STATE OF CALIFORNIA

DEPARTMENT OF CONSUMER AFFAIRS

Governor Edmund G. Brown Jr.
State of California

Anna Caballero, Secretary
State and Consumer Services Agency

Brian Stiger, Acting Director
Department of Consumer Affairs

Larry L. Renner, BS, RCP
President

Murray Olson, RCP, RRT
Vice President

Lupe Aguilera
Member

Sandra Magaña
Member

Charles B. Spearman, MSEd, RCP
Member

Barbara M. Stenson, RCP, RRT
Member

Stephanie Nunez
Executive Officer

2BeARespiratoryTherapist.ca.gov

Telephone: (916) 323-9983
Toll Free: (866) 375-0386
Fax: (916) 323-9999
Website: www.rcb.ca.gov
E-mail: rcbinfo@dca.ca.gov

Respiratory Care Board of California

444 North 3rd Street, Suite 270, Sacramento, CA 95811

Board Meeting Agenda

Friday, October 7, 2011

Department of Consumer Affairs
1625 North Market Blvd.
South Building, Room S-102
(First Floor Hearing Room)
Sacramento, CA 95834

10:45 AM Call to Order

1. **Approval of May 10, 2011 Minutes** *(Larry Renner)*

2. **Public Comment** *(Larry Renner)*
   Public comment will be accepted after any agenda item or toward the end of the agenda for public comment not related to any particular agenda item. The President may set a time limit for public comment as needed.

3. **BreEZe Database Presentation** *(Debbie Balaam, Chief Information Officer, DCA and Brandon Rutschmann, BreEZe Project Team Manager, DCA)*

4. **Executive Officer's Report** *(Stephanie Nunez)*
   a. On-Line License Renewal Update
   b. Staffing/BCPs
   c. DCA Change Control Board
   d. Travel Directive
   e. Office Move
   f. Sunset Review 2012/2013

5. **CSRC RCP Staffing Ratios Initiative-Update** *(Barbara Stenson)*

6. **Fiscal Review** *(Larry Renner)*

7. **California Code of Regulations Concerning New and Amended Language Related to Disciplinary Guidelines, Citations and Fines, Fees, and Various Regulatory Sections: Vote to Finalize Regulatory Package** *(Larry Renner)*

8. **Enforcement Update** *(Bud Spearman)*
   a. Enforcement Statistics
   b. Enforcement Performance Measures

9. **"Transitioning the Respiratory Therapist Workforce for 2015 and Beyond" Update** *(Bud Spearman)*

10. **Polysomnography/CDPH Meeting Update** *(Larry Renner and Murray Olson)*

The Respiratory Care Board of California's mission is to protect and serve the consumer by enforcing the Respiratory Care Practice Act and its regulations, expanding the delivery and availability of services, increasing public awareness of respiratory care as a profession and supporting the development and education of all respiratory care practitioners.

· Closed Session ·

The Board will convene into Closed Session, as authorized by Government Code Section 11126(c), subdivision (3), to deliberate on any matters that may arise after the issuance of this agenda notice.

11. Legislation of Interest - Discussion/Action *(Larry Renner)*

a. 2011 Legislation

Senate Bills: 103, 231, 538, 539, 541, 544, 943, and 944; Assembly Bills: 569, 958, 991, and 1273
And any other newly discovered bills relevant to the Board's activities

b. Board-Sponsored Proposed 2012 Legislation

12. Election of Officers for 2012

13. 2012 Meeting Dates: Calendar

14. Public Comment on Items Not on the Agenda

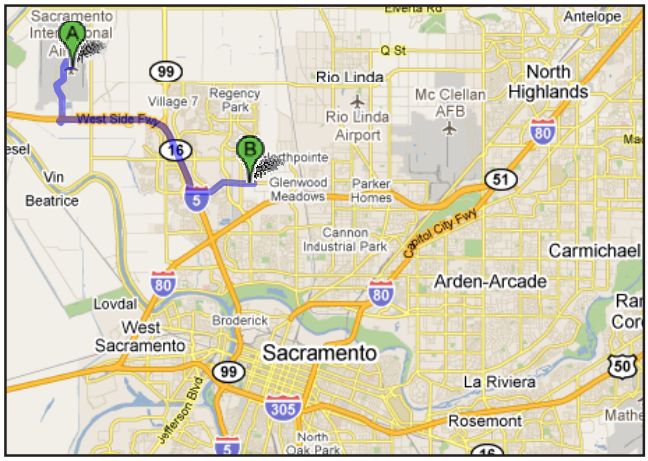
15. Future Agenda Items

1:30 p.m. 16. Adjournment

DIRECTIONS FROM AIRPORT

From the Sacramento International Airport:
(approximately 9 miles from airport)

Exit Airport
Take I-5 South towards Sacramento
Take the Arena Blvd. Exit
  Turn Left onto Arena Blvd.
Continue onto N. Market Blvd.
  (Arena turns into N. Market)
Make a U-turn at Sierra Point Drive
Destination is a 4 story building on right



NOTICE

This meeting will be Webcast. To view the Webcast, please visit
http://www.dca.ca.gov/publications/multimedia/webcast_current.shtml.

Action may be taken on any item on the agenda. Time and order of agenda items are subject to change at the discretion of the President. Meetings of the Respiratory Care Board are open to the public except when specifically noticed otherwise in accordance with the Open Meeting Act. In addition to the agenda item which addresses public comment, the audience will be given appropriate opportunities to comment on any issue before the Board, but the President may, at his discretion, apportion available time among those who wish to speak. Contact person: Paula Velasquez, telephone: (916) 323-9983.

The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Paula Velasquez at (916) 323-9983 or sending a written request to: Paula Velasquez, Respiratory Care Board, 444 North 3rd Street, Suite 270, Sacramento, CA 95811. Providing your request at least five (5) business days before the meeting will help ensure availability of the requested accommodation.

PUBLIC SESSION MINUTES

Tuesday, May 10, 2011

Bahia Resort Hotel Mission Bay, San Diego
998 West Mission Bay Drive
San Diego, CA 92109
(858) 488-0551

Members Present: Larry L. Renner, BS, RCP, RRT, RPFT, President
Barbara M. Stenson, RCP, RRT
Lupe V. Aguilera
Murray Olson, RCP, RRT-NPS, RPFT
Richard L. Sheldon, M.D.
Charles B. Spearman, MSEd, 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 9:09 a.m. by President Renner. President Renner stated the Board did not have a quorum, however, two members were expected to arrive shortly.

President Renner stated this Board meeting was being webcasted.

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DCA DIRECTOR COMMENT

(LaVonne Powell)

Ms. Powell, Special Advisor to the Acting Director, provided an update on the projects and issues currently at the Department of Consumer Affairs (DCA):

Hiring Freeze: Another hiring freeze Executive Order was issued requiring DCA to seek hiring exemptions for core functions which would be Licensing and Enforcement, when feasible. Ms. Powell reviewed the process: A board submits the exemption to the Department, the Department submits to Agency (who then approves or denies the exemption), Agency sends to the Department of Finance, then finally, the request is sent to the Governor's Office for approval.

President Renner welcomed Mr. Spearman to the meeting and stated a quorum was now present. (9:10 am)

Travel Restrictions: An Executive Order was issued restricting travel. DCA is waiting for the Department of Finance to come out with the Budget Letter detailing the process. Until the letter is released, the Secretary of the State and Consumer Services Agency, Anna Caballero, will be approving all travel. While recognizing the necessity for travel at times, the Department has asked all boards to be very conservative with arrangements.

Enforcement Workshop: Ms. Powell thanked Ms. Nunez for actively participating in the workshop to help the boards maximize their resources to focus on the highest priority complaints. The objective was to have the assessment be more of a tool for the boards to identify their strengths and weaknesses, and changes that can be made to maximize resources to protect the public.

Drug Testing Standards: Ms. Powell thanked Ms. Nunez for chairing the subcommittee concerning drug testing frequency for substance abusing licensees, and for the huge accomplishment of being the driving force achieving middle ground within the affected groups.

BREEZE Project: This project replaces the Department's antiquated licensing and enforcement IT programs. The Department is currently in confidential negotiations with a bidder and hopes to have a contract in place by August.

APPROVAL OF FEBRUARY 25, 2011 PUBLIC SESSION MINUTES

Vice President Olson moved to approve the February 25, 2011 Public Session minutes as written.

M/ Olson /S/Sheldon
Unanimous: Aguilera, Olson, Renner, Sheldon, Spearman
MOTION PASSED

ON-LINE LICENSE RENEWAL UPDATE

(Christine Molina)

Ms. Molina reviewed the status of the on-line license renewal project stating there are details that need to be ironed out with the contracted vendors. She advised that at this time, the Board and the Department have prepared for implementation and are simply waiting for the contracts to be executed.

CONSIDERATION TO ADOPT PROPOSED PROBATION MONITORING DRUG TESTING FREQUENCY POLICY

(Stephanie Nunez)

Ms. Nunez presented a proposed policy based on the standard developed by a subcommittee of the Substance Abuse Coordination Committee (SACC).

Ms. Nunez suggested using July 1 as the Boards implementation date. Anyone with orders effective prior to July 1, would be tested 36-104 times per year and effective dates after July 1 would be tested 52-104 times per year for the first year. Ms. Nunez stated unless a cause existed, the Board anticipates staying at the minimum number of tests on the range presented. Some exceptions apply that might reduce the times tested per year from 52 to 36 times, such as having a single conviction. Ms. Nunez stated the probationers would still pay the cost in this proposed policy but added the subcommittee is beginning to gather more statistics to review the impact and effectiveness of increased testing on the probationer. Ms. Nunez explained that "Major Violations" as identified in the Board's Disciplinary Guidelines, would likely result in an increased testing frequency.

Dr. Sheldon inquired what the financial impact is on a licensee in the first year including testing, enforcement, investigation and all related costs, and if there is a publication that identifies all these potential costs.

Ms. Nunez stated the Board does not currently have something like that though one could be developed.

President Renner added that every program in California could benefit from the information.

Dr. Sheldon motioned that the Board adopt the proposed policy.

M/ Sheldon /S/Aguilera
Unanimous: Aguilera, Olson, Renner, Sheldon, Spearman
MOTION PASSED

BOARD ACTION IN RESPONSE TO AFFIRMATIVE RESPONSE TO APPLICATION QUESTION NO. 20 – DISCUSSION/ACTION

(Murray Olson)

Vice President Olson recalled a previous case where the applicant responded affirmative to question # 20 on the application (concerning the use of chemical substances) after becoming addicted to pain medicine following an automobile accident, and referred himself to a treatment program as a result. Vice President Olson stated this is the type of person the Board should be supporting and that not working with them seemed 'heavy handed.'

Ms. Powell suggested adding the word "current" to the question as in "Do you have a *current* medical condition or does your *current* use of chemical substances in any way impair or limit your ability …"

The Board agreed with Ms. Powell's suggestion and staff will modify the question accordingly.

STUDENT BACKGROUND CHECKS – DISCUSSION/ACTION

(Barbara Stenson)

Ms. Stenson brought up the issue that not all schools and/or clinics perform background checks on students before placing them in clinical sites, and as a result, may have someone who is unable to get a license caring for a patient.

Ms. Nunez stated it is the hospital's responsibility to screen applicants. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires hospitals to run the same background check on students as on their employees.

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President Renner added if the correct process is followed, there is always a licensed practitioner with each student. It is that licensee's responsibility to make sure the student does what is right for the patient. He added, because the student is not licensed yet, it is beyond the Board's purview. President Renner suggested, since patient safety is the Board's concern, perhaps the Board could re-emphasize this with program directors.

Discussion ensued.

Ms. Nunez suggested the Board add some examples of different types of application denials to the pamphlet discussed earlier by Dr. Sheldon.

President Renner stated any student who has questions about violations and licensing can contact the Board directly to get answers.

Ms. Nunez added that information is also available in the Board's In-House Guidelines.

"TRANSITIONING THE RESPIRATORY THERAPIST WORKFORCE FOR 2015 AND BEYOND" UPDATE

(Charles Spearman)

Mr. Spearman stated that the third publication has been released.

Mr. Spearman stated he has not yet heard any official recommendations from the NBRC whether they are in agreement with making the RRT an entry level exam, and agreed with staff's recommendation to take no action at this time and revisit the issue at each Board meeting.

Dr. Sheldon inquired whether the deadlines would conflict with one another.

Ms. Nunez replied the major hurdle would be getting Legislation passed.

Discussion ensued.

Ms. Nunez stated staff's recommendation is to explore the willingness of the NBRC to allow the Board to use the RRT examination for licensure.

Further discussion ensued.

To assist the Board in moving forward in the investigation process, President Renner suggested the Board contact the NBRC to inquire about its position.

Mr. Spearman thanked Ms. Nunez for the great job putting into perspective the potential impact the proposal would have on the Board and the State.

RECOGNITION OF SERVICE: RICHARD L. SHELDON, MD, FACP

(Larry Renner)

President Renner, on behalf of the Board, thanked Dr. Sheldon for more than twelve years of dedicated service, significant contributions, leadership, knowledge, commitment and passion for consumer protection. The Board then presented Dr. Sheldon with a display case as a token of its appreciation.

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POLOSOMNOGRAPHY/CDPH MEETING UPDATE

(Stephanie Nunez)

Ms. Nunez explained that she met with the California Department of Public Health and expressed the Board's concerns surrounding the requirements for nursing services in sleep studies, stating a respiratory therapist is the most qualified in 99 percent of sleep studies.

Dr. Sheldon suggested the Board collaborate with other organizations for support and recommendation.

President Renner directed Ms. Nunez to arrange for another meeting with the CDPH, so that all key players could be present to further discuss this issue.

RCP RECOGNITION

(Larry Renner)

Board members convened to the Mission Bay Ballroom at 10:45 to meet with members of the California Society for Respiratory Care, and participate in a Respiratory Care Practitioner recognition ceremony honoring Dr. Barry Winn, Past President of the Board. The Board meeting reconvened in the Del Mar room at 11:11 a.m.

LEGISLATION OF INTEREST – DISCUSSION/ACTION

(Larry Renner)

President Renner recommended the following positions on legislation of interest:

SB 103 - Watch
SB 231 – Watch
SB 538 – Watch (changes do not impact RCB)
SB 539 – Watch (changes do not impact RCB)
SB 541 – Support (letter mailed to author 4/21/11)
SB 544 – Watch
SB 943 – Watch (changes do not currently impact RCB)
SB 944 – Watch (changes do not currently impact RCB)
AB 569 – Watch
AB 958 – Oppose unless amended (letter mailed to author 3/25/11)
AB 991 – Watch
AB 1273 – Watch

Dr. Sheldon moved to accept the positions as recommended and give the Executive Committee the authority to act as necessary and adopt staff recommended positions.

M/ Sheldon /S/ Spearman
Unanimous: Aguilera, Renner, Sheldon, Spearman, Stenson
MOTION PASSED

PROPOSED 2012 LEGISLATION

Ms. Stenson inquired about legislation requiring clinical supervisors to have a current and valid license.

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Ms. Nunez cited Business and Profession Code section 3742 which states, “During the period of any clinical training, a student respiratory care practitioner shall be under the direct supervision of a person holding a valid and current license issued under this chapter”. She suggested adding the wording “undisciplined license” to the language.

Vice President Murray suggested using the word “unrestricted” as opposed to “undisciplined.”

President Renner advised the Board to research this further and discuss it as an agenda item at the next Board meeting

PUBLIC COMMENT ON ITEMS NOT ON THE AGENDA

No public comment was received.

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CLOSED SESSION I

The Board convened into Closed Session, as authorized by Government Code Section 11126c, subdivision (3) at 11:47 p.m. and reconvened into Public Session at 12:04 p.m.

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ADJOURNMENT

The Public Session Meeting was adjourned by President Renner at 12:06 p.m.

LARRY L. RENNER	STEPHANIE A. NUNEZ
President	Executive Officer

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FISCAL REVIEW

Agenda Item: 6
Meeting Date: 10/7/11

REVENUE

Revenue Category	2009/10	2010/11	Projected 2011/12	Projected Workload	Current Fees 2011/12
Application (CA)	$256,600	$241,800	$250,000	1,250	$200
Application (Foreign)	$200	$200	$250	1	$250
Application (O-O-S)	$31,800	$29,400	$30,000	150	$200
Initial License	$119,328	$127,488	$139,200	1,450	var
Renewal	$1,915,180	$1,987,767	$2,006,750	8,725	$230
Delinquent Fees	$43,480	$40,250	$41,400	140 / 20	$230 / $460
Endorsement	$23,100	$24,975	$24,375	325	$75
Duplicate License	$2,475	$2,400	$2,375	95	$25
Cite and Fine	$41,863	$41,378	$45,000	var	var
Miscellaneous	$37,751	$38,449	$23,140	var	var
Total Revenue	**$2,471,777**	**$2,534,107**	**$2,562,490**		

EXPENDITURES

Expenditure Items	2009/10	2010/11	Projected 2011/12	Actual Exp. thru 08/31/11	Budgeted 2011/12
Salary & Benefits	$1,141,805	$1,219,374	$1,344,320	$201,775	$1,260,986
Training	$199	$403	$1,000	$0	$20,180
Travel	$18,199	$18,522	$20,000	$1,847	$41,805
Printing	$46,739	$33,432	$41,515	$2,450	$41,515
Postage	$65,127	$40,774	$41,000	$4,757	$44,952
Equipment	$5,946	$829	$13,000	$0	$13,000
ProRata[1]	$370,391	$395,142	$437,041	$30,949	$437,041
Fingerprints	$6,324	$5,610	$6,000	$459	$65,000
All Other Fixed Expenses[2]	$229,668	$195,473	$286,869	$16,587	$548,235
Investigations	$8,396	$27,385	$33,940	$0	$33,940
Attorney General	$513,784	$448,138	$462,214	$70,968	$462,214
Office of Admin Hearings	$84,824	$76,644	$137,082	$9,062	$137,082
Court Reporter Services	$11,311	$6,547	$12,000	$0	$0
Evidence and Witness	$30,849	$39,227	$50,000	$5,866	$32,050
Total Expenditures	**$2,533,562**	**$2,507,500**	**$2,885,981**	**$344,720**	**$3,138,000**

[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

	2010/11	2011/12*	2012/13*	2013/14*
Beginning Reserve, July 1	$2,017,000	$2,225,168	$2,079,929	$1,510,218
Prior Year Adjustments	$0			
Revenues	$2,534,107	$2,562,490	$2,607,490	$2,607,490
Interest		$22,252	$20,799	$15,102
TOTAL RESOURCES	**$4,551,107**	**$4,809,910**	**$4,708,218**	**$4,132,810**
Budget Expenditure	$2,507,500	$2,885,981	$3,138,000	$3,138,000
FSCU (State Operations)	$5,000	$3,000		
FISC	$2,000	$13,000		
BreEZe SPR Funding		$36,000	$58,000	$77,000
BreEZe Credit Card BCP			$21,000	$42,000
EO B-3-11 CS 3.91 DCA Savings Plan		($17,000)	($17,000)	($17,000)
BL 11-08 Cellular Phone Reduction		($2,000)	($2,000)	($2,000)
Reimbursements	($188,561)	($189,000)		
TOTAL EXPENDITURES	**$2,325,939**	**$2,729,981**	**$3,198,000**	**$3,238,000**
RESERVE, JUNE 30	**$2,225,168**	**$2,079,929**	**$1,510,218**	**$894,810**

* Projected

RESPIRATORY CARE BOARD
Department of Consumer Affairs
California Code of Regulations. Title 16. Division 13.6 Respiratory Care Board
DISCIPLINARY GUIDELINES, CITATION AND FINE, FEES, AND VARIOUS REGULATORY REVISIONS

PROPOSED LANGUAGE

California Code of Regulations
Title 16. Professional and Vocational Regulations
Division 13.6. Respiratory Care Board of California

ARTICLE 1. GENERAL PROVISIONS

Amend Section 1399.301 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

§ 1399.301. Location of Office.
The principal office of the Respiratory Care Board of California is located at 444 North 3rd Street, Suite 270, Sacramento, CA 958~~14~~11.

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

Amend Section 1399.302 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

§ 1399.302. Definitions.
Unless the context otherwise requires, the following definitions shall apply:
(a) "Board" means the Respiratory Care Board of California.
(b) "B&P~~C~~" means the Business and Professions Code.
(c) "Act" means the Respiratory Care Practice Act.
(d) "Direct Supervision" means assigned to a currently licensed respiratory care practitioner who is on duty and immediately available in the assigned patient area.
(e) "Employer" means any company, corporation, partnership, health maintenance organization, registry, staffing agent or agency, or any other entity or person that employs or contracts with, one or more respiratory care practitioners, ~~or~~ unlicensed personnel, or any person, to provide respiratory care services as provided in the Act.
(f) "Licensed Home Care Employer" means a Home Medical Device Retail Facility, Home Health Agency, or any home care provider licensed by the California Department of Public Health, the Department of Health Care Services or ~~its~~ their successors.
(g) "Regulations" means Division 13.6 of Title 16 of the California Code of Regulations.
(h) "Unlicensed Personnel" means any individual who is not otherwise exempt, or who does not hold a valid and current license issued by the board. ~~not otherwise authorized or exempt to provide respiratory care services except as provided for in Article 6.~~
Note: Authority cited: Sections 3704, ~~and~~ 3722, 3739, 3742, 3760, and 3761 Business and Professions Code. Reference: Sections 3704, ~~and~~ 3717, 3722, 3739, 3742, 3758, 3758.6, 3760, 3761, 3767, 3773, and 3777 Business and Professions Code.

Amend Section 1399.303 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

§ 1399.303. Delegation of Authority.
(a) Except for those powers reserved exclusively for the "agency itself" under the Administrative Procedure Act (Section 11500 et seq. of the Government Code), the board delegates and confers upon the executive officer of the board, or in his or her absence, the president of the board, the power and discretion to prepare, receive and file accusations, statements of issues and stipulated settlements; issue notices of hearings~~,~~ and statements to respondents~~ and statements of issues~~; receive and file notices of defense and proposed and final decisions; determine the time and place of hearings under Section 11508 of the Government Code; issue subpoenas and subpoenas duces tecum; calendar cases for hearing; prepare and file, proposed default decisions; adopt stipulated settlements where an action to revoke the license has been filed, and the respondent agrees to surrender his or her license, and perform other functions necessary to the businesslike dispatch of the business of the board in connection with proceedings under the provisions of Sections 11500 through 11528 of the Government Code, prior to the hearing of such proceedings; and the certification and delivery or mailing of copies of decisions under Section 11518 of said code.
(b) The executive officer is further authorized~~, subject to the approval of the board,~~ to investigate and evaluate each applicant for licensure under the Act, and to issue or deny a license in conformance with the provisions of the B&P~~C~~, the Act, this chapter, and disciplinary guidelines.

Note: Authority cited: Section 3722, Business and Professions Code. Reference: Sections 3716 and 3753, Business and Professions Code.

ARTICLE 2. APPLICATIONS

Amend Section 1399.320 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

§ 1399.320. Applications.
(a) Documentation related to the initial application process shall not be submitted more than ~~30~~ 90 days prior to the receipt of an initial application. If an application is not received within ~~30~~ 90 days, the submitted material will be destroyed.

Note: Authority cited: Section 3730, Business and Professions Code. Reference: Sections 3732, 3733, 3735, ~~3735.3~~, 3735.5 and 3740, Business and Professions Code.

ARTICLE 3. EDUCATION AND EXPERIENCE

Amend Section 1399.330 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

§ 1399.330. Education Waiver Criteria.
(a) The board may waive the education requirements in ~~s~~Section 3740 of the B&P~~C~~ if an applicant for licensure

(1) Either successfully completed a minimum of a one-year respiratory care program supported by the Committee on Accreditation for Respiratory Care or its predecessor, prior to July 1, 2004 or previously held a license in good standing issued by the board and
(A) Holds a current valid license in good standing in another state, United States territory or Canadian province and has practiced respiratory care in that jurisdiction for a minimum of two years full time within the three years immediately preceding filing an application for licensure in this state; or
(B) Has practiced respiratory care in another state or United States territory, for a minimum of three years full time within the four years immediately preceding filing an application for licensure in this

state, and that state or territory does not regulate the practice of respiratory care at the time the application for licensure is filed.

(2) Has not completed a respiratory care program described in subdivision (1) above but either
(A) Holds a current valid license in good standing in another state, United States territory or Canadian province and has competently practiced respiratory care in that state, United States territory or Canadian province for a minimum of four years full time within the five years immediately preceding filing an application for licensure in this state; or
(B) Has practiced respiratory care in another state or United States territory, for a minimum of five years full time within the six years immediately preceding filing an application for licensure in this state, and that state or territory does not license the practice of respiratory care at the time the application for licensure is filed.

