

Governor Edmund G. Brown Jr.
State of California

Anna Caballero, Secretary
Business, Consumer Services
and Housing Agency

Denise Brown, Director
Department of Consumer Affairs



Charles B. Spearman, MSED, RCP
President

Mark Goldstein, BS, RRT, RCP
Vice President

Mary Ellen Early
Member

Rebecca F. Franzoia
Member

Michael Hardeman
Member

Ronald H. Lewis, MD
Member

Murray Olson, RCP, RRT-NPS, RPFT
Member

Laura C. Romero, PhD
Member

Alan Roth, MS, MBA, RRT-NPS, FAARC
Member

Stephanie Nunez
Executive Officer

Toll Free: (866) 375-0386
Website: www.rcb.ca.gov
E-mail: rcbinfo@dca.ca.gov

Respiratory Care Board of California

3750 Rosin Court, Suite 100, Sacramento, CA 95834

Board Meeting Agenda Friday, November 15, 2013

Anaheim Marriott
Platinum Ballroom No. 5
700 West Convention Way
Anaheim, CA 92802-3483
714-750-8000

11:00 AM **Call to Order**

1. New Member Introductions

Laura C. Romero, PhD, Ronald H. Lewis, MD, and Michael Hardeman

2. Public Comment

Public comment will be accepted after each agenda item and 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. Approval of May 6, 2013 Minutes

4. Executive Officer's Report (Stephanie Nunez)

- a. BreZE, On-Line Application/License System
- b. Agenda Distribution Method

5. Strategic Plan

- a. Mission Statement
- b. Plan Approval

6. Bureau for Private Postsecondary Education Memorandum of Understanding (Stephanie Nunez)

7. Professional Qualifications Committee Report (Mark Goldstein)

- a. Coalition for Baccalaureate and Graduate Respiratory Therapy Education
Round Table Discussion November 16, 2013 [<http://www.cobgrte.org/>]
- b. California Community Colleges, Baccalaureate Degree Study Group
[<http://extranet.cccco.edu/Divisions/AcademicAffairs.aspx>]

8. Fiscal Review

9. Enforcement Statistics (Murray Olson)

10. Disciplinary Process Overview/Discussion (Dianne Dobbs, Legal Counsel)

11. Pulmonary Function Testing: Request for Attorney General Legal Opinion (Stephanie Nunez)

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), subdivisions (1) and (3), to deliberate on the following matters and any other matters that may arise after the issuance of this agenda notice.

- I. Consideration of Proposed Stipulated Decision: Scott Howard Siegman, RCP 11116
- II. Consideration of ALJ Proposed Decision: Samnang San, Applicant
- III. Consideration to Approve 2014 Proposed Ethics Courses (*Professional Qualifications Committee*)
 - a. AARC On-Line Course
 - b. CSRC On-Line & Live Forum Courses

12. Report on Resources Needed to Identify Highest Earned Credential for Respondents Disciplined

13. Legislative Report

- a. 2013 Legislation of Interest (*Christine Molina*)
- b. 2014 Proposed Legislation (*Stephanie Nunez*)
 - i. RRT Minimum Examination Threshold
 - ii. Interim Suspension Order
 - iii. Enforcement/Substantially Related Acts

14. Election of Officers for 2014

15. 2014 Meeting Dates: Calendar

16. Public Comment on Items Not on the Agenda

17. Future Agenda Items

4:30 p.m. **18. Adjournment**

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



PUBLIC SESSION MINUTES

Monday, May 6, 2013

**998 West Mission Bay Drive
(Del Mar Room)
San Diego, CA 92109**

Members Present: Charles B. Spearman, MEd, RCP, RRT, President
Mark Goldstein, BS, RRT, RCP, Vice President
Mary Ellen Early
Rebecca Franzoia
Murray Olson, RCP, RRT-NPS, RPFT
Alan Roth, MS MBA RRT-NPS FAARC

Staff Present: Dianne Dobbs, Legal Counsel
Stephanie Nunez, Executive Officer
Christine Molina, Staff Services Manager
V. Craig Martinez, Associate Governmental Program Analyst

CALL TO ORDER

The Public Session was called to order at 9:00 a.m. by President Spearman.

NEW MEMBER INTRODUCTION

President Spearman introduced and welcomed Mary Ellen Early, the Board's newest member.

