilities in the future. The third task force conference was charged with creating plans to change the professional education process so that RTs are able to achieve the needed skills, attitudes, and competencies identified in the previous conferences. Transition plans were developed by participants after review and discussion of the outcomes of 2015 conferences 1 and 2, and after 1022 surveys completed by RT department managers and RT educational program directors were reviewed. This is a report of the recommendations of the third taskforce conference held July 12-14, 2010 on Marco Island, Florida. The participants, who represented groups concerned with RT education, licensure, and practice, proposed, discussed, and accepted that to be successful in the future a baccalaureate degree must be the minimum entry level for respiratory care practice. Also accepted was the recommendation that the Certified Respiratory Therapist examination be retired, and instead, passing of the Registered Respiratory Therapist examination would be required for beginning clinical practice. A date of 2020 for achieving these changes was proposed, debated and accepted. Recommendations were approved requesting resources be

provided to help educational programs, existing respiratory workforce, and state societies work through the issues raised by these changes.

Key words: respiratory care; respiratory therapist; manpower; education; training; competency; licensure; credentialing; accreditation; credentials; specialty; protocols.

Introduction

In 2007 the American Association for Respiratory Care (AARC) established the 2015 and Beyond Task Force. The charge to this task force was to determine the changes required by the profession of respiratory care to meet the evolving demands of the medical community and to position respiratory therapists (RTs) as a vital member of the medical community in 2015 and beyond.¹ The specific questions the Task Force was asked to address were:¹ How will patients receive healthcare services in the future? How will respiratory therapy be provided? What knowledge, skills and attributes (KSAs) will respiratory therapists need to provide care safely, efficiently and cost-effectively? What educational and credentialing systems are needed to provide these KSAs? How do we get from the present to the future with minimal impact on the respiratory therapy workforce?

The Task Force elected to address these questions through a series of three conferences. The first conference was held in the spring of 2008. The results of this conference¹ indicated that the respiratory therapist of today barely resembles the RTs of the 1950's and 1960's and the future role of the respiratory therapist will most likely be different from today. Health care is going through dramatic changes, third party payers are challenging payment for iatrogenic injury, the entire health care financial system is being debated, the focus of care is shifting from acute to chronic care, manpower issues are expected to affect all disciplines, the workforce is

aging and rapid introduction of innovation in the provision of medicine and information technology is expected to be the norm.¹

Conference two was held in the spring of 2009. In this conference the attendees focused on identifying the competencies graduate RTs as well as the practicing therapist will need in 2015 and beyond.² The attendees identified 73 competencies in 7 major areas needed by the graduate and practicing respiratory therapists; diagnostics, disease management, evidence-based medicine and respiratory care protocols, patient assessment, leadership, emergency and critical care, and therapeutics.²

The third conference of this series was conducted on Marco Island, Florida, on July 12-14, 2010. The goal of this conference was to determine what changes in the profession are necessary to position respiratory therapists to fulfill the roles and responsibilities identified in conference one and to insure that future and practicing respiratory therapists in 2015 and beyond acquire the competencies identified in conference two. It was postulated that changes would be needed in the education, accreditation and the credentialing process of the respiratory therapist to meet the needs identified from conferences one and two. This paper reports the results and recommendations formulated during the third 2015 and Beyond conference.

Methods

The conference started with a series of presentations (Appendix 1) designed to facilitate discussion and decision making from the 35 voting participants from 18 stakeholder organizations in attendance (Appendix2). Appendix 3 lists the stakeholder organizations that were invited to participate in the conference by the Respiratory Care 2015 Task Force. The Task Force members are listed in Appendix4. Preconference surveys of RT program directors, RT

department directors, and deans of health science divisions were conducted in May of 2010 by the 2015 Research Group (Appendix5).

The first day of the conference began with presentations (Appendix 1) that reviewed the conclusions and recommendations from the first two conferences.^{1,2} These were followed by workforce data from the 2009 AARC Human Resources Study³ and presentations of the results of two preconference surveys which generated 1020 responses from respiratory therapy educators⁴ and directors of respiratory care departments.⁵ The survey questions included the competencies needed, education level, and credentials needed for entry into practice in 2015 and beyond. Three preconference surveys of deans that are members of the Association of Schools of Allied Health Professions (ASHAP), two-year college deans without RT programs, and deans with RT programs were not presented because of low response rate. The first day ended with an overview of the AARC's Medicare Part B Respiratory Therapy Initiative in the United States Congress.

The second day of the conference focused on generating, discussing, and accepting recommendations for change. Voting key pads, version 5.62.0090 (eInstruction, Denton, Texas, www.einstruction.com), were used to record and display voting on all proposals. A simple majority was used to approve all proposals made by conference attendees with "yes", "no", or "abstention" votes recorded by a computer and the tally projected on the screen at the front of the room following the close of voting. On the third day of the conference, the agreed upon conference goal, attributes used to evaluate recommendations and eleven recommendations to be forwarded to the AARC Board of Directors were reviewed again by the participants. Post conference plans for a public hearing, an informational time line, visits to stakeholder groups and plans for publication of a conference paper were discussed by the conference participants before

the conference adjourned. A public hearing on the recommendations accepted and approved by conference three participants was held the day after the conference adjourned.

Results

The overall goal of the conference was accepted and approved by the attendees. The attributes that transition recommendations needed to meet were approved by conference participants (Table1). The voting results for recommendations presented and debated can be found in Table2.

Conference Goal

The overall goal of the conference was to determine what changes in the profession are necessary to position respiratory therapists to fulfill the roles and responsibilities identified in conference one and to insure that future and practicing respiratory therapists in 2015 and beyond acquire the competencies identified in conference two.

Education

A single recommendation regarding respiratory therapy education was accepted and approved by majority vote:

That the AARC request CoARC to change by 7/1/12 accreditation standard 1.01 to read as follows:

1.01 The sponsoring institution must be a post-secondary academic institution accredited by a regional or national accrediting agency that is recognized by the U.S. Department of Education

(USDE) and must be authorized under applicable law or other acceptable authority to award graduates of the program a baccalaureate or graduate degree at the completion of the program. Programs accredited prior to 2013 that do not currently offer a baccalaureate or graduate degree must transition to conferring a baccalaureate or graduate degree, which should be awarded by the sponsoring institution, upon all RT students who matriculate into the program after 2020.

Credentials

Two specific recommendations regarding credentialing were approved:

- *That the AARC recommends to the NBRC on July 1, 2011, that the CRT examination be retired after 2014.*
- *That the AARC recommends to the NBRC on July 1, 2011 that the multiple choice examination components (CRT and RRT written) for the RRT should be combined after 2014.*

Licensure

The following licensure recommendation was approved: *That the AARC establish on July 1, 2011, a commission to assist state regulatory boards transition to a RRT requirement for licensure as a respiratory therapist.*

Transition of Respiratory Therapist Workforce

A number of recommendations regarding the existing workforce were approved:

That the AARC Executive Office request that the AARC Board of Directors ask the appropriate existing sections to develop standards to assess competency of RTs in the workforce relative to job assignments of the RT.

- *Standards should address the variety of work sites that employ RTs.*
- *Standards should address RT knowledge, skills and attributes relative to the tasks being evaluated.*

Continuing Education

The following recommendation regarding continuing education was approved: *The AARC encourage clinical department educators and state affiliates continuing education venues use clinical simulation as a major tactic for increasing competency levels for the current workforce.*

Consortia and Cooperative Models

The following recommendation regarding associate degree programs transitioning to bachelor degree programs was approved: *That the AARC, in cooperation with CoARC, consider development of consortia and cooperative models for associate degree programs that wish to align with bachelor degree granting institutions for the award of the Bachelors degree.*

Budgetary Resources

The following recommendation regarding financial resources was approved: *That the AARC provide budgetary resources to assist associate degree programs with the transition to baccalaureate level respiratory therapist education.*

Promotion of a Career Ladder

The following recommendation regarding a respiratory therapy career ladder was approved: *That the AARC BOD explores development and promotion of career ladder educational options for the members of the existing workforce to obtain advanced competencies and the baccalaureate degree.*

American Respiratory Care Foundation

The following recommendation regarding the foundation was approved: *That the AARC request the American Respiratory Care Foundation to establish a restricted fund for donations to support the transition of associate degree programs to baccalaureate level respiratory therapist education.*

Recommendations Not Approved

The following recommendations considered by the Conference attendees were not approved:

- *Two levels of practice, with details to follow.*
- *That the AARC recommend to chartered affiliates on July 1, 2011, that they recommend to their state regulatory board:*
 1. *That the RRT credential be required to obtain a license to practice as a respiratory therapist for all new applicants after 2012;*
 2. *That a provisional or limited license, effective for three years from the date of graduation from an CoARC accredited respiratory therapist program, be granted to*

all new applicants after 2012 who have passed the NBRC written registry examination but not the clinical simulation examination.

- *That a model career pathway be developed by the AARC with the identified 2015 competencies incorporated into existing program levels but distinguishing between the competencies needed at each level (e.g. Registry and Registry PLUS).*

Discussion

Education

As defined in the results of the 2015 and Beyond conference two² the knowledge, skills and attributes that future respiratory therapists will need, exceed those of today's respiratory therapy program graduate. The educational requirements of the graduate respiratory therapist have not changed in 40 years. However, during this same period the role of the respiratory therapist has greatly expanded. The RTs of today are expected to perform therapeutic techniques, deliver medications, and operate medical devices used to evaluate and treat patients with increasingly complex cardiopulmonary disorders that were not even available 20 years ago.^{1, 6} The respiratory therapist of today is expected to assess and quantify patients' cardiopulmonary status, to provide appropriate respiratory care by applying protocols, and to evaluate the medical and cost effectiveness of the care that RTs deliver.² The expectation is that in 2015 and beyond, in addition to an active role as a bedside care provider, all RTs will be consultants on how respiratory care should be provided. On patient rounds therapists are expected to contribute to the discussion of goals and direction of therapy and to provide evidence supporting various approaches to respiratory care used in the intensive care unit. Specifically, RTs should possess

the ability to discuss and recommend care for patients presenting with diseases that affect the respiratory system.²

Respiratory therapists must achieve higher levels of education and training to respond to these increasing future demands projected by the 2015 Task Force conferences.^{7, 8} The attraction of respiratory therapy as a potential career choice by both young people and adults is influenced by minimal educational standards. The profession's current failure to demand an adequate entry level education negatively affects the perception of the profession, suggesting a more technical and less professional career. Governmental agencies, legislators, third-party payers, and the military services all use the baccalaureate degree as the minimal educational level as a method to differentiate professions from technician groups.⁹⁻¹¹

Educators are constantly challenged to expand their curricula to prepare students for these new responsibilities.^{12, 13} These demands on RT curriculums will only increase in the future and will have a significant impact on the education system. Associate degree RT (ASRT) programs are already stretched too thin to teach the knowledge, skills and attributes that students need to enter the workforce today let alone those needed in 2015 and beyond. On a preconference survey, 161 (46.5%) RT program directors indicated that because of state and institutional credit constraints for degree completion, they could not increase the credit hours in their curriculum. For example, the Texas Higher Education Coordinating Board restricts ASRT programs to 72 semester hours of credit.¹⁴ A preconference survey of deans and directors of health science divisions with accredited RT programs indicated that only 21 (29.6%) said that BSRT degree should be required for entry into the profession.¹⁵ However, 46 (66.7 %) of these respondents stated that a baccalaureate should be required after licensure for continued practice. The results of this survey lack validity because of the low response rate of only 18.2% (75 of 411 colleges).

The increased knowledge, new skills and professional attributes simply can't be easily taught in an already crowded two-year curriculum. As medical science advances, it will be increasingly difficult for RT educators to add additional material to their curriculum. Too few ASRT programs teach their students how to read and critique research, understand the statistical data, and search for evidence to support respiratory care practice. Evidence-based medicine (EBM) has become the standard for practice of all professions and the graduate respiratory therapists must be proficient in the tenets of EBM today and certainly by 2015 and beyond.¹³

The 2015 Research Group survey of respiratory therapy program directors has shown that EBM and protocols, and leadership skills are not currently taught by the majority of ASRT programs nor mastered by graduates.⁴ Only 33.1% of ASRT programs teach their students about EBM and protocols compared to 88% of baccalaureate RT (BSRT) programs.⁴ The survey showed that 81.8% of BSRT programs teach students how to understand and critique published research, a necessary skill to practice EBM, compared to 41.0% of ASRT program.⁴ Only one-third of ASRT programs teach students the meaning of general statistical tests compared to over 80% of BSRT programs.