(3) Does not meet the criteria described in subdivisions (1) or (2) above, but
(A) Has completed a minimum of a one-year respiratory care program supported by the Committee on Accreditation for Respiratory Care or its predecessor, and
(B) Has practiced respiratory care while serving in the U.S. military for a minimum of two years, full time, within the four years immediately preceding filing an application for licensure in this state, and
(C) The U.S. military verifies the applicant is in “good standing” as it pertains to his or her past or current employment.

(b) As used in this section, "good standing" means the applicant
(1) is not currently under investigation;
(2) has not been charged with an offense for any act substantially related to the practice of respiratory care by any public agency;
(3) has not entered into any consent agreement or been subject to an administrative disciplinary decision including any voluntary surrender of license; and
(4) has not been the subject of an adverse judgment or arbitration award resulting from a claim or action for damages for death or personal injury caused by that person's negligence, error or omission in the practice of respiratory care.

(c) An applicant must provide sufficient documentary evidence to establish to the satisfaction of the board, that the applicant meets each requirement in the pathway under which the applicant is attempting to qualify. An applicant shall sign a release authorizing the board to obtain copies of personnel records or any other documentation that establishes the applicant's qualifications for a waiver of the educational requirements.

(d) This section shall not be construed to require the board to waive education requirements for any reason including, but not limited to, poor work performance, habits or communication, insufficient documentation to ascertain waiver criteria has been met, or employment with staffing agencies or registries where the applicant’s experience is based on working at three or more sites.

(e) The application fee shall not be refunded for any application where education requirements are not waived pursuant to this section.

Note: Authority cited: Sections 3722 and 3740, Business and Professions Code. Reference: Sections 35 and 3740, Business and Professions Code.

ARTICLE 4. EXAMINATIONS

Repeal Section 1399.340 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

~~**§ 1399.340. Failure on Examinations.**~~
~~For purposes of B&PC section 3739, the "next available examination" shall mean the board's state licensing examination, or the National Board for Respiratory Care, Inc. entry level certification examination for respiratory therapy. Failure of either examination, or failure to take either examination as scheduled except for due cause, shall result in termination of the privilege to work as a "respiratory care practitioner applicant".~~

~~Note: Authority cited: Section 3722, Business and Professions Code. Reference: Section 3739, Business and Professions Code.~~

ARTICLE 5. CONTINUING EDUCATION

Amend Section 1399.352.7 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

§ 1399.352.7. Law and Professional Ethics Course Criteria.
An acceptable course in law and professional ethics shall meet the following criteria and be approved by the board:

(a) The course shall be provided by the American Association for Respiratory Care or the California Society for Respiratory Care.

(b) The course shall be three hours in length. <u>One hour of instruction shall consist of not less than 50 minutes of actual classroom time or actual time spent by the licensee completing the coursework on the internet.</u>

(c) The content of the course shall consist of the following subject areas:
(1) Obligations of licensed respiratory care practitioners to patients under their care;
(2) Responsibilities of respiratory care practitioners to report illegal activities occurring in the work place; and
(3) Acts that jeopardize licensure and licensure status.

~~(d) One hour of instruction shall consist of not less than 50 minutes of actual classroom time or actual time spent by the licensee completing the coursework on the internet.~~

<u>(d) The course shall meet all of the following requirements:</u>
<u>(1) The course shall consist of two (2) hours dedicated to professional ethics and one (1) hour toward California law. The board may opt to prepare or edit in full or part, any portion of the course.</u>
<u>(2) The course title shall be "Law and Professional Ethics."</u>
<u>(3) Delivery and format of the course shall be user-friendly and captivating with sufficient visual capabilities as determined by the board.</u>
<u>(4) The course will be at least thirty (30) pages of written material with at least twenty (20) test questions related to professional ethics and ten (10) related to California law.</u>
<u>(5) Course content must include course description, course objectives, references, scenarios, questions, certificate of completion and legal disclosures, as applicable.</u>
<u>(6) The course shall provide several segments. Each segment must include a narrative or discussion, a scenario, and at least one question. For each question there must be between three and six possible responses with only one correct answer. Each response must include an explanation as to why the response is incorrect or correct. The number of questions tied to each segment may vary, as each component will differ in length and content.</u>

(7) The course will include at least thirty (30) scenario-based questions that require critical thinking skills.

(8) The provider shall submit course test scores, names and other course related information to the board, as requested by the board.

(9) The provider shall not charge more than thirty dollars ($30) for board applicants and sixty dollars ($60) for board licensees or petitioners.

(10) The provider shall ensure that procedures are in place to address Americans with Disabilities Act (ADA) requests.

(11) The participant shall be allowed one (1) year to complete the course/exam after enrollment.

(12) The participant shall not be able to exit the post examination once commenced.

(13) The participant shall not have a time limit to take the post examination.

(14) The minimum post examination passing score shall be 70%. The post examination shall be scored on all cumulative components, not by each section.

(15) As applicable, the provider shall offer and allow participants who failed the initial post examination to retake the post examination free of charge. There shall be no wait time to retake the post examination if previously failed.

(16) The course will include a survey, optional to participants, to gather feedback for the board.

(e) The course is solely the product of the provider and the provider assumes full responsibility for the course.

(f) The course must be revised once every four years. Each revision must be approved by the board. The board's Education Committee may rescind the approval of a course at any time if it believes it has been altered or finds that the course does not meet the requirements as provided for in this Article.

(g) The provider may advertise and or reference that an approved course is "approved" by the board.

Note: Authority cited: Sections 3719.5 and 3722, Business and Professions Code. Reference: Sections 3719 and 3719.5, Business and Professions Code.

Amend Section 1399.353 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

§ 1399.353. Audit and Sanctions for Noncompliance.

(a) The board shall audit a random sample of RCPs for compliance with the CE requirements.

(b) If documentation of the CE requirement is improper or inadequate, or the licensee fails to provide the requested documentation within 30 days, the license becomes inactive. The practice of respiratory care, or representation that one is an RCP, is prohibited while the license is inactive. Practice on an inactive license shall constitute grounds for appropriate disciplinary action pursuant to the B&P~~C~~.

(c) Notwithstanding subdivision (b), if the ~~B~~board determines that through no fault of the licensee the CE completed does not meet the criteria set forth in this Article, the ~~B~~board may grant an extension, not to exceed six months, for the licensee to complete approved CE.

(d) Misrepresentation of compliance shall constitute grounds for disciplinary action.

(e) Documentation supporting compliance with CE requirements shall be available to the board upon request during the four year period following relicensure.

Note: Authority cited: Sections 3719 and 3722, Business and Professions Code. Reference: Sections 3719, 3719.5 and 3750, Business and Professions Code.

ARTICLE 6. SCOPE OF PRACTICE

Amend Section 1399.360 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

§ 1399.360. Unlicensed Personnel Services; Home Care.

(a) Unlicensed personnel (UP) may perform limited and basic respiratory care or respiratory care related services identified in subdivisions (b) and (c) in the home setting, ~~or~~ for the purposes of patient transfer to the home setting, or at the facility of a Licensed Home Care Employer, provided the following conditions are met:

(1) The UP is providing services through his or her employment with a Licensed Home Care Employer (LHCE);

(2) The UP has been provided initial training, and at least annually, ongoing in-service education, and periodic competency testing specific to each service and equipment-type by either a California licensed respiratory care practitioner (RCP) or other qualified licensed personnel, in accordance with his or her scope of practice, and documentation of such training, education and testing is maintained by the LHCE for a period of four years, and

(3) The LHCE ensures that the patient, the patient's family, or the patient's caregiver(s) are advised prior to or at the time equipment or supplies are delivered, that a RCP or other qualified licensed personnel, in accordance with his or her scope of practice, shall provide follow up checks, by telephone or in-person as appropriate, at the request of the patient or the patient's family, caregiver, or physician, or any person who has had contact with the patient, or as otherwise directed by a plan of care, and such services are provided accordingly.

(b) In accordance with this section and as it relates to:

- positive airway pressure (with or without a back-up rate) devices and supplies;
- intermittent positive pressure breathing devices and supplies;
- ventilators, ventilatory devices and supplies;
- nasotracheal or tracheal suctioning devices and supplies;
- apnea monitors and alarms and supplies;
- tracheostomy care devices and supplies;
- respiratory diagnostic testing devices and supplies, including but not limited to pulse oximetry, CO2 monitoring, and spirometry devices and supplies;
- pulse-dose type or demand conserving oxygen delivery devices or high flow oxygen systems beyond the capabilities of a simple mask or cannula or requiring particulate or molecular therapy in conjunction with oxygen, and
- any other respiratory care equipment and supplies not identified in subdivisions (b) and (c),

(1) UP may:

(A) Deliver equipment and supplies~~;~~ , and

(B) Instruct the patient, the patient's family or the patient's caregiver(s) on how to order equipment and supplies and the telephone number to call 24 hours a day, 7 days a week, in case of emergency in which a live person will be available to respond~~;~~ .

(C) Set up equipment to the extent that the set-up is not dependent upon or influenced by any written or oral communication with the patient or the patient's family, caregiver(s) or physician (with the exception of identifying a physical location in the home for set-up), and

(D) Provide instruction to the patient, the patient's family or the patient's caregiver(s) limited to the mechanical operation of the equipment (e.g. switch, knob, and dial locations) or the general use of equipment or supplies.

(2) UP are prohibited from:

(A) Setting up equipment, including but not limited to, ~~to an extent that it constitutes patient care such as~~ applying or fitting any device to the patient or making any adjustment or taking any action, including but not limited to, applying positive pressure, that requires or is dependent upon or influenced by a

prescription or any written or oral communication with the patient or the patient's family, caregiver(s) or physician;

(B) Providing any instruction ~~to an extent that it constitutes patient care, such as instruction~~ in the operation or use of the equipment ~~for the purpose of deriving an intended medical benefit~~ or instruction in the clinical application of equipment and/or supplies;

(C) Performing any level of clinical assessment of the patient;

(D) Directly engaging in any discussion of clinical care plans, therapy, prescriptions, or clinical application;

(E) Touching the patient for the purposes of making an assessment or placing any device upon the patient, and

(F) Providing any service that is not expressly authorized by this section.

(c) In accordance with this section and as it relates to oxygen delivery systems and prefilled cylinders, with the exception of pulse-dose or demand conserving oxygen systems and high flow oxygen systems beyond the capabilities of a simple mask or cannula or requiring particulate or molecular therapy in conjunction with oxygen,

(1) UP may:

(A) Deliver equipment and supplies;

(B) Instruct the patient, the patient's family or the patient's caregiver(s) on how to order oxygen equipment and supplies and the telephone number to call 24 hours a day, 7 days a week, in case of emergency in which a live person will be available to respond;

(C) Instruct the patient, the patient's family or the patient's caregiver(s) in the proper and safe operation of oxygen equipment including:

(I) equipment set-up for the purpose of making the equipment patient-ready;

(ii) connecting disposable tubing, cannulas, and masks;

(iii) verification of oxygen flow;

(iv) demonstration to the patient of prescribed flow rate(s);

(v) connection and cleaning of oxygen humidifying equipment and devices;

(vi) use of portable back-up oxygen cylinders and equipment, and

(vii) removal and disposition of disposable tubing, cannulas, and masks, and

(D) Use a mock, self-demonstration as a method of instruction for subdivision (c)(1)(C).

(E) Conduct regular in-home evaluations and gather information from the patient and home setting pertaining to the set-up, instruction, and provision of information as described in this subdivision for the use of the prescribing physician.

(2) UP are prohibited from:

(A) Direct administration of ~~home~~ oxygen;

(B) Handling or adjusting ~~home~~ oxygen equipment while it is in use by the patient or on the patient;

(C) Performing any level of clinical assessment of the patient;

~~(C)~~ (D) Touching the patient or placing any device upon the patient while engaged in the set-up and instruction of equipment, including, but not limited to, applying a cannula or performing an oximetry evaluation or oxygen saturation test, and

~~(D)~~ (E) Directly engaging in any discussion of clinical care plans, oxygen therapy or any modifications of physician prescribe equipment, dosages, or instructions or clinical applications.

Note: Authority cited: Sections 3722 and 3765, Business and Professions Code. Reference: Sections 3701, 3702, 3703, 3704, 3717 ~~and~~ 3760, and 3761, Business and Professions Code; and Sections 109948.1 and 111656.3, Health and Safety Code.

Adopt Section 1399.364 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

§ 1399.364. Orders

(a) RCPs may work under the orders of qualified and licensed practitioners who are authorized by the licensed health facility's medical staff, pursuant to protocol(s) developed in accordance with Sections 3702 and 3703 of the B&P.

Note: Authority cited: Sections 3702, 3703, and 3722, Business and Professions Code. Reference: Sections 3702, 3702.7, and 3703, Business and Professions Code.

ARTICLE 7. MISCELLANEOUS

Amend Section 1399.370 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

§ 1399.370. Substantial Relationship Criteria.

For the purposes of denial, suspension, or revocation of a license, a crime or act shall be considered to be substantially related to the qualifications, functions or duties of a respiratory care practitioner, if it evidences present or potential unfitness of a licensee to perform the functions authorized by his or her license or in a manner inconsistent with the public health, safety, or welfare. Such crimes or acts include but are not limited to those involving the following:

(a) Violating or attempting to violate, directly or indirectly, or assisting or abetting the violation of or conspiring to violate any provision or term of the ~~Act~~ B&P.

(b) Commission of an act or ~~C~~conviction of a crime involving fraud, fiscal dishonesty theft, or larceny.

(c) Commission of an act or ~~C~~conviction of a crime involving driving under the influence or reckless driving while under the influence.

(d) Commission of an act or ~~C~~conviction of a crime involving harassment or stalking as defined by the Penal Code and/or Civil Code.

(e) Commission of an act or ~~C~~conviction of a crime involving lewd conduct, prostitution or solicitation thereof, or pandering and/or indecent exposure, as defined by the Penal Code.

(f) Commission of an act or conviction of a crime involving human trafficking, as defined by the Penal Code.

(g) Commission of an act or conviction of a crime involving gross negligence in the care of an animal or any form of animal cruelty as defined by the B&P or Penal Code.

(h) Failure to comply with a court order.

(i) Commission of an act or conviction of a crime, involving verbally abusive conduct or unlawful possession of a firearm or weapon.

Note: Authority cited: Section 481 and 3722, Business and Professions Code. Reference: Sections 481, 3750, 3750.5, 3752, 3752.5, 3752.6, ~~and~~ 3752.7, 3754.5, and 3755, Business and Professions Code; and Sections 266, 288, 314, 646.9, 647, 1203.097, 11414, 13519.6 and 13519.7, Penal Code.

Amend Section 1399.374 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

§ 1399.374. Disciplinary Guidelines.

In reaching a decision on the disciplinary action under the Administrative Procedure Act (Government Code Section 11400 et seq.), determining terms and conditions of probation, or consequences for non compliance of ordered probation, the board shall consider the disciplinary guidelines entitled "Disciplinary Guidelines" [~~3/02~~ 2011 Edition] which are hereby incorporated by reference. Deviation from these standards, guidelines and orders, including the standard terms of probation, is appropriate where the board in its sole discretion determines that the facts of the particular case warrant such a deviation -for example: the presence of mitigating factors; the age of the case; evidentiary problems.

Note: Authority cited: Sections 315, 3718, 3722 and 3750, Business and Professions Code; and Sections 11400.20 and 11400.21, Government Code. Reference: Section 315, Business and Professions Code and Sections 11400.20 and 11425.50(e), Government Code.

Adopt Section 1399.375 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

1399.375. Cease Practice-Probation

a) Any licensee placed on probation who has committed a “Major Violation,” as identified in the Disciplinary Guidelines, incorporated by reference pursuant to section 1399.374, shall receive a notice to cease the practice of respiratory care, as directed by the Board.

b) The Board shall attempt to contact the probationer by electronic and/or telephonic means to advise him/her of the notice to cease practice and shall deliver such notice by certified and regular mail. The Board shall update its licensing database to reflect the status of the license.

c) The probationer may file a written appeal, within ten days of the date of the notice to cease practice, to provide additional evidence disputing the finding of the violation(s) that was cause for the notice to cease practice. The Executive Officer will review the appeal and make a determination in the matter, within ten days from the date the written appeal and all supporting evidence or documentation is received. The probationer shall be notified of the outcome by certified mail.

d) The probationer shall not resume the practice of respiratory care until a final decision on an accusation and/or petition to revoke probation is made or until such time as the Board delivers written notification that the notice to cease practice has been dissolved.

e) The cessation of practice shall not apply to the reduction of the probationary period.

Note: Authority cited: Sections 315.2, 315.4, and 3722, Business and Professions Code. Reference: Sections 315.2 and 315.4, Business and Professions Code and Section 1399.374, Title 16, California Code of Regulations.

Adopt Section 1399.377 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

§ 1399.377. Records from Employer
Records requested by the board, or on behalf of the board, as provided for in Section 3717 of the B&P, shall be provided by the employer, within 10 business days from a written, electronic or oral request or be made available for review at the time of an inspection.

Note: Authority cited: Section 3717, Business and Professions Code. Reference: Section 3717, Business and Professions Code.

Amend and Renumber Section 1399.384 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

§ ~~1399.384.~~ 1399.378. Licensee Reporting.
Information required to be disclosed by any person issued a license to practice respiratory care, whether that license is valid or invalid, as provided in Section 3758.5 of the B&P~~C~~ shall be disclosed to the board within 10 calendar days from the date the person knows or should have reasonably known of a violation or probable violation has occurred.

Note: Authority cited: Sections 3722, ~~and~~ 3758, and 3758.5, Business and Professions Code. Reference: Section 3758 and 3758.5, Business and Professions Code.

Amend and Renumber Section 1399.385 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

§ ~~1399.385.~~ 1399.379. Employer Reporting.
Information required to be disclosed by any employer of a respiratory care practitioner as provided in Section~~s~~ 3758 or ~~and~~ 3758.6 of the B&P~~C~~ shall be disclosed to the board within 10 calendar days from the date of suspension or termination, whichever occurs first.

Note: Authority cited: Sections 3722, ~~and~~ 3758, and 3758.6, Business and Professions Code. Reference: Section 3758 and 3758.6, Business and Professions Code.

ARTICLE 8. CITATIONS AND FINES

Amend Section 1399.380 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

§ 1399.380. Citations.
(a) The executive officer of the board or his or her designee is authorized to issue a citation to any person or employer ~~who holds a permit, certificate or license from the board~~ for a violation of any provision of Division 1.5 and Chapter 1 of Division 2 of the B&P, as permitted, the Act, or any regulation adopted by the board.

(b) ~~Each~~ A citation shall be in writing and shall describe with particularity the nature ~~and facts~~ of ~~each~~ the violation ~~specified in the citation~~, including ~~a~~ specific reference to the statute or regulation ~~alleged~~ determined to have been violated.

(c) ~~Each~~ A citation ~~may~~ shall, where appropriate, contain an ~~assessment of an administrative fine, payable within a time period designated by the board, not to exceed 365 days, an~~ order of abatement fixing a reasonable time for abatement of the violation~~, or both, for each alleged violation~~.

(d) A citation may also contain an assessment of an administrative fine as provided for in Section 1399.381, payable within 120 days.

(~~d~~e) ~~Each~~A citation shall inform the cited person or employer of his or her right to a citation review, as provided in Section 1399.382, and/or a hearing to appeal the citation, as provided in Section 1399.383, and that such a request ~~for a hearing~~ be made in writing within 30 calendar days from the issuance date of the citation.

(~~e~~f) ~~Each~~A citation shall be served upon the individual or employer by certified mail at the last address of record.

(~~f~~g) In assessing an administrative fine or issuing an order of correction or abatement, due consideration shall be given to the following factors:

(1) the gravity of the violation
(2) the good or bad faith exhibited by the cited person or employer
(3) the history of previous violations
(4) the extent to which the cited person or employer has cooperated with the board's investigation

(~~g~~h) The sanctions authorized under this section shall be separate from and in addition to any other administrative discipline, civil remedies, or criminal penalties.

(~~h~~i) Every citation ~~that is~~ issued pursuant to this article is a public record.

(~~i~~j) Once a fine is paid to satisfy an assessment based on the finding of a violation, the payment of the fine becomes public record.

Note: Authority cited: Sections 125.9, ~~and~~ 3722, 3766, and 3767, Business and Professions Code. Reference: Sections 125.9, 3766, and 3767 Business and Professions Code and Sections 1399.382 and 1399.383, Title 16, California Code of Regulations..

Repeal Section 1399.381 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

~~**§ 1399.381. Fines.**~~

~~(a) Fines shall be assessed in accordance with the following schedule, provided, however, in no case shall the total exceed $2,500 for each violation.~~

~~B&PC~~	~~Description~~	~~Range of Fines~~
~~480~~	~~Grounds for denial of an application for licensure/certificate~~	~~$100 to $2,500~~
~~3731~~	~~Title Used by Licensee~~	~~$25 to $2,500~~
~~3739~~	~~Practice During License Process~~	~~$100 to $2,500~~
~~3750(a)~~	~~Advertising~~	~~$250 to $2,500~~
~~3750(b)~~	~~Fraud in the procurement of any license~~	~~$1,000 to $2,500~~
~~3750(c)~~	~~Knowingly employing unlicensed persons~~	~~$100 to $2,500~~
~~3750(d)~~	~~Conviction of Crime~~	~~$100 to $500~~
~~3750(e)~~	~~Impersonating an applicant in any examination~~	~~$1,500 to $2,500~~
~~3750(f)~~	~~Negligence~~	~~$100 to $2,500~~
~~3750(g)~~	~~Conviction of a violation of any provision of Division 2~~	~~$100 to $2,500~~
~~3750(h)~~	~~Aiding/Abetting person to violate this chapter~~	~~$1000 to $2,500~~
~~3750(I)~~	~~Aiding/abetting person to engage in unlawful practice~~	~~$1000 to $2,500~~
~~3750(j)~~	~~Commission of any fraudulent, dishonest or corrupt act~~	~~$100 to $2,500~~
~~3750(k)~~	~~Falsifying/ incorrect/ inconsistent entries in record~~	~~$500 to $2,500~~
~~3750(l)~~	~~Changing prescription/falsifying orders for treatment~~	~~$1000 to $2,500~~
~~3750(m)~~	~~Discipline taken by another agency~~	~~$100 to $2,500~~

~~3750(n) Knowing failure to protect patients -infection control~~	~~$1000 to $2,500~~
~~3750(o) Incompetence~~	~~$500 to $2,500~~
~~3750(p) Pattern of substandard care~~	~~$1000 to $2,500~~
~~3750.5 Obtained/Possessed/Use of Drugs~~	~~$100 to $2,500~~
~~3750.6 Production of Work Permit or Pocket License for Inspection~~	~~$25 to $100~~
~~3753.1 Probation Monitoring Costs~~	~~Actual +$25 to $500~~
~~3753.5 Cost Recovery~~	~~Actual +$25 to $500~~
~~3754.5 Licensee who obtains license by fraud or misrepresentation~~	~~$1000 to $2,500~~
~~3755 Unprofessional Conduct~~	~~$250 to $2,500~~
~~3758.5 RCP to report any known violation made by other RCP~~	~~$250 to $2,500~~
~~3760(a) Practice without a License~~	~~$50 to $2,500~~
~~3761(a) Misrepresentation in claim of license to practice~~	~~$100 to $1,000~~
~~3761(b) Knowingly employ unlicensed personnel~~	~~$100 to $2,500~~
~~3773(a) License renewal - notice of conviction~~	~~$100 to $2,500~~
~~3773(b) License renewal - identification of current employer(s)~~	~~$100 to $2,500~~
~~Regulations Description~~	~~Range of Fines~~
~~1399.304 Current address~~	~~$25 to $250~~
~~1399.350 CE requirements~~	~~$50 to $1,500~~

~~(b) Administrative fines collected pursuant to this section shall be deposited into the board's special fund.~~

Adopt Section 1399.381 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

§ 1399.381. Fines.