PUBLIC COMMENT

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

1 **APPROVAL OF JANUARY 31/FEBRUARY 1, 2013 MINUTES**

2
3 Vice President Goldstein moved to approve the January 31/February 1, 2013 Public Session minutes
4 as written.

5
6 All were in favor. No one opposed.

7 M/Goldstein /S/Roth

8 In favor: Early, Franzoia, Goldstein, Olson, Roth, Spearman

9 MOTION PASSED

10
11 **EXECUTIVE OFFICER'S REPORT**

12 *(Nunez)*

13
14
15 Ms. Nunez discussed the following:

16
17 **a. BreEZe On-Line Application/License System:**

18 The tentative rollout date for the BreEZe system (which will replace the Board's current applicant,
19 licensing and enforcement tracking systems) is scheduled for July 2013.

20
21 **b. Ethics Course Revisions by CSRC/AARC**

22 Letters were mailed to the American Association for Respiratory Care (AARC) and California Society
23 for Respiratory Care (CSRC) on February 7, 2013, regarding revisions to the ethics course. Ms.
24 Nunez indicated that the AARC and CSRC were requested to provide initial submissions of the
25 revised courses by July 1, 2013 at which point, the Board's Professional Qualifications Committee,
26 Charles Spearman and Mark Goldstein, will have 30 days to review and provide feedback. Each
27 ethics course should be in its final format for full Board approval at the next board meeting (November
28 15) to ensure implementation on January 1, 2014.

29
30 **c. Strategic Planning**

31 Board staff will be working on fine tuning the draft Strategic Plan over the summer, and will present a
32 final draft to the Board for further discussion and/or approval at the November meeting.

33
34
35 **FISCAL REVIEW/CONSIDERATION TO REDUCE RENEWAL FEE**

36 *(Nunez)*

37
38 Ms. Nunez recommended the Board continue to watch the fund condition with no refund of monies at
39 this time. She stated projected expenses have increased slightly, resulting in decreased funds and
40 explained that should the Board receive approval to hire additional staff, existing funds would be
41 needed to support these positions.

42
43 Mr. Olson moved that the Board not pursue a refund at this time, but closely watch revenues,
44 expenditures, and the fund condition at future Board meetings.

45
46 All were in favor. No one opposed.

47 M/Olson /S/Roth

48 In favor: Early, Franzoia, Goldstein, Olson, Roth, Spearman

49 MOTION PASSED

1 **ENFORCEMENT STATISTICS**

2
3 Mr. Olson reviewed the enforcement statistics through March 31, 2013. Mr. Olson also requested
4 staff to present a cost proposal to identify the highest level of exam passage/license qualification
5 method (i.e., grandfather/CRT/RRT) for respondents in all final disciplinary matters.
6

7
8 **REGISTERED RESPIRATORY THERAPIST EXAMINATION/CREDENTIAL AS MINIMUM**
9 **STANDARD FOR LICENSURE: TRANSITION PLANNING**

10 Board members discussed the Registered Respiratory Therapist (RRT) examination as the minimum
11 standard for licensure. Discussion ensued concerning the proposed transition plan including
12 information and data to assist the Board in determining a date to transition from the CRT examination
13 to the RRT examination.
14

15
16 Vice President Goldstein moved to accept the proposed transition plan, to recognize the RRT as the
17 minimum standard for licensure and move forward with a January 1, 2015 date for implementation.
18

19 M/Goldstein /S/Roth

20 In favor: Early, Franzoia, Goldstein, Roth, Spearman

21 Opposed: Olson

22 MOTION PASSED
23

24
25 **PULMONARY FUNCTION TESTING**
26 (Nunez)
27

28 Ms. Nunez stated that the proposed amendment exempted specified pulmonary function testing
29 personnel employed by the Los Angeles Department of Health Services was included as part of the
30 Legislative Report (SB 305).
31

32 Ms. Nunez advised the Board that the issue of unlicensed practice related to pulmonary function
33 testing has continued to be an ongoing issue. Public comment was received regarding concerns
34 related to unlicensed practice in this area of respiratory care. The Board discussed the ramifications,
35 including the potential for patient harm, if pulmonary function testing is performed inadequately.
36

37 Mr. Olson moved to begin enforcing violations of unlicensed practice of respiratory care as it relates to
38 pulmonary function testing with a period of education and public notice.
39