Changes in healthcare policy, regulation, and reimbursements have required RTs to adopt expanded roles, work more independently in settings across the continuum of care, and collaborate as partners on the health care delivery team. Greater than two-thirds (70.1%) of BSRT programs teach students how to lead groups in care planning and facilitate collaboration compared to only 50.2% of ASRT programs.⁴ Other areas where leadership is taught more often by BSRT programs than ASRT programs are regulatory requirements on the healthcare system, financial reimbursement, and contributing to organizational teams for planning and collaborative decision making.⁴

Many ASRT programs have had to increase their length from two to three years to meet current needs and to prepare students to be successful on the CRT and RRT examinations offered by the National Board for Respiratory Care (NBRC).⁴ Add a fourth year to a three-year ASRT program and the student qualifies for a BSRT degree in many institutions. Requiring three years of coursework and only awarding an associate degree is grossly unfair to the student in these expanded associate degree programs.⁴

The 2015 conference three recommendations include a transition period of ten years for ASRT programs to make the arrangements necessary to be able to award a BSRT degree. Several senior colleges and universities have consortia agreements to award the baccalaureate degree in respiratory therapy to accredited BSRT programs located in academic medical centers and community colleges. Further, there are several accredited BSRT programs that have online curriculums for ASRT students to complete requirements for a BSRT degree. These are proven methods for awarding a baccalaureate degree when the parent institution does not have baccalaureate degree granting authority. In addition, some community colleges are able to award baccalaureate degrees.¹⁶⁻¹⁸

Three conference recommendations were made to help ASRT programs transition over 10 years to award a baccalaureate degree or higher in respiratory therapy. Development of consortia and cooperative models was recommended since many currently accredited registry-eligible programs use this method to award a baccalaureate degree to their graduates. This recommendation is important because it is designed to show with time-tested models how ASRT, BSRT programs, and senior colleges can work together to reach a minimum baccalaureate degree entry level by 2020. Conference participants also requested that the AARC and the American Respiratory Care Foundation (ARCF) provide financial resources to help ASRT

programs transition to the point where they can award a baccalaureate degree directly or with a consortium agreement with a BSRT program or senior college. The AARC was requested by conference participants to ask the ARCF to establish a restricted fund for donations to help finance the transition of ASRT to BSRT programs.

The 2015 conference three heard both “pro” and “con” positions on the recommendation for transitioning to a BSRT degree entry level by 2020. Participants had no authority to vote on behalf of their respective agencies. The opposition position to change in education level is discussed below.

The RT profession has grown significantly over the past 50 years.¹ Its growth corresponds to an ever-increasing body of knowledge and technology along with the skills required to serve patients in various settings.¹ However, the recommendation approved by the majority of attendees at conference three may not be a feasible option for many of the current accredited RT programs. While conference three and the two previous conferences explored numerous issues related to increasing the RT educational requirement to the baccalaureate level, it failed to discuss important attributes concerning the transition that could limit the successful implementation.

1. *Transitioning from an associates' to baccalaureate degree by secondary institutions is politically charged and not likely to occur.*

Our nation's community colleges have played a major role in educating the respiratory care workforce. Currently there are 356 (86.7%) community college RT programs with an approximate enrollment of 6230 RT students that award an associates' degree. There are also 55 programs (13.3%) that award a BSRT degree, most based at four-year colleges.^{3,4} While many

current program directors may be interested in pursuing additional educational opportunities for their students, there is no analysis that shows four-year institutions are willing to engage the transition and education of the respiratory care workforce from community colleges. Many four-year colleges might be reluctant to invest in this workforce program if the return on investment was not profitable. In the states that only allow baccalaureate degrees to be offered in specified four-year institutions, the current two-year RT programs in community colleges would need to be transitioned to this new standard. Additionally, due to force structure and degree requirements for its officers and enlisted corps, the current military programs will unlikely be able to make a successful transition. Despite feasibility being accepted as an important attribute for any transition plan, this conference failed to assess the likelihood or cost involved in converting current two-year programs or establishing new baccalaureate programs.

2. *Necessity of baccalaureate degree to maintain an entry level qualified workforce.*

The goal of the three conferences was to discuss the attributes for the future graduate RT, recommend competencies for this therapist, and identify the educational pathway needed to reach this goal. However, there is a clear difference between recommended competencies and the required educational level. Many of the competencies needed in 2015 and beyond are currently being taught in ASRT programs and additional education is not absolutely required for trained and competent RTs. There currently are numerous additional career pathways with additional skills for RTs to pursue that are recognized in the absence of a BSRT degree. This list includes the Pulmonary Function Technologist, Neonatal/Pediatric Respiratory Care Specialist, and Certified Sleep Disorders Specialist. These specialties require additional education and on-the-job training but they are specialized training and not expected of the graduate RT. The evidence

that RTs with a BSRT degree are more prepared to enter the workforce than RTs with ASRT degree is minimal and insufficient to undertake such a large-scale restructuring of the respiratory care educational system.

3. *Increased competency based on increased educational level not proven.*

Current evidence does not suggest that additional education leads to a more qualified or competent RT. The NBRC study “*Effects from Education Program Type on RRT Candidate Outcomes*” demonstrated interesting characteristics of education level compared to pass rates on the CRT and RRT examinations.¹⁹ Candidates who had earned a BSRT degree had a pass rate of 86.8% on the CRT while ASRT degree holders had a pass rate of 79.2%. Candidates with a BSRT degree had a pass rate of 72.9% on the RRT while those with an ASRT degree had a pass rate of 68.0%. Increasing the education level does not result in such large improvement in certifying examination pass rates.

Before undertaking this transition further consideration should be given to alternatives that will achieve the desired outcome, that being a prepared RT for today’s and tomorrow’s workforce. Examples of alternatives include the following.

- a. Encourage programs to affiliate with a four-year college to allow students to continue with studies for a BSRT degree after earning an ASRT degree.
- b. Continue to support specialty certification that allows students to continue their education with a focus on the needs for their specific job duties.
- c. Develop an internship model through healthcare facilities with a structured curriculum that allows the therapist to take specialty examinations.

Credentials and Licensure

Graduate RTs are currently required to take three examinations to become a RRT.² First they must pass the CRT examination and be recognized as a Certified Respiratory Therapist. This examination is also used by most states as the state licensure examination. Upon successful completion of the CRT examination, graduate therapists are expected to take the RRT examination. The RRT examination is taken in two parts: a written multiple choice examination, followed by a clinical simulation examination. While most graduates of RT programs take the CRT examination, a smaller percentage takes the RRT examination. The current two-tier credentialing system and state laws that require successful completion of only the CRT examination for licensure offer insufficient incentives to graduating RTs to demonstrate competency in areas tested by the RRT examinations. In 2003, the AARC, the Commission on Accreditation of Respiratory Care (CoARC), and the National Board for Respiratory Care (NBRC) recognized the RRT credential as the “standard of excellence” for RTs.

Both Conference three recommendations on the appropriate credential to enter practice in 2015 stem from the widely held view that there is no difference in job duties between those holding the CRT and RRT credentials. RRT was selected over CRT as the credential that future graduates should earn to enter the profession by 81.1% RT department directors that responded to the 2015 preconference survey.⁵ The same question on a survey sent to directors of accredited RT programs elicited a two-thirds majority (68.2%) in favor of RRT over CRT.⁴ A majority of Conference three participants believe that the scope of practice in 2015 will require the level of knowledge and critical thinking tested by the RRT examination. They were confident that the knowledge, skills, and attributes tested on the CRT examination, but not currently on the RRT examination, could be easily incorporated into the two RRT examinations. The vast majority felt

that educators prepare students for the RRT examinations and 2015 was the right time to require the RRT credential for entry into practice. The same question asked of deans and directors of health science divisions with accredited RT programs on a preconference survey¹⁵ shows that 50 (74.6%) of respondents were in favor of the RRT being required to enter practice as a respiratory therapist. Another preconference survey of members of the ASAHP had 81.3% (13) of respondents indicating a baccalaureate or graduate degree should be required of RTs for licensure.²⁰ Both of these surveys of deans had low response rates of 18.2% and 13.1% respectively. By 2015 the graduate therapist must enter the profession demonstrating that they have the confidence and skills required for practice at the registry level.² The American public should feel assured that patient care is given by the most competent and highly trained therapist possible. Many RT educators and department directors surveyed prior to the conference stated that having two credentials (CRT and RRT) confuses the public, patients and other healthcare colleagues who are not aware of the difference. This is primarily the result of CRTs and RRTs being assigned to the same job responsibilities. The majority of conference participants believe that the respiratory therapy profession needs one level of credential (RRT), one educational goal, and one expectation for competency of graduate therapists entering the workforce in 2015 and beyond. Of great concern to conference participants was the fact that the CRT credential was developed for 12 month training programs that will no longer exist in 2015. Any change in the credentialing system may require changes in some state regulations controlling who may deliver respiratory care.

Participants at the conference recognized the need to prepare for changes in state legislation and regulations regarding licensure of RTs to practice if the CRT examination was retired. Accordingly, the conference recommended that the AARC establish on July 1, 2011 a

commission to assist state regulatory board transition to a RRT license. Many state licensure regulations currently state that the CRT or RRT is required for a license to practice. This type of regulatory language will accommodate grandfathered therapists with the CRT credential and also be able to license RRTs without the CRT credential.²¹ Currently, the reference to the "entry level exam" means the CRT examination (but in most cases does not actually state it is the CRT examination, simply the "entry level exam"). If the entry level were to become the RRT, most laws would not have to be amended. Most boards have fairly flexible regulatory authority and could shift over to the RRT exam if that were to become the entry level (including, presumably, some type of grandfather provision).²¹ The purpose of the recommended AARC Licensure Commission is to develop models of regulatory language and to work with state licensure boards to make the transition needed by 2015.

Impact of Change on the Existing Workforce

As the expectations of the respiratory care entry level workforce change, increasing pressures will develop for assisting existing practitioners to meet these new standards by documenting their success at acquiring the new competencies. Additional pressures will come from state licensing boards and the public will demand that all healthcare professionals maintain evidence of continued basic competence throughout their professional career. Time-limited medical specialty certification with required periodic re-certification is now the standard for physicians and other professionals. While individuals already in the workforce are likely to be "grandfathered", employers and the public will likely demand evidence of continued competence of all healthcare workers.²²

Professional development, life-long learning, and validation of continued competence is the responsibility of each individual practitioner. Professions have a duty to define what a professional should know and how a professional should act, and then provide continued education and documentation tools for their members to achieve these goals. This has traditionally been achieved in the form of scientific meetings, publications, and workshops with or without an examination or certificate to demonstrate acquisition of the new knowledge. However, professional success depends on more than just knowledge – it requires acquiring new skills, new attitudes and application of new knowledge to daily clinical practice. Employers are required to teach, test, and certify clinical competency with regard to required tasks of a particular job. The AARC should establish practice standards which include knowledge, skills, attitudes, judgment, abilities, experience, and ethics. The AARC should foster the development of tools that can be used to assess competence in all these areas for respiratory care practitioners throughout the duration of their careers. Clinical simulation techniques are useful for both teaching and assessing successful acquisition of new knowledge, skills, and attitudes in moving the current workforce members into the workforce of the future. Acceptance of the conference recommendation to elevate the entry level for respiratory therapist practice to RRT will require individuals to achieve a higher level of problem-solving skills and pass a more comprehensive examination of clinical reasoning before entering into practice. Elimination of the current three examination system, also a recommendation of this third conference, will go a long way to change the expectations placed on students as they begin their educational program and will result in a different performance of successful program graduates throughout their professional career.

Addressing Workforce Education Issues

The conference participants recommended that the AARC Executive Office and Board of Directors ask existing specialty sections to develop standards to assess and increase competency of RTs in the workforce relative to job assignments. The precedence of experienced RTs working in specialized areas such as neonatology and pediatrics, pulmonary function technology, sleep disorders, diagnostics, ground and air transport, long term care, adult acute care, management and education is well established.² Competency standards should address the variety of work sites that employ RTs and delineate the knowledge, skills and attributes relative to the tasks needed in each specialty area.