(a) Fines shall be assessed in accordance with the following schedule as provided for by law:

BUSINESS AND PROFESSIONS CODES	Maximum Fine
3717 Records from employer	$10,000
3731 Title Used by licensee	$5,000
3739 Practice during license process	$5,000
3750(a) Advertising	$5,000
3750(b) Fraud in the procurement of any license	$5,000
3750(c) Knowingly employing unlicensed persons	$15,000
3750(d) Conviction of crime	$5,000
3750(e) Impersonating an applicant in any examination	$5,000
3750(f) Negligence	$5,000
3750(g) Conviction of any violation of Division 2	$5,000
3750(h) Aiding/Abetting person to violate this chapter	$5,000
3750(i) Aiding/abetting person to engage in unlawful practice	$5,000
3750(j) Commission of fraudulent, dishonest or corrupt act	$5,000
3750(k) Falsifying/ incorrect/ inconsistent entries in record	$5,000
3750(l) Changing prescription/falsifying orders for treatment	$5,000
3750(m) Discipline taken by another agency	$5,000
3750(n) Knowing failure to protect patients -infection control	$5,000
3750(o) Incompetence	$5,000
3750(p) Pattern of substandard care	$5,000
3750.5 Obtained/possessed/use of drugs	$5,000
3750.6 Production of work permit/pocket license	$5,000
3753.1 Probation monitoring costs	$5,000
3753.5 Cost recovery	$5,000

3754.5 Obtains license by fraud or misrepresentation	$5,000
3755 Unprofessional conduct	$5,000
3758 Employer report on suspension/termination	$10,000
3758.5 RCP report on violation made by other RCP	$5,000
3758.6 Employer report on supervisor	$10,000
3760 Practice without a license/Misrepresentation	$15,000
3761(a) Misrepresentation in claim of license to practice	$15,000
3761(b) Knowingly employing an unlicensed person	$15,000
3773(a)(1) License renewal - notice of conviction	$5,000
3773(a)(2) License renewal - identify employer	$5,000
3773(b) License renewal - additional information	$5,000
REGULATIONS	
1399.304 Current address	$5,000
1399.350 CE requirements	$5,000
1399.350.5 Completion of ethics/professional law course	$5,000
1399.360 Unlicensed personnel/home care	$15,000
1399.377 Records from employer	$10,000
1399.378 Licensee reporting	$5,000
1399.379 Employer reporting	$10,000

(b) The methodology for assessing fine amounts shall be for each inspection or investigation made with respect to the violation, except as provided below:

(1) The assessment of fine amounts for a violation involving fraudulent billing submitted to an insurance company, the Medi-Cal program, or Medicare, shall be based on each violation or count.

(2) The assessment of fine amounts for a violation of Section 3717 of the B&P or Section 1399.377 of the regulations, shall be based upon each incident in which the employer fails to respond to a request to inspect or produce records as provided for in Section 3717 of the B&P or Section 1399.377 of the regulations.

(3) The assessment of fine amounts for a violation of Section 3758, 3758.5 or 3758.6 of the B&P, or Section 1399.378 or 1399.379 of the regulations, shall be based upon each person and/or each incident required to be reported to the board.

(4) The assessment of fine amounts for a violation of Section 3750(c), 3760, 3761(a), or 3761(b) of the B&P or Section 1399.360 of the regulations, shall be based upon each person who acts in the capacity of, or engages in the business of, or represents themselves as, a respiratory care practitioner, at each facility or location.

(c) Administrative fines collected pursuant to this section shall be deposited into the board's special fund.

Note: Authority cited: Sections 125.9, ~~and~~ 3722, 3758, 3766, and 3767, Business and Professions Code. Reference: Sections 125.9, ~~136, 480,~~ 3717, 3731, 3739, 3750, 3750.5, 3750.6, 3753.1, 3753.5, 3754.5, 3755, 3758, 3758.5, 3758.6, 3760, 3761, 3766, 3767, and 3773, Business and Professions Code; and Sections 1399.304, ~~and~~ 1399.350, 1399.350.5, 1399.360, 1399.377, 1399.378, and 1399.379 Title 16, California Code of Regulations.

Amend and Renumber Section 1399.376 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

§ ~~1399.376.~~ 1399.382. Citation Review.

(a) If ~~T~~the person cited is afforded the opportunity for a citation review, he or she may, within 30 calendar days after the date of service of the citation, notify the ~~E~~executive ~~O~~officer, in writing, of his or her request for a citation review by the executive officer, ~~or a designated committee of the Board~~ regarding the acts

charged in the citation. Notification shall be through the United States Postal Service by certified or registered mail.

(b) The executive officer ~~or committee~~ shall hold, within ~~240~~ 60 calendar days from the receipt of the request, a citation review with the person cited or his or her legal counsel or other authorized representative in person or by telephone. At the conclusion of the citation review, the executive officer ~~committee~~ may affirm, modify or dismiss the citation, including any fine levied. The executive officer ~~or committee~~ shall state in writing the reasons for the action and serve a copy of ~~it's~~ the findings and decision on the person cited within 30 calendar days of the date of the citation review. ~~This decision shall be deemed to be a final order of the Board with regard to the citation issued, including the fine levied.~~ The decision shall inform the cited person of his or her right to a hearing as provided in Section 1399.383 of this Article, and that such a request must be made in writing within 30 calendar days from the issuance date of the decision resulting from the citation review.

Note: Authority cited: Section 3722, Business and Professions Code. Reference: Section~~s~~ ~~3761~~ 125.9, 3766, and 3767, Business and Professions Code.

Amend and Renumber Section 1399.382 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

§ ~~1399.382.~~ 1399.383. Appeals.

(a) Any person or employer served with a citation or a decision resulting from a citation review, as provided in Section 1399.382 of this Article, may contest the citation by appealing to the board in writing, within 30 calendar days of the issuance of the citation or decision.

~~(b) If the cited person fails to notify the board of his or her intent to contest the citation, the citation shall be deemed a final order of the board.~~

(~~c~~b) If a cited person or employer requests a hearing to appeal the citation, ~~notifies the board that he or she intends to contest a citation,~~ the board shall afford an opportunity for ~~a citation review in accordance with section 1399.376 of the board's regulations or~~ a hearing in accordance with the provisions of Chapter 5 (commencing with ~~s~~Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

~~(d) The failure of a cited person who has appealed to the board to appear at the time and place of the citation review or hearing shall be deemed a withdrawal of his or her appeal, and the citation shall constitute a final order of the board.~~

Note: Authority cited: Sections 125.9, ~~and~~ 3722, and 3767, Business and Professions Code. Reference: Section 125.9, and 3767, Business and Professions Code; Sections ~~1399.376,~~ 1399.380, and 1399.382, Title 16, California Code of Regulations; and Sections 11500, et seq., Government Code.

Adopt Section 1399.384 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

1399.384. Failure to Respond or Appear

(a) If the cited person or employer fails to request a citation review or a hearing as provided in subdivision (e) of Section 1399.380, or fails to request a hearing as provided in subdivision (a) of Section 1399.383, the citation shall be deemed a final order of the board and shall not be subject to administrative review.

(b) The failure of a cited person or employer who has requested a citation review, if applicable, or hearing, to appear at the time and place of the citation review or hearing shall be deemed a withdrawal of his or her

request, and the citation shall be deemed a final order of the board and shall not be subject to administrative review.

Note: Authority cited: Sections 125.9, 3722, and 3767, Business and Professions Code. Reference: Section 125.9, and 3767, Business and Professions Code; Sections 1399.380, 1399.382, and 1399.383, Title 16, California Code of Regulations; and Sections 11500, et seq., Government Code.

Amend and Renumber Section 1399.383 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

§ ~~1399.383.~~ 1399.385. Failure to Comply with Citation.
The failure to comply with a citation containing an assessment of an administrative fine or an order of abatement or both, after the citation is final and has been properly served, shall result in one or more of the following:

(a) the non renewal of a license.

(b) referral to collection entities to collect the fine.

(c) the pursuit of further legal action by the board to collect the fine.

Note: Authority cited: Sections 125.9, ~~and~~ 3722, 3768, and 3778, Business and Professions Code. Reference: Sections125.9, 3767, and 3768, Business and Professions Code.

Repeal Section 1399.387 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

~~**§ 1399.387. Citations -Employer.**~~
~~(a) The executive officer of the board or his or her designee is authorized to issue a citation to any employer for a violation of sections 3717, 3758 and 3758.6 of the B&PC or Section 1399.385 of the regulations.~~

~~(b) Each citation shall be in writing and shall describe with particularity the nature and facts of each violation specified in the citation, including a reference to the statute or regulation alleged to have been violated.~~

~~(c) Each citation may contain an assessment of an administrative fine, payable within a time period designated by the board, not to exceed 365 days, an order of abatement fixing a reasonable time for abatement of the violation, or both, for each alleged violation.~~

~~(d) Each citation shall inform the cited employer of its right to a hearing and that such a request for a hearing be made in writing within 30 days from the issuance date of the citation.~~

~~(e) Each citation shall be served upon the employer by certified mail at the last address of record.~~

~~(f) In assessing an administrative fine or issuing an order of correction or abatement, due consideration shall be given to the following factors:~~
~~(1) the gravity of the violation~~
~~(2) the good or bad faith exhibited by the employer~~
~~(3) the history of previous violations~~
~~(4) the extent to which the employer has cooperated with the board's investigation~~

~~(g) The sanctions authorized under this section shall be separate from and in addition to any other administrative discipline, civil remedies, or criminal penalties.~~

~~(h) Every citation that is issued pursuant to this article is a public record.~~

~~(I) Once a fine is paid to satisfy an assessment based on the finding of a violation, the payment of the fine becomes a public record.~~

~~Note: Authority cited: Sections 125.9, 3722, 3758 and 3758.6, Business and Professions Code. Reference: Sections 125.9, 3717, 3758 and 3758.6, Business and Professions Code.~~

Repeal Section 1399.388 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

~~§ 1399.388. Fines -Employer.~~
~~(a) Failure of an employer to provide reports or records or allow inspections as required by Section 3717 of the B&PC shall be punishable by an administrative fine ranging from $250 to $2,500.~~

~~(b) Failure of an employer to make a report required by Section 3758 of the B&PC shall be punishable by an administrative fine ranging from $2,500 to $10,000.~~

~~(c) Failure of an employer to make a report as required by Section 3758.6 of the B&PC shall be punishable by an administrative fine ranging from $500 to $2,500.~~

~~(d) Administrative fines collected pursuant to this section shall be deposited into the board's special fund.~~

~~Note: Authority cited: Sections 3722 and 3758, Business and Professions Code. Reference: Sections 3717, 3758 and 3758.6, Business and Professions Code.~~

Repeal Section 1399.389 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

~~§ 1399.389. Appeals -Employer.~~
~~(a) Any employer served with a citation, may contest the citation by appealing to the board in writing, within 30 calendar days of the issuance of the citation.~~

~~(b) If the cited employer fails to notify the board of his or her intent to contest the citation, the citation shall be deemed a final order of the board and shall not be subject to administrative review.~~

~~(c) If a cited employer notifies the board that it intends to contest a citation, the board shall afford an opportunity for a hearing. The board shall thereafter issue a decision based on findings of fact, affirming, modifying or vacating the citation or penalty or both, or directing other appropriate relief. The proceedings under this section shall be conducted in accordance with the provisions of Chapter 5 (commencing with section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.~~

~~(d) The failure of a cited employer that has appealed to the board to appear at the time and place of the hearing shall be deemed a withdrawal of its appeal, and the citation shall constitute a final order of the board and shall not be subject to administrative review.~~

~~Note: Authority cited: Sections 125.9 and 3722, Business and Professions Code. Reference: Section 125.9, Business and Professions Code; and Section 11500, et seq., Government Code.~~

Repeal Section 1399.390 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

~~§ 1399.390. Failure to Comply with Citation -Employer.~~
~~The failure to comply with a citation containing an assessment of an administrative fine or an order of abatement or both after the citation is final and has been properly served shall result in the pursuit of further action by the board to collect the fine.~~

~~Note: Authority cited: Sections 3722 and 3758, Business and Professions Code. Reference: Section 3758, Business and Professions Code.~~

Repeal Section 1399.391 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

~~§ 1399.391. Citation and Fine - Unlicensed Personnel.~~
~~(a) The executive officer or his or her designee is authorized to determine when and against whom a citation will be issued and to issue a citation to any person, or employer of a person, who acts in the capacity of or engages in the business of a respiratory care practitioner in this state without having a license in good standing pursuant to the Act and who is not otherwise exempted from the provisions of the Act. Each citation for unlicensed activity shall contain an order of abatement, and shall be in writing and state with particularity the basis of the citation. "Employer," as used in this section, means any entity or person that employs or contracts with one or more persons who are acting in the capacity of, or engaged in the business of, a respiratory care practitioner, including but not limited to, any person, facility, company, corporation, partnership, organization or health maintenance organization.~~

~~(b) An administrative fine shall be paid within the time period designated in the citation, not to exceed 365 days. The amount of an administrative fine shall be separate from section 1399.381 and in accordance with section 3767(b)(2) of the B&PC.~~

~~(c) A citation shall inform the cited person or employer of his or her right to a hearing and that such a request for a hearing be made in writing within 15 calendar days after service of the citation. A citation shall be served upon the individual or employer by certified mail.~~

~~(d) In assessing an administrative fine and issuing an order of abatement, due consideration shall be given to the following factors for each violation:~~
~~(1) the gravity of the violation;~~
~~(2) the good or bad faith exhibited by the cited person or employer;~~
~~(3) the history of previous violations;~~
~~(4) the extent to which the cited person or employer has cooperated with the board's investigation.~~

~~(e) A cited person or employer who wishes to contest the citation may serve a written appeal on the board, within 15 calendar days after service of the citation, through the United States Postal Service by certified or registered mail.~~

~~(f) If the cited person or employer notifies the board that he/she/it intends to contest a citation, the board shall afford an opportunity for a hearing. The board shall thereafter issue a decision based on findings of fact, affirming, modifying or vacating the citation with its fine or order of abatement, or directing other appropriate relief. The proceedings under this section shall be conducted in accordance with the provisions of Chapter 5 (commencing with section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.~~

~~(g) The failure of a cited person or employer to appear at the time and place of the hearing shall be deemed a withdrawal of the appeal, and the citation shall constitute a final order of the board and shall not be subject to further administrative review.~~

~~Note: Authority cited: Sections 3722, 3760, 3761, 3766 and 3767, Business and Professions Code. Reference: Sections 3760, 3761, 3766 and 3767, Business and Professions Code.~~

ARTICLE 9. FEES

Amend Section 1399.395 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

§ 1399.395. Fee Schedule.

The following schedule of fees is hereby adopted pursuant to Sections 3775 and 3775.5 of the B&P~~C~~:

(a) Application fee . . . . . ~~$200~~ 300
~~(b) Application fee [pursuant to Section 3740(c)]~~ . . . . . ~~$250~~
(b~~e~~) Examination fee $190
(c~~d~~) Re-examination fee $150
~~(e) Initial license fee~~ . . . . . ~~$200~~
~~(This fee is prorated based on the length of the initial license period)~~
(d~~f~~) Renewal fee for licenses expiring on or after January 1, 2002 . . . . . $230
(e~~g~~) Delinquency fee (not more than 2 years after expiration) $230
(f~~h~~) Delinquency fee (after 2 years but not more than 3 years after expiration) . . . $460
(g~~i~~) Inactive license fee $230
(h~~j~~) Duplicate license fee $25
(i~~k~~) Endorsement fee . . . . . ~~$75~~ 25

Note: Authority cited: Sections 3722, 3775 and 3775.5, Business and Professions Code. Reference: Sections 3775 and 3775.5, Business and Professions Code.

REPEAL DISCIPLINARY GUIDELINES 3/02 EDITION AND ADOPT DISCIPLINARY GUIDELINES 2010 EDITION AS FOLLOWS:

~~Disciplinary Guidelines~~

~~3/02 Edition~~

~~Issued by~~
~~Respiratory Care Board of California~~
~~444 North 3rd Street, Suite 270~~
~~Sacramento, CA 95814~~
~~Telephone (916) 323-9983~~
~~Fax (916) 323-9999~~

INTRODUCTION

The Respiratory Care Board of California (Board) licenses the practice of respiratory care in the State of California. The Board is mandated to protect the public from unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care. The Board has the authority to issue or deny, suspend, and revoke licenses to practice respiratory care as provided in the Respiratory Care Practice Act and respiratory care regulations (Business and Profession Code, sections 475, 490, 3718, 3733, 3750, 3750.5, 3754, 3754.5, 3755, and California Code of Regulations, sections 1399.303, 1399.370, 1399.374).

The Board's mission is to protect and serve the consumer by enforcing the Respiratory Care Practice Act and its regulations, expanding the delivery and availability of services, and promoting the profession by increasing public awareness of respiratory care as a profession and supporting the development and education of all respiratory care practitioners.

The Board strives to ensure that only eligible, qualified, capable and competent individuals are licensed, and to expeditiously respond to all consumer complaints by efficiently and effectively investigating every complaint and pursuing disciplinary action in all appropriate cases. Finally, the Board strives to ensure that appropriate post-disciplinary monitoring occurs.

The Board's disciplinary guidelines were designed for use by Administrative Law Judges, attorneys, licensees and others involved in the Board's disciplinary process and are to be followed in all disciplinary actions involving the Board. The Board has the final authority over the disposition of its cases, and to complete its work, it utilizes the Office of the Attorney General and the Office of Administrative Hearings.

This manual includes factors to be considered in aggravation or mitigation, guidelines to be used by Administrative Law Judges for a violation(s) of specific statutes, and standard and speciality probationary terms and conditions.

The Board recognizes that these recommended penalties and conditions of probation are merely guidelines and that aggravating or mitigating circumstances and other factors may necessitate deviation from these guidelines in particular cases.

PUBLIC RECORD

It is the Board's policy that all letters of license denial, citations issued, legal pleadings filed and final decisions will be published as a matter of public record.

COST RECOVERY

The Board seeks recovery of all investigative and prosecution costs in all disciplinary cases. The costs include all charges incurred from the Office of the Attorney General, the Division of Investigation, and Board services, including but not limited to expert consultant opinions and services. The Board seeks recovery of these costs because the burden for payment of the costs of investigation and prosecution of disciplinary cases should fall upon those whose proven conduct had required investigation and prosecution, not upon the profession as a whole.

PROBATION MONITORING

The purpose of the probation monitoring program is to maintain public protection by proactively monitoring probationers to ensure terms and conditions are met. The purpose is NOT for the Board to rehabilitate the probationer. Probation is a privilege afforded by the Board:

1) to allow for the probationer's rehabilitation if that is his/her choice;
2) to allow the probationer an opportunity to practice in a professional manner with restrictions and guidance from a community support system and designated probation monitor to prevent future occurrences, and
3) to allow for education of the individual as to the responsibilities, requirements and professionalism mandated of a respiratory care practitioner.

It is the policy of the Board that if a probationer is found to be in violation of any term of probation at any time during the probation period, the Board shall immediately be notified of the violation so that disciplinary action may be considered.

CITATIONS

The Board has the authority to issue citations and fines for violations of several sections of the Respiratory Care Practice Act and its regulations. Citations issued may include an order for abatement, a fine, or both. Citations are issued at the discretion of the Board. The issuance of a citation is separate from and may be in addition to any other administrative discipline, civil remedies, or criminal penalties. [Reference: California Code of Regulations section 1399.380(g)]. However, an applicant who stipulates to the issuance of a citation and fine in lieu of the Board filing a formal statement of issues is not subject to additional discipline for the same offense. Any prior citation may be used in future actions as aggravating evidence.

STIPULATED SETTLEMENTS

The Board will consider stipulated settlements to promote cost effectiveness and to expedite disciplinary decisions if such agreements are consistent with the Board's mission.

~~The following is incorporated by reference in Section 1399.374 of Division 13.6 of Title 16 of the California Code of Regulations~~

~~DISCIPLINARY GUIDELINES~~
~~3/02 Edition~~

~~The following are examples of aggravating and mitigating circumstances which may be considered by Administrative Law Judges in providing for discipline in their proposed decisions:~~

~~EVIDENCE IN~~
~~AGGRAVATION OF PENALTY~~

1. ~~Patient's trust, health, safety or well-being was jeopardized.~~
2. ~~Patient's or employer's trust violated (i.e. theft, embezzlement, fraud, etc...).~~
3. ~~Violations involved or were in the presence of children.~~
4. ~~History of prior discipline.~~
5. ~~Patterned behavior: Respondent has a history of one or more violations or convictions related to the current violation(s).~~
6. ~~Perjury on official Board forms.~~
7. ~~Violent nature of crime or act.~~
8. ~~Violation of Board Probation.~~
9. ~~Failure to provide a specimen for testing in violation of terms and conditions of probation.~~

~~EVIDENCE IN~~
~~MITIGATION OF PENALTY~~

1. ~~Recognition by Respondent of his or her wrongdoing and demonstration of corrective action to prevent recurrence.~~
2. ~~Respondent was forthcoming and reported violation or conviction to the Board.~~
3. ~~A substantial amount of time since the violation or conviction (generally 4 or more years) occurred.~~
4. ~~No prior criminal or disciplinary history.~~

~~DISCIPLINARY GUIDELINES SUMMARY~~
~~for use by Administrative Law Judges~~

~~These guidelines were developed for use by Administrative Law Judges. In determining the appropriate discipline, consideration should be given to any mitigating or aggravating circumstances. All decisions shall include cost recovery in accordance with Business and Professions Code section 3753.5.~~

~~The following page includes a brief description and suggestion for the use of each specialty condition of probation.~~

~~Maximum Penalty: Revocation~~
~~Medium Penalty: Revocation stayed, 3-5 years probation~~
~~Minimum Penalty: Revocation stayed, 2 years probation~~

~~Standard Conditions of Probation for All Disciplinary Actions Resulting in Probation~~
~~Obey All Laws~~
~~Quarterly Reports~~
~~Probation Monitoring Program~~
~~Probation Monitoring Costs~~
~~Employment Requirement~~
~~Notice to Employer~~
~~Changes of Employment or Residence~~
~~Cost Recovery~~
~~Tolling for Out-of-State Residence or Practice~~
~~Valid License Status~~
~~Violation of Probation~~
~~Completion of Probation~~

~~Standard Conditions of Probation for All Disciplinary Actions That Involve Alcohol and/or Drugs in Any Manner~~
~~Standard Conditions Listed Above and~~
~~Work Schedules~~
~~Biological Fluid Testing~~
~~Abstention from Use of Mood Altering Substances~~

~~Specialty Conditions of Probation~~
~~Supervisor Quarterly Reports~~
~~Restriction of Practice~~
~~Direct Supervision~~
~~Additional Continuing Education~~
~~Education Course Work~~
~~Statute and Regulation Examination~~
~~Suspension~~
~~Alcohol and Drug Treatment~~
~~Competency Examination~~
~~Psychological Evaluation~~
~~Physical Examination~~

~~SPECIALTY CONDITIONS OF PROBATION DESCRIPTIONS AND RECOMMENDATIONS FOR USE~~

~~(Actual language for each term and condition is located at the end of this manual)~~

~~Supervisor Quarterly Reports~~

~~Recommended for use when evidence presents a possible alcohol or drug addiction or in cases directly related to the functions and responsibilities of a respiratory care practitioner. The Respondent's employer is required to complete a one-page form every three months, updating the Board on any irregularities.~~

~~Restriction of Practice~~

~~Recommended for use in any case that involves dishonesty or negligence, incompetence or unprofessional conduct in his or her duties as a respiratory care practitioner or any other circumstances that may directly affect the patient safety or the Board's ability to monitor the probationer. This condition is three-fold. Respondent will be restricted from working in the capacity of a supervisor or manager and may include three additional restrictions.~~

~~Direct Supervision~~

~~Recommended for use in cases where evidence of drug or alcohol addiction exists or in any case where negligence, incompetence, or unprofessional conduct in his or her duties as a respiratory care practitioner exists. This condition requires direct supervision, defined as a supervisor within immediate distance (same hospital floor), at all times during practice by Respondent.~~

~~Additional Continuing Education~~

~~Recommended for use in any case where negligence, incompetence, or unprofessional conduct in his or her duties as a respiratory care practitioner exists. This condition requires Respondent to gain additional continuing education than what is required as part of the renewal of his/her respiratory care practitioner license.~~

~~Education Course Work~~

~~Recommended for use in any case where negligence, incompetence, or unprofessional conduct in his or her duties as a respiratory care practitioner exists or in any case where the Respondent would benefit from additional course work (i.e. possible cocaine addiction - class on the effects of cocaine or drugs).~~

~~Statute and Regulation Examination~~

~~Recommended for use in any case where it is believed that Respondent is not aware that he or she has jeopardized his/her license or is unclear on the Board's legislative intent and authority.~~

~~Suspension~~

~~Recommended for use as an additional penalty. Respondent would be required to temporarily cease practicing as a respiratory care practitioner for a period of time as ordered.~~

~~Alcohol and Drug Treatment~~

~~Recommended for use in cases where evidence of drug or alcohol addiction exists. This condition requires Respondent to enter into a formal rehabilitation program.~~

~~Competency Examination~~

~~Recommended for use if it is suspected that Respondent may not be competent to perform as a respiratory care practitioner, weighted on the gravity of negligence or incompetence.~~

~~Psychological Evaluation~~

~~Recommended for use when circumstances indicate Respondent may have a mental instability which in turn, may affect his or her ability to practice safely. Respondent would be required to have a full evaluation performed by a licensed psychiatrist or psychologist to determine if he or she can practice safely.~~

~~Physical Examination~~

~~This specialty term and condition is rarely ordered. Recommended for use in cases where patient safety is at risk.~~

DISCIPLINARY GUIDELINES BY CODE

for use by Administrative Law Judges
and in order of sections of the Business and Professions Code

All decisions shall include cost recovery in accordance with Business and Professions Code section 3753.5.