40 All were in favor. No one opposed.

41 M/Olson /S/Goldstein

42 In favor: Early, Franzoia, Goldstein, Olson, Roth, Spearman

43 MOTION PASSED
44

45 Staff will ask Secretary Caballero to assist the Board and will work with the Medical Board of
46 California to assist in providing notification and repealing the regulation regarding plethysmography.
47
48

49 **2012-2013 SUNSET REVIEW HEARINGS AND FOLLOW UP**
50 (Goldstein)
51

52 Vice President Goldstein provided an overview of the Sunset Review hearings.
53

1 Ms. Nunez reviewed the Committee's recommendations and thanked Larry Renner for his assistance
2 during the hearings.

3
4 Ms. Nunez highlighted SB 1441 and the Substance Abuse Coordination Committee (SACC) charged
5 with developing uniform standards for healing arts boards to use in addressing substance-abusing
6 licensees placed in diversion or on probation. Staff recommended the Board update the Committee
7 on the implementation of the "Uniform Substance Abuse Standards" and questioned whether more
8 frequent testing is an appropriate mechanism for monitoring probationers who abuse substances. As
9 well as, whether it believes the Uniform Standards are providing the intended consumer protections
10 (for example: is increased testing resulting in desired outcomes).

11 Discussion ensued.

12
13
14
15 **LEGISLATIVE REPORT**
16 (Molina)

17
18 Ms. Molina reviewed the 2013 Legislation of Interest:

19

20	AB 186:	Watch	Professions and vocations: military spouses; temporary licenses
21	AB 258:	Watch	State agencies: veterans
22	AB 291:	Watch	California Sunset Review Commission
23	AB 512:	Watch	Healing arts: licensure exemption
24	AB 809:	Watch	Healing arts: telehealth
25	AB 1013:	Watch	Consumer affairs
26	AB 1057:	Watch	Professions and vocations: licenses: military service
27	SB 305:	Support	Healing arts: boards. (RCB Sunset Extension Bill)
28	AB 690:	Watch	Licenses

29

30 Ms. Franzoia moved to accept staff recommendations to support SB 305 and to "watch" all the other
31 bills.

32
33 All were in favor. No one opposed.
34 M/Franzoia /S/Olson
35 In favor: Early, Franzoia, Goldstein, Olson, Roth, Spearman
36 MOTION PASSED

37
38 The Board approved staff to continue to pursue legislative proposals contained in the Sunset
39 Recommendations in the event opportunities arise between Board meetings. Any other proposals will
40 be vetted through the Executive Committee and reported to the full Board at subsequent meetings,
41 pursuant to the Board's policy.

42
43
44 **BOARD COMMITTEE ASSIGNMENTS**

45
46 Changes to Board committee assignments were made as follows:

47
48 Enforcement Committee
49 Chair: Murray Olson. RCP, RRT-NPS, RPFT
50 Member: Mary Ellen
51

1 Outreach Committee:

2 Chair: Mark Goldstein, BS, RRT, RCP

3 Member: Murray Olson. RCP, RRT-NPS, RPFT

4
5 Ms. Franzoia offered to provide assistance to any of the committees as needed.

6
7
8 **PUBLIC COMMENT ON ITEMS NOT ON THE AGENDA**

9
10 No public comment was provided at this time.

11
12 =====
13 **CLOSED SESSION**

14
15 The Board convened into Closed Session, as authorized by Government Code Section 11126c,
16 subdivision (3) at 12:30 p.m. and reconvened into Public Session at 1:25 p.m.

17 =====
18
19
20 **FUTURE AGENDA ITEMS**

21
22 No future items were identified.

23
24
25 **ADJOURNMENT**

26
27 The Public Session Meeting was adjourned by President Spearman at 1:30 p.m.

28
29
30
31
32
33
34
35 _____
36 CHARLES B. SPEARMAN
President

35 _____
36 STEPHANIE A. NUNEZ
Executive Officer

MISSION STATEMENT

EXISTING MISSION STATEMENT

The Respiratory Care 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.

OPTION 1 (DECIDED AT MEETING)

To protect and serve California consumers by licensing and enforcing individuals in accordance with the Respiratory Care Practice Act, and expanding the availability of respiratory care services by increasing public awareness of the profession, and supporting the development and education of Respiratory Care Practitioners.