Participants attending the conference requested that the AARC Board of Directors explore development and promotion of career ladder educational options for the members of the existing workforce to obtain advanced competencies and the baccalaureate degree. This stems from the findings of 2015 conference one that the roles and responsibilities of the RT workforce will change substantially in the near future, in response to major changes in the United States healthcare system.^{1,2} The AARC must develop options for the current RT workforce to prepare for the new roles and responsibilities in 2015 and beyond. Further education and training in each of the seven competency areas identified by the 2015 conference and in all the specialty areas needs to begin immediately for the profession to ready by 2015.^{1,2}

In the current and future education of RTs, the use of simulation undoubtedly will need to increase significantly. There are numerous capabilities both in computer and human simulation that may play a valuable role in RT education. One challenge in increasing the educational requirement to the baccalaureate level may be in providing additional training opportunities. While the experience of direct patient care cannot be replaced, valuable knowledge and practice

can be gained in the safety of the simulation environment. Many of the current capabilities for simulation use were explored in “*Respiratory System Simulations and Modeling.*”²³ MacIntyre categorized the simulation assets as 1) computerized simulation of patient signs and symptoms, 2) computerized anatomic simulation and modeling of the respiratory system, and 3) computerized physiologic simulation and modeling. Patient simulation systems include the full-size human patient simulator (to include ventilators) with modeling of upper airway anatomy, breath sounds, respiratory system mechanics, and gas exchange. Airway simulation and modeling includes bronchoscopy simulation and three-dimensional virtual bronchoscopy. Physiologic simulation and modeling can include respiratory system mechanics, distribution of ventilation, and gas exchange. Continued advances in this simulation technology can be directly applied to education of providers of mechanical ventilation.²⁴

Simulation is already an effective clinical tool to train RTs and other medical providers in multiple clinical scenarios. The most frequent application has been in teaching basic resuscitation skills where use of human patient simulators is extensive and is shown to be superior to traditional teaching methods.²⁵ The use of mechanical ventilation simulators with medical residents for treatment of ARDS has demonstrated improvement in selecting proper ventilator settings.²⁶ Other specific respiratory therapy techniques such as mini-bronchoalveolar lavage are likewise effectively taught through simulation.²⁷ Preparation of the RT for ICU patient care can be accomplished safely, effectively, and provide immediate feedback for individuals or an entire team and clearly should be an integral part of any RT curriculum.²⁸ The value of simulation has been demonstrated in many different scenarios such as trauma and ICU training.²⁹ Given the current variety of simulation platforms and the expanding educational needs of future RTs, simulation use in didactic and clinical scenarios will prove an invaluable teaching method.

Summary

In response to major changes evolving in the United States healthcare system, the role and responsibilities of the RT workforce will change substantially. As predicted in the first conference, there will be increasing pressure on improved quality, reduced cost, and higher expectations of healthcare professionals. The second AARC conference reached general agreement on entry-level competencies needed by graduate therapists to be successful in this emerging healthcare environment. This third conference reached majority agreement on the need for a baccalaureate degree as the minimum entry education level and the RRT as the credential for beginning respiratory care practice. Discussion about how such changes would affect current program accreditation and migration, licensure, and the existing workforce led to recommendations that the AARC commit resources to support individuals and organizations in overcoming these challenges. Time lines (Table3) to achieve these needed changes were proposed and accepted by a majority of the participants in this conference.

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Table 1 Attributes that 2015 transition plans must meet.

-
-
- Maintain an adequate number of respiratory therapists throughout the transition.
 - Address unintended consequences such as respiratory therapist shortages.
 - Require multiple options and flexibility in educating both students and the existing workforce. (e.g. affiliation agreements, internships, special skills workshops, continuing education, etc)
 - Require competency documentation options for new graduates.
 - Support a process of competency documentation for the existing workforce.
 - Assure that credentialing and licensure recommendations evolve with changes in practice.
 - Address implications of changes in licensing and credentialing
 - Establish practical timelines for recommended actions.
 - Assure that emerging conference recommendations must be supported by a plurality of the stakeholders in attendance.
 - Reflect the outcomes of the previous two 2015 and Beyond conferences
 - Identify the agency most appropriate to implement identified elements.
-

Table 2 Results of Electronic Voting on Recommendations

Recommendations	Voting Yes N (%)*	Voting No N (%)*	Abstentions N	Total N**
<i>Approved</i>				
Conference Goal	28 (87.5)	4 (12.5)	2	34
Evaluation Attributes	26 (83.9)	5 (16.1)	4	34
Education	20 (62.5)	12 (37.5)	3	35
Credentials	25 (75.8)	8 (24.2)	2	35
Licensure	28 (93.3)	2(6.7)	5	35
Transition of RT Workforce	28 (90.3)	3 (9.7)	0	31
Continuing Education	31 (96.9)	1 (3.1)	0	32
Consortia and Cooperative Models	29 (100.0)	0 (0.0)	3	32
Budgetary Resources	23 (95.8)	1 (4.2)	7	31
Promotion of Career Ladders	27 (100.0)	0 (0.0)	4	31
American Respiratory Care Foundation	25 (96.2)	1 (3.8)	4	30
<i>Not Approved</i>				
Two Levels of Practice	13 (40.6)	19 (59.4)	3	35
Licensure Recommendation to Chartered Affiliates	2 (6.7)	28 (93.3)	5	35
Model Career pathway	7 (25.0)	21 (75.0)	6	34
*Percentage of those voting yes or no.				
**AARC staff members attending the conference did not vote on recommendations.				

Table 3. Recommendation Time Lines for Major Policy Changes and Effective Dates for Implementation

Recommendation	Change Timeline	Effective Date
Change CoARC accreditation standard to require new programs after 2012 to offer a baccalaureate degree in Respiratory Therapy	7/1/2012	1/1/2013
Change CoARC accreditation standard to require all accredited programs after 2020 to offer a baccalaureate degree in Respiratory Therapy	7/1/2012	1/1/2021
Retire NBRC Certified Respiratory Therapist Examination after 2014	7/1/2011	1/1/2015

CoARC, Commission on Accreditation of Respiratory Care;
NBRC, National Board for Respiratory Care

Appendix 1. Conference Program Presentations

Topic	Speaker(s)
Welcome and Introductory Remarks	Sam P Giordano MBA, RRT, FAARC, American Association for Respiratory Care
Overview of Conference Structure, Expected Outcomes and Ground Rules	Thomas A Barnes EdD, RRT FAARC, Northeastern University, Boston, Massachusetts
	Charles G Durbin MD FAARC, University of Virginia Medical Center, University of Virginia School of Medicine, Charlottesville, Virginia.
	Woody V Kageler MD MBA, Tarrant County College, Hurst, Texas
Overview of Previous Conferences	Thomas A Barnes EdD, RRT FAARC, Northeastern University, Boston, Massachusetts
	Robert M Kacmarek PhD RRT FAARC, Massachusetts General Hospital, Boston, Massachusetts
Workforce Data Research and Projections	William H Dubbs RRT MHA MEd FAARC, American Association for Respiratory Care
Survey Data from Educators and Deans	Thomas A Barnes EdD, RRT FAARC, Northeastern University, Boston, Massachusetts
Survey Data from Respiratory Therapy Managers	Robert M Kacmarek PhD RRT FAARC, Massachusetts General Hospital, Boston, Massachusetts
Overview of AARC's Medicare Part B RT Initiative	Miriam O'Day, American Association for Respiratory Care
	Anne Marie Hummel. American Association for Respiratory Care

Appendix 2

Attendees at the Third Conference on the Future of Respiratory Care**

Thomas A Barnes EdD RRT FAARC, Northeastern University

Sherry L Barnhart RRT-NPS, National Board for Respiratory Care President

*Will D Beachey PhD RRT FAARC, Commission on Accreditation of Respiratory Care

Hugh W Bonner PhD, Association of Schools of Allied Health Professions

Kent Christopher MD, AARC Board of Medical Advisors Chair

Kimberly Clark EdD MBA RRT-NPS, North Carolina Board for Respiratory Care

*William H Dubbs RRT MHA MEd FAARC, AARC Staff

Charles G Durbin MD FAARC FCCM, Society for Critical Care Medicine

Edna Fiore, Emphysema Foundation for Our Right to Survive

Roxanne Fulcher, American Association of Community Colleges

Thomas Furman MD MMSc RRT, American Society of Anesthesiologists

David D Gale PhD, Association of Schools of Allied Health Professions

*Sam P Giordano MBA RRT FAARC, AARC Staff

Lynda T Goodfellow EdD RRT AE-C FAARC, AARC Education Section Chair

*Anne Marie Hummel, AARC Staff

Robert M Kacmarek PhD RRT FAARC, Massachusetts General Hospital

Woody V Kageler MD MBA FACP FCCP, Tarrant County College

Thomas J Kallstrom RRT AEC FAARC, AARC Staff

Douglas S Laher MBA RRT, AARC Management Section Chair

Thomas Lamphere BS RRT RPFT, AARC House of Delegates Speaker

Christopher H Logsdon MBA RRT, Ohio Board for Respiratory Care

Mark Mangus RRT RPFT, Emphysema Foundation for Our Right to Survive

Jolene Miller Med RRT, Commission on Accreditation of Respiratory Care

Michael J Morris MD FACP FCCP, Brooke Army Medical Center

Timothy R Myers RRT-NPS, AARC President

Natalie Napolitano MPH RRT-NPS, COPD Foundation

Graham Nelan PhD, American Thoracic Society

*Steven B Nelson MSc RRT CPFT FAARC, AARC Staff

Carolyn O'Daniel EdD RRT FAARC, National Network of Health Career Programs in Two Year Colleges

*Miriam O'Day, Alpha-1 Association and Alpha-1 Foundation

Timothy O'pt Holt EdD RRT AE-C FAARC, Association of Asthma Educators

Gregg Ruppel Med RRT FAARC, National Board for Respiratory Care President

Kathy J Rye EdD RRT FAARC, Commission on Accreditation of Respiratory Care

Deborah Schwarzberg, Career College Association

Robert C. Shaw Jr PhD RRT FAARC, National Board for Respiratory Care

David C Shelledy PhD RRT FAARC, Association of Schools of Allied Health Professions

Thomas R Smalling PhD RRT RPFT RPSGT FAARC, Commission on Accreditation of Respiratory Care

Gary A Smith FAARC, National Board for Respiratory Care

Charles B Spearman MEd RRT FAARC, California Board for Respiratory Care

Karen J Stewart MSc RRT FAARC, AARC President-Elect

Alvin Thomas MD, American College of Chest Physicians

*Mark W Thomas MS RPh, American Society of Health System Pharmacists

Jeffrey J Ward MEd RRT FAARC, AARC Education Section Immediate Past Chair

*Non-voting attendees

**Participants had no authority to vote on behalf of their respective agencies.

Appendix 3

Organizations Invited to the Third Conference on the Future of Respiratory Care

Allergy and Asthma Network-Mothers of Asthmatics	COPD-ALERT
Alpha-1 Advocacy Alliance	COPD Foundation
Alpha-1 Foundation	Department of Defense Health Affairs
American Academy of Family Physicians	Disease Management Association of America
American Academy of Pediatrics	Emphysema Foundation for Our Right to Survive
American Association for Cardiovascular and Pulmonary Rehabilitation	Federation of American Hospitals
American Association for Homecare	Genetic Alliance
American Association for Homes and Service for the Aging	Healthcare Financial Management Association
American Association for Respiratory Care	Leapfrog
American Association of Community Colleges	Medical Group Management Association
American Association of Critical Care Nurses	National Association for Home Care & Hospice
American College of Allergy and Immunology	National Association for Long Term Hospitals and Acute Long Term Hospital Association
American College of Chest Physicians	National Association for Medical Direction of Respiratory Care
American College of Physicians	National Board for Respiratory Care
American Health Care Association	National Heart Lung and Blood Institute
American Hospital Association	National Home Oxygen Patients Association
American Lung Association	National Network of Health Career Programs in Two Year Colleges
American Respiratory Care Foundation	New York State Board of Respiratory Therapy
American Sleep Apnea Association	North Carolina Board for Respiratory Care
American Society of Anesthesiologists	Ohio Board for Respiratory Care
American Society of Health System Pharmacists	Pulmonary Fibrosis Foundation