SECTION 3750(a): FALSE / MISLEADING ADVERTISING

Maximum Penalty: Revocation stayed, 5 years probation
Minimum Penalty: Revocation stayed, 2 years probation

Conditions of Probation

Required: Revocation stayed, 2 to 5 years probationary period
Standard Terms and Conditions of Probation [1-12]
Statute and Regulation Examination [21]

If Warranted: Direct Supervision [18]
Additional Continuing Education [19]
Suspension [22]

SECTION 3750(b): FRAUD IN THE PROCUREMENT OF ANY LICENSE

Maximum Penalty: Revocation or Denial of License
Minimum Penalty: Revocation stayed, 3 years probation

Conditions of Probation

Required: Revocation stayed, 3 to 5 years probationary period
Standard Terms and Conditions of Probation [1-12]
Quarterly Reports [12]
Statute and Regulation Examination [21]

If Warranted: Additional Continuing Education [19]
Suspension [22]

Note: "Good" practice while unauthorized or unlicensed shall NOT mitigate such practice

SECTION 3750(c): KNOWINGLY EMPLOYING UNLICENSED PERSONS

Maximum Penalty: Revocation or Denial of License
Minimum Penalty: Revocation stayed, 2 years probation

Conditions of Probation

Required: Revocation stayed, 2 to 5 years probationary period
Standard Terms and Conditions of Probation [1-12]
Statute and Regulation Examination [21]

If Warranted: Direct Supervision [18]
Suspension [22]

~~SECTION 3750(d):~~ **~~CONVICTION OF A CRIME~~**

~~Maximum Penalty: Revocation or Denial of License~~
~~Minimum Penalty: Revocation stayed, 2 years probation~~

~~*Conditions of Probation*~~

~~Required: Revocation stayed, 2 to 5 years probationary period~~
~~Standard Terms and Conditions of Probation [1-12]~~

~~If Warranted: Work Schedules [13]~~
~~Biological Fluid Testing [14]~~
~~Abstention from Use of Mood Altering Substances [15]~~
~~Supervisor Quarterly Reports [16]~~
~~Restriction of Practice [17]~~
~~Direct Supervision [18]~~
~~Additional Continuing Education [19]~~
~~Education /Course Work [20]~~
~~Statute and Regulation Examination [21]~~
~~Suspension [22]~~
~~Alcohol and Drug Treatment [23]~~
~~Competency Examination [24]~~
~~Psychological Evaluation [25]~~
~~Physical Examination [26]~~

~~Note: Nature of crime should be cross referenced if applicable, i.e., Bodily Injury Conviction - also see 3752.5~~

~~SECTION 3750(e):~~ **~~IMPERSONATING OR ACTING AS A PROXY FOR AN APPLICANT~~**

~~Maximum Penalty: Revocation or Denial of License~~
~~Minimum Penalty: Revocation stayed, 5 years probation~~

~~*Conditions of Probation*~~

~~Required: Revocation stayed, 5 years probationary period~~
~~Standard Terms and Conditions of Probation [1-12]~~
~~Statute and Regulation Examination [21]~~

~~If Warranted: Restriction of Practice [17]~~
~~Direct Supervision [18]~~
~~Additional Continuing Education [19]~~
~~Education /Course Work [20]~~
~~Suspension [22]~~

SECTION 3750(f): **NEGLIGENCE**

Maximum Penalty: Revocation or Denial of License
Minimum Penalty: Revocation stayed, 3 years probation

Conditions of Probation

Required: Revocation stayed, 3 to 5 years probationary period
Standard Terms and Conditions of Probation [1-12]
Supervisor Quarterly Reports [16]
Restriction of Practice [17]
Direct Supervision [18]
Additional Continuing Education [19]
Statute and Regulation Examination [21]
Competency Examination [24]

If Warranted: Suspension [22]
Psychological Evaluation [25]
Physical Examination [26]

SECTION 3750(g): **Conviction of a violation of any of the provisions of this chapter or of any provision of Division 2 or violating, or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision or term of this chapter or of any provision of Division 2**

Maximum Penalty: Revocation or Denial of License
Minimum Penalty: Revocation stayed, 2 years probation

Conditions of Probation

Required: Revocation stayed, 2 to 5 years probationary period
Standard Terms and Conditions of Probation [1-12]
Statute and Regulation Examination [21]

If Warranted: Work Schedules [13]
Biological Fluid Testing [14]
Abstention from Use of Mood Altering Substances [15]
Supervisor Quarterly Reports [16]
Restriction of Practice [17]
Direct Supervision [18]
Additional Continuing Education [19]
Education /Course Work [20]
Suspension [22]
Alcohol and Drug Treatment [23]
Competency Examination [24]
Psychological Evaluation [25]
Physical Examination [26]

Note: Nature of crime should be cross referenced if applicable, i.e., Bodily Injury Conviction - also see 3752.5

~~SECTION 3750(h):~~ **~~AIDING OR ABETTING A VIOLATION~~**

~~Maximum Penalty: Revocation or Denial of License~~
~~Minimum Penalty: Revocation stayed, 3 years probation~~

~~*Conditions of Probation*~~

~~Required: Revocation stayed, 3 years probationary period~~
~~Standard Terms and Conditions of Probation [1-12]~~
~~Statute and Regulation Examination [21]~~

~~If Warranted: Restriction of Practice [17]~~
~~Direct Supervision [18]~~
~~Additional Continuing Education [19]~~
~~Education /Course Work [20]~~
~~Suspension [22]~~

~~SECTION 3750(i):~~ **~~AIDING OR ABETTING UNLAWFUL PRACTICE~~**

~~Maximum Penalty: Revocation or Denial of License~~
~~Minimum Penalty: Revocation stayed, 3 years probation~~

~~*Conditions of Probation*~~

~~Required: Revocation stayed, 3 years probationary period~~
~~Standard Terms and Conditions of Probation [1-12]~~
~~Statute and Regulation Examination [21]~~

~~If Warranted: Restriction of Practice [17]~~
~~Additional Continuing Education [19]~~
~~Direct Supervision [18]~~
~~Education /Course Work [20]~~
~~Suspension [22]~~

~~SECTION 3750(j):~~ **~~COMMISSION OF ANY FRAUDULENT, DISHONEST OR CORRUPT ACT~~**

~~Maximum Penalty: Revocation or Denial of License~~
~~Minimum Penalty: Revocation stayed, 3 years probation~~

~~*Conditions of Probation*~~

~~Required: Revocation stayed, 3 to 5 years probationary period~~
~~Standard Terms and Conditions of Probation [1-12]~~
~~Restriction of Practice [17]~~
~~Statute and Regulation Examination [21]~~

~~If Warranted: Direct Supervision [18]~~
~~Suspension [22]~~
~~Psychological Evaluation [25]~~

~~SECTION 3750(k):~~ **~~PATIENT, HOSPITAL OR OTHER RECORDS - ENTRIES~~**

~~Maximum Penalty: Revocation or Denial of License~~
~~Minimum Penalty: Revocation stayed, 3 years probation~~

~~*Conditions of Probation*~~

~~Required: Revocation stayed, 3 to 5 years probationary period~~
~~Standard Terms and Conditions of Probation [1-12]~~
~~Supervisor Quarterly Reports [16]~~
~~Restriction of Practice [17]~~
~~Direct Supervision [18]~~
~~Additional Continuing Education [19]~~
~~Statute and Regulation Examination [21]~~
~~Competency Examination [24]~~

~~If Warranted: Suspension [22]~~
~~Psychological Evaluation [25]~~
~~Physical Examination [26]~~

~~SECTION 3750(l):~~ **~~CHANGING PRESCRIPTION / FALSIFYING VERBAL OR WRITTEN ORDERS~~**

~~Maximum Penalty: Revocation or Denial of License~~
~~Minimum Penalty: Revocation stayed, 3 years probation~~

~~*Conditions of Probation*~~

~~Required: Revocation stayed, 3 to 5 years probationary period~~
~~Standard Terms and Conditions of Probation [1-12]~~
~~Supervisor Quarterly Reports [16]~~
~~Restriction of Practice [17]~~
~~Direct Supervision [18]~~
~~Additional Continuing Education [19]~~
~~Statute and Regulation Examination [21]~~
~~Competency Examination [24]~~

~~If Warranted: Biological Fluid Testing [14]~~
~~Abstention from Use of Mood Altering Substances [15]~~
~~Suspension [22]~~
~~Alcohol and Drug Treatment [23]~~
~~Psychological Evaluation [25]~~
~~Physical Examination [26]~~

~~SECTION 3750(m):~~ **~~DISCIPLINE TAKEN BY ANOTHER AGENCY~~**

~~Maximum Penalty: Revocation or Denial of License~~
~~Minimum Penalty: Revocation stayed, 2 years probation~~

~~Note: Terms are dependent upon actual grounds or offense~~

~~SECTION 3750(n):~~ **~~FAILURE TO FOLLOW INFECTION CONTROL GUIDELINES~~**

~~Maximum Penalty: Revocation or Denial of License~~
~~Minimum Penalty: Revocation stayed, 3 years probation~~

~~*Conditions of Probation*~~

~~Required: Revocation stayed, 3 to 5 years probationary period~~
~~Standard Terms and Conditions of Probation [1-12]~~
~~Supervisor Quarterly Reports [16]~~
~~Restriction of Practice [17]~~
~~Direct Supervision [18]~~
~~Additional Continuing Education [19]~~
~~Statute and Regulation Examination [21]~~
~~Competency Examination [24]~~

~~If Warranted: Suspension [22]~~
~~Psychological Evaluation [25]~~
~~Physical Examination [26]~~

~~SECTION 3750(o):~~ **~~INCOMPETENCE~~**

~~Maximum Penalty: Revocation or Denial of License~~
~~Minimum Penalty: Revocation stayed, 3 years probation~~

~~*Conditions of Probation*~~

~~Required: Revocation stayed, 3 to 5 years probationary period~~
~~Standard Terms and Conditions of Probation [1-12]~~
~~Supervisor Quarterly Reports [16]~~
~~Restriction of Practice [17]~~
~~Direct Supervision [18]~~
~~Additional Continuing Education [19]~~
~~Statute and Regulation Examination [21]~~
~~Competency Examination [24]~~

~~If Warranted: Suspension [22]~~
~~Psychological Evaluation [25]~~
~~Physical Examination [26]~~

~~SECTION 3750(p):~~ **~~PATTERN OF SUBSTANDARD CARE~~**

~~Maximum Penalty: Revocation or Denial of License~~
~~Minimum Penalty: Revocation stayed, 5 years probation~~

~~*Conditions of Probation*~~

~~Required: Revocation stayed, 5 years probationary period~~
~~Standard Terms and Conditions of Probation [1-12]~~
~~Supervisor Quarterly Reports [16]~~
~~Restriction of Practice [17]~~
~~Direct Supervision [18]~~
~~Additional Continuing Education [19]~~
~~Statute and Regulation Examination [21]~~
~~Competency Examination [24]~~

~~If Warranted: Suspension [22]~~
~~Psychological Evaluation [25]~~
~~Physical Examination [26]~~

SECTION 3750.5(a): OBTAINED / POSSESSED / ADMINISTERED / FURNISHED ANY CONTROLLED SUBSTANCE OR DANGEROUS DRUG

Maximum Penalty: Revocation or Denial of License
Minimum Penalty: Revocation stayed, 2 years probation

Conditions of Probation

Required:
- Revocation stayed, 2 to 5 years probationary period
- Standard Terms and Conditions of Probation [1-12]
- Work Schedules [13]
- Biological Fluid Testing [14]
- Abstention from Use of Mood Altering Substances [15]

If Warranted:
- Supervisor Quarterly Reports [16]
- Restriction of Practice [17]
- Direct Supervision [18]
- Additional Continuing Education [19]
- Education /Course Work [20]
- Statute and Regulation Examination [21]
- Suspension [22]
- Alcohol and Drug Treatment [23]
- Competency Examination [24]
- Psychological Evaluation [25]
- Physical Examination [26]

SECTION 3750.5(b): USED CONTROLLED SUBSTANCE, DANGEROUS DRUG OR ALCOHOLIC BEVERAGE, IN DANGEROUS MANNER

Maximum Penalty: Revocation or Denial of License
Minimum Penalty: Revocation stayed, 2 years probation

Conditions of Probation

Required:
- Revocation stayed, 2 to 5 years probationary period
- Standard Terms and Conditions of Probation [1-12]
- Work Schedules [13]
- Biological Fluid Testing [14]
- Abstention from Use of Mood Altering Substances [15]

If Warranted:
- Supervisor Quarterly Reports [16]
- Restriction of Practice [17]
- Direct Supervision [18]
- Additional Continuing Education [19]
- Education /Course Work [20]
- Statute and Regulation Examination [21]
- Suspension [22]
- Alcohol and Drug Treatment [23]
- Competency Examination [24]
- Psychological Evaluation [25]
- Physical Examination [26]

~~SECTION 3750.5(c):~~ **~~CONVICTION OF A CRIMINAL OFFENSE INVOLVING SUBDIVISIONS (a) OR (b), FALSIFICATION OF A RECORD PERTAINING TO THE SUBSTANCES DESCRIBED IN SUBDIVISION (a)~~**

~~Maximum Penalty: Revocation or Denial of License~~
~~Minimum Penalty: Revocation stayed, 2 years probation~~

~~*Conditions of Probation*~~

~~Required:~~
~~Revocation stayed, 2 to 5 years probationary period~~
~~Standard Terms and Conditions of Probation [1-12]~~
~~Work Schedules [13]~~
~~Biological Fluid Testing [14]~~
~~Abstention from Use of Mood Altering Substances [15]~~

~~If Warranted:~~
~~Supervisor Quarterly Reports [16]~~
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~~Competency Examination [24]~~
~~Psychological Evaluation [25]~~
~~Physical Examination [26]~~

~~SECTION 3750.5(d):~~ **~~COMMITTED OR CONFINED BY COURT FOR INTEMPERATE USE OF OR RELATING TO ADDICTION TO ANY SUBSTANCES DESCRIBED IN SUBDIVISIONS (a) OR (b)~~**

~~Maximum Penalty: Revocation or Denial of License~~
~~Minimum Penalty: Revocation stayed, 5 years probation~~

~~*Conditions of Probation*~~

~~Required:~~
~~Revocation stayed, 5 years probationary period~~
~~Standard Terms and Conditions of Probation [1-12]~~
~~Work Schedules [13]~~
~~Biological Fluid Testing [14]~~
~~Abstention from Use of Mood Altering Substances [15]~~
~~Supervisor Quarterly Reports [16]~~
~~Restriction of Practice [17]~~
~~Direct Supervision [18]~~

~~If Warranted:~~
~~Additional Continuing Education [19]~~
~~Education /Course Work [20]~~
~~Statute and Regulation Examination [21]~~
~~Suspension [22]~~
~~Alcohol and Drug Treatment [23]~~
~~Competency Examination [24]~~
~~Psychological Evaluation [25]~~
~~Physical Examination [26]~~

~~SECTION 3750.5(e):~~ **~~PATIENT, HOSPITAL OR OTHER RECORDS - ENTRIES PERTAINING TO THE SUBSTANCES DESCRIBED IN SUBDIVISION (a)~~**

~~Maximum Penalty: Revocation or Denial of License~~
~~Minimum Penalty: Revocation stayed, 3 years probation~~

~~*Conditions of Probation*~~

~~Required: Revocation stayed, 3 to 5 years probationary period~~
~~Standard Terms and Conditions of Probation [1-12]~~
~~Supervisor Quarterly Reports [16]~~
~~Restriction of Practice [17]~~
~~Direct Supervision [18]~~
~~Additional Continuing Education [19]~~
~~Statute and Regulation Examination [21]~~
~~Competency Examination [24]~~

~~If Warranted: Work Schedules [13]~~
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~~Psychological Evaluation [25]~~
~~Physical Examination [26]~~

~~SECTION 3752.5:~~ **~~A CRIME INVOLVING BODILY INJURY OR ATTEMPTED BODILY INJURY~~**

~~Maximum Penalty: Revocation or Denial of License~~
~~Minimum Penalty: Revocation stayed, 2 years probation~~

~~*Conditions of Probation*~~

~~Required: Revocation stayed, 2 to 5 years probationary period~~
~~Standard Terms and Conditions of Probation [1-12]~~

~~If Warranted: Work Schedules [13]~~
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~~Psychological Evaluation [25]~~
~~Physical Examination [26]~~

~~SECTION 3752.6:~~ **~~A CRIME INVOLVING SEXUAL MISCONDUCT IS SUBSTANTIALLY RELATED TO THE QUALIFICATIONS, FUNCTIONS OR DUTIES OF RESPIRATORY CARE~~**

~~See 3752.7~~

~~SECTION 3752.7:~~ **~~SEXUAL CONTACT W/PATIENT / SEX OFFENSES CONVICTION~~**

~~Maximum Penalty: Revocation or Denial of License~~
~~Minimum Penalty: Revocation or Denial of License~~

~~See statute.~~

~~SECTION 3754.5~~ **~~OBTAIN LICENSE BY FRAUD OR MISREPRESENTATION~~**

~~Maximum Penalty: Revocation or Denial of License~~
~~Minimum Penalty: Revocation stayed, 3 years probation~~

~~*Conditions of Probation*~~

~~Required:~~	~~Revocation stayed, 3 to 5 years probationary period~~
	~~Standard Terms and Conditions of Probation [1-12]~~
	~~Statute and Regulation Examination [21]~~
~~If Warranted:~~	~~Additional Continuing Education [19]~~
	~~Suspension [22]~~

~~SECTION 3755:~~ **~~UNPROFESSIONAL CONDUCT~~**

~~Maximum Penalty: Revocation or Denial of License~~
~~Minimum Penalty: Revocation stayed, 3 years probation~~

~~*Conditions of Probation*~~

~~Required:~~	~~Revocation stayed, 3 to 5 years probationary period~~
	~~Standard Terms and Conditions of Probation [1-12]~~
	~~Supervisor Quarterly Reports [16]~~
	~~Restriction of Practice [17]~~
	~~Direct Supervision [18]~~
	~~Additional Continuing Education [19]~~
	~~Statute and Regulation Examination [21]~~
	~~Competency Examination [24]~~
~~If Warranted:~~	~~Suspension [22]~~
	~~Psychological Evaluation [25]~~
	~~Physical Examination [26]~~

~~SECTION 3760:~~ **~~UNLAWFUL PRACTICE~~**

~~Authority 3750(g)~~ ~~Maximum Penalty: Revocation or Denial of License~~
~~Minimum Penalty: Revocation stayed, 3 years probation~~

~~*Conditions of Probation*~~

~~Required:~~	~~Revocation stayed, 3 to 5 years probationary period~~
	~~Standard Terms and Conditions of Probation [1-12]~~
	~~Statute and Regulation Examination [21]~~
	~~Suspension [22]~~
~~If Warranted:~~	~~Restriction of Practice [17]~~
	~~Additional Continuing Education [19]~~

~~SECTION 3761:~~ **~~MISREPRESENTATION (FOR LICENSEES)~~**

~~Authority 3750(g)~~ ~~Maximum Penalty: Revocation or Denial of License~~
~~Minimum Penalty: Revocation stayed, 3 years probation~~

~~*Conditions of Probation*~~

~~Required:~~	~~Revocation stayed, 3 to 5 years probationary period~~
	~~Standard Terms and Conditions of Probation [1-12]~~
	~~Statute and Regulation Examination [21]~~
	~~Suspension [22]~~
~~If Warranted:~~	~~Restriction of Practice [17]~~
	~~Additional Continuing Education [19]~~

~~PROBATIONARY TERMS AND CONDITIONS~~

~~A probationary or conditional license is generally issued for a period between 2 and 5 years, dependant upon whether any aggravating or mitigating factors exist.~~

~~STANDARD CONDITIONS~~

~~The standard conditions are conditions which are imposed on each and every probationer regardless of cause for discipline.~~

1. ~~**OBEY ALL LAWS** Respondent shall obey all laws, whether federal, state, or local. The Respondent shall also obey all regulations governing the practice of respiratory care in California.~~

   ~~Respondent shall notify the Board in writing within 14 days of any incident resulting in his/her arrest, or charges filed against, or a citation issued against, Respondent.~~

2. ~~**QUARTERLY REPORTS** Respondent shall file quarterly reports of compliance under penalty of perjury, on forms to be provided, to the probation monitor assigned by the Board. Omission or falsification in any manner of any information on these reports shall constitute a violation of probation and shall result in the filing of an accusation and/or a petition to revoke probation against Respondent's respiratory care practitioner license.~~

   ~~Quarterly report forms will be provided by the Board. Respondent is responsible for contacting the Board to obtain additional forms if needed. Quarterly reports are due for each year of probation and the entire length of probation as follows:~~

   ~~For the period covering January 1st through March 31st, reports are to be completed and submitted between April 1st and April 7th.~~

   ~~For the period covering April 1st through June 30th, reports are to be completed and submitted between July 1st and July 7th.~~

   ~~For the period covering July 1st through September 30th, reports are to be completed and submitted between October 1st and October 7th.~~

   ~~For the period covering October 1st through December 31st, reports are to be completed and submitted between January 1st and January 7th.~~

   ~~Failure to submit complete and timely reports shall constitute a violation of probation.~~

3. ~~**PROBATION MONITORING PROGRAM** Respondent shall comply with requirements of the Board appointed probation monitoring program, and shall, upon reasonable request, report to or appear to a local venue as directed.~~

   ~~Respondent shall claim all certified mail issued by the Board, respond to all notices of reasonable requests timely, and submit Annual Reports, Identification Update reports or other reports similar in nature, as requested and directed by the Board or its representative.~~

Respondent is encouraged to contact the Board's Probation Program at any time he/she has a question or concern regarding his/her terms and conditions of probation.

Failure to appear for any scheduled meeting or examination, or cooperate with the requirements of the program, including timely submission of requested information, shall constitute a violation of probation and will result in the filing of an accusation and/or a petition to revoke probation against Respondent's respiratory care practitioner license.

4. **PROBATION MONITORING COSTS** All costs incurred for probation monitoring during the entire probation shall be paid by the Respondent. The monthly cost may be adjusted as expenses are reduced or increased. Respondent's failure to comply with all terms and conditions may also cause this amount to be increased.

All payments for costs are to be sent directly to the Respiratory Care Board and must be received by the date(s) specified. (Periods of tolling will not toll the probation monitoring costs incurred.)

If Respondent is unable to submit costs for any month, he/she shall be required, instead to submit an explanation of why he/she is unable to submit the costs, and the date(s) he/she will be able to submit the costs including payment amount(s). Supporting documentation and evidence of why the Respondent is unable to make such payment(s) must accompany this submission.

Respondent understands that failure to submit costs timely is a violation of probation and submission of evidence demonstrating financial hardship does not preclude the Board from pursuing further disciplinary action. However, Respondent understands that by providing evidence and supporting documentation of financial hardship it may delay further disciplinary action.

In addition to any other disciplinary action taken by the Board, an unrestricted license will not be issued at the end of the probationary period and the respiratory care practitioner license will not be renewed, until such time all probation monitoring costs have been paid.

The filing of bankruptcy by the Respondent shall not relieve the Respondent of his/her responsibility to reimburse the Board for costs incurred.

5. **EMPLOYMENT REQUIREMENT** Respondent shall be employed a minimum of 24 hours per week as a respiratory care practitioner for a minimum of 2/3 of his/her probation period.

Respondent may substitute successful completion of a minimum of thirty (30) additional continuing education hours, beyond that which is required for license renewal, for each 8 months of employment required. Respondent shall submit proof to the Board of successful completion of all continuing education requirements. Respondent is responsible for paying all costs associated with fulfilling this term and condition of probation.

6. **NOTICE TO EMPLOYER** Respondent shall be required to inform his/her employer, and each subsequent employer during the probation period, of the discipline imposed by this decision by providing his/her supervisor and director and all subsequent supervisors and directors with a copy of the decision and order, and the Statement(s) of Issues or Accusation(s) in this matter prior to the beginning of or returning to employment or within 14 days from each change in a supervisor or director.

If Respondent is employed by or through a registry [and is not restricted from working for a registry], Respondent shall make each hospital or establishment to which he/she is sent aware of the discipline imposed by this decision by providing his/her direct supervisor and administrator at each hospital or establishment with a copy of this decision, and the Statement(s) of Issues or Accusation(s) in this matter prior to the beginning of employment. This must be done each time there is a change in supervisors or administrators.

The employer will then inform the Board, in writing, that he/she is aware of the discipline, on forms to be provided to the Respondent. Respondent is responsible for contacting the Board to obtain additional forms if needed. All reports completed by the employer must be submitted from the employer directly to the Board.