OPTION A

To protect and serve consumers by licensing individuals in accordance with, and enforcing the provisions of, the Respiratory Care Practice Act, expanding the awareness of respiratory care services, and supporting the development and education of licensed Respiratory Care Practitioners.

OPTION B

To protect and serve California consumers by licensing qualified respiratory care practitioners, enforcing the provisions of the Respiratory Care Practice Act, and expanding the availability of respiratory care services.

OPTION C

To protect and serve California consumers by licensing qualified respiratory care practitioners, enforcing the provisions of the Respiratory Care Practice Act, and expanding the availability of respiratory care services through the support and advocacy of public awareness of the profession, and the development and education of respiratory care practitioners.

OPTION C w/Amendments

To protect and serve California consumers by licensing qualified respiratory care practitioners, enforcing the provisions of the Respiratory Care Practice Act, and expanding the availability of respiratory care services, increasing public awareness of the profession ~~through the support and advocacy of public awareness of the profession,~~ and supporting the development and education of respiratory care practitioners.



Strategic Plan

2013-2016

**Respiratory Care
Board of California**

MEMBERS OF THE RESPIRATORY CARE BOARD OF CALIFORNIA

CHARLES B. SPEARMAN, MSED, RCP, RRT, PRESIDENT

MARK D. GOLDSTEIN, BS, RRT, RCP, VICE PRESIDENT

MARY ELLEN EARLY, MEMBER

REBECCA F. FRANZOIA, MEMBER

MICHAEL HARDEMAN, MEMBER

RONALD H. LEWIS, MD, MEMBER

MURRY L. OLSON, RCP, RRT-NPS, RPFT, MEMBER

LAURA C. ROMERO, PHD, MEMBER

ALAN ROTH, MS, MBA, RRT-NPS, FAARC, MEMBER

STEPHANIE NUNEZ, EXECUTIVE OFFICER

TABLE OF CONTENTS

ABOUT THE RESPIRTORY CARE BOARD OF CALIFORNIA..... 1

RECENT ACCOMPLISHMENTS 2

MISSION, VISION AND VALUES 5

GOALS AND OBJECTIVES..... 6

DRAFT

ABOUT THE RESPIRATORY CARE BOARD OF CALIFORNIA

The Respiratory Care Board of California (RCB) licenses and regulates Respiratory Care Practitioners (RCPs) who perform critical lifesaving and life support procedures prescribed by physicians, which directly affect the body's major organs. Working with patients of all ages in different care settings, RCPs treat people who suffer from chronic lung problems, cystic fibrosis, lung cancer, AIDS, as well as heart attack and accident victims and premature infants.

The mandate of the RCB 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. To accomplish this, the RCB must ensure that applicants meet education and examination requirements in addition to passing a criminal history background check, prior to receiving an RCP license. The Board assures the continued qualification of its licensees through license renewal, continuing education, investigation of complaints, and discipline of those found in violation. The Respiratory Care Practice Act (RCPA) is comprised of the Business and Professions Code Section 3700, et. seq. and the California Code of Regulations, Title 16, Division 13.6, Article 1, et. seq.

The enabling statute to license RCPs was signed into law over 30 years ago in 1982. The Board is comprised of a total of nine members, including four public members, four RCP members, and one physician and surgeon member. Each appointing authority - the Governor, the Senate Rules Committee, and the Speaker of the Assembly- appoints three members. The Board appoints the Executive Officer who oversees a staff of 18 permanent positions and 2 temporary positions. This current framework provides a balanced representation needed to accomplish the Board's mandate to protect the public from the unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care.

The Board continually strives to enforce its mandate and mission in the most efficient manner, through exploring new and/or revised policies, programs, and processes. The Board also pursues increasing the quality or availability of services, as well as regularly providing courteous and competent service to its stakeholders.