American Thoracic Society	Robert Wood Johnson Foundation
Association of Asthma Educators	Society of Critical Care Medicine
Association of Schools of Allied Health Professions	Society of Hospital Medicine
Asthma and Allergy Foundation of America	Texas Department of State Health Services- Respiratory Therapy Program
Blue Cross	The Joint Commission
California Board for Respiratory Care	U.S Department of Health & Human Services
California Health Care Foundation	U.S Department of Health & Human Services/HRSA
Catholic Health Association of the United States	U.S. Office of Personnel Management
Centers for Disease Control and Prevention	United Health Care
Center For The Health Professions	United States Public Health Service
Centers for Medicare and Medicaid Services	
College Career Association	
Commission on Accreditation of Allied Health Education Programs	
Commission on Accreditation of Respiratory Care	
Community College Baccalaureate Association	

Appendix 4

Task Force on the Future of Respiratory Care

Sam P Giordano MBA RRT FAARC, Chair

Thomas A Barnes EdD RRT FAARC

William H Dubbs RRT MHA MEd FAARC

Charles G Durbin MD FAARC FCCM

David D Gale PhD

Robert M Kacmarek PhD RRT FAARC

Woody V Kageler MD MBA FACP FCCP

Thomas J Kallstrom RRT AE-C FAARC

Michael J Morris MD FACP FCCP

Karen J Stewart MS RRT FAARC

John W Walsh

John R Walton MBA RRT FAARC

Appendix 5

2015 Task Force Research Group

Thomas A Barnes EdD RRT FAARC, Chair

William H Dubbs RRT MHA MEd FAARC

Charles G Durbin MD FAARC FCCM

David D Gale PhD

Sam P Giordano MBA RRT FAARC

Robert M Kacmarek PhD RRT FAARC

Woody V Kageler MD MBA FACP FCCP

Michael J Morris MD FACP FCCP

Robert C. Shaw Jr PhD RRT FAARC

Thomas R Smalling PhD RRT RPFT RPSGT FAARC

Karen J Stewart MS RRT FAARC

David L Vines MHS RRT FAARC

Jeffrey J Ward MEd RRT FAARC

I am pleased to provide you with a report of the actions taken by your board of directors related to the 2015 and Beyond Project at its recent meeting in Las Vegas, NV.

Background:

The AARC Executive Director was directed by the AARC president to organize a series of conferences to address the following questions:

- What will the future health care system look like?
- What will the roles and responsibilities of respiratory therapists be in the future system?
- What competencies will be required for RTs to succeed in the future?
- How do we transition the profession from where it is today to where we need to be in the future?

He selected a planning group of individuals representing key stakeholders of the profession to plan and implemented a series of 3 conferences.

The first two questions were established as the goals for Conference I which convened in the spring of 2008. A manuscript describing the outcomes of this conference was published in *Respiratory Care* in March of 2008.

Based on the findings of the first conference a second conference was convened in the spring of 2009 to identify the competencies required to fulfill the roles previously identified. The envisioned competencies were embedded in a manuscript that included the conference proceedings published in *Respiratory Care* in May of 2010.

Following the publication of that manuscript a third conference was convened in July 2010. This conference was to identify options for transitioning the profession to meet the envisioned future demands. A manuscript describing the proceedings of this conference and the recommendations of the conferee stakeholders is now being prepared and will be submitted to *Respiratory Care*.

Following the completion of the third conference, the AARC Executive Director provided the AARC board of directors with a final report of the three conference project and his recommendations for approval.

Recommendation #1

“That the ‘transition plan attributes’ be approved by the Board.”

The transition plan must:

- Maintain an adequate respiratory therapist workforce throughout the transition.
- Address unintended consequences such as respiratory therapist shortages.
- Require multiple options and flexibility in educating both students and the existing workforce. (e.g. affiliation agreements, internships, special skills workshops, continuing education, etc)
- Require competency documentation options for new graduates.
- Support a process of competency documentation for the existing workforce.

- Assure that credentialing and licensure recommendations evolve with changes in practice.
- Address implications of changes in licensing, credentialing and accreditation.
- Assure that emerging conference recommendations must be supported by a plurality of the stakeholders in attendance.
- Establish practical timelines for recommended actions.
- Reflect the outcomes of the previous two 2015 and Beyond conferences
- Identify the agencies most appropriate to implement identified elements.

This recommendation was amended to delete the following attribute:

- Assure that emerging conference recommendations must be supported by a plurality of the stakeholders in attendance.

Had this attribute been accepted by the board it would be unable to consider recommendations that failed to receive the support of the plurality of attendees. In rejecting this attribute, the board will consider all recommendations that were brought forth at the conference

Board Action:

The board unanimously accepted the recommendation as amended. This list of transition plan attributes was developed by the 2015 planning group prior to the third and final conference. These attributes will provide assurance to all stakeholders that as we move forward, we will not create new problems to solve old ones. We must not create a new system which cannot adequately provide adequate numbers of graduates. By adhering to these attributes we will consider virtually all tactics and strategies put forth while providing assurance of goal-directed change which will not only move the profession forward but also address the many challenges manifest in such a transition.

Recommendation #2

“That AARC Leadership after reviewing recommendations generated in Conference III identify additional research, additional communication needs, legal issues, including but not limited to legal credentialing, feasibility and other potential impact brought about by implementation of the recommendations.”

Board Action:

The board unanimously accepted the recommendation. Even though we conducted several pre-Conference 3 surveys, the statistical power of many of these surveys does not permit generalization across the population being surveyed. While the surveys were useful in giving us a feel for certain issues, these surveys should in no way be considered as the ultimate research required to responsibly consider the recommendations.

Recommendation #3

“That if the transition plan attributes are approved by the Board, it conduct at minimum, a cursory crosswalk of Conference III recommendations with the attributes.”

Board Action:

The board unanimously accepted the recommendation. Each of the recommendations emerging from Conference 3 will be evaluated to assure that if implemented, it will not violate the transition attributes. This will permit the Board to know how realistic some of these recommendations are at this point in time. It will also serve to inform the Board of all potential consequences, both negative and positive, as further consideration is given in the future.

Recommendation #4

“That AARC’s leadership use the next year to conduct a briefing/listening tour to provide key stakeholder groups with an opportunity to better understand the project and allow AARC to gain additional input before it takes action on the remaining recommendation.”

Board Action:

The board unanimously accepted the recommendation. During the next year we will visit with key stakeholder groups to help them better understand the project and gain additional input from them before it takes action on recommendations generated by the Conference 3 stakeholder conferees. The AARC needs to carefully assess the impact of each potential approach to transition. Also, it is reasonable to assume that other ideas, tactics, and strategies will be generated by these groups. Moreover, we recognize the concerns of all stakeholders and should do everything possible to promote clarity and understanding by all parties

Closing Comments:

I have appointed an ad hoc committee composed of members of the AARC Board of Directors to assure that these actions are addressed in 2011.

I hope this information is helpful in clarifying your understanding what has been done to address the future needs of the profession and the initiatives that will be conducted during 2011 to help assure a smooth transition of the respiratory therapist workforce to meet those needs.

PROPOSED LEGISLATIVE CHANGES

§ 3730. Issuance of license; Filing of application; Fee

All licenses for the practice of respiratory care in this state shall be issued by the board, and all applications for those licenses shall be submitted directly to and filed with the board. Except as otherwise required by the director pursuant to Section 164, the license issued by the board shall describe the license holder as a "respiratory care practitioner licensed by the Respiratory Care Board of California."

Each application shall be accompanied by the application fee prescribed in Section 3775, shall be signed by the applicant, and shall contain a statement under oath of the facts entitling the applicant to receive a license without examination(s) or to take ~~an~~ one or more examinations.

The application shall contain other information as the board deems necessary to determine the qualifications of the applicant.

§ 3735. Successful completion of written examination prerequisite to license

(a) Except as otherwise provided in this chapter, no applicant shall receive a license under this chapter without first successfully passing the national respiratory therapist examination conducted by those persons, and in the manner and under the rules and regulations, as the board may prescribe.

(b) Notwithstanding subdivision (a), any person applying for licensure or any person who has an application pending, on or after January 1, 2014, shall not receive a license under this chapter without first successfully passing both the written entry and written and clinical simulation advanced level national respiratory therapist examinations, or any subsequent equivalent examination(s).

(c) Any person applying for licensure, who currently holds a valid and current license in another state that was issued prior to January 1, 2014 and the license has never been disciplined, may not be required to pass the advance level national respiratory therapist examination, at the discretion of the board.

§ 3735.5. Equivalent examination for credentialing

The requirements to pass the ~~written~~ examination(s) shall not apply to an applicant who at the time of his or her application has passed, to the satisfaction of the board, ~~an~~ examination(s) that ~~is~~ are, in the opinion of the board, equivalent to the examination(s) given in this state.

§ 3739. Practice by graduate prior to receipt of license

(a)(1) Except as otherwise provided in this section, every person who has filed an application for licensure with the board may, between the dates specified by the board, perform as a respiratory care practitioner applicant under the direct supervision of a respiratory care practitioner licensed in this state provided he or she has met education requirements for licensure as may be certified by his or her respiratory care program, and if ever attempted, has passed the written entry and written and clinical simulation advanced level national respiratory therapist examination(s), or any subsequent equivalent examination(s).

(2) During this period the applicant shall identify himself or herself only as a "respiratory care practitioner applicant."

(3) If for any reason the license is not issued, all privileges under this subdivision shall automatically cease on the date specified by the board.

(b) If an applicant fails either the written entry or written or clinical simulation advanced level national respiratory therapist examination(s), or any subsequent equivalent examination(s), all privileges under this section shall automatically cease on the date specified by the board.

(c) No applicant for a respiratory care practitioner license shall be authorized to perform as a respiratory care practitioner applicant if cause exists to deny the license.

(d) "Under the direct supervision" means assigned to a respiratory care practitioner who is on duty and immediately available in the assigned patient care area.

PROPOSED REGULATORY CHANGES

§1399.351. Approved CE Programs.

(a) Any course or program meeting the criteria set forth in this Article will be accepted by the board for CE credit.

(b) Passing an official credentialing or proctored self-evaluation examination shall be approved for CE as follows:

~~(1) Registered Respiratory Therapist (RRT) - 15 CE hours if not taken for licensure;~~

~~(2) Certified Pulmonary Function Technologist (CPFT) - 15 CE hours;~~

~~(3) Registered Pulmonary Function Technologist (RPFT) - 15 CE hours;~~

~~(4) Neonatal/Pediatric Respiratory Care Specialist (NPS) - 15 CE hours;~~

(45) Advanced Cardiac Life Support (ACLS) - number of CE hours to be designated by the provider;

(56) Neonatal Resuscitation Program (NRP) - number of CE hours to be designated by the provider;

and

(67) Pediatrics Advanced Life Support (PALS) - number of CE hours to be designated by the provider.

(78) Advanced Trauma Life Support (ATLS) - number of CE hours to be designated by the provider

(c) Examinations listed in subdivisions (b)(1) through (b)43 of this section shall be those offered by the National Board for Respiratory Care and each successfully completed examination may be counted only once for credit.

(d) Successful completion of each examination listed in subdivisions (b)(45) through (b)(78) of this section may be counted only once for credit and must be for the initial certification. See section 1399.352 for re-certification CE. These programs and examinations shall be provided by an approved entity listed in subdivision (h) of Section 1399.352.

(e) The board shall have the authority to audit programs offering CE for compliance with the criteria set forth in this Article.

Note: Authority cited: Sections 3719 and 3722, Business and Professions Code. Reference: Section 3719, Business and Professions Code.

§1399.352. Criteria for Acceptability of Courses.

Acceptable courses and programs shall meet the following criteria:

(a) The content of the course or program shall be relevant to the scope of practice of respiratory care. Credit may be given for a course that is not directly related to clinical practice if the content of the course or program relates to any of the following:

(1) Those activities relevant to specialized aspects of respiratory care, which activities include education, supervision, and management.

(2) Health care cost containment or cost management.

(3) Preventative health services and health promotion.

(4) Required abuse reporting.

(5) Other subject matter which is directed by legislation to be included in CE for licensed healing arts practitioners.

(6) Re-certification for ACLS, NRP, PALS, and ATLS.

(7) Review and/or preparation courses for credentialing examinations provided by the National Board for Respiratory Care, excluding those courses for entry-level or advanced-level respiratory therapy certification.

(b) The faculty shall be knowledgeable in the subject matter as evidenced by:

(1) A degree from an accredited college or university and verifiable experience in the subject matter, or

(2) Teaching and/or clinical experience in the same or similar subject matter.

(c) Educational objectives shall be listed.

(d) The teaching methods shall be described, e.g., lecture, seminar, audio-visual, simulation.