Respondent shall execute a release authorizing the Board or any of its representatives to review and obtain copies of all employment records and discuss and inquire of the probationary status with any of Respondent's supervisors or directors.

7. **CHANGES OF EMPLOYMENT OR RESIDENCE** Respondent shall notify the Board, and appointed probation monitor, in writing, of any and all changes of employment, location, and address within 14 days of such change. This includes but is not limited to applying for employment, termination or resignation from employment, change in employment status, change in supervisors, administrators or directors.

Respondent shall also notify his/her probation monitor AND the Board IN WRITING of any changes of residence or mailing address within 14 days. P.O. Boxes are accepted for mailing purposes, however the Respondent must also provide his/her physical residence address as well.

8. **COST RECOVERY** Respondent shall pay to the Board a sum not to exceed the costs of the investigation and prosecution of this case. That sum shall be $ _____ and shall be paid in full directly to the Board, in equal quarterly payments, within 12 months from the effective date of this decision. Cost recovery will not be tolled.

If Respondent is unable to submit costs timely, he/she shall be required, instead to submit an explanation of why he/she is unable to submit these costs in part or in entirety, and the date(s) he/she will be able to submit the costs including payment amount(s). Supporting documentation and evidence of why the Respondent is unable to make such payment(s) must accompany this submission.

Respondent understands that failure to submit costs timely is a violation of probation and submission of evidence demonstrating financial hardship does not preclude the Board from pursuing further disciplinary action. However, Respondent understands that by providing evidence and supporting documentation of financial hardship may delay further disciplinary action.

Consideration to financial hardship will not be given should Respondent violate this term and condition, unless an unexpected AND unavoidable hardship is established from the date of this order to the date payment(s) is due.

The filing of bankruptcy by the Respondent shall not relieve the Respondent of his/her responsibility to reimburse the Board for these costs.

9. ~~**TOLLING FOR OUT-OF-STATE RESIDENCE OR PRACTICE** Periods of residency or practice outside California, whether the periods of residency or practice are temporary or permanent, will toll the probation period but will not toll the cost recovery requirement, nor the probation monitoring costs incurred. Travel out of California for more than 30 days must be reported to the Board in writing prior to departure. Respondent shall notify the Board, in writing, within 14 days, upon his/her return to California and prior to the commencement of any employment where representation as a respiratory care practitioner is/was provided.~~

10. ~~**VALID LICENSE STATUS** Respondent shall maintain a current, active and valid license for the length of the probation period. Failure to pay all fees and meet CE requirements prior to his/her license expiration date shall constitute a violation of probation.~~

11. ~~**VIOLATION OF PROBATION** If Respondent violates any term of the probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If a petition to revoke probation is filed against Respondent during probation, the Board shall have continuing jurisdiction and the period of probation shall be extended until the matter is final. No petition for modification of penalty shall be considered while there is an accusation or petition to revoke probation or other penalty pending against Respondent.~~

12. ~~**COMPLETION OF PROBATION** Upon successful completion of probation, Respondent's license shall be fully restored.~~

~~STANDARD ALCOHOL/ DRUG CONDITIONS~~

13. **~~WORK SCHEDULES~~** ~~Respondent shall be required to submit to the probation monitor work schedules on a weekly/monthly basis for the length of probation. Respondent shall ensure the Board has a copy of her/his current work schedule at all times for each place of employment.~~

~~Failure to submit current work schedules on a continuous basis, shall constitute a violation of probation and shall result in the filing of an accusation and/or a petition to revoke probation against Respondent's respiratory care practitioner license.~~

14. **~~BIOLOGICAL FLUID TESTING~~** ~~Respondent, at his/her expense, shall participate in random testing, including but not limited to biological fluid testing (i.e. urine, blood, saliva), breathalyzer, hair follicle testing, or any drug screening program approved by the Board. Test costs range from $21.00 to $200.00 each. The length of time shall be for the entire probation period. The frequency and location of testing will be determined by the Board.~~

~~At all times Respondent shall fully cooperate with the Board or any of its representatives, and shall, when directed, appear for testing as requested and submit to such tests and samples for the detection of alcohol, narcotics, hypnotic, dangerous drugs or other controlled substances.~~

~~If Respondent is unable to provide a specimen in a reasonable amount of time from the request, while at the work site, Respondent understands that any Board representative may request from the supervisor, manager or director on duty to observe Respondent in a manner that does not interrupt or jeopardize patient care in any manner until such time Respondent provides a specimen acceptable to the Board.~~

~~Failure to submit to testing or appear as requested by any Board representative for testing, as directed shall constitute a violation of probation and shall result in the filing of an accusation and/or a petition to revoke probation against Respondent's respiratory care practitioner license.~~

15. **~~ABSTENTION FROM USE OF MOOD ALTERING SUBSTANCES~~** ~~Respondent shall completely abstain from the possession or use of alcohol, any and all other mood altering drugs, substances and their associated paraphernalia, except when the drugs are lawfully prescribed by a licensed practitioner as part of a documented medical treatment.~~

~~Respondent shall execute a release authorizing the release of pharmacy and prescribing records as well as physical and mental health medical records. Respondent shall also provide information of treating physicians, counselors or any other treating professional as requested by the Board.~~

~~Respondent shall ensure that he/she is not in the presence of or in the same physical location as individuals who are using illegal substances, even if Respondent is not personally ingesting the drug(s).~~

~~Any positive result that registers over the established laboratory cutoff level shall constitute a violation of probation and shall result in the filing of an accusation and/or a petition to revoke probation against Respondent's respiratory care practitioner license.~~

~~Respondent also understands and agrees that any positive result that registers over the established laboratory cutoff level shall be reported to each of Respondent's employers.~~

~~SPECIALTY CONDITIONS~~

~~The conditions imposed are dependent upon the violation(s) committed.~~

16. **~~SUPERVISOR QUARTERLY REPORTS~~** ~~Supervisor Quarterly Reports of Performance are due for each year of probation and the entire length of probation from each employer, as follows:~~

~~For the period covering January 1st through March 31st, reports are to be completed and submitted between April 1st and April 7th.~~

~~For the period covering April 1st through June 30th, reports are to be completed and submitted between July 1st and July 7th.~~

~~For the period covering July 1st through September 30th, reports are to be completed and submitted between October 1st and October 7th.~~

~~For the period covering October 1st through December 31st, reports are to be completed and submitted between January 1st and January 7th.~~

~~Respondent is ultimately responsible for ensuring his/her employer(s) submits complete and timely reports. Failure to ensure each employer submits complete and timely reports shall constitute a violation of probation.~~

17. **~~RESTRICTION OF PRACTICE~~** ~~Respondent may not be employed or function as a member of a respiratory care management or supervisory staff during the entire length of probation. This includes lead functions.~~

~~[ ] Respondent is prohibited from working in home care unless it is under direct supervision and personal observation.~~

~~[ ] Respondent is prohibited from working for a registry.~~

~~[ ] Respondent is prohibited from working with _____ (i.e. neonates, elderly, comatose patients, children)~~

18. **~~DIRECT SUPERVISION~~** ~~During the period of probation, Respondent shall be under the direct supervision of a person holding a current and valid non-restricted Board license. "Under the direct supervision" means assigned to a respiratory care practitioner who is on duty and immediately available in the assigned patient area. The Board shall be informed in writing of and approve the level of supervision provided to the Respondent while he/she is functioning as a licensed respiratory care practitioner. The appropriate level of supervision must be approved by the Board prior to commencement of work.~~

19. **~~ADDITIONAL CONTINUING EDUCATION~~** ~~Respondent shall be required to complete additional Continuing Education beyond that which is required for license renewal. A minimum of fifteen (15) additional hours is required for each year of probation. Respondent shall submit proof to the Board of successful completion of all continuing education requirements.~~

20. **EDUCATION/COURSE WORK** Respondent shall be required to successfully complete _____ semester (or its equivalent) units of education courses in California at an institution approved by the Board in addition to the continuing education required for the renewal of licensure. The course selection shall be submitted to and approved by the Board in advance. The Board, at its discretion, may require the education to be in a specific area of study. Successful completion is a grade of "C" or "70%" or better for any completed course.

Respondent shall be required to submit proof of successful completion in the form of official transcripts no later than six (6) months prior to the date probation is scheduled to end.

Failure to timely and successfully complete approved courses at an approved institution(s), or provide documentation thereof shall constitute a violation of probation.

Respondent is responsible for paying all costs associated with fulfilling this term and condition of probation.

21. **STATUTE AND REGULATION EXAMINATION** Within six months of the effective date of this decision, Respondent shall be required to take and pass an examination on the Respiratory Care Practice Act, the Respiratory Care Practitioner Regulations, and other provisions that affect the practice of respiratory care. This examination shall be taken on a date specified by the Board.

Respondent shall be responsible for paying all costs for any scheduled examination(s) prior to taking any examination [$50 per each scheduled exam].

Failure to appear for any scheduled examination, or to pass the examination after two attempts shall constitute a violation of probation and shall result in the filing of an accusation and/or a petition to revoke probation against Respondent's respiratory care practitioner license.

Failure to submit timely fees for one or more examinations shall constitute a violation of probation.

22. **SUSPENSION** As part of probation, Respondent shall be suspended from the practice of respiratory care for a period of _____, beginning the effective date of this decision. If not employed as a respiratory care practitioner or if currently on any other type of leave from employment, the suspension shall be served once employment has been established or reestablished and prior to the end of the probationary period. Respondent shall ensure that each employer informs the Board, in writing, that it is aware of the dates of suspension.

23. **ALCOHOL AND DRUG TREATMENT** Respondent, at his/her expense, shall successfully complete a treatment regime at a recognized and established program in California of at least six months duration approved by the Board. The treatment program shall be successfully completed within the first nine months of probation. The program director, psychiatrist or psychologist shall confirm that Respondent has complied with the requirement of this decision and shall notify the Board immediately if he/she believes the Respondent cannot safely practice. Respondent shall execute a release authorizing divulgence of this information to the Board.

Respondent shall inform the program director, psychiatrist or psychologist, of his/her probationary status with the Board, and shall cause that individual to submit monthly reports to the Board providing information concerning Respondent's progress and prognosis. Such reports shall include results of biological fluid testing. Positive results shall be reported immediately to the Board and shall be used in administrative discipline.

24. **COMPETENCY EXAMINATION** Within 6 months of the effective date of this decision and/or as designated by the Board, Respondent shall be required to take and pass a written competency examination as designated by the Board. This examination shall be taken on a date specified by the Board and Respondent shall pay all examination fees.

Respondent's failure to appear for or pass any scheduled examination will be noted as failure to pass or failure to successfully complete the examination. Respondent's failure to successfully complete the examination after one scheduled examination, shall constitute incompetence and a violation of probation for the purposes of disciplinary proceedings and shall result in the filing of an accusation and/or a petition to revoke probation against Respondent's respiratory care practitioner license.

Failure to pay costs for the examination, will constitute a violation of probation.

25. **PSYCHOLOGICAL EVALUATION** Within _____ days of the effective date of this decision, and on a periodic basis thereafter as may be required or directed by the Board, Respondent, at his/her own expense, shall have a mental health examination, including psychological assessment and testing as appropriate, to determine his/her capacity to perform all professional duties with safety to self and to the public. The examination will be performed by a licensed psychiatrist or psychologist appointed by the Board. Respondent shall provide this evaluator with a copy of the Board's disciplinary order prior to the evaluation. The examiner must submit a written report of that assessment and recommendations to the Board. Recommendations for cessation of practice for safety of patients, treatment, therapy or counseling made as a result of the mental health examination will be instituted and followed by the Respondent. All costs incurred for evaluation and treatment are the responsibility of the Respondent.

Any examination required of a Respondent whose violation(s) involves substance abuse must be performed by a licensed psychiatrist or psychologist who has established expertise in the field of alcohol and drug assessment, treatment, and recovery.

Respondent shall execute a release authorizing the evaluator to divulge the aforementioned information to the Board.

26. **PHYSICAL EXAMINATION** Within 45 days of the effective date of this decision, Respondent, at his/her expense, shall undergo an assessment of his/her physical condition by a physician appointed by the Board. Respondent shall provide the examining physician with a copy of the Board's disciplinary order prior to the examination. The examining physician must submit a written report of his/her findings to the Board. If medically determined, a recommended treatment program will be instituted and followed by the Respondent with the physician providing written reports to the Board on forms provided by the Board.

If the examining physician finds that Respondent is not physically fit to practice or can only practice with restrictions, the examining physician shall notify the Board within three (3) working days. The Board shall notify Respondent in writing of the examining physician's determination of unfitness to practice and shall order the Respondent to cease or restrict licensed activities as a condition of probation. Respondent shall comply with this condition until the Board is satisfied of Respondent's fitness to practice safely and has so notified the Respondent. Respondent shall document compliance in the manner required by the Board.

Respondent shall execute a release authorizing the physician to divulge the aforementioned information to the Board.

Adopt this package of the 2011 Edition of “Disciplinary Guidelines” which are incorporated by reference in Section 1399.374.

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These guidelines are incorporated by reference in Section 1399.374 of Division 13.6 of Title 16 of the California Code of Regulations

INTRODUCTION

Licensed Respiratory Care Practitioners (RCPs) regularly perform critical lifesaving and life support procedures prescribed by physicians that directly affect major organs of the body. Respiratory care provides relief to millions of Americans, from newborns to the elderly, who have difficulty breathing or cannot breathe on their own due to impaired or nonfunctioning lungs. Typical patients of RCPs suffer from asthma, chronic obstructive pulmonary disease (COPD), bronchitis, lung cancer, stroke, drowning accidents, heart attacks, birth defects, emphysema, cystic fibrosis, or sleep apnea. Trauma victims and surgery patients are also treated by respiratory therapists. In addition to treatment, respiratory care also includes education and rehabilitation services, plus diagnostic testing.

Typical respiratory care duties include, but are not limited to:

- Employing life support mechanical ventilation including assessment, analysis, application and monitoring.
- Administrating of medications in aerosol form.
- Monitoring equipment and patients' responses to therapy.
- Obtaining blood specimens and analyzing them to determine levels of oxygen, carbon dioxide, and other gases.
- Maintaining artificial airways (tracheostomy or intubation).
- Measuring the capacity of patients' lungs to determine if there is impairment.
- Obtaining and analyzing sputum specimens and chest X-rays.
- Interpreting data from tests.
- Assessing vital signs and other indicators of respiratory dysfunction.
- Performing stress tests and other studies of the cardiopulmonary system.
- Assessing and treating people with disruptive sleep patterns.
- Conducting rehabilitation activities.
- Leading asthma education and smoking cessation programs.

Most respiratory care therapists work in hospitals (emergency, intensive care, neonatal/pediatric units, cardiac care, etc.), but there is a growing number being employed in other settings, including:

- Medical flight transports
- Hyperbaric oxygen units
- Private homes
- Skilled nursing facilities
- Various laboratories (e.g., Rehabilitation, Cardiopulmonary, Blood gas, Sleep testing)

The minimum education requirements for licensure as an RCP include an associate degree with completion of an approved respiratory care program. However, over 1/3 of licensed RCPs hold baccalaureate, masters or doctorate degrees. There are approximately 33 schools throughout California that offer respiratory care programs. Areas of study include human anatomy and physiology, chemistry, physics, microbiology, and mathematics. Programs also include clinical practice at local hospitals. Respiratory care students receive on average, 300 hours of intense education and training specific to ventilator assessments and care. Programs take more than two years of full-time dedication to complete.

The Respiratory Care Board of California (Board) has issued over 30,000 RCP licenses since its inception in 1985. Applicants for licensure complete a criminal background check (DOJ/FBI/DMV), are competency tested, and must provide official transcripts and other documentation to verify they have met educational and other requirements.

The Board's mandate is "...to protect the public from the **unauthorized and unqualified practice** of respiratory care and from **unprofessional conduct** by persons licensed to practice respiratory care..." *[reference, §3701, Business and Professions Code]*. In addition, "**Protection of the public shall be the highest priority for the [Board]** in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount" *[reference §3710.1, Business and Professions Code]*.

The Board's mission is to protect and serve the consumer by enforcing the Respiratory Care Practice Act and its regulations, expanding the delivery and availability of services, increasing public awareness of respiratory care as a profession, and supporting the development and education of all respiratory care practitioners.

The Board has the authority to issue or deny, suspend, and revoke licenses to practice respiratory care as provided in the Respiratory Care Practice Act and respiratory care regulations (Business and Profession Code, sections 475, 480, 490, 3718, 3732, 3750, 3750.5, 3752.7, 3754, 3754.5, 3755, 3757, 3752.5, 3752.6, and California Code of Regulations, Title 16, Division 13.6, sections 1399.303, 1399.370, 1399.374).

The Board strives to ensure that only eligible, qualified, capable and competent individuals are licensed, and to expeditiously respond to all consumer complaints by efficiently and effectively investigating every complaint and pursuing disciplinary action in all appropriate cases. Finally, the Board strives to ensure that appropriate and aggressive post-disciplinary monitoring occurs.

The Board's disciplinary guidelines were designed for use by Administrative Law Judges, attorneys, licensees and others involved in the Board's disciplinary process and are to be followed in all disciplinary actions involving the Board. The Board has the final authority over the disposition of its cases, and to complete its work, it utilizes the Office of the Attorney General and the Office of Administrative Hearings.

This manual includes factors to be considered in aggravation or mitigation, guidelines to be used by Administrative Law Judges for a violation(s) of specific statutes, and standard and speciality probationary terms and conditions.

The Board recognizes that these recommended penalties and conditions of probation are merely guidelines and that aggravating or mitigating circumstances and other factors may necessitate deviation from these guidelines in particular cases.

PUBLIC RECORD

It is the Board's policy that all letters of license denial, citations issued, legal pleadings filed and final decisions will be published as a matter of public record.

COST RECOVERY

The Board seeks recovery of all investigative and prosecution costs in all disciplinary cases. The costs include all charges incurred from the Office of the Attorney General, the Division of Investigation, and Board services, including but not limited to expert consultant opinions and services. The Board seeks recovery of these costs because the burden for payment of the costs of investigation and prosecution of disciplinary cases should fall upon those whose proven conduct had required investigation and prosecution, not upon the profession as a whole.

References

§ 3753.5. Payment of costs of investigation and prosecution of disciplinary action

(a) In any order issued in resolution of a disciplinary proceeding before the board, the board or the administrative law judge may direct any practitioner or applicant found to have committed a violation or violations of law or any term and condition of board probation to pay to the board a sum not to exceed the costs of the investigation and prosecution of the case. A certified copy of the actual costs, or a good faith estimate of costs where actual costs are

not available, signed by the official custodian of the record or his or her designated representative shall be prima facie evidence of the actual costs of the investigation and prosecution of the case.

(b) The costs shall be assessed by the administrative law judge and shall not be increased by the board; however, the costs may be imposed or increased by the board if it does not adopt the proposed decision of the case. Where an order for recovery of costs is made and timely payment is not made as directed in the board's decision the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any practitioner directed to pay costs...

§ 3753.7. Items included in costs of prosecution

For purposes of this chapter, costs of prosecution shall include attorney general or other prosecuting attorney fees, expert witness fees, and other administrative, filing, and service fees.

PROBATION MONITORING PURPOSE

The purpose of the probation monitoring program is to maintain public protection by proactively monitoring probationers to ensure terms and conditions are met. **The purpose is NOT for the Board to rehabilitate the probationer.** Probation is a privilege afforded by the Board to:

1) Allow for the probationer's rehabilitation if that is his/her choice;

2) Allow the probationer an opportunity to practice in a professional manner with restrictions and guidance from a community support system and designated probation monitor to prevent future occurrences, and

3) Allow for education of the individual as to the responsibilities, requirements and professionalism mandated of a respiratory care practitioner.

It is the policy of the Board that if a probationer is found to be in violation of any term of probation at any time during the probation period, the Board shall immediately be notified of the violation so that disciplinary action may be considered.

CITATIONS

The Board has the authority to issue citations and fines for violations of several sections of the Respiratory Care Practice Act and its regulations. Citations issued may include an order for abatement, a fine, or both. Citations are issued at the discretion of the Board. The issuance of a citation is separate from and may be in addition to any other administrative discipline, civil remedies, or criminal penalties. [Reference: California Code of Regulations section 1399.380(h)]. Any prior citation may be used in future actions as aggravating evidence.

STIPULATED SETTLEMENTS

The Board will consider stipulated settlements to promote cost effectiveness and to expedite disciplinary decisions if such agreements are consistent with the Board's mandate.

DISCIPLINARY GUIDELINES

2011 Edition

EVIDENCE IN AGGRAVATION/MITIGATION OF PENALTY

The following are examples of aggravating and mitigating circumstances which may be considered by Administrative Law Judges in providing for discipline in their proposed decisions:

EVIDENCE IN AGGRAVATION OF PENALTY

1. Patient's trust, health, safety or well-being was jeopardized.
2. Patient's or employer's trust violated (i.e. theft, embezzlement, fraud, etc...).
3. History of prior discipline.
4. Patterned behavior: Respondent has a history of one or more violations or convictions related to the current violation(s).
5. Perjury on official Board forms.
6. Violent nature of crime or act.
7. Violation of Board Probation.
8. Failure to provide a specimen for testing in violation of terms and conditions of probation.
9. Commission of any crime against a minor, or while knowingly in the presence of, or while caring for, a minor.

EVIDENCE IN MITIGATION OF PENALTY

1. Recognition by Respondent of his or her wrongdoing and demonstration of corrective action to prevent recurrence.
2. Respondent was forthcoming and reported violation or conviction to the Board.
3. A substantial amount of time since the violation or conviction occurred.
4. No prior criminal or disciplinary history.

DISCIPLINARY GUIDELINES SUMMARY FOR USE BY ADMINISTRATIVE LAW JUDGES

These guidelines were developed for use by Administrative Law Judges. In determining the appropriate discipline, consideration should be given to any mitigating or aggravating circumstances. All decisions shall include cost recovery in accordance with Business and Professions Code section 3753.5.