RECENT ACCOMPLISHMENTS

As a part of the strategic planning process, Board members evaluated the goals set forth in its previous strategic plan, and identified the objectives that were accomplished. The following are the significant Board accomplishments since the last strategic plan was adopted in 2008:

- Commenced publishing and annually updating Respiratory Care Practitioner examination pass rates for all California educational programs on website.
- Developed practice issues in emergency situations and included recommendations for improved procedures, including training for the LTV 1200 machine.
- Informed RCPs about proper protocol for concurrent therapy through the RCB Newsletter and website.
- Used the 25-year RCB anniversary as a springboard to conduct a public outreach media campaign with the California Society for Respiratory Care.
- Revised Disciplinary Guidelines including terms and conditions of probation for use by Administrative Law Judges and Board Members to determine consistent and appropriate discipline against RCPs who have violated the RCPA.
- Delegated authority to the Executive Officer to prepare and file proposed default decisions, and to adopt stipulated settlements where an action to revoke the license has been filed and the respondent agrees to surrender his or her license. The Executive Officer's authority to sign maximizes consumer protection by expediting enforcement.
- Improved consumer protection by increasing the frequency of testing for licensees on probation for substance abuse/use issues.
- Began acceptance of alternative payment methods (i.e., credit cards) for license fees and reduced application processing times for license renewals.

- Promulgated regulations to:
 - Incorporate the newly developed Uniform Standards regarding substance abusing healing arts licensees, consistent with the requirements of Senate Bill 1441, Ridley-Thomas (Chapter 548, Statutes of 2008).
 - Authorize the issuance of a notice to cease practice to any licensee placed on probation who has committed a “Major Violation” as identified in the Board’s Disciplinary Guidelines.
 - Further recognize military education and experience as part of education waiver criteria.
 - Streamline the citation and fine process.
 - Clarify and add criteria substantially related to the practice of respiratory care.
- Maintained Board Member quorum at all Board meetings since 2007.
- Increased outreach by fostering relationships with professional societies and associations, and through the distribution of the RCB newsletters.
- Created a process to query out-of-state applicants with the National Practitioner Data Bank to ensure that the applicant has not been disciplined in another state before applying for licensure in California.
- Developed a record retention policy to ensure cost effective and efficient record keeping practices, while preserving historical information.
- In accordance with SB 1441 (Ridley-Thomas, Chapter 548, Statutes of 2008), the Board adopted a policy concerning drug testing frequency (including increased testing to 52-104 times per year) for persons whose licenses have been placed on probation.

- Participated in “Transitioning the Respiratory Therapist Workforce for 2015 and Beyond,” a professional planning conference hosted by the American Association for Respiratory Care.
- Validated the disciplinary cycle by implementing and reviewing process changes consistent with the Department’s Consumer Protection Enforcement Initiative (CPEI) spearheaded by the RCB, thereby reducing disciplinary case processing times within 12 to 18 months.
- Launched the “Inspire” campaign to bring awareness to the profession as a meaningful and smart career choice. The Board also launched its “Inspire” Facebook page and a dedicated website. (www.2BeARespiratoryTherapist.ca.gov).
- Initiated the momentum resulting in Senate Bill 132 (Denham, Chapter 635, Statutes of 2009) which established certification for polysomnographic technologists under the Medical Board of California. [Previous legislative attempts in 2008: SB 1125 (Denham) and SB 1526 (Perata)].
- Senate Bill 819 (Committee on Business, Professions and Economic Development, Chapter 308, Statutes of 2009) clarifies existing law authorizing the Board to recoup costs for disciplinary matters and added the Respiratory Care Practitioner to a list of other health care providers who are not held liable for any injury sustained in a state of an emergency.
- Continued to place priority on customer service to RCB stakeholders by rejecting the use of automated voice response systems.
- Reengineered internal processes and eliminated the initial licensing fee to improve initial application processing times.

OUR MISSION

[TO BE FINALIZED AT 11/15/13 BOARD MEETING]

OUR VISION

All California consumers are aware of the Respiratory Care profession and its licensing Board, and receive competent and qualified respiratory care.

OUR VALUES

Ethical – Possession of the morals and values to make decisions with integrity that are consistent with the Board’s mandate and mission.

Diversity – Recognize the rights of all individuals to mutual respect and acceptance of others without biases based on differences of any kind.

Dignity – Conduct business honorably without compromise to the Board or individual values.

Quality – Strive for superior service and products and meaningful actions in serving stakeholders.

Flexibility – Provide sincere considerations of other interests, factors, and conditions and be willing and/or able to modify previous positions for the betterment of the Board and its mandate and mission.

Teamwork – Strive to work cooperatively and in a positive manner to reach common goals and objectives.

Efficiency – Continually improve our system of service delivery through innovation, effective communications, and development, while mindful of the time, costs, and expectations stakeholders have invested.