(e) Evaluation methods shall document that the objectives have been met.

(f) Each course must be provided in accordance with this Article.

(g) Each course or provider shall hold approval from one of the entities listed in subdivision (h) from the time the course is distributed or instruction is given through the completion of the course.

(h) Each course must be provided or approved by one of the following entities. Courses that are provided by one of the following entities must be approved by the entity's president, director, or other appropriate personnel:

- (1) Any post-secondary institution accredited by a regional accreditation agency or association recognized by the United States Department of Education.
 - (2) A hospital or health-care facility licensed by the California Department of Health Services.
 - (3) The American Association for Respiratory Care.
 - (4) The California Society for Respiratory Care (and all other state societies directly affiliated with the American Association for Respiratory Care).
 - (5) The American Medical Association.
 - (6) The California Medical Association.
 - (7) The California Thoracic Society.
 - (8) The American College of Surgeons.
 - (9) The American College of Chest Physicians.
 - (10) Any entity approved or accredited by the California Board of Registered Nursing or the Accreditation Council for Continuing Medical Education.
 - (i) Course organizers shall maintain a record of attendance of participants, documentation of participant's completion, and evidence of course approval for four years.
 - (j) All program information by providers of CE shall state: "This course meets the requirements for CE for RCPs in California."
 - (k) All course providers shall provide documentation to course participants that includes participants name, RCP number, course title, course approval identifying information, number of hours of CE, date(s), and name and address of course provider.
 - (l) For quarter or semester-long courses (or their equivalent), completed at any post-secondary institution accredited by a regional accreditation agency or association recognized by the United States Department of Education, an official transcript showing successful completion of the course accompanied by the catalog's course description shall fulfill the requirements in subdivisions (i), (j) and (k).
 - (m) The board may audit providers offering CE for compliance with the criteria set forth in this Article.
- Note: Authority cited: Sections 3719 and 3722, Business and Professions Code. Reference: Section 3719, Business and Professions Code.

§1399.395. Fee Schedule. (Shown with recent proposed regulation amendments)

The following schedule of fees is hereby adopted pursuant to Sections 3775 and 3775.5 of the Business and Professions Code:

List of Application	Application Type	Fees
(a)	Application fee	\$ 300
(b)	<u>Entry Level Examination fee</u>	\$ 190
(c)	<u>Entry Level Re-examination fee</u>	\$ 150
(d)	<u>Advance Level Written Examination fee</u>	<u>\$ 190</u>
(e)	<u>Advance Level Written Re-examination fee</u>	<u>\$ 150</u>
(f)	<u>Advance Level Clinical Simulation Examination fee</u>	<u>\$ 200</u>
(g)	<u>Advance Level Clinical Simulation Re-examination fee</u>	<u>\$ 200</u>
(jd)	Renewal fee for licenses expiring on or after January 1, 2002	\$ 230
(ke)	Delinquency fee (not more than 2 years after expiration)	\$ 230
(lf)	Delinquency fee (after 2 years but not more than 3 years after expiration)	\$ 460
(mg)	Inactive license fee.	\$ 230
(nh)	Duplicate license fee	\$ 25
(oi)	Endorsement fee	\$ 25



CSRC Position Paper for RRT as Minimum Requirement for Licensure

California Society for Respiratory Care (CSRC), an organization focused on patient care advocacy, promotion of healthcare safety and professional advancement, affirms its position that the Registered Respiratory Therapist (RRT) credential should be the minimum competency requirement for Respiratory Care Practitioners (RCP's) to practice in California. This position strategically aligns the profession for upcoming changes in healthcare, improves patient care outcomes, improves consumer confidence, and provides leadership to advance the profession.^{1, 2}

The CSRC recognizes the following current and emerging trends that validate our position:

- Healthcare focus shifting towards clinical management of chronic disease processes as a primary work requirement in healthcare.^{1, 5, 7}
- An expanded patient care focus to include specialty areas such as sub-acute, rehabilitation, polysomnography and home care along with traditional hospital based services.^{1, 2, 7}
- Reimbursement changes focused on patient care outcomes, evidence-based treatment and effectiveness of protocol driven therapy.^{1, 2, 3}
- Advancement of the profession and competency level to be consistent with recent changes adopted by Registered Nurses and Physical Therapists.^{6, 7}
- Other states progressing towards RRT as a requirement for licensure.^{8, 9}

The CSRC expects the following benefits from this proactive position:

- **Consumers**
Patient outcome focused care leading to improved quality and safety across the healthcare continuum.⁵
- **Practitioners**
Confirmed advanced knowledge and skills required by the practitioners to provide quality care in all healthcare settings.^{2, 6}
- **Educators**
Standardized and improved graduate competency level to perform effectively in current and future healthcare systems.^{4, 6}
- **Leaders**
Leadership model adept in implementing and standardizing protocol-based care, systems based delivery process, continuous quality improvement, organizational efficiency and research.¹⁰

Summary:

The CSRC requests the Respiratory Care Board (RCB) take immediate action in implementing the RRT credential as the licensure requirement for all new candidates entering the profession. This action will effectively position the profession for current healthcare environments and maintain its relevancy in the emerging healthcare industry.

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5. Ross, M. (2011). H. R. 941. 112th Congress 1st Session. United States Government Printing Office. 1 – 4.
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Board Meeting - Scheduling

2013 Calendar

January	February	March																																																																																																																																					
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22	23	24	25	26	27	28																																																																																																																																	
29	30	31																																																																																																																																					

Proposed Locations

May: Southern California
 October: Sacramento

REVENUE

Revenue Category	2010/11 Actual	2011/12 Actual	2012/13 Projected
Application (CA)	\$241,800	\$284,900	\$480,000
Application (Foreign)	\$200	\$0	
Application (O-O-S)	\$29,400	\$33,800	
Initial License	\$127,488	\$115,068	n/a
Renewal	\$1,987,767	\$2,095,565	\$2,104,500
Delinquent Fees	\$40,250	\$43,930	\$42,780
Endorsement	\$24,975	\$24,470	\$8,750
Duplicate License	\$2,400	\$2,075	\$2,250
Cite and Fine	\$41,378	\$28,646	\$30,000
Miscellaneous	\$38,449	\$30,360	\$21,430
Total Revenue	\$2,534,107	\$2,658,814	\$2,689,710

Projected Workload 2002/03	Current Fees 2012/13
1,600	\$300
n/a	n/a
9,150	\$230
150 / 18	\$230 / \$460
350	\$25
90	\$25
var	var
var	var

EXPENDITURES

Expenditure Items	2010/11 Actual	2011/12 Actual	2012/13 Projected
Salary & Benefits	\$1,219,374	\$1,281,348	\$1,307,168
Training	\$403	\$1,038	\$5,000
Travel	\$18,522	\$25,631	\$30,000
Printing	\$33,432	\$11,974	\$30,000
Postage	\$40,774	\$31,124	\$40,000
Equipment	\$829	\$86,103	\$10,000
ProRata ¹	\$395,142	\$438,489	\$495,323
Fingerprints	\$5,610	\$5,707	\$6,000
All Other Fixed Expenses ²	\$195,473	\$230,629	\$210,000
Investigations	\$27,385	\$31,803	\$44,366
Attorney General	\$448,138	\$384,651	\$400,000
Office of Admin Hearings	\$76,644	\$105,342	\$110,000
Court Reporter Services	\$6,547	\$11,577	\$15,000
Evidence and Witness	\$39,227	\$34,756	\$35,000
Total Expenditures	\$2,507,500	\$2,680,172	\$2,737,857

Actual Exp. thru 08/31/12	Budgeted 2012/13
\$216,921	\$1,385,941
\$0	\$11,227
\$757	\$41,805
\$20	\$26,515
\$4,766	\$39,952
\$0	\$3,150
\$123,754	\$495,323
\$0	\$55,000
\$25,324	\$484,375
\$11,092	\$44,366
\$45,393	\$462,214
\$8,050	\$137,082
\$150	\$0
\$1,463	\$32,050
\$437,690	\$3,219,000

¹ ProRata includes departmental and central administrative services.

² All Other Fixed Expenses include general expenses, communications, facility operations, data processing maintenance, consultant and professional services, examinations and Teale Data Center.

FUND CONDITION

	<u>2011/12*</u>	<u>2012/13</u>	<u>2013/14</u>	<u>2014/15</u>
Beginning Reserve, July 1	\$2,176,982	\$2,363,124	\$2,558,608	2,594,236
Prior Year Adjustments				
Revenues	\$2,658,814	\$2,689,710	\$2,716,055	2,716,055
Interest		\$23,631	\$25,586	25,942
TOTAL RESOURCES	\$4,835,796	\$5,076,465	\$5,300,249	5,336,234
Budget Expenditure ¹	\$2,680,172	\$2,671,857	\$2,822,013	2,906,673
Disbursements ²	\$12,000			
BreEZe Funding ¹		\$45,000	\$62,000	63,860
BreEZe Credit Card ¹		\$21,000	\$42,000	43,260
Reimbursements	(\$219,500)	(\$220,000)	(\$220,000)	(\$220,000)
TOTAL EXPENDITURES	\$2,472,672	\$2,517,857	\$2,706,013	2,793,793
RESERVE, JUNE 30	\$2,363,124	\$2,558,608	\$2,594,236	\$2,542,441

* Actual

¹ BreEZe funding is identified separately (below)
FY 13/14 expenditures reflect a \$70k increase in personnel services (5% PLP & 3% COLA), actual BreEZE expenses, and a 3% increase in overall expenditures.
FY 14/15 expenditures reflect a 3% projected increase in overall expenditures.

² Represents FSCU (State Operations) and FISC (State Controller Operations) disbursements



FUND CONDITION STATE SALARIES RESTORED 7/1/13 AS SCHEDULED

	<u>2011/12*</u>	<u>2012/13</u>	<u>2013/14</u>	<u>2014/15</u>	<u>2015/16</u>	<u>2016/17</u>	<u>2017/18</u>	<u>2018/19</u>
Beginning Reserve, July 1 Prior Year Adjustments	\$2,176,982	\$2,363,124	\$2,558,608	2,594,236	\$2,542,441	\$2,490,645	\$2,492,709	\$2,494,774
Revenues	\$2,658,814	\$2,689,710	\$2,716,055	2,716,055	\$2,716,055	\$2,716,055	\$2,716,055	\$2,716,055
Interest		\$23,631	\$25,586	25,942	\$25,942	\$25,942	\$25,942	\$25,942
TOTAL RESOURCES	\$4,835,796	\$5,076,465	\$5,300,249	5,336,234	\$5,284,438	\$5,232,642	\$5,234,707	\$5,236,771
Budget Expenditure ¹	\$2,680,172	\$2,671,857	\$2,822,013	2,906,673	\$2,906,673	\$2,906,673	\$2,906,673	\$2,906,673
Disbursements ²	\$12,000							
BreEZe Funding ¹		\$45,000	\$62,000	63,860	\$63,860	\$10,000	\$10,000	\$10,000
BreEZe Credit Card ¹		\$21,000	\$42,000	43,260	\$43,260	\$43,260	\$43,260	\$43,260
Reimbursements	(\$219,500)	(\$220,000)	(\$220,000)	-220,000	(\$220,000)	(\$220,000)	(\$220,000)	(\$220,000)
TOTAL EXPENDITURES	\$2,472,672	\$2,517,857	\$2,706,013	2,793,793	\$2,793,793	\$2,739,933	\$2,739,933	\$2,739,933
RESERVE, JUNE 30	\$2,363,124	\$2,558,608	\$2,594,236	2,542,441	\$2,490,645	\$2,492,709	\$2,494,774	\$2,496,838
MONTHS IN RESERVE³	9.0	9.5	9.4	9.2	9.0	9.0	9.0	9.0

* Actual

¹ BreEZe funding is identified separately (below)

FY 13/14 expenditures reflect a \$70k increase in personnel services (5% PLP & 3% COLA), actual BreEZe expenses, and a 3% increase in overall expenditures.

FY 14/15 expenditures reflect a 3% projected increase in overall expenditures.