KEY
"R" - Required Term and Condition
"W" - Include Term and Condition if Warranted

B&P Code		CONDITIONS OF PROBATION											
		1-13. Standard Terms & Conditions	14. Work Schedules	15. Biological Fluid Testing	16. Abstention from Mood Altering Sub.	17. Suspension	18. Restriction of Practice	19. Direct Supervision	20. Education	21. Competency Exam	22. Alcohol/Drug Treatment	23. Psychological Evaluation	24. Physical Examination
3750 (a)	**False/Misleading Advertising** Maximum: Revocation or Denial Minimum: Revocation stayed, 2 years probation	R				W	W	W					
3750 (b)	**Fraud in Procurement of License** Maximum: Revocation or Denial Minimum: Revocation stayed, 3 years probation	R				W	R	W					
3750 (c)	**Knowingly Employing Unlicensed Persons** Maximum: Revocation or Denial Minimum: Revocation stayed, 2 years probation	R				W	R	R					
3750 (d)	**Conviction of a Crime** Maximum: Revocation or Denial Minimum: Revocation stayed, 2 years probation	R	W	W	W	W	W	W	W	W	W	W	W
3750 (e)	**Impersonating/Acting as a Proxy for Applicant** Maximum: Revocation or Denial Minimum: Revocation stayed, 5 years probation	R				W	R	W					
3750 (f)	**Negligence** Maximum: Revocation or Denial Minimum: Revocation stayed, 3 years probation	R				W	W	R	R	W		W	W
3750 (g)	**Violation of Any Provision** Maximum: Revocation or Denial Minimum: Revocation stayed, 2 years probation	R	W	W	W	W	W	W	W	W	W	W	W

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"R" - Required Term and Condition
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B&P Code		CONDITIONS OF PROBATION											
		1-13. Standard Terms & Conditions	14. Work Schedules	15. Biological Fluid Testing	16. Abstention from Mood Altering Sub.	17. Suspension	18. Restriction of Practice	19. Direct Supervision	20. Education	21. Competency Exam	22. Alcohol/Drug Treatment	23. Psychological Evaluation	24. Physical Examination
3750 (h)	**Aiding or Abetting a Violation** Maximum: Revocation or Denial Minimum: Revocation stayed, 2 years probation	R				W	R	W					
3750 (i)	**Aiding or Abetting Unlawful Practice** Maximum: Revocation or Denial Minimum: Revocation stayed, 2 years probation	R				W	R	R					
3750 (j)	**Fraudulent, Dishonest or Corrupt Act** Maximum: Revocation or Denial Minimum: Revocation stayed, 3 years probation	R				W	R	W				W	
3750 (k)	**Patient, Hospital, or Other Records - Entries** Maximum: Revocation or Denial Minimum: Revocation stayed, 3 years probation	R				W	W	R	R	W		W	W
3750 (l)	**Falsifying Verbal or Written Order/Prescription** Maximum: Revocation or Denial Minimum: Revocation stayed, 3 years probation	R	W	W	W	W	R	R				W	
3750 (m)	**Discipline Taken by Another Agency** Maximum: Revocation or Denial Minimum: Revocation stayed, 2 years probation	R	W	W	W	W	W	W	W	W	W	W	W
3750 (n)	**Failure to Follow Infection Control Guidelines** Maximum: Revocation or Denial Minimum: Revocation stayed, 3 years probation	R				W	W	R	R	W		W	W

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B&P Code		CONDITIONS OF PROBATION											
		1-13. Standard Terms & Conditions	14. Work Schedules	15. Biological Fluid Testing	16. Abstention from Mood Altering Sub.	17. Suspension	18. Restriction of Practice	19. Direct Supervision	20. Education	21. Competency Exam	22. Alcohol/Drug Treatment	23. Psychological Evaluation	24. Physical Examination
3750 (o)	**Incompetence** Maximum: Revocation or Denial Minimum: Revocation stayed, 3 years probation	R				W	W	R	R	R		W	W
3750 (p)	**Pattern of Substandard Care** Maximum: Revocation or Denial Minimum: Revocation stayed, 3 years probation	R				W	W	R	R	W		W	W
3750.5 (a)	**Obtained, Possessed, Used, or Administered Controlled Substance or Dangerous Drug** Maximum: Revocation or Denial Minimum: Revocation stayed, 3 years probation	R	R	R	R	R	W	W			W	W	
3750.5 (b)	**Used Drugs or Alcohol in Dangerous Manner or Impaired Ability to Practice Safely** Maximum: Revocation or Denial Minimum: Revocation stayed, 3 years probation	R	R	R	R	R	W	W			W	W	
3750.5 (c)	**Applied for Employment or Worked While Under the Influence of Alcohol** Maximum: Revocation or Denial Minimum: Revocation stayed, 3 years probation	R	R	R	R	R	W	W			W	W	
3750.5 (d)	**Conviction of Offense Involving (a) or (b), Falsify Record Pertaining to Substances** Maximum: Revocation or Denial Minimum: Revocation stayed, 5 years probation	R	R	R	R	R	R	R			W	W	
3750.5 (e)	**Committed or Confined for Use of or Addiction to Substances Described in 3750.5 (a) (b) & (c)** Maximum: Revocation or Denial Minimum: Revocation stayed, 5 years probation	R	R	R	R	R	R	R			W	W	

KEY
"R" - Required Term and Condition
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B&P Code		CONDITIONS OF PROBATION											
		1-13. Standard Terms & Conditions	14. Work Schedules	15. Biological Fluid Testing	16. Abstention from Mood Altering Sub.	17. Suspension	18. Restriction of Practice	19. Direct Supervision	20. Education	21. Competency Exam	22. Alcohol/Drug Treatment	23. Psychological Evaluation	24. Physical Examination
3752.5	**Bodily Injury or Attempted Bodily Injury** Maximum: Revocation or Denial Minimum: Revocation stayed, 2 years probation	R	W	W	W	W	R	W			W	W	
3752.6	**Sexual Misconduct** Maximum: Revocation or Denial Minimum: Revocation or Denial	See Statute											
3752.7	**Sexual Contact w/Patient or Conviction of Sexual Offense** Maximum: Revocation or Denial Minimum: Revocation or Denial	See Statute											
3755	**Unprofessional Conduct** Maximum: Revocation or Denial Minimum: Revocation stayed, 2 years probation	R				W	W	W				W	
3760	**Unlawful Practice** Maximum: Revocation or Denial Minimum: Revocation stayed, 3 years probation	R				W	R	R					
3761	**Misrepresentation** Maximum: Revocation or Denial Minimum: Revocation stayed, 3 years probation	R				W	R	R					

PROBATIONARY TERMS AND CONDITIONS

A probationary or conditional license is generally issued for a period between 2 and 5 years (see corresponding code violations on pages 6-9), with consideration given to any aggravating or mitigating factors present. Following is a summary of terms and conditions of probation:

STANDARD CONDITIONS

1. Obey All Laws
2. Quarterly Reports
3. Probation Monitoring Program
4. Probation Monitoring Costs
5. Employment Requirement
6. Notice to Employer
7. Supervisor Quarterly Reports
8. Changes of Employment or Residence
9. Cost Recovery
10. Tolling for Out-of-State Residence or Practice
11. Valid License Status
12. Violation of Probation
13. Completion of Probation

STANDARD ALCOHOL/DRUG CONDITIONS

14. Work Schedules
15. Biological Fluid Testing
16. Abstention from Use of Mood Altering Substances

SPECIALTY CONDITIONS

17. Suspension
18. Restriction of Practice
19. Direct Supervision
20. Education
21. Competency Examination
22. Alcohol and Drug Treatment
23. Psychological Evaluation
24. Physical Examination

STANDARD TERMS AND CONDITIONS

Standard conditions are imposed on each and every probationer, regardless of cause for discipline.

1. **OBEY ALL LAWS** Respondent shall obey all laws, whether federal, state, or local. The Respondent shall also obey all regulations governing the practice of respiratory care in California.

   Respondent shall notify the Board in writing within three days of any incident resulting in his/her arrest, or charges filed against, or a citation issued against, Respondent.

2. **QUARTERLY REPORTS** Respondent shall file quarterly reports of compliance under penalty of perjury, on forms to be provided, to the probation monitor assigned by the Board. Omission or falsification in any manner of any information on these reports shall constitute a violation of probation and shall result in the filing of an accusation and/or a petition to revoke probation against Respondent's respiratory care practitioner license.

   Quarterly report forms will be provided by the Board. Respondent is responsible for contacting the Board to obtain additional forms if needed. Quarterly reports are due for each year of probation and the entire length of probation as follows:

   For the period covering January 1st through March 31st, reports are to be completed and submitted between April 1st and April 7th.

   For the period covering April 1st through June 30th, reports are to be completed and submitted between July 1st and July 7th.

   For the period covering July 1st through September 30th, reports are to be completed and submitted between October 1st and October 7th.

   For the period covering October 1st through December 31st, reports are to be completed and submitted between January 1st and January 7th.

3. **PROBATION MONITORING PROGRAM** Respondent shall comply with requirements of the Board appointed probation monitoring program, and shall, upon reasonable request, report to or appear to a local venue as directed.

   Respondent shall claim all certified mail issued by the Board, respond to all notices of reasonable requests timely, appear as requested by the Board, and submit Annual Reports, Identification Update reports or other reports similar in nature, as requested and directed by the Board or its representative.

   Respondent shall provide to the Board the names, physical work addresses, work mailing addresses, telephone numbers, and e-mail addresses of all employers, human resources personnel, directors, managers, supervisors, and contractors, and any person providing direct supervision, and shall give specific, written consent that the Respondent authorizes the Board and its representatives and the employers, human resources personnel, directors, managers, supervisors, and contractors, and any person providing direct supervision, to communicate regarding the Respondent's work status, performance, and monitoring. Monitoring includes, but is not limited to, any violation or potential violation of any probationary term and condition.

   Respondent is encouraged to contact the Board's Probation Program at any time he/she has a question or concern regarding his/her terms and conditions of probation.

4. **PROBATION MONITORING COSTS** All costs incurred for probation monitoring during the entire probation shall be paid by the Respondent. The monthly cost may be adjusted as expenses are reduced or increased. Respondent's failure to comply with all terms and conditions may also cause this amount to be increased. Probation monitoring costs will not be tolled.

   All payments for costs are to be sent directly to the Respiratory Care Board and must be received by the date(s) specified. (Periods of tolling will not toll the probation monitoring costs incurred.)

   If Respondent is unable to submit costs for any month, he/she shall be required, instead to submit an explanation of why he/she is unable to submit the costs, and the date(s) he/she will be able to submit the costs including payment amount(s). Supporting documentation and evidence of why the Respondent is unable to make such payment(s) must accompany this submission.

   Respondent understands that failure to submit costs timely is a violation of probation and submission of evidence demonstrating financial hardship does not preclude the Board from pursuing further disciplinary action. However, Respondent understands that by providing evidence and supporting documentation of financial hardship it may delay further disciplinary action.

   In addition to any other disciplinary action taken by the Board, an unrestricted license will not be issued at the end of the probationary period and the respiratory care practitioner license will not be renewed, until such time all probation monitoring costs have been paid.

   The filing of bankruptcy by the Respondent shall not relieve the Respondent of his/her responsibility to reimburse the Board for costs incurred.

5. **EMPLOYMENT REQUIREMENT** Respondent shall be employed a minimum of 24 hours per week as a respiratory care practitioner for a minimum of 2/3 of his/her probation period.

   Respondent may substitute successful completion of a minimum of thirty (30) additional continuing education hours, beyond that which is required for license renewal, for each 8 months of employment required. Respondent shall submit proof to the Board of successful completion of all continuing education requirements. Respondent is responsible for paying all costs associated with fulfilling this term and condition of probation.

6. **NOTICE TO EMPLOYER** Respondent shall be required to inform all current and subsequent employers, directors, managers, supervisors, and contractors during the probation period, of the discipline imposed by this decision by providing his/her current and subsequent human resources personnel, directors, managers, supervisors, and contractors with a complete copy of the decision and order, and the Statement(s) of Issues or Accusation(s) in this matter prior to the beginning of or returning to employment or within 3 days from each change in a supervisor or director.

   If Respondent is employed by or through a registry [and is not restricted from working for a registry], Respondent shall also make each hospital or establishment to which he/she is sent aware of the discipline imposed by this decision by providing his/her human resources personnel, manager, and supervisor for each shift, at each hospital or establishment with a copy of this decision, and the Statement(s) of Issues or Accusation(s) in this matter prior to the beginning of employment. This must be done each time there is a change in supervisors or administrators.

   The employer will then inform the Board, in writing, that he/she is aware of the discipline, on forms to be provided to the Respondent. Respondent is responsible for contacting the Board to obtain additional forms if needed. All reports completed by the employer must be submitted from the employer directly to the Board.

In addition, any employer, director, manager, supervisor or contractor, shall report to the Board immediately, within 24 hours, if he/she suspects Respondent is under the influence of alcohol or any substance or has had any occurrence of substance abuse.

7. **SUPERVISOR QUARTERLY REPORTS** Supervisor Quarterly Reports of Performance are due for each year of probation and the entire length of probation from each employer, as follows:

   For the period covering January 1st through March 31st, reports are to be completed and submitted between April 1st and April 7th.

   For the period covering April 1st through June 30th, reports are to be completed and submitted between July 1st and July 7th.

   For the period covering July 1st through September 30th, reports are to be completed and submitted between October 1st and October 7th.

   For the period covering October 1st through December 31st, reports are to be completed and submitted between January 1st and January 7th.

   Respondent is ultimately responsible for ensuring his/her employer(s) submits complete and timely reports.

8. **CHANGES OF EMPLOYMENT OR RESIDENCE** Respondent shall notify the Board, and appointed probation monitor, in writing, of any and all changes of employment, location, and address within 3 days of such change. This includes but is not limited to applying for employment, termination or resignation from employment, change in employment status, change in supervisors, administrators or directors.

   Respondent shall also notify his/her probation monitor AND the Board IN WRITING of any changes of residence or mailing address within 3 days. P.O. Boxes are accepted for mailing purposes, however the Respondent must also provide his/her physical residence address as well.

9. **COST RECOVERY** Respondent shall pay to the Board a sum not to exceed the costs of the investigation and prosecution of this case. That sum shall be $ _____ and shall be paid in full directly to the Board, in equal quarterly payments, within 12 months from the effective date of this decision. Cost recovery will not be tolled.

   If Respondent is unable to submit costs timely, he/she shall be required, instead to submit an explanation of why he/she is unable to submit these costs in part or in entirety, and the date(s) he/she will be able to submit the costs including payment amount(s). Supporting documentation and evidence of why the Respondent is unable to make such payment(s) must accompany this submission.

   Respondent understands that failure to submit costs timely is a violation of probation and submission of evidence demonstrating financial hardship does not preclude the Board from pursuing further disciplinary action. However, Respondent understands that by providing evidence and supporting documentation of financial hardship may delay further disciplinary action.

   Consideration to financial hardship will not be given should Respondent violate this term and condition, unless an unexpected AND unavoidable hardship is established from the date of this order to the date payment(s) is due.

   The filing of bankruptcy by the Respondent shall not relieve the Respondent of his/her responsibility to reimburse the Board for these costs.

10. **TOLLING FOR OUT-OF-STATE RESIDENCE OR PRACTICE** Periods of residency or practice outside California, whether the periods of residency or practice are temporary or permanent, will toll the probation period but will not toll the obey all laws, quarterly reports, probation monitoring program, probation monitoring costs, or cost recovery requirements. Travel out of California for more than 30 days must be reported to the Board in writing prior to departure. Respondent shall notify the Board, in writing, within 3 days, upon his/her return to California and prior to the commencement of any employment where representation as a respiratory care practitioner is/was provided.

    Respondent's license shall automatically be cancelled if respondent's cumulative period tolling is greater than five years. However, the cancellation of the license does not relieve the respondent from outstanding cost recovery or probation monitoring costs.

11. **VALID LICENSE STATUS** Respondent shall maintain a current, active and valid license for the length of the probation period. Failure to pay all fees and meet CE requirements prior to his/her license expiration date shall constitute a violation of probation.

12. **VIOLATION OF PROBATION** If Respondent commits a "Major Violation," as identified in the Disciplinary Guidelines, incorporated by reference pursuant to section 1399.374, he/she shall receive a notice to cease the practice of respiratory care, as directed by the Board. The Board shall attempt to contact Respondent by electronic and/or telephonic means to advise him/her of the notice to cease practice and shall deliver such notice by certified and regular mail. The Board shall update its licensing database to reflect the status of the license.

    If the Respondent is ordered to cease practice, he/she may file a written appeal, within ten days of the date of the notice to cease practice, to provide additional evidence disputing the finding of the violation(s) that was cause for the notice to cease practice. The Executive Officer will review the appeal and make a determination in the matter, within ten days from the date the written appeal and all supporting evidence or documentation is received. The probationer shall be notified of the outcome by certified mail.

    Respondent shall not resume the practice of respiratory care until a final decision on an accusation and/or petition to revoke probation is made or until such time as the Board delivers written notification that the notice to cease practice has been dissolved. The cessation of practice shall not apply to the reduction of the probationary time period.

    The Board will contact the Respondent and his/her employers, human resources personnel, directors, managers, supervisors, and contractors and notify them that Respondent has been issued a notice to cease practice.

    In addition, if Respondent violates any term of the probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed.

    If a petition to revoke probation is filed against Respondent during probation, the Board shall have continuing jurisdiction and the period of probation shall be extended until the matter is final. No petition for modification of penalty shall be considered while there is an accusation or petition to revoke probation or other penalty pending against Respondent.

13. **COMPLETION OF PROBATION** Upon successful completion of probation, Respondent's license shall be fully restored.

STANDARD ALCOHOL/DRUG CONDITIONS

14. **WORK SCHEDULES** Respondent shall be required to submit to the probation monitor work schedules on a weekly/monthly basis for the length of probation for each and every place of employment. Respondent shall ensure the Board has a copy of her/his current work schedule at all times for each place of employment.

15. **BIOLOGICAL FLUID TESTING** Respondent, at his/her expense, shall participate in random testing, including but not limited to biological fluid testing (i.e. urine, blood, saliva), breathalyzer, hair follicle testing, and/or any drug screening program approved by the Board.

    Respondent shall be required to make daily contact, to determine if he/she is required to submit a specimen for testing, each day, including weekends, holidays, and vacations in or outside of California, at a lab approved by the Board. Board representatives may also appear unannounced, at any time to collect a specimen. All collections will be observed.

    At all times, Respondent shall fully cooperate with the Board or any of its representatives, and shall, when directed, appear for testing as requested and submit to such tests and samples for the detection of alcohol, narcotics, hypnotic, dangerous drugs or other controlled substances. All alternative testing sites, due to vacation or travel outside of California must be approved by the Board, 30 days prior to the vacation or travel.

    If Respondent is unable to provide a specimen in a reasonable amount of time from the request, while at the work site, Respondent understands that any Board representative may request from the supervisor, manager or director on duty to observe Respondent in a manner that does not interrupt or jeopardize patient care in any manner until such time Respondent provides a specimen acceptable to the Board.

    If Respondent tests positive for a banned substance (including testing positive for ETG), the Board will contact the Respondent and his/her employers, human resources personnel, directors, managers, supervisors, and/or contractors and notify them of the positive test, including the substance(s) and levels detected. Thereafter, the Board may contact the specimen collector, laboratory, Respondent, treating physician, treatment provider and/or support group facilitators to determine whether the positive test is evidence of prohibited use. If the Board determines the positive test is not evidence of prohibited use, the Board shall inform the Respondent and others previously contacted, that the positive test was not a violation of his/her probationary order.

16. **ABSTENTION FROM USE OF MOOD ALTERING SUBSTANCES** For purposes of these terms and conditions, a banned substance includes alcohol, marijuana, controlled substances and any and all other mood altering drugs and substances. Respondent shall completely abstain from the possession or use of all banned substances and their associated paraphernalia. Respondent may take other medication when lawfully prescribed by a licensed practitioner as part of a documented medical treatment. Respondent shall provide the Board a copy of a prescription within five days of the date the prescription was filled.

    Respondent shall execute a release authorizing the release of pharmacy and prescribing records as well as physical and mental health medical records. Respondent shall also provide information of treating physicians, counselors or any other treating professional as requested by the Board.

Respondent shall ensure that he/she is not in the presence of or in the same physical location as individuals who are using illegal substances, even if Respondent is not personally ingesting the drug(s). Respondent shall also ensure he/she is not ingesting or using any product that contains trace amounts of alcohol or any other banned substances (e.g. cold/flu medications, cough syrups, diet pills/products, mouth wash, skin care or hygiene products, perfumes, poppy seeds, dessert or any foods, etc...).

Any positive result that registers over the established laboratory cutoff level for a banned substance, shall be reported to each of Respondent's employers.

SPECIALTY CONDITIONS

The following conditions imposed are dependent upon the violation(s) committed.

17. SUSPENSION As part of probation, Respondent shall be suspended from the practice of respiratory care for a period of _____, beginning the effective date of this decision. If not employed as a respiratory care practitioner or if currently on any other type of leave from employment, the suspension shall be served once employment has been established or reestablished and prior to the end of the probationary period. Respondent shall ensure that each employer informs the Board, in writing, that it is aware of the dates of suspension.

Respondents required to engage in Biological Fluid Testing, shall be suspended for a minimum of 10-60 days.

Respondents required to undergo a Psychological Evaluation, shall be suspended for a minimum of 30-90 days.

18. RESTRICTION OF PRACTICE Respondent may not be employed or function as a member of respiratory care management or supervisory staff during the entire length of probation. This includes lead functions. Respondent is prohibited from working as part of a transport team.

[ ] Respondent is prohibited from working in home care or for a registry. Respondent is also prohibited from providing instruction or supervision to respiratory care students or applicants whether in a clinical or classroom setting.

[ ] Respondent is prohibited from working with _____(i.e. neonates, elderly, comatose patients, children).

19. DIRECT SUPERVISION During the period of probation, Respondent shall be under the direct supervision of a person holding a current and valid non-restricted Board license, who has not previously been disciplined by the Board. The Respondent shall not have a financial, personal, or familial relationship with the licensee, or other relationship that could reasonably be expected to compromise the ability to provide supervision and render impartial and unbiased reports to the board.

Respondent shall be required to provide a copy of the Statement of Issues or Accusation and decision in this matter and the person providing direct supervision shall inform the Board in writing that he/she is aware of the discipline. "Under the direct supervision" means assigned to a respiratory care practitioner who is on duty and immediately available in the assigned patient area. The Board shall be informed in writing of and approve the persons authorized to provide supervision and the level of supervision prior to the commencement of work.

Respondent shall be required to submit to the probation monitor work schedules on a weekly/monthly basis for the length of probation and identify who is providing supervision for each shift. Respondent shall ensure the Board has a copy of her/his current work schedule identifying supervisor(s) at all times for each place of employment.

In addition to completing supervisor quarterly reports, any employer, director, manager, supervisor or contractor, shall report to the Board immediately, within 24 hours, if he/she suspects Respondent is under the influence of alcohol or any substance or has had any occurrence of substance abuse.

20. EDUCATION

[ ] **CONTINUING EDUCATION** Respondent shall be required to complete additional Continuing Education, approved by the Board, beyond that which is required for license renewal. A minimum of fifteen (15) additional hours is required for each year of probation. Respondent shall submit proposed courses to the Board 30 days in advance for approval consideration. Respondent shall also submit proof to the Board of successful completion of all continuing education requirements.

[ ] **EDUCATION/COURSE WORK** As directed by the Board, Respondent shall be required to successfully complete 3-12 semester units (or its equivalent) of education courses in California at an institution approved by the Board in addition to the continuing education required for the renewal of licensure. The course selection shall be submitted to and approved by the Board in advance. The Board, at its discretion, may require the education to be in a specific area of study. Successful completion is a grade of "C" or "70%" or better for any completed course.

Respondent shall be required to submit proof of successful completion in the form of official transcripts no later than twelve (12) months prior to the date probation is scheduled to end.

Failure to timely and successfully complete approved courses at an approved institution(s), or provide documentation thereof shall constitute a violation of probation.

Respondent is responsible for paying all costs associated with fulfilling this term and condition of probation.

21. COMPETENCY EXAMINATION Within 6 months of the effective date of this decision and/or as designated by the Board, Respondent shall be required to take and pass a written competency examination as designated by the Board. This examination shall be taken on a date specified by the Board and Respondent shall pay all examination fees.

Respondent's failure to appear for or pass any scheduled examination will be noted as failure to pass or failure to successfully complete the examination. Respondent's failure to successfully complete the examination after one scheduled examination, shall constitute incompetence and a violation of probation. Failure to pay costs for the examination, shall also constitute a violation of probation.

22. ALCOHOL AND DRUG TREATMENT Respondent, at his/her expense, shall successfully complete a treatment regimen at a recognized and established program in California of at least six months duration approved by the Board. The treatment program shall be successfully completed within the first nine months of probation. The program director, psychiatrist or psychologist shall confirm that Respondent has complied with the requirement of this decision and shall notify the Board immediately if he/she believes the Respondent cannot safely practice. Respondent shall execute a release authorizing divulgence of this information to the Board.

Respondent shall inform the program director, psychiatrist or psychologist, of his/her probationary status with the Board, and shall cause that individual to submit monthly reports to the Board providing information concerning Respondent's progress and prognosis. Such reports shall include results of biological fluid testing. Positive results shall be reported immediately to the Board and shall be used in administrative discipline. Respondent shall execute a release authorizing clinical providers to divulge the aforementioned information to the Board.

23. PSYCHOLOGICAL EVALUATION Within 60 days of the effective date of this decision, and on a periodic basis thereafter as may be required or directed by the Board, Respondent, at his/her own expense, shall have a mental health examination, including psychological assessment and testing as appropriate, to determine his/her capacity to perform all professional duties with safety to self and to the public.

The examination will be performed by a licensed psychiatrist or psychologist appointed by the Board. The evaluator shall have three years experience in conducting evaluations in accordance with acceptable professional standards. The evaluator shall not have a current or past financial relationship, personal relationship, or business relationship with the licensee.

Respondent shall provide this evaluator with a copy of the Board's disciplinary order prior to the evaluation.

The examiner must submit a written report of that assessment and recommendations to the Board within 10 days, unless additional time is needed, but not to exceed 30 days. If the evaluator determines that a licensee is a threat to himself/herself or others, the evaluator shall notify the board within 24 hours of such a determination. Recommendations for cessation or restriction of practice for the safety of patients, treatment, therapy or counseling made as a result of the mental health examination, will be instituted and followed by the Respondent.

Respondent shall execute a release authorizing the evaluator to divulge all findings and/or information revealed through the evaluation process, to the Board.

All costs incurred for evaluation and treatment are the responsibility of the Respondent. Failure to timely pay for the evaluation shall also constitute a violation of probation.

24. PHYSICAL EXAMINATION Within 60 days of the effective date of this decision, Respondent, at his/her expense, shall undergo an assessment of his/her physical condition by a physician appointed by the Board. Respondent shall provide the examining physician with a copy of the Board's disciplinary order prior to the examination. The examining physician must submit a written report of his/her findings to the Board. If medically determined, a recommended treatment program will be instituted and followed by the Respondent with the physician providing written reports to the Board on forms provided by the Board.

If the examining physician finds that Respondent is not physically fit to practice or can only practice with restrictions, the examining physician shall notify the Board within three (3) working days. The Board shall notify Respondent in writing of the examining physician's determination of unfitness to practice and shall order the Respondent to cease or restrict licensed activities as a condition of probation. Respondent shall comply with this condition until the Board is satisfied of Respondent's fitness to practice safely and has so notified the Respondent. Respondent shall document compliance in the manner required by the Board.