GOAL 1: ENFORCEMENT

Protect consumers by preventing violations and effectively enforcing laws and regulations when violations occur.

1.1 Pursue legislation to allow the release of criminal records without authorization for individuals seeking licensure with the Board. (Essential)

1.2 Partner with other healing arts boards to pursue legislation that will allow for the immediate suspension of a license for an egregious act. (Essential)

1.3 Establish a maximum time period to post on the internet, citations, fines and disciplinary matters. (Essential)

1.4 Reengineer the Board's enforcement processes for formal disciplinary actions by securing authority to draft routine accusations, statements of issue, and possibly stipulated agreements. (Important)

1.5 Further define the process for addressing practice-related violations using the Board's authority to issue reprimands. (Important)

*The Board established three levels of priorities for objectives within a goal category that include:
Essential (E) *Necessary to support our most critical functions or ensure our compliance with law and/or regulation*
Important (I) *Increase the functionality of our business processes and greatly enhance our effectiveness*
Beneficial (B) *Implementation would be beneficial to our organization but not critical to our success*
During the course of the facilitation consensus was reached on the priority level with the status annotated.

GOAL 2: PRACTICE STANDARDS

Establish regulatory standards for respiratory care practice in California and ensure the professional qualifications of all Respiratory Care Practitioners (RCPs).

2.1 Transition from using the Certified Respiratory Technician (CRT) exam to the Registered Respiratory Technician (RRT) exam as the minimum standard.

(Essential)

2.2 Strengthen law and regulations governing student and/or applicant clinical supervision requirements. (Essential)

2.3 Identify exemption level, if any, for Pulmonary Function Therapists (including persons holding the Certified Pulmonary Function Therapist/Registered Pulmonary Function Therapist credential and medical assistants). (Important)

2.4 Define limits of RCP's responsibility on home delivery of equipment and patient care. (Important)

2.5 Evaluate the effectiveness and impact of the Professional Ethics and Law courses to determine whether or not the courses should be mandated.

(Important)

2.6 Consider whether or not continuing education hour requirements are sufficient to ensure clinical and technical relevance. (Important)

2.7 Explore the feasibility of modifying the minimum entry educational requirements from an AA to BS degree. (Important)

2.8 Pursue legislative or regulatory amendment to require respiratory care instructors, program directors and clinical instructors to have a valid and current RCP license or required credential. (Beneficial)

2.9 Pursue legislative or regulatory amendments to gain or clarify authorization that would allow RCPs who meet certain requirements to write orders including medications under protocol. (Beneficial)

2.10 Clarify in regulation that “associated aspects of cardiopulmonary” as used in B&P, section 3702, includes cardiac diseases and cardiac rehabilitation. (Beneficial)

2.11 Pursue legislative or regulatory amendment to authorize RCPs to test, manage and educate (not treat or diagnose) diabetic patients. (*Currently rely on “overlapping functions” in section 3701*) (Beneficial)

2.12 Update Continuing Education regulations including recognition of NBRC specialty exams, Adult Critical Care, Sleep Disorders Testing, and recognition of training and education on the characteristics and method of assessment and treatment of acquired immune deficiency syndrome (AIDS) as acceptable continuing education (pursuant to B&P 32-amended 2011). (Beneficial)

DRAFT

GOAL 3: OUTREACH

Increase public and professional awareness of the RCB's mission, activities and services as well as enhance communication with stakeholders.

3.1 Keep applicants and licensees informed about the changes and new functionality that will be offered by the new BreZE system (*e.g., Contact program directors and request assistance in educating applicants; promote the e-blast sign up and provide updates; capture in newsletters*). (Important)

3.2 Establish a routine email outreach program to inform and educate the RCP community on current RCB updates, trends and news items related to respiratory care in place of the RCB's biannual/annual newsletter. (Beneficial)

DRAFT

GOAL 4: ORGANIZATIONAL EFFECTIVENESS

Enhance organizational effectiveness and improve processes and the quality of customer service in all programs.

4.1. Review and update the RCB website to ensure information is current, timely and accurate, and ensure website is accessible and easy to use. (Essential)

4.2 Pursue budget change proposals to secure additional staffing to meet strategic objectives. (Important)

4.3 Create and carry out a transition plan for the BreZE license tracking system including providing public access to on-line licensing and renewals