² Represents FSCU (State Operations) and FISC (State Controller Operations) disbursements

³ Months in Reserve are calculated based on actual budget schedule amounts for FY 12/13 and FY 13/14 and then a one-time projected increase of 3% for FY 14/15. FY 12/13: \$3,153,000; FY 13/14: \$3,216,000; and FY 14/15 (and thereafter): \$3,312,480

ONE-TIME Reduction over Two-Year Cycle (1/1/2014 - 12/31/15)

Assumption: State Salaries Restored 7/1/13 as Scheduled

Renewal Fee Reduction: \$60

	<u>2011/12</u>	<u>2012/13*</u>	<u>2013/14</u>	<u>2014/15</u>	<u>2015/16</u>	<u>2016/17</u>	<u>2017/18</u>	<u>2018/19</u>
Beginning Reserve, July 1	\$2,176,982	\$2,363,124	\$2,558,608	\$2,318,236	\$1,711,681	\$1,381,125	\$1,380,429	\$1,379,734
Revenues	\$2,658,814	\$2,689,710	\$2,440,055	\$2,164,055	\$2,440,055	\$2,716,055	\$2,716,055	\$2,716,055
Interest		\$23,631	\$25,586	\$23,182	\$23,182	\$23,182	\$23,182	\$23,182
TOTAL RESOURCES	\$4,835,796	\$5,076,465	\$5,024,249	\$4,505,474	\$4,174,918	\$4,120,362	\$4,119,667	\$4,118,971
Budget Expenditure ¹	\$2,680,172	\$2,671,857	\$2,822,013	\$2,906,673	\$2,906,673	\$2,906,673	\$2,906,673	\$2,906,673
TOTAL EXPENDITURES	\$2,472,672	\$2,517,857	\$2,706,013	\$2,793,793	\$2,793,793	\$2,739,933	\$2,739,933	\$2,739,933
RESERVE, JUNE 30	\$2,363,124	\$2,558,608	\$2,318,236	\$1,711,681	\$1,381,125	\$1,380,429	\$1,379,734	\$1,379,038
MONTHS IN RESERVE	9.0	9.5	8.4	6.2	5.0	5.0	5.0	5.0

Renewal Fee Reduction: \$50

	<u>2011/12</u>	<u>2012/13*</u>	<u>2013/14</u>	<u>2014/15</u>	<u>2015/16</u>	<u>2016/17</u>	<u>2017/18</u>	<u>2018/19</u>
Beginning Reserve, July 1	\$2,176,982	\$2,363,124	\$2,558,608	\$2,364,236	\$1,850,141	\$1,566,045	\$1,565,809	\$1,565,574
Revenues	\$2,658,814	\$2,689,710	\$2,486,055	\$2,256,055	\$2,486,055	\$2,716,055	\$2,716,055	\$2,716,055
Interest		\$23,631	\$25,586	\$23,642	\$23,642	\$23,642	\$23,642	\$23,642
TOTAL RESOURCES	\$4,835,796	\$5,076,465	\$5,070,249	\$4,643,934	\$4,359,838	\$4,305,742	\$4,305,507	\$4,305,271
Budget Expenditure ¹	\$2,680,172	\$2,671,857	\$2,822,013	\$2,906,673	\$2,906,673	\$2,906,673	\$2,906,673	\$2,906,673
TOTAL EXPENDITURES	\$2,472,672	\$2,517,857	\$2,706,013	\$2,793,793	\$2,793,793	\$2,739,933	\$2,739,933	\$2,739,933
RESERVE, JUNE 30	\$2,363,124	\$2,558,608	\$2,364,236	\$1,850,141	\$1,566,045	\$1,565,809	\$1,565,574	\$1,565,338
MONTHS IN RESERVE	9.0	9.5	8.6	6.7	5.7	5.7	5.7	5.7

Renewal Fee Reduction: \$40

	<u>2011/12</u>	<u>2012/13*</u>	<u>2013/14</u>	<u>2014/15</u>	<u>2015/16</u>	<u>2016/17</u>	<u>2017/18</u>	<u>2018/19</u>
Beginning Reserve, July 1	\$2,176,982	\$2,363,124	\$2,558,608	\$2,410,236	\$1,988,601	\$1,750,965	\$1,751,189	\$1,751,414
Revenues	\$2,658,814	\$2,689,710	\$2,532,055	\$2,348,055	\$2,532,055	\$2,716,055	\$2,716,055	\$2,716,055
Interest		\$23,631	\$25,586	\$24,102	\$24,102	\$24,102	\$24,102	\$24,102
TOTAL RESOURCES	\$4,835,796	\$5,076,465	\$5,116,249	\$4,782,394	\$4,544,758	\$4,491,122	\$4,491,347	\$4,491,571
Budget Expenditure ¹	\$2,680,172	\$2,671,857	\$2,822,013	\$2,906,673	\$2,906,673	\$2,906,673	\$2,906,673	\$2,906,673
TOTAL EXPENDITURES	\$2,472,672	\$2,517,857	\$2,706,013	\$2,793,793	\$2,793,793	\$2,739,933	\$2,739,933	\$2,739,933
RESERVE, JUNE 30	\$2,363,124	\$2,558,608	\$2,410,236	\$1,988,601	\$1,750,965	\$1,751,189	\$1,751,414	\$1,751,638
MONTHS IN RESERVE	9.0	9.5	8.7	7.2	6.3	6.3	6.3	6.3

Renewal Fee Reduction: \$30

	<u>2011/12</u>	<u>2012/13*</u>	<u>2013/14</u>	<u>2014/15</u>	<u>2015/16</u>	<u>2016/17</u>	<u>2017/18</u>	<u>2018/19</u>
Beginning Reserve, July 1	\$2,176,982	\$2,363,124	\$2,558,608	\$2,456,236	\$2,127,061	\$1,935,885	\$1,936,569	\$1,937,254
Revenues	\$2,658,814	\$2,689,710	\$2,578,055	\$2,440,055	\$2,578,055	\$2,716,055	\$2,716,055	\$2,716,055
Interest		\$23,631	\$25,586	\$24,562	\$24,562	\$24,562	\$24,562	\$24,562
TOTAL RESOURCES	\$4,835,796	\$5,076,465	\$5,162,249	\$4,920,854	\$4,729,678	\$4,676,502	\$4,677,187	\$4,677,871
Budget Expenditure ¹	\$2,680,172	\$2,671,857	\$2,822,013	\$2,906,673	\$2,906,673	\$2,906,673	\$2,906,673	\$2,906,673
TOTAL EXPENDITURES	\$2,472,672	\$2,517,857	\$2,706,013	\$2,793,793	\$2,793,793	\$2,739,933	\$2,739,933	\$2,739,933
RESERVE, JUNE 30	\$2,363,124	\$2,558,608	\$2,456,236	\$2,127,061	\$1,935,885	\$1,936,569	\$1,937,254	\$1,937,938
MONTHS IN RESERVE	9.0	9.5	8.9	7.7	7.0	7.0	7.0	7.0

CONTINUOUS Reduction (Effective 1/1/2014)
Assumption: State Salaries Restored 7/1/13 as Scheduled

Renewal Fee Reduction: \$30

	<u>2011/12</u>	<u>2012/13*</u>	<u>2013/14</u>	<u>2014/15</u>	<u>2015/16</u>	<u>2016/17</u>	<u>2017/18</u>	<u>2018/19</u>
Beginning Reserve, July 1	\$2,176,982	\$2,363,124	\$2,558,608	\$2,456,236	\$2,127,061	\$1,797,885	\$1,522,569	\$1,247,254
Revenues	\$2,658,814	\$2,689,710	\$2,578,055	\$2,440,055	\$2,440,055	\$2,440,055	\$2,440,055	\$2,440,055
Interest		\$23,631	\$25,586	\$24,562	\$24,562	\$24,562	\$24,562	\$24,562
TOTAL RESOURCES	\$4,835,796	\$5,076,465	\$5,162,249	\$4,920,854	\$4,591,678	\$4,262,502	\$3,987,187	\$3,711,871
Budget Expenditure ¹	\$2,680,172	\$2,671,857	\$2,822,013	\$2,906,673	\$2,906,673	\$2,906,673	\$2,906,673	\$2,906,673
TOTAL EXPENDITURES	\$2,472,672	\$2,517,857	\$2,706,013	\$2,793,793	\$2,793,793	\$2,739,933	\$2,739,933	\$2,739,933
RESERVE, JUNE 30	\$2,363,124	\$2,558,608	\$2,456,236	\$2,127,061	\$1,797,885	\$1,522,569	\$1,247,254	\$971,938
MONTHS IN RESERVE	9.0	9.5	8.9	7.7	6.5	5.5	4.5	3.5

Renewal Fee Reduction: \$20

	<u>2011/12</u>	<u>2012/13*</u>	<u>2013/14</u>	<u>2014/15</u>	<u>2015/16</u>	<u>2016/17</u>	<u>2017/18</u>	<u>2018/19</u>
Beginning Reserve, July 1	\$2,176,982	\$2,363,124	\$2,558,608	\$2,502,236	\$2,265,521	\$2,028,805	\$1,845,949	\$1,663,094
Revenues	\$2,658,814	\$2,689,710	\$2,624,055	\$2,532,055	\$2,532,055	\$2,532,055	\$2,532,055	\$2,532,055
Interest		\$23,631	\$25,586	\$25,022	\$25,022	\$25,022	\$25,022	\$25,022
TOTAL RESOURCES	\$4,835,796	\$5,076,465	\$5,208,249	\$5,059,314	\$4,822,598	\$4,585,882	\$4,403,027	\$4,220,171
Budget Expenditure ¹	\$2,680,172	\$2,671,857	\$2,822,013	\$2,906,673	\$2,906,673	\$2,906,673	\$2,906,673	\$2,906,673
TOTAL EXPENDITURES	\$2,472,672	\$2,517,857	\$2,706,013	\$2,793,793	\$2,793,793	\$2,739,933	\$2,739,933	\$2,739,933
RESERVE, JUNE 30	\$2,363,124	\$2,558,608	\$2,502,236	\$2,265,521	\$2,028,805	\$1,845,949	\$1,663,094	\$1,480,238
MONTHS IN RESERVE	9.0	9.5	9.1	8.2	7.3	6.7	6.0	5.4

Renewal Fee Reduction: \$15

	<u>2011/12</u>	<u>2012/13*</u>	<u>2013/14</u>	<u>2014/15</u>	<u>2015/16</u>	<u>2016/17</u>	<u>2017/18</u>	<u>2018/19</u>
Beginning Reserve, July 1	\$2,176,982	\$2,363,124	\$2,558,608	\$2,525,236	\$2,334,751	\$2,144,265	\$2,007,639	\$1,871,014
Revenues	\$2,658,814	\$2,689,710	\$2,647,055	\$2,578,055	\$2,578,055	\$2,578,055	\$2,578,055	\$2,578,055
Interest		\$23,631	\$25,586	\$25,252	\$25,252	\$25,252	\$25,252	\$25,252
TOTAL RESOURCES	\$4,835,796	\$5,076,465	\$5,231,249	\$5,128,544	\$4,938,058	\$4,747,572	\$4,610,947	\$4,474,321
Budget Expenditure ¹	\$2,680,172	\$2,671,857	\$2,822,013	\$2,906,673	\$2,906,673	\$2,906,673	\$2,906,673	\$2,906,673
TOTAL EXPENDITURES	\$2,472,672	\$2,517,857	\$2,706,013	\$2,793,793	\$2,793,793	\$2,739,933	\$2,739,933	\$2,739,933
RESERVE, JUNE 30	\$2,363,124	\$2,558,608	\$2,525,236	\$2,334,751	\$2,144,265	\$2,007,639	\$1,871,014	\$1,734,388
MONTHS IN RESERVE	9.0	9.5	9.1	8.5	7.8	7.3	6.8	6.3

Renewal Fee Reduction: \$10

	<u>2011/12</u>	<u>2012/13*</u>	<u>2013/14</u>	<u>2014/15</u>	<u>2015/16</u>	<u>2016/17</u>	<u>2017/18</u>	<u>2018/19</u>
Beginning Reserve, July 1	\$2,176,982	\$2,363,124	\$2,558,608	\$2,548,236	\$2,403,981	\$2,259,725	\$2,169,329	\$2,078,934
Revenues	\$2,658,814	\$2,689,710	\$2,670,055	\$2,624,055	\$2,624,055	\$2,624,055	\$2,624,055	\$2,624,055
Interest		\$23,631	\$25,586	\$25,482	\$25,482	\$25,482	\$25,482	\$25,482
TOTAL RESOURCES	\$4,835,796	\$5,076,465	\$5,254,249	\$5,197,774	\$5,053,518	\$4,909,262	\$4,818,867	\$4,728,471
Budget Expenditure ¹	\$2,680,172	\$2,671,857	\$2,822,013	\$2,906,673	\$2,906,673	\$2,906,673	\$2,906,673	\$2,906,673
TOTAL EXPENDITURES	\$2,472,672	\$2,517,857	\$2,706,013	\$2,793,793	\$2,793,793	\$2,739,933	\$2,739,933	\$2,739,933
RESERVE, JUNE 30	\$2,363,124	\$2,558,608	\$2,548,236	\$2,403,981	\$2,259,725	\$2,169,329	\$2,078,934	\$1,988,538
MONTHS IN RESERVE	9.0	9.5	9.2	8.7	8.2	7.9	7.5	7.2