Respondent shall execute a release authorizing the physician to divulge the aforementioned information to the Board.

Failure to timely pay for the evaluation shall also constitute a violation of probation.

VIOLATION STANDARDS

MAJOR VIOLATIONS

Major violations include, but are not limited to, the following:

1. Any act that presents a threat to a patient, the public, or the respondent him/herself;
2. Failure to timely complete a board-ordered program or evaluation;
3. Committing two or more minor violations of probation;
4. Practicing respiratory care or making patient contact while under the influence of drugs or alcohol;
5. Committing any drug or alcohol offense, or any other offense that may or may not be related to drugs or alcohol, that is a violation of the Business and Professions Code or state or federal law;
6. Failure to make daily contact as directed, submit to testing on the day requested, or appear as requested by any Board representative for testing, in accordance with the "biological fluid testing" term and condition;
7. Testing positive for a banned substance;
8. Knowingly using, making, altering or possessing any object or product in such a way as to defraud a drug test designed to detect the presence of a banned substance;
9. Failure to adhere to any suspension or restriction in practice;
10. Falsifying any document in connection with the terms and conditions of probation;

If a Respondent commits a major violation, the Board shall issue a notice to cease practice, pursuant to section 1399.375 of Division 13.6, Title 16, California Code of Regulations, and the Board shall refer the matter for formal disciplinary action.

MINOR VIOLATIONS

Minor violations include, but are not limited to, the following:

1. Failure to submit complete and required documentation in a timely manner to the Board, an employer, or any other party, in accordance with the terms and conditions of probation;
2. Unexcused absence at required meetings;
3. Failure to contact a monitor as required;
4. Failure to submit cost recovery or monthly probation monitoring costs timely.
5. Any other violation that does not present a threat to the Respondent or public.

If a Respondent commits a minor violation, the Board shall determine the appropriate action, up to and including referral of the matter for disciplinary action.

Disciplinary Guidelines
2011 Edition

Published by
Respiratory Care Board of California
444 North 3rd Street, Suite 270
Sacramento, CA 95811
T: 916.323.9983 • F: 916.323.9999 • E: rcbinfo@dca.ca.gov

ENFORCEMENT STATISTICS

Data through June 30, 2011

Applicant Licensed Unlicensed	CASELOAD	FY 01/02	FY 02/03	FY 03/04	FY 04/05	FY 05/06	FY 06/07	FY 07/08	FY 08/09	FY 09/10	FY 10/11
A	Applications Received	526	680	713	853	1003	1283	1359	1360	1443	1357
L	Total Licensed	22,414	23,056	23,674	24,408	25,246	26,338	27,545	28,847	30,120	31,511
A L U	Enforcement Budget	$725,452	$568,422	$436,421	$494,771	$514,365	$557,312	$584,409	$579,161	$640,576	$661,077
L	Licenses Active	15,202	15,268	15,367	15,503	15,835	16,511	17,202	18,077	18,803	19,658
A	Applicants Investigated (RCB Staff)	99	98	113	141	205	238	269	270	311	260
A	Applicants Denied/Initial	12	17	19	11	23	19	31	46	35	21
L U	Complaints Received	470	603	521	515	495	476	472	493	583	575
A L U	Cases to Investigation (sworn investigators)	6	3	0	4	3	9	5	11	3	6
L U	Citations Issued	25	5	68	99	57	71	63	102	75	96
A L	Cases to the DAG	107	105	125	46	56	71	64	99	69	80
L	Probation Cases to AG for Revocation	21	15	15	13	13	10	9	17	23	9
A L U	Cases to the DA	2	0	1	0	1	0	1	0	0	1
L	Accusations Filed	90	90	102	60	34	51	51	46	42	58
A	Statement of Issues Filed	11	17	17	9	15	21	22	40	29	20
L	Petitions to Revoke Probation Filed	25	18	12	11	18	8	9	11	20	9
A L	Stipulated Settlements	66	97	85	71	34	46	59	61	57	50
A L	Disciplinary Hearings Completed/Final Decisions	20	19	19	11	13	7	14	9	20	17
L	Revocations/Surrenders	35	44	36	31	27	24	29	30	45	32
A	Applications Denied (Final Decision)	1	2	2	0	3	2	3	1	6	5
A L	Public Reprimands	22	52	50	20	5	6	9	6	4	10
A L	Probationers (New)	42	46	38	53	27	32	40	48	39	29
L	Probationers (Active)	138	80	81	100	80	77	84	108	92	84
L U	Fines Imposed	$25,000	$5,000	$51,600	$61,050	$33,600	$33,413	$32,450	$60,950	$123,975	$51,450
L U	Fines Reduced, Withdrawn, Dismissed	$5,000	$2,000	$1,550	$1,350	$900	$900	$1,225	$2,715	$400	$3,500
L U	Fines **Collected**	**$18,729**	**$9,379**	**$23,386**	**$41,942**	**$37,941**	**$31,919**	**$31,061**	**$30,121**	**$41,863**	**$41,378**
A L	Cost Recovery Requested	$169,256	$230,033	$213,720	$233,873	$198,758	$183,032	$208,563	$198,892	$263,848	$267,310
A L	Cost Recovery Awarded	$162,692	$226,878	$195,354	$223,996	$173,771	$174,142	$168,976	$184,082	$214,040	$245,009
A L	Cost Recovery **Collected**	**$68,036**	**$107,028**	**$130,994**	**$130,378**	**$142,061**	**$120,820**	**$96,454**	**$55,820**	**$81,483**	**$84,285**
L	Probation Monitoring Costs **Collected**	**$146,344**	**$111,907**	**$83,447**	**$100,746**	**$102,596**	**$81,613**	**$79,748**	**$85,176**	**$90,316**	**$87,604**
A L U	Franchise Tax Board **Collected**	**$12,696**	**$20,508**	**$16,064**	**$13,676**	**$20,288**	**$13,542**	**$17,697**	**$10,440**	**$8,796**	**$8,826**
A L U	Collection Agency **Collected ***	Not Applicable		**$17,402**	**$32,285**	**$56,826**	**$19,414**	**$22,568**	**$2,292**	**$1,100**	**$11,216**

Agenda Item: 8a
Meeting Date: 10/7/11

Department of Consumer Affairs

Respiratory Care Board of California

Performance Measures

Annual Report *(2010 – 2011 Fiscal Year)*

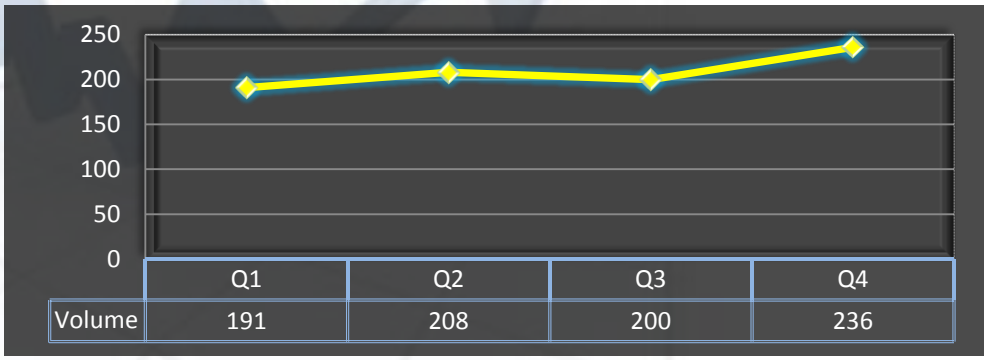
To ensure stakeholders can review the Board's progress in meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures are posted publicly on a quarterly basis.

This annual report represents the culmination of the first four quarters worth of data.

Volume

Number of complaints and convictions received.

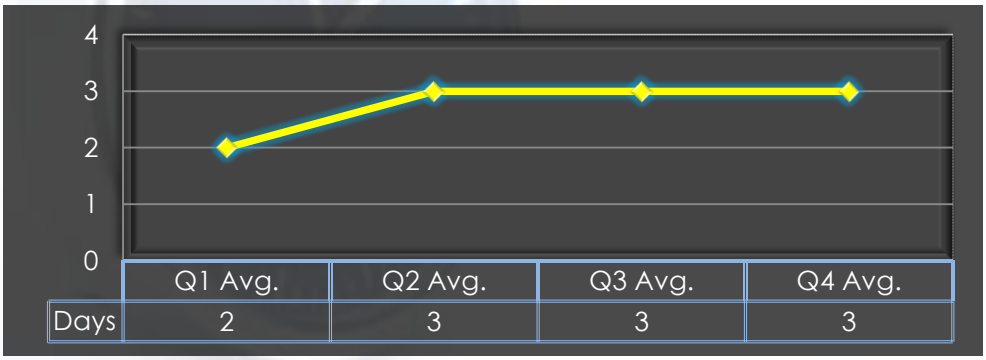
The Board had an annual total of 835 this fiscal year.



Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

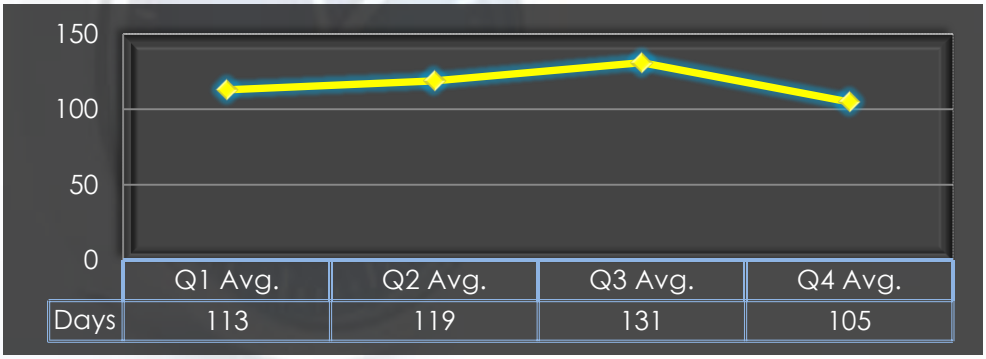
The Board has set a target of 7 days for this measure.



Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

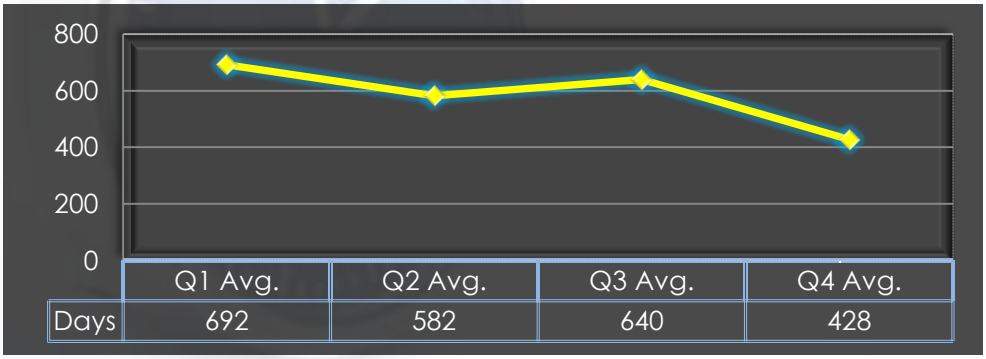
The Board has set a target of 210 days for this measure.



Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. Includes intake and investigation by the Board, and dispensation by the AG.

The Board has set a target of 540 days for this measure.



Probation Intake

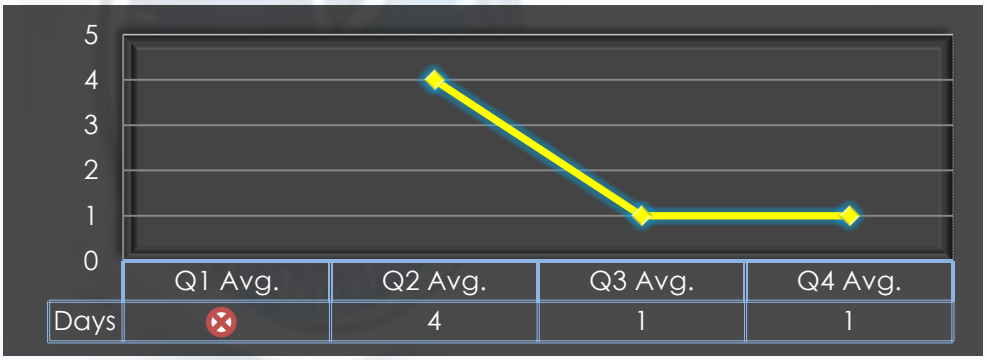
Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

The Board has set a target of 6 days for this measure.

Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

The Board has set a target of 10 days for this measure.



[Prepared by AARC; June 2011]

Gap Analysis for 2015

Recommendation 1 – *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.

Violates Attribute 1. Maintain an adequate respiratory therapist workforce throughout the transition.

Violates Attribute 2. Address unintended consequences such as respiratory therapist shortages.

- **GAP -Will need determination of workforce needs and areas of need.**
- **GAP – Will need to determine locations of schools in comparison to the workforce needs and shortages.**
- **GAP – Will need to identify process to which AS can become BS for future.**

Violates Attribute 3. Require multiple options and flexibility in educating both students and the existing workforce. (e.g. affiliation agreements, internships, special skills workshops, continuing education, etc)

- **GAP – Will need a determination if there is enough geographically located to replace current AS programs, consider a tretch to 2020 or make a determination that the content of the AS programs must change to meet the demands of the emerging needs.**

- **The past transistion place to all associate programs took 7 years so this must be considered if there is a transition to the BS level.**

  - Information needed:

    - Current vacancy rate by regions of the country
    - Determine if shortages will actually occur.
    - Create a list of schoold and options for schools
    - Create practical time line
    - Identify any and all committements needed.

Recommendation 2 :. *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.

Violates Attribute 1. Maintain an adequate respiratory therapist workforce throughout the transition.

Violates Attribute 2. Address unintended consequences such as respiratory therapist shortages.

- **GAP –** The recommendation has the potential of affecting licensure laws and may require costly and risky changes to legislation. Will need to identify state statues that specifically address CRT exam.
- **GAP –** will need todetermine the legal implications of those respiratory therapist who only hold the CRT credential.
- **GAP –** will need to determine the cost of changing the examination to include the missing components from the CRT which would need to be added to the RRT examinations.
    - Information needed:
        - Determine if shortagles will occur.
        - List any and all options for schools
        - List options for licensure and evalute impact of opening licensure bills by each state.

Recommendation 3 :. *That the AARC establish on July1, 2011, a commission to assist state regulatory boards transition to a RRT requirement for licensure as a respiratory therapist.*

No attribute violated

- **GAP –** Practical time line needs to be established and can only occur after other decisions are made.
    - Information Needed
        - Review with NBRC agreements that may be in conflict with the recommendation.
        - Options would need to be created for schools and employers.
        - Identify impact on current licesnsed individuals with CRT only.

Recommendation 4: *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.

No attribute violated

- Information needed:
    - Compenticies needs to be identified with recommendations for meeting new competncies in each area of emplyment.

Recommendation 5: *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.*

No attribute violated

- Information needed:
  - Establish the ability for use of clinical simulation by school, hosptial and region.

Recommendation 6. *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.*

No attribute violated

Recommendation 7. *That the AARC provide budgetary resources to assist associate degree programs with the transition to baccalaureate level respiratory therapist education.*

No attribute violated

Recommendation 8. *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.*

No attribute violated

Attributes

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

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 recredentialling 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
Total:	*$581*

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***

Attachment: A

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 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.

Sam P Giordano MBA RRT FAARC
American Association for Respiratory Care
Irving, Texas

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Correspondence: Sam P. Giordano MBA RRT FAARC, American Association for Respiratory Care, 9425 . MacArthur Blvd. Suite 100, Irving, TX 75063-4706; email: Giordano@aarc.org.

Respir Care Articles in Press. Published on January 24, 2011 as DOI: 10.4187/respcare.01169

Attachment: B

Transitioning the Respiratory Therapy Workforce for 2015 and Beyond

Thomas A Barnes EdD RRT FAARC, Robert M Kacmarek PhD RRT FAARC,

Woody V Kageler MD MBA FACP FCCP, Michael J Morris MD FACP FCCP

and Charles G Durbin Jr MD FAARC FCCM

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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

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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 conference[1] 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

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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 majors 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

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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 Study[3] and presentations of the results of two preconference surveys which generated 1020 responses from respiratory therapy educators[4] 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

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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

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(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:

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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.*

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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*

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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 two[2] 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

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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).

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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]

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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

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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

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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

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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.

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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

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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 survey[15] 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

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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]

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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.

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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

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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.

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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.

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Table 2 Results of Electronic Voting on Recommendations

Recommendations	Voting Yes N (%)*	Voting No N (%)*	Abstentions N	Total N**
Approved				
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
Not Approved				
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.

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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

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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

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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

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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 MSEd 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.

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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

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American Thoracic Society

Association of Asthma Educators

Association of Schools of Allied Health Professions

Asthma and Allergy Foundation of America

Blue Cross

California Board for Respiratory Care

California Health Care Foundation

Catholic Health Association of the United States

Centers for Disease Control and Prevention

Center For The Health Professions

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

Robert Wood Johnson Foundation

Society of Critical Care Medicine

Society of Hospital Medicine

Texas Department of State Health Services-Respiratory Therapy Program

The Joint Commission

U.S Department of Health & Human Services

U.S Department of Health & Human Services/HRSA

U.S. Office of Personnel Management

United Health Care

United States Public Health Service

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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

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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

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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 <u>all</u> 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;~~
(1~~2~~) Certified Pulmonary Function Technologist (CPFT) - 15 CE hours;
(2~~3~~) Registered Pulmonary Function Technologist (RPFT) - 15 CE hours;
(3~~4~~) Neonatal/Pediatric Respiratory Care Specialist (NPS) - 15 CE hours;
(4~~5~~) Advanced Cardiac Life Support (ACLS) - number of CE hours to be designated by the provider;
(5~~6~~) Neonatal Resuscitation Program (NRP) - number of CE hours to be designated by the provider; and
(6~~7~~) Pediatrics Advanced Life Support (PALS) - number of CE hours to be designated by the provider.
(7~~8~~) Advanced Trauma Life Support (ATLS) - number of CE hours to be designated by the provider
(c) Examinations listed in subdivisions (b)(1) through (b)~~4~~3 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)(4~~5~~) through (b)(7~~8~~) 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)	Entry Level Examination fee	$ 190
(c)	Entry Level Re-examination fee	$ 150
(d)	Advance Level Written Examination fee	$ 190
(e)	Advance Level Written Re-examination fee	$ 150
(f)	Advance Level Clinical Simulation Examination fee	$ 200
(g)	Advance Level Clinical Simulation Re-examination fee	$ 200
(j~~d~~)	Renewal fee for licenses expiring on or after January 1, 2002	$ 230
(k~~e~~)	Delinquency fee (not more than 2 years after expiration)	$ 230
(l~~f~~)	Delinquency fee (after 2 years but not more than 3 years after expiration)	$ 460
(m~~g~~)	Inactive license fee.	$ 230
(n~~h~~)	Duplicate license fee	$ 25
(o~~i~~)	Endorsement fee	$ 25

CDPH's AFL 10-22, Issued October 18, 2010
California Department of Public Health
Respiratory Care Board

September 28, 2011

AGENDA

I. Introductions

II. Outpatient Service vs. Diagnostic Testing Service

Dialogue on how sleep testing, which has predominantly been performed as a diagnostic test within a pulmonary function lab or respiratory department (with no involvement of registered nurses) is now considered an outpatient service requiring assessment by registered nurses.

III. Nursing Services/Nursing Care

Dialogue on the tasks or definition of "nursing services" or "nursing care" involved with diagnostic and laboratory testing. The Board contends that a diagnostic study, itself, does not fit the criteria to require "nursing services" or "nursing care," and therefore, would not require an RN to provide needed assessments, with limited exceptions. A patient admitted to the hospital, who is later transferred to have a sleep test performed, would continue to be under the care of an RN and the regulations cited in AFL 10-22 would apply. However, the need for an assessment as part of any diagnostic or laboratory test would not be a basis for requiring "nursing services" or "nursing care."

IV. Moving Forward

Where do we go from here? Dialogue on the opportunity to develop or amend AFLs, regulations, or laws to provide equitable and safe patient care and accountable government practices.

CDPH's AFL 10-22, Issued October 18, 2010
California Department of Public Health
Respiratory Care Board

September 28, 2011

The issue at hand, is CDPH's All Facilities Letter (AFL) 10-22 (and subsequent interpretations), wherein CDPH contends that an RN must provide assessments on patients undergoing sleep testing in a sleep lab within a General Acute Care Hospital.

The Board has several concerns with AFL 10-22, as follows:

Two Standards of Care

AFL 10-22 and the CDPH have made clear that the requirements set forth and outlined in AFL 10-22, apply only to sleep laboratories within a General Acute Care Hospital setting and that free-standing sleep laboratories are exempt from such requirements. By doing this, the CDPH is establishing two standards of care in California. The Board believes this establishes a precedent that is both inequitable and dangerous to patient safety. Applying two standards for the same care will further propel free-standing laboratories (where patient safety is at greater risk) in the belief that they are exempt from regulation or that all of the "rules" do not apply to them. Patients would be provided greater protection if the same standards were applied and enforced by a united and collected belief from California government.

"Nursing Care" and "Nursing Services"

AFL 10-22 cites several regulations and interprets these regulations to require "nursing care" and "nursing services" in connection with patients undergoing sleep studies. The Board contends that "nursing care" and "nursing services" are not provided in connection with sleep testing, with few exceptions. Exceptions would include a patient who has been admitted to the hospital, who is later transferred to have a sleep test performed. In this case, the patient would continue to be under the care of an RN and the regulations cited in AFL 10-22 concerning "nursing care" and nursing services" would apply. Another exception is the extremely rare instance of an unexpected urgent or emergency situation arising. As with any other diagnostic test or laboratory procedure, when an emergency arises, personnel would rely on protocols and procedures, established by the hospital, which may include the need for "nursing care" or "nursing services."

Patient Assessments

While sleep testing, and usually other diagnostic or laboratory tests, requires patient assessments, other personnel, who are legally authorized, educated and trained, can and do provide such assessments. In an overwhelming 99% of cases, RCPs are the most qualified personnel to provide assessments in connection with sleep laboratory testing. RCPs are legally authorized, per their scope of practice, and are educated and trained to provide assessments, with specialized training and education in the pulmonary and cardiopulmonary systems. The mere need for an "assessment" is not enough to say that "nursing care" or "nursing services" are required. Furthermore, the Chief of Nursing would continue to have oversight of all care at a higher level.

To clarify, the Board is not opposed to RNs providing assessments as part of sleep studies; however, it would be a misnomer to establish a basis that the need for an "assessment" for a sleep testing diagnostic procedure is therefore a need for "nursing care" or "nursing services." In the interest of "Moving California Forward" to provide equitable and safe patient care and accountable government practices, the Board contends that AFL 10-22 be revisited and revised to recognize the issues outlined by the Board, accordingly.

2011 LEGISLATION OF INTEREST

[We are in the first year of a two year legislative cycle. Therefore, bills that did not move forward in 2011 may continue through the legislative process in 2012.]