B

FUND CONDITION STATE SALARIES PARTIALLY RESTORED 7/1/13

	<u>2011/12*</u>	<u>2012/13</u>	<u>2013/14</u>	<u>2014/15</u>	<u>2015/16</u>	<u>2016/17</u>	<u>2017/18</u>	<u>2018/19</u>
Beginning Reserve, July 1	\$2,176,982	\$2,363,124	\$2,558,608	\$2,678,064	\$2,741,872	\$2,674,958	\$2,664,046	\$2,653,135
Prior Year Adjustments								
Revenues	\$2,658,814	\$2,689,710	\$2,716,055	\$2,716,055	\$2,716,055	\$2,716,055	\$2,716,055	\$2,716,055
Interest		\$23,631	\$25,586	\$26,781	\$26,781	\$26,781	\$26,781	\$26,781
TOTAL RESOURCES	\$4,835,796	\$5,076,465	\$5,300,249	\$5,420,900	\$5,484,707	\$5,417,793	\$5,406,882	\$5,395,971
Budget Expenditure ¹	\$2,680,172	\$2,671,857	\$2,738,185	\$2,792,949	\$2,920,487	\$2,920,487	\$2,920,487	\$2,920,487
Disbursements ²	\$12,000							
BreEZe Funding ¹		\$45,000	\$62,000	\$63,240	\$65,137	\$10,000	\$10,000	\$10,000
BreEZe Credit Card ¹		\$21,000	\$42,000	\$42,840	\$44,125	\$43,260	\$43,260	\$43,260
Reimbursements	(\$219,500)	(\$220,000)	(\$220,000)	(\$220,000)	(\$220,000)	(\$220,000)	(\$220,000)	(\$220,000)
TOTAL EXPENDITURES	\$2,472,672	\$2,517,857	\$2,622,185	\$2,679,029	\$2,809,749	\$2,753,747	\$2,753,747	\$2,753,747
RESERVE, JUNE 30	\$2,363,124	\$2,558,608	\$2,678,064	\$2,741,872	\$2,674,958	\$2,664,046	\$2,653,135	\$2,642,224
MONTHS IN RESERVE³	9.0	9.5	9.7	9.9	9.7	9.7	9.6	9.6

* Actual

¹ BreEZe funding is identified separately (below)

FY 13/14 expenditures reflect a **\$26,250 increase in personnel services** (3% COLA), actual BreEZe expenses, and a 1.5% increase in overall expenditures.

FY 14/15 expenditures reflect a 2% projected increase in overall expenditures.

FY 15/16 expenditures reflect a **\$43,750 increase in personnel services** (5% PLP Returned) and a 3% increase in overall expenditures.

² Represents FSCU (State Operations) and FISC (State Controller Operations) disbursements

³ Months in Reserve are calculated based on actual budget schedule amounts for FY 12/13 and FY 13/14 and then a one-time projected increase of 3% for FY 14/15. FY 12/13: \$3,153,000; FY 13/14: \$3,216,000; and FY 14/15 (and thereafter): \$3,312,480

ONE-TIME Reduction over Two-Year Cycle (1/1/2014 - 12/31/15)

Assumption: State Salaries Partially Restored 7/1/13

Renewal Fee Reduction: \$60

	<u>2011/12</u>	<u>2012/13*</u>	<u>2013/14</u>	<u>2014/15</u>	<u>2015/16</u>	<u>2016/17</u>	<u>2017/18</u>	<u>2018/19</u>
Beginning Reserve, July 1	\$2,176,982	\$2,363,124	\$2,558,608	\$2,402,064	\$1,911,112	\$1,565,438	\$1,551,766	\$1,538,095
Revenues	\$2,658,814	\$2,689,710	\$2,440,055	\$2,164,055	\$2,440,055	\$2,716,055	\$2,716,055	\$2,716,055
Interest		\$23,631	\$25,586	\$24,021	\$24,021	\$24,021	\$24,021	\$24,021
TOTAL RESOURCES	\$4,835,796	\$5,076,465	\$5,024,249	\$4,590,140	\$4,375,187	\$4,305,513	\$4,291,842	\$4,278,171
Budget Expenditure ¹	\$2,680,172	\$2,671,857	\$2,738,185	\$2,792,949	\$2,920,487	\$2,920,487	\$2,920,487	\$2,920,487
TOTAL EXPENDITURES	\$2,472,672	\$2,517,857	\$2,622,185	\$2,679,029	\$2,809,749	\$2,753,747	\$2,753,747	\$2,753,747
RESERVE, JUNE 30	\$2,363,124	\$2,558,608	\$2,402,064	\$1,911,112	\$1,565,438	\$1,551,766	\$1,538,095	\$1,524,424
MONTHS IN RESERVE	9.0	9.5	8.7	6.9	5.7	5.6	5.6	5.5

Renewal Fee Reduction: \$50

	<u>2011/12</u>	<u>2012/13*</u>	<u>2013/14</u>	<u>2014/15</u>	<u>2015/16</u>	<u>2016/17</u>	<u>2017/18</u>	<u>2018/19</u>
Beginning Reserve, July 1	\$2,176,982	\$2,363,124	\$2,558,608	\$2,448,064	\$2,049,572	\$1,750,358	\$1,737,146	\$1,723,935
Revenues	\$2,658,814	\$2,689,710	\$2,486,055	\$2,256,055	\$2,486,055	\$2,716,055	\$2,716,055	\$2,716,055
Interest		\$23,631	\$25,586	\$24,481	\$24,481	\$24,481	\$24,481	\$24,481
TOTAL RESOURCES	\$4,835,796	\$5,076,465	\$5,070,249	\$4,728,600	\$4,560,107	\$4,490,893	\$4,477,682	\$4,464,471
Budget Expenditure ¹	\$2,680,172	\$2,671,857	\$2,738,185	\$2,792,949	\$2,920,487	\$2,920,487	\$2,920,487	\$2,920,487
TOTAL EXPENDITURES	\$2,472,672	\$2,517,857	\$2,622,185	\$2,679,029	\$2,809,749	\$2,753,747	\$2,753,747	\$2,753,747
RESERVE, JUNE 30	\$2,363,124	\$2,558,608	\$2,448,064	\$2,049,572	\$1,750,358	\$1,737,146	\$1,723,935	\$1,710,724
MONTHS IN RESERVE	9.0	9.5	8.9	7.4	6.3	6.3	6.2	6.2

Renewal Fee Reduction: \$40

	<u>2011/12</u>	<u>2012/13*</u>	<u>2013/14</u>	<u>2014/15</u>	<u>2015/16</u>	<u>2016/17</u>	<u>2017/18</u>	<u>2018/19</u>
Beginning Reserve, July 1	\$2,176,982	\$2,363,124	\$2,558,608	\$2,494,064	\$2,188,032	\$1,935,278	\$1,922,526	\$1,909,775
Revenues	\$2,658,814	\$2,689,710	\$2,532,055	\$2,348,055	\$2,532,055	\$2,716,055	\$2,716,055	\$2,716,055
Interest		\$23,631	\$25,586	\$24,941	\$24,941	\$24,941	\$24,941	\$24,941
TOTAL RESOURCES	\$4,835,796	\$5,076,465	\$5,116,249	\$4,867,060	\$4,745,027	\$4,676,273	\$4,663,522	\$4,650,771
Budget Expenditure ¹	\$2,680,172	\$2,671,857	\$2,738,185	\$2,792,949	\$2,920,487	\$2,920,487	\$2,920,487	\$2,920,487
TOTAL EXPENDITURES	\$2,472,672	\$2,517,857	\$2,622,185	\$2,679,029	\$2,809,749	\$2,753,747	\$2,753,747	\$2,753,747
RESERVE, JUNE 30	\$2,363,124	\$2,558,608	\$2,494,064	\$2,188,032	\$1,935,278	\$1,922,526	\$1,909,775	\$1,897,024
MONTHS IN RESERVE	9.0	9.5	9.0	7.9	7.0	7.0	6.9	6.9

Renewal Fee Reduction: \$30

	<u>2011/12</u>	<u>2012/13*</u>	<u>2013/14</u>	<u>2014/15</u>	<u>2015/16</u>	<u>2016/17</u>	<u>2017/18</u>	<u>2018/19</u>
Beginning Reserve, July 1	\$2,176,982	\$2,363,124	\$2,558,608	\$2,540,064	\$2,326,492	\$2,120,198	\$2,107,906	\$2,095,615
Revenues	\$2,658,814	\$2,689,710	\$2,578,055	\$2,440,055	\$2,578,055	\$2,716,055	\$2,716,055	\$2,716,055
Interest		\$23,631	\$25,586	\$25,401	\$25,401	\$25,401	\$25,401	\$25,401
TOTAL RESOURCES	\$4,835,796	\$5,076,465	\$5,162,249	\$5,005,520	\$4,929,947	\$4,861,653	\$4,849,362	\$4,837,071
Budget Expenditure ¹	\$2,680,172	\$2,671,857	\$2,738,185	\$2,792,949	\$2,920,487	\$2,920,487	\$2,920,487	\$2,920,487
TOTAL EXPENDITURES	\$2,472,672	\$2,517,857	\$2,622,185	\$2,679,029	\$2,809,749	\$2,753,747	\$2,753,747	\$2,753,747
RESERVE, JUNE 30	\$2,363,124	\$2,558,608	\$2,540,064	\$2,326,492	\$2,120,198	\$2,107,906	\$2,095,615	\$2,083,324
MONTHS IN RESERVE	9.0	9.5	9.2	8.4	7.7	7.6	7.6	7.5

CONTINUOUS Reduction (Effective 1/1/2014)
Assumption: State Salaries Partially Restored 7/1/13

Renewal Fee Reduction: \$30

	<u>2011/12</u>	<u>2012/13*</u>	<u>2013/14</u>	<u>2014/15</u>	<u>2015/16</u>	<u>2016/17</u>	<u>2017/18</u>	<u>2018/19</u>
Beginning Reserve, July 1	\$2,176,982	\$2,363,124	\$2,558,608	\$2,540,064	\$2,326,492	\$1,982,198	\$1,693,906	\$1,405,615
Revenues	\$2,658,814	\$2,689,710	\$2,578,055	\$2,440,055	\$2,440,055	\$2,440,055	\$2,440,055	\$2,440,055
Interest		\$23,631	\$25,586	\$25,401	\$25,401	\$25,401	\$25,401	\$25,401
TOTAL RESOURCES	\$4,835,796	\$5,076,465	\$5,162,249	\$5,005,520	\$4,791,947	\$4,447,653	\$4,159,362	\$3,871,071
Budget Expenditure ¹	\$2,680,172	\$2,671,857	\$2,738,185	\$2,792,949	\$2,920,487	\$2,920,487	\$2,920,487	\$2,920,487
TOTAL EXPENDITURES	\$2,472,672	\$2,517,857	\$2,622,185	\$2,679,029	\$2,809,749	\$2,753,747	\$2,753,747	\$2,753,747
RESERVE, JUNE 30	\$2,363,124	\$2,558,608	\$2,540,064	\$2,326,492	\$1,982,198	\$1,693,906	\$1,405,615	\$1,117,324
MONTHS IN RESERVE	9.0	9.5	9.2	8.4	7.2	6.1	5.1	4.0