SB 103	Author:	Liu [D]
	Title:	State governments: meetings
	Last Amended:	7/12/11
	Status:	**8/25/11: Held under submission In Assembly Appropriations**
	Summary:	This bill would authorize a state body, to the extent practicable, to conduct teleconference meetings. This bill would require, upon the request of a member of a state body, a state body to hold an open or closed meeting by teleconference, unless the chair of that state body determines that it would be more costly to hold the meeting by teleconference than it would be to hold it in person. This bill would prohibit a member of a state body from requesting a meeting by teleconference solely because it would be more convenient than holding a meeting in person. This bill would require a state body that operates an Internet Web site to provide a supplemental live audio or video broadcast on the Internet Web site of its board meetings that are open to the public, and would specify that a technical failure to provide a live broadcast would not prohibit the body from meeting and taking actions.
	Staff Recommended Position	**WATCH**

SB 231	Author:	Emmerson [R]
	Title:	Regulatory Boards: healing arts
	Last Amended:	N/A
	Status:	**2/17/11: Referred to Committee on Rules - no hearing scheduled**
	Summary:	Existing law authorizes health-related boards to adopt regulations requiring licensees to display their license or registration in the locality in which they are treating patients and to make specified disclosures to patients. This bill would make non-substantive, technical changes to that provision.
	Staff Recommended Position	**WATCH**

SB 538	Author:	Price [D]
	Title:	Nursing
	Last Amended:	8/15/11
	Status:	**9/12/11: Enrolled and Presented to the Governor**
	Summary:	This bill now contains various provisions relating to the operations of the Board of Registered Nursing, including but not limited to, sunset extension, hiring of investigators/inspectors, and actions related to approved schools.
	Staff Recommended Position	**WATCH [changes do not impact RCB]**

SB 539	Author:	Price [D]
	Title:	Nursing
	Last Amended:	6/9/11
	Status:	**9/12/11: Enrolled and Presented to the Governor**
	Summary:	The bill contains various provisions relating to the operations of the Board of Vocational Nursing and Psychiatric Technicians, including but not limited to sunset extension, inspections, entry level course work, and reporting requirements.
	Staff Recommended Position	**WATCH [changes do not impact RCB]**

SB 541	Author:	Price [D]
	Title:	Regulatory boards: expert consultants
	Last Amended:	6/21/11
	Status:	**9/12/11: Enrolled and Presented to the Governor**
	Summary:	Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs, generally requires applicants for a license to pass an examination, and authorizes boards to take disciplinary action against licensees for violations of law. Existing law establishes standards relating to personal service contracts in state employment. This bill would authorize these boards to enter into an agreement with an expert consultant, subject to the standards regarding personal service contracts described above, to provide enforcement and examination assistance. The bill would require each board to establish policies and procedures for the selection and use of these consultants. This bill would declare that it is to take effect immediately as an urgency statute.
	Board Position	**SUPPORT** [Letter mailed to author 4/21/11, and Governor on 9/12/11]

SB 544	Author:	Senate Business, Professions and Economic Development Committee
	Title:	Professions and vocations: regulatory boards
	Last Amended:	4/14/11
	Status:	**5/2/11 hearing before the Senate Business, Professions & Economic Development Committee cancelled at the request of the author**
	Summary:	Includes various proposals from the Consumer Protection Enforcement Initiative (previously proposed in SB 1111 which failed during the prior legislative session).
	Staff Recommended Position	**WATCH**

SB 943	Author:	Senate Business, Professions and Economic Development Committee
	Title:	Healing Arts
	Last Amended:	8/29/11
	Status:	**9/9/11: Enrolled and Presented to the Governor**
	Summary:	Omnibus bill for DCA health boards.
	Staff Recommended Position	**WATCH [changes do not impact RCB]**

SB 944	Author:	Senate Business, Professions and Economic Development Committee
	Title:	Committee on Business, Professions and Economic Redevelopment
	Last Amended:	7/12/11
	Status:	**9/12/11: Enrolled and Presented to the Governor**
	Summary:	Omnibus bill for DCA non-health boards.
	Staff Recommended Position	**WATCH [changes do not impact RCB]**

AB 569	Author:	Berryhill [R]
	Title:	Business licensing: Business Master License Center.
	Last Amended:	N/A
	Status:	**5/27/11: Held under submission in Assembly Appropriations**
	Summary:	Under existing law, businesses are required to obtain various licenses from regulatory agencies. Existing law also requires state agencies to take specified actions, including, but not limited to, designating a small business liaison, to assist small businesses achieve compliance with statutory and regulatory requirements. This bill would create the Business Master License Center, which would have prescribed duties, including, but not limited to, developing and administering a computerized one-stop master license system capable of storing, retrieving, and exchanging license information, as well as issuing and renewing master licenses, as specified. The bill would permit the Governor to appoint a 3rd-party facilitator from the business community, to provide oversight over the creation of the center and the development of its master license system. This bill would charge license applicants, in addition to any other fees or deposits required to obtain a particular license, a master license administrative fee in specified amounts, to be deposited into the Master License Fund, which this bill would create. This bill would require that the moneys in the fund, upon appropriation by the Legislature, be used only to administer the Business Master License Center.
	Staff Recommended Position	**WATCH**

AB 958	Author:	Berryhill [R]
	Title:	Regulatory boards: limitations period.
	Last Amended:	N/A
	Status:	**3/10/11: Referred to Assembly Committee on Business, Professions and Consumer Protection - no hearing scheduled**
	Summary:	Existing law requires licensing boards to file disciplinary action accusations against licensees for various violations within a specified limitations period particular to each board. This bill would delete those specified limitation periods for each board and would instead impose a specified limitations period on all boards within the Department of Consumer Affairs.
	Board Position	**OPPOSE UNLESS AMENDED** [Letter mailed to author 3/25/11]

AB 991	Author:	Olsen [R]
	Title:	State government: licenses: California Licensing and Permit Center
	Last Amended:	4/13/11
	Status:	**5/27/11: Held under submission in Assembly Appropriations**
	Summary:	Existing law requires members of the public to obtain license, permits, or to register with state agencies prior to undertaking certain types of tasks. This bill would require the Governor to establish a Internet Web site, known as the California Licensing and Permit Center (CLPC), to assist the public with licensing, permitting, and registration requirements of state agencies. This bill would require the Governor to operate, via both e-mail and telephone methods, a help center to assist applicants with licensing, permitting, and registration requirements. This bill would require state agencies that the Governor determines has licensing authority to cooperate with this program by providing accurate updated information about their licensing requirements. This bill would create the California License and Permit Fund in the State Treasury, and require state agencies that are required to participate in the CLPC to reallocate a portion of their operating budget, as specified, to pay for the operating cost of the CLPC. This bill would state that upon appropriation by the Legislature, revenues from the fund will be used only for purposes of the bill. This bill would require the CLPC to be provided to the public free of charge.
	Staff Recommended Position	**WATCH**

AB 1273	Author:	Grove [R]
	Title:	Boards and commissions
	Last Amended:	N/A
	Status:	**Not referred to any policy committee - no hearing scheduled**
	Summary:	Existing law establishes various boards and commissions to carry out particular tasks, investigations, or other activities. This bill would state that it is the intent of the Legislature to enact legislation that would codify Governor Arnold Schwarzenegger's "Governor's Reorganization Plan 1: Reforming California's Boards and Commissions" from 2004.
	Staff Recommended Position	**WATCH**

Senate Bill No. 541

Passed the Senate September 6, 2011

_____

Secretary of the Senate

Passed the Assembly August 25, 2011

_____

Chief Clerk of the Assembly

This bill was received by the Governor this _____ day of _____, 2011, at _____ o'clock ____M.

_____

Private Secretary of the Governor

CHAPTER _____

An act to add Section 40 to the Business and Professions Code, relating to professions and vocations, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 541, Price. Regulatory boards: expert consultants.

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs. Existing law, the Chiropractic Act, enacted by initiative, provides for the licensure and regulation of chiropractors by the State Board of Chiropractic Examiners. Existing law, the Osteopathic Act, requires the Osteopathic Medical Board of California to regulate osteopathic physicians and surgeons. Existing law generally requires applicants for a license to pass an examination and authorizes boards to take disciplinary action against licensees for violations of law. Existing law establishes standards relating to personal service contracts in state employment.

This bill would authorize these boards to enter into an agreement with an expert consultant, subject to the standards regarding personal service contracts described above, to provide enforcement and examination assistance. The bill would require each board to establish policies and procedures for the selection and use of these consultants.

This bill would declare that it is to take effect immediately as an urgency statute.

The people of the State of California do enact as follows:

SECTION 1. Section 40 is added to the Business and Professions Code, to read:

40. (a) Subject to the standards described in Section 19130 of the Government Code, any board, as defined in Section 22, the State Board of Chiropractic Examiners, or the Osteopathic Medical Board of California may enter into an agreement with an expert consultant to do any of the following:

(1) Provide an expert opinion on enforcement-related matters, including providing testimony at an administrative hearing.

(2) Assist the board as a subject matter expert in examination development, examination validation, or occupational analyses.

(3) Evaluate the mental or physical health of a licensee or an applicant for a license as may be necessary to protect the public health and safety.

(b) An executed contract between a board and an expert consultant shall be exempt from the provisions of Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

(c) Each board shall establish policies and procedures for the selection and use of expert consultants.

(d) Nothing in this section shall be construed to expand the scope of practice of an expert consultant providing services pursuant to this section.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

To ensure that licensees engaging in certain professions and vocations are adequately regulated at the earliest possible time in order to protect and safeguard consumers and the public in this state, it is necessary that this act take effect immediately.

Approved _____, 2011

_____

Governor

DCA 2012 Legislative Proposal Concept Paper

RESPIRATORY CARE BOARD

NON SUBSTANTIVE ENFORCEMENT AMENDMENTS

REVISED 9-22-11

SUMMARY

This proposal encompasses three amendments to the Respiratory Care Act. Two amendments add additional causes for disciplining a respiratory care practitioner (RCP) license, and one amendment will strengthen appropriate clinical supervision of students.

IDENTIFICATION OF PROBLEM

Cause for Discipline: Possession of Paraphernalia
The RCB recently had a case where a licensee, who previously was placed on probation for use and possession of controlled substances, was arrested for possession of two crack pipes in a motel room. The licensee ended up with an infraction for disturbing the peace. Because the licensee has already completed probation and the existing statute is limited to the unlawful possession of controlled substances, the Attorney General declined to file on the matter.

Cause for Discipline: Negligence or Pattern of Substandard Care in Any Capacity
The RCB recently had a case where the California Department of Public Health (CDPH) forwarded its investigation files on a health facility owner, who also happened to be an RCP, who was responsible for negligent care of a patient. The patient harm was so egregious, the CDPH ended up stripping the RCP of her health facility license. While the RCB continues to attempt to pursue discipline, the Attorney General, has already declined to file once and is currently considering other arguments the RCB is putting forth. The RCB's statute is specific to negligent care provided in the *capacity of an RCP*, but leaves little leeway for the RCB to take action against a licensee for negligence or a pattern of substandard care when the licensee is working under a different title, yet still responsible for the care of another.

Clinical Supervision by Disciplined Respiratory Care Practitioners
Respiratory care program students are required to have direct supervision by a RCP with a current and valid license. In recent years, the RCB has become aware of a few students who were receiving supervision from licensed RCPs who had a current and valid license; however, the licensee was on probation. Licensees on probation have generally committed acts of negligence or crimes of moral turpitude, and the RCB would like to ensure that students entering the profession are receiving supervision from persons who are not currently disciplined.

PROPOSED SOLUTION

Cause for Discipline: Possession of Paraphernalia
Amend subdivision (a) of Section 3750.5 to include illegal possession of drug paraphernalia as grounds to take disciplinary action.

Cause for Discipline: Negligence or Pattern of Substandard Care in Any Capacity
Amend subdivision (p) of Section 3750 to include substandard care or negligence in the capacity as a RCP or any capacity responsible for the care of another.

Clinical Supervision by Disciplined Respiratory Care Practitioners
Amend Section 3742 to include that the person providing supervision must hold an unrestricted license.

JUSTIFICATION

All of the proposals set forth are appropriate for legislative amendments, primarily because they are amendments to the existing structure of the Act. While the regulatory process could be used for some of the amendments, it would require creating a whole new section, convoluting the RCB's regulations, and would be misplaced with similar provisions that are already structured in statute. Failure to move forward with the additional causes for discipline could allow additional violations to pass, knowing that the RCP is a danger to patient safety. Similarly, allowing a disciplined licensee to provide supervision of a student, could potentially negatively influence the education, training or morality of a new student entering the profession

PROGRAM BACKGROUND/LEGISLATIVE HISTORY

The enabling statute to license Respiratory Care Practitioners (RCPs) was signed into law in 1982, thus establishing the Respiratory Care Board of California. The Board is mandated to protect the public from unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care.

The first RCP license was issued in 1985. Nearly 10,000 applicants were licensed through a grandfather provision in 1985. As of September 2011, nearly 32,000 licenses have been issued. The Board ensures that applicants meet the minimum education and competency standards and conducts a thorough criminal background check on each applicant prior to licensure.

Respiratory Care Practitioners treat patients with chronic lung problems, such as asthma, bronchitis, and emphysema, their patients also include heart attack and accident victims, premature infants, and people with cystic fibrosis, lung cancer, or AIDS. In each case, the patient will most likely receive treatment from a respiratory therapist (RT) under the direction of a physician. Respiratory therapists work to evaluate, treat, and care for patients with breathing disorders.

RCPs work with patients of all ages and in many different care settings. Most respiratory therapists work in hospitals where they perform intensive care, critical care, and neonatal procedures. They are also typically a vital part of the hospital's lifesaving response team that handles patient emergencies. Of the more than 7,000 hospitals in this country, about 5,700 have separate respiratory care departments. An increasing number of respiratory therapists are now working in sub acute facilities, physicians' offices, home health agencies, specialized care hospitals, medical equipment supply companies, and patients' homes.

The respiratory care profession is a relatively young profession and has grown at a rapid rate. This is evident in part by the fact that the first professional association, now known as the American Association for Respiratory Care, was only founded fifty years ago in 1947. This Association estimates that there are over 150,000 respiratory therapists in the United States with California contributing 12% of this figure.

ARGUMENTS PRO AND CON

The RCB is proposing these amendments, ultimately, to increase consumer protection. No fiscal impact exists and no opposition or support is anticipated.

These amendments will bring about greater consumer protection by giving the RCB the authority to pursue discipline against 1) RCPs who have committed crimes of possession of paraphernalia used to ingest controlled substances, 2) RCPs who have demonstrated negligence or substandard care for persons that are vulnerable and rely upon appropriate care, and 3) RCPs who are currently disciplined and providing supervision to students.

PROBABLE SUPPORT AND OPPOSITION

The Board anticipates no opposition or support for this proposal.

FISCAL IMPACT

No fiscal impact exists.

ECONOMIC IMPACT

The economic impact is expected to be insignificant. The Board has had a handful of cases that would be impacted by any of the proposed changes. All of which, are licensees who are facing or who have been disciplined for behavior that demonstrates a potential threat to patient safety.

COMPARISON WITH OTHER STATES

The Board is unaware of other states with similar statutes.

PERFORMANCE INDICATORS

Future violations concerning amendments related to causes for discipline and clinical supervision by undisciplined licensees will be measured in all of our quarterly and annual statistical enforcement data.

OTHER AFFECTED AGENCIES AND THEIR ROLES/VIEWS

No other agencies will be affected by the proposed amendments. However, the RCB has worked with the California Department of Public Health (CDPH) on related cases. In some instances, the CDPH actually performs the investigation and then shares their information with the RCB to pursue additional discipline, as appropriate. These changes will ensure the RCB has clear authority to pursue acts affecting patient safety, which is in line with the CDPH's mission.

APPOINTMENTS

The Board currently has six of its nine-member board positions filled. Current vacancies include one public Governor appointee, one public Assembly appointee, and one physician Senate Rules appointee (term just ended 6/1/11).

LANGUAGE

§ 3742. Supervision of student respiratory care practitioner
During the period of any clinical training, a student respiratory care practitioner shall be under the direct supervision of a person holding a valid, current, and unrestricted license issued under this chapter. "Under the direct supervision" means assigned to a respiratory care practitioner who is on duty and immediately available in the assigned patient care area.
Added Stats 1989 ch 645 § 6. Amended Stats 1991 ch 654 § 24 (AB 1893).

§ 3750. Causes for denial of, suspension of, revocation of, or probationary conditions upon license
The board may order the denial, suspension, or revocation of, or the imposition of probationary conditions upon, a license issued under this chapter, for any of the following causes:
(a) Advertising in violation of Section 651 or Section 17500.
(b) Fraud in the procurement of any license under this chapter.
(c) Knowingly employing unlicensed persons who present themselves as licensed respiratory care practitioners.
(d) Conviction of a crime that substantially relates to the qualifications, functions, or duties of a respiratory care practitioner. The record of conviction or a certified copy thereof shall be conclusive evidence of the conviction.
(e) Impersonating or acting as a proxy for an applicant in any examination given under this chapter.
(f) Negligence in his or her practice as a respiratory care practitioner.
(g) Conviction of a violation of any of the provisions of this chapter or of any provision of Division 2 (commencing with Section 500), or violating, or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision or term of this chapter or of any provision of Division 2 (commencing with Section 500).
(h) The aiding or abetting of any person to violate this chapter or any regulations duly adopted under this chapter.
(I) The aiding or abetting of any person to engage in the unlawful practice of respiratory care.
(j) The commission of any fraudulent, dishonest, or corrupt act which is substantially related to the qualifications, functions, or duties of a respiratory care practitioner.
(k) Falsifying, or making grossly incorrect, grossly inconsistent, or unintelligible entries in any patient, hospital, or other record.
(l)Changing the prescription of a physician and surgeon, or falsifying verbal or written orders for treatment or a diagnostic regime received, whether or not that action resulted in actual patient harm.
(m) Denial, suspension, or revocation of any license to practice by another agency, state, or territory of the United States for any act or omission that would constitute grounds for the denial, suspension, or revocation of a license in this state.
(n) Except for good cause, the knowing failure to protect patients by failing to follow infection control guidelines of the board, thereby risking transmission of blood-borne infectious diseases from licensee to patient, from patient to patient, and from patient to licensee. In administering this subdivision, the board shall consider referencing the standards, regulations, and guidelines of the State Department of Health Services developed pursuant to Section 1250.11 of the Health and Safety Code and the standards, regulations, and guidelines pursuant to the

California Occupational Safety and Health Act of 1973 (Part 1 (commencing with Section 6300) of Division 5 of the Labor Code) for preventing the transmission of HIV, hepatitis B, and other blood-borne pathogens in health care settings. As necessary, the board shall consult with the California Medical Board, the Board of Podiatric Medicine, the Board of Dental Examiners, the Board of Registered Nursing, and the Board of Vocational Nursing and Psychiatric Technicians, to encourage appropriate consistency in the implementation of this subdivision. The board shall seek to ensure that licensees are informed of the responsibility of licensees and others to follow infection control guidelines, and of the most recent scientifically recognized safeguards for minimizing the risk of transmission of blood-borne infectious diseases.
(o) Incompetence in his or her practice as a respiratory care practitioner.
(p) A pattern of substandard care or negligence in his or her practice as a respiratory care practitioner, or in any capacity as a health care worker, consultant, supervisor, manager or health facility owner, or as a party responsible for the care of another.
Added Stats 1982 ch 1344 § 1, operative July 1, 1983. Amended Stats 1987 ch 839 § 6; Stats 1991 ch 654 § 25 (AB 1893); Stats 1992 ch 1289 § 28 (AB 2743), ch 1350 § 7.5 (SB 1813); Stats 1993 ch 589 § 8 (AB 2211); Stats 1994 ch 1274 § 16 (SB 2039); Stats 1997 ch 759 § 27 (SB 827). Amended Stats 1998 ch 553 § 3 (AB 123). Amended Stats 2003 ch 586 § 11 (AB 1777).

§ 3750.5. Additional grounds for denial, suspension, or revocation of license
In addition to any other grounds specified in this chapter, the board may deny, suspend, or revoke the license of any applicant or license holder who has done any of the following:
(a) Obtained or possessed, used, or administered to himself or herself in violation of law, or furnished or administered to another any controlled substances as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, ~~or~~ any dangerous drug as defined in Article 2 (commencing with Section 4015) of Chapter 9, except as directed by a licensed physician and surgeon, dentist, podiatrist or other authorized health care provider or illegally possess any associated paraphernalia.
(b) Used any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug as defined in Article 2 (commencing with Section 4015) of Chapter 9 of this code, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, or to others, or that impaired his or her ability to conduct with safety the practice authorized by his or her license.
(c) Applied for employment or worked in any health care profession or environment while under the influence of alcohol.
(d) Been convicted of a criminal offense involving the consumption or self-administration of any of the substances described in subdivisions (a) and (b), or the possession of, or falsification of a record pertaining to, the substances described in subdivision (a), in which event the record of the conviction is conclusive evidence thereof.
(e) Been committed or confined by a court of competent jurisdiction for intemperate use of or addiction to the use of any of the substances described in subdivisions (a), (b), and (c), in which event the court order of commitment or confinement is prima facie evidence of that commitment or confinement.
(f) Falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a).
Added Stats 1987 ch 839 § 7. Amended Stats 1991 ch 654 § 26 (AB 1893); Stats 1994 ch 1274 § 17 (SB 2039). Amended Stats 2002 ch 1150 (SB 1955). Amended Stats 2004 ch 695 (SB 1913). Amended Stats 2009 ch 307 § 34 (SB 821)

DCA 2012 Legislative Proposal Concept Paper

RESPIRATORY CARE BOARD
ON BEHALF OF BOARDS/BUREAUS

RECORDS RELEASE
GENERAL B&P AMENDMENT

SUMMARY
This proposal is set forth on behalf of all boards and bureaus and would add language to the general Business and Professions Code (B&P) to require all government agencies to release criminal records to a State licensing agency upon request.

IDENTIFICATION OF PROBLEM
Earlier this year (2011), the Respiratory Care Board (RCB) came across a police department in California that refused to release an arrest report for one of the RCB's applicants. Upon consulting with the Department of Consumer Affairs' (DCA's) Legal Counsel, it was discovered that other boards/bureaus had encountered the same problem.

PROPOSED SOLUTION
Add Section 144.5 to the Business and Professions Code to ensure all boards and bureaus can obtain certified criminal records, necessary to complete an applicant or licensee investigation.

JUSTIFICATION
It is customary for most boards and bureaus to obtain complete arrest, conviction and other-related documentation as part of an applicant or licensee investigation. Each board relies upon various authorities to retrieve documentation, and it is unheard of that another government agency would refuse to release any such records to a state agency, without an authorization to release records submitted by the party in question. This additional language is necessary to prevent delays in investigations, and quite possibly, prevent a board from taking appropriate disciplinary action.

PROGRAM BACKGROUND/LEGISLATIVE HISTORY
The Department of Consumer Affairs (DCA) is here to protect and serve California consumers while ensuring a competent and fair marketplace. DCA helps consumers learn how to protect themselves from unscrupulous and unqualified individuals. The Department also protects professionals from unfair competition by unlicensed practitioners.

To protect and serve consumers, the Department issues licenses in more than 100 business and 200 professional categories, including doctors, dentists, respiratory care practitioners, contractors, cosmetologists and automotive repair facilities. The Department of Consumer Affairs includes 40 regulatory entities (nine bureaus, one program, twenty-five boards, three committees, one commission, and one office). These entities establish minimum qualifications and levels of competency for licensure. They also license, register, or certify practitioners, investigate complaints and discipline violators. The committees, commission and boards are semiautonomous bodies whose members are appointed by the Governor and the Legislature. DCA provides them administrative support. DCA's operations are funded exclusively by license fees.

One of the California Legislature's earliest efforts to protect the public was through the passage of the Medical Practice Act in 1876. The Act was designed to regulate the state's medical industry, which up to that time had operated virtually unchecked. Over the next thirty years, the state regulated more professions. By the late 1920s, 10 state boards were in existence under the Department of Vocational and Professional Standards. The Department licensed or certified accountants, architects, barbers, cosmetologists, dentists, embalmers, optometrists, pharmacists, physicians and veterinarians. The Consumer Affairs Act of 1970 gave the Department its current name.

ARGUMENTS PRO AND CON
The RCB is proposing these amendments, ultimately, to increase consumer protection and conform to the goal in the Consumer Protection Enforcement Initiative of completing all investigations and discipline within 18 months. No fiscal impact exists and no opposition or support is anticipated.

It is crucial to the mission of every board and bureau of consumer safety, to be able to access all arrest, court and other related documentation through the course of an applicant or licensee investigation. Requiring an authorization to release impedes the ability of licensing entities' to efficiently take appropriate disciplinary action or thoroughly investigate applicants. Given that a licensee is not required to provide the release, it could ultimately result in a licensing entity's inability to take disciplinary action. Furthermore, obtaining an authorization to release drastically slows the investigative and disciplinary process.

PROBABLE SUPPORT AND OPPOSITION
No opposition or support is anticipated for this proposal. Obtaining criminal documentation is a very standard process for every board and bureau; it is a core function of each licensing entity's ability to meet its mission. It is illogical and absurd that another government agency would require a release in order for a licensing entity to obtain such records.

FISCAL IMPACT
No fiscal impact exists. However, should requiring a release become the standard rather than the exception, a significant fiscal impact could result for those boards that have a high number of investigations that surround criminal actions, attributed to the additional time needed in the pursuit of releases.

ECONOMIC IMPACT
None.

COMPARISON WITH OTHER STATES
The Board is unaware of other states with similar statutes.

PERFORMANCE INDICATORS
Board and bureaus are subject to various statistical reporting (e.g. quarterly, annually). While the problem currently seems to be isolated to the San Francisco Bay Area, should the problem continue to expand, reported statistical data would reflect slower processing times for investigations.

OTHER AFFECTED AGENCIES AND THEIR ROLES/VIEWS
Government agencies that are currently requiring a release to obtain criminal documentation would be affected. However, it is surmised that this proposal would reduce bureaucracy for those agencies by eliminating responses to state entities that a release is needed.

APPOINTMENTS
N/A

LANGUAGE

§ 144.5. Release of Criminal Records
<u>A local, state or other government agency shall provide certified records of all arrest, conviction, probation and any and all other related documentation to any agency identified in Section 144, upon request of that agency.</u>

Board Meeting - Scheduling

2012 Calendar

January

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
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February

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June

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October

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November

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December

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Proposed Locations

February: Southern California
May: Sacramento
October: Sacramento