Renewal Fee Reduction: \$20

	<u>2011/12</u>	<u>2012/13*</u>	<u>2013/14</u>	<u>2014/15</u>	<u>2015/16</u>	<u>2016/17</u>	<u>2017/18</u>	<u>2018/19</u>
Beginning Reserve, July 1	\$2,176,982	\$2,363,124	\$2,558,608	\$2,586,064	\$2,464,952	\$2,213,118	\$2,017,286	\$1,821,455
Revenues	\$2,658,814	\$2,689,710	\$2,624,055	\$2,532,055	\$2,532,055	\$2,532,055	\$2,532,055	\$2,532,055
Interest		\$23,631	\$25,586	\$25,861	\$25,861	\$25,861	\$25,861	\$25,861
TOTAL RESOURCES	\$4,835,796	\$5,076,465	\$5,208,249	\$5,143,980	\$5,022,867	\$4,771,033	\$4,575,202	\$4,379,371
Budget Expenditure ¹	\$2,680,172	\$2,671,857	\$2,738,185	\$2,792,949	\$2,920,487	\$2,920,487	\$2,920,487	\$2,920,487
TOTAL EXPENDITURES	\$2,472,672	\$2,517,857	\$2,622,185	\$2,679,029	\$2,809,749	\$2,753,747	\$2,753,747	\$2,753,747
RESERVE, JUNE 30	\$2,363,124	\$2,558,608	\$2,586,064	\$2,464,952	\$2,213,118	\$2,017,286	\$1,821,455	\$1,625,624
MONTHS IN RESERVE	9.0	9.5	9.4	8.9	8.0	7.3	6.6	5.9

Renewal Fee Reduction: \$15

	<u>2011/12</u>	<u>2012/13*</u>	<u>2013/14</u>	<u>2014/15</u>	<u>2015/16</u>	<u>2016/17</u>	<u>2017/18</u>	<u>2018/19</u>
Beginning Reserve, July 1	\$2,176,982	\$2,363,124	\$2,558,608	\$2,609,064	\$2,534,182	\$2,328,578	\$2,178,976	\$2,029,375
Revenues	\$2,658,814	\$2,689,710	\$2,647,055	\$2,578,055	\$2,578,055	\$2,578,055	\$2,578,055	\$2,578,055
Interest		\$23,631	\$25,586	\$26,091	\$26,091	\$26,091	\$26,091	\$26,091
TOTAL RESOURCES	\$4,835,796	\$5,076,465	\$5,231,249	\$5,213,210	\$5,138,327	\$4,932,723	\$4,783,122	\$4,633,521
Budget Expenditure ¹	\$2,680,172	\$2,671,857	\$2,738,185	\$2,792,949	\$2,920,487	\$2,920,487	\$2,920,487	\$2,920,487
TOTAL EXPENDITURES	\$2,472,672	\$2,517,857	\$2,622,185	\$2,679,029	\$2,809,749	\$2,753,747	\$2,753,747	\$2,753,747
RESERVE, JUNE 30	\$2,363,124	\$2,558,608	\$2,609,064	\$2,534,182	\$2,328,578	\$2,178,976	\$2,029,375	\$1,879,774
MONTHS IN RESERVE	9.0	9.5	9.5	9.2	8.4	7.9	7.4	6.8

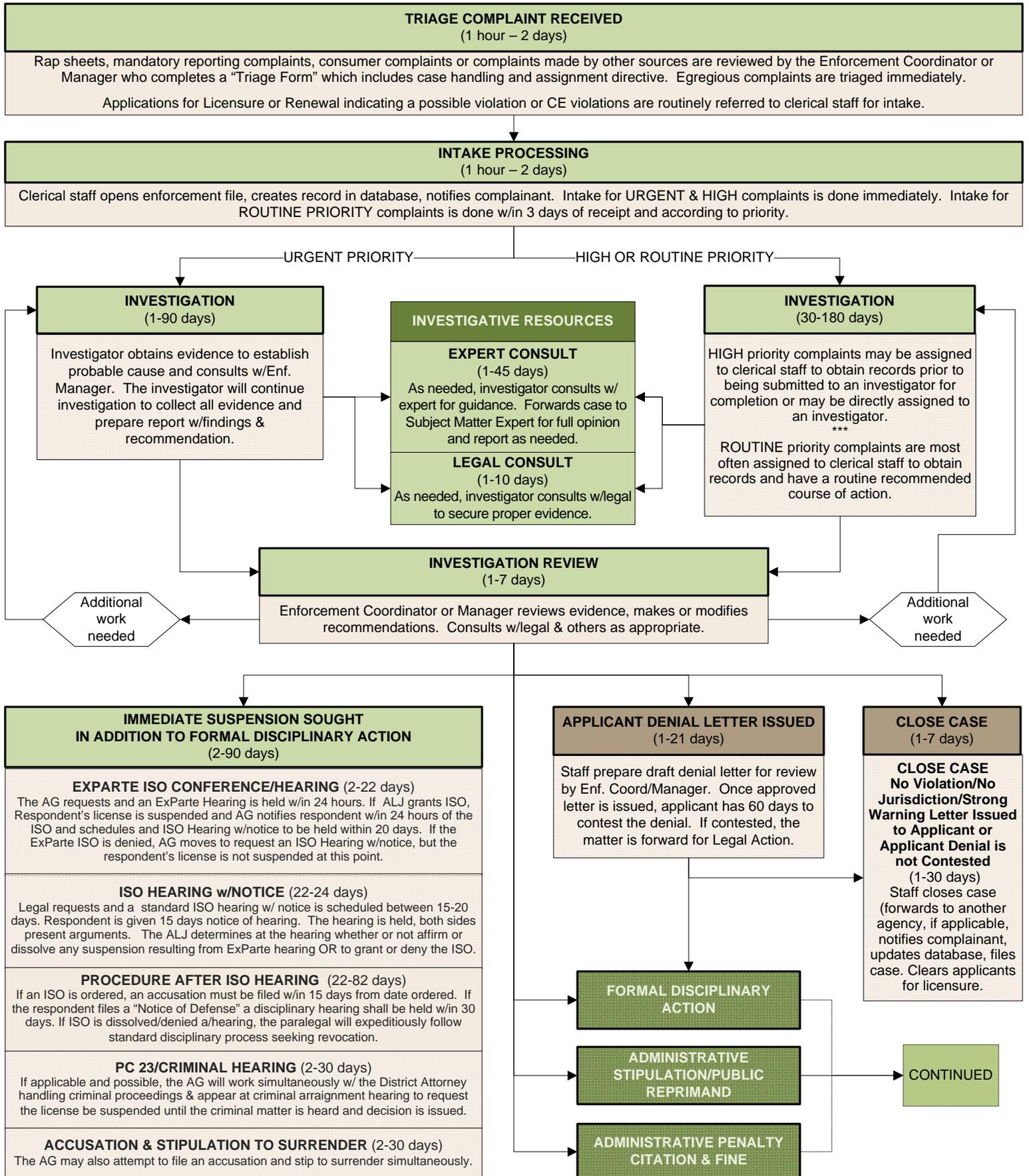
Renewal Fee Reduction: \$10

	<u>2011/12</u>	<u>2012/13*</u>	<u>2013/14</u>	<u>2014/15</u>	<u>2015/16</u>	<u>2016/17</u>	<u>2017/18</u>	<u>2018/19</u>
Beginning Reserve, July 1	\$2,176,982	\$2,363,124	\$2,558,608	\$2,632,064	\$2,603,412	\$2,444,038	\$2,340,666	\$2,237,295
Revenues	\$2,658,814	\$2,689,710	\$2,670,055	\$2,624,055	\$2,624,055	\$2,624,055	\$2,624,055	\$2,624,055
Interest		\$23,631	\$25,586	\$26,321	\$26,321	\$26,321	\$26,321	\$26,321
TOTAL RESOURCES	\$4,835,796	\$5,076,465	\$5,254,249	\$5,282,440	\$5,253,787	\$5,094,413	\$4,991,042	\$4,887,671
Budget Expenditure ¹	\$2,680,172	\$2,671,857	\$2,738,185	\$2,792,949	\$2,920,487	\$2,920,487	\$2,920,487	\$2,920,487
TOTAL EXPENDITURES	\$2,472,672	\$2,517,857	\$2,622,185	\$2,679,029	\$2,809,749	\$2,753,747	\$2,753,747	\$2,753,747
RESERVE, JUNE 30	\$2,363,124	\$2,558,608	\$2,632,064	\$2,603,412	\$2,444,038	\$2,340,666	\$2,237,295	\$2,133,924
MONTHS IN RESERVE	9.0	9.5	9.5	9.4	8.9	8.5	8.1	7.7

Respiratory Care Board of California
DISCIPLINARY PROCESS MODEL

(Revised 1/1/13)

Agenda Item: 9
Meeting Date: 2/1/13



FORMAL DISCIPLINARY ACTION

**ADMINISTRATIVE STIPULATION
IN-HOUSE PUBLIC REPRIMAND**

**ADMINISTRATIVE PENALTY
CITATION AND FINE**

STAFF REQUEST AG TO PREPARE PLEADING
(Accusation or Statement of Issues) (1-14 days)
Request is prepared by staff and reviewed by Enf. Coor/Manager for edits and final approval before sent.

STAFF PREPARE PROPOSED STIPULATION
(1-30 days)
Board staff prepare stipulation and mail to respondent for consideration.

CITATION & FINE PREPARED & ISSUED
(1-14 days)
C&F is prepared by staff and reviewed by Enf. Coor/Manager for edits and final approval before issued via certified mail.

AG DRAFTS PLEADING (2-120 Days)
Draft pleading is forwarded to Board staff for review, edits made by AG and returned to Board staff to serve (via certified mail).

RESPONDENT REJECTS PROPOSED STIPULATION
(1-30 days)
Respondent declines to enter into In-House Stipulation.

CITATION AND FINE HEARING REQUESTED
Staff receives request w/ in 30 days and schedules informal hearing or proceeds to request a formal hearing.

TIME TO APPEAL CITATION LAPSED
(30 days)
Staff closes case and pursues collection of fine, places license renewal on hold until paid as applicable.

DEFAULT DECISION NO HEARING REQUESTED
(15-90 days)
AG drafts default decision, forwards to Board staff for review, edits made by AG and returned to Board staff for processing.

RESPONDENT REQUESTS HEARING
(2-30 days)
Unless otherwise directed, AG will contact respondent or his/her attorney to determine if a settlement can be reached.

RESPONDENT AGREES TO PROPOSED STIPULATION
(1-30 days)
Respondent signs and returns stipulation.

STIPULATED SETTLEMENT REACHED
(30-210 days)
AG works w/Board staff & respondent/attorney to reach agreeable discipline. AG forwards complete stipulation to Board for review, AG makes edits and returns to Board staff for final approval & processing.

HEARING SCHEDULED
Stipulated settlement unlikely or not an option. AG requests hearing date.

PROPOSED IN-HOUSE STIPULATED DECISION NON ADOPTED
Board staff forward case to AG.

INFORMAL CITATION AND FINE HEARING
(30-60 days)
Staff schedule and hearing is held with Executive Officer.

INFORMAL HEARING DECISION ISSUED
(7-30 days to issue)
Executive Officer hears testimony & issues order to affirm, dismiss or modify original citation/fine. Final decision is drafted & served. Licensee may appeal w/in 30 days.

FORMAL HEARING PHASE

ALJ HEARING
(90-300 days)
ALJ hears case.

BOARD HEARING
(90-240 days)
The Board and ALJ hear case. The ALJ or Legal Counsel drafts final decision. Decision is filed by Board staff and if applicable, forwarded to Probation Unit.

PROPOSED STIPULATED DECISION NON ADOPTED
(1-7 days)
Board staff returns case to AG to adjust stipulated terms and conditions or set for hearing.

FORMAL C&F HEARING REQUESTED
(Forward to AG/10-14 days)
Staff prepare request and forward to AG for formal hearing.

DEFAULT DECISION FAILURE TO APPEAR (10-60 days)
Respondent fails to appear at hearing. AG drafts default decision.

ALJ PROPOSED DECISION RECEIVED (30-100 days)
ALJ submits proposed decision to the Board staff for processing.

BOARD MEMBERS VOTE
(5-14 days)
Staff forwards appropriate documentation to members. Board Members vote to 1) Adopt, 2) Non-Adopt, or 3) Discuss & vote at meeting (Additional 14-180 days for option 3)

PROPOSED ALJ DECISION NON ADOPTED
(120-180 days)
Staff notifies respondent and legal of decision and requests hearing transcripts. Transcripts are forwarded to members for discussion at board meeting. Board adopts ALJ proposed decision or issues their own.

DECISION ADOPTED
(1-5 days)
Decision is filed by Board staff and if applicable, forwarded to the Probation Unit for monitoring. Effective dates of decisions differ depending upon order.

STAFF PROCESS PROPOSED DECISION (2-7 days)
Board staff prepare decision for Board Member Vote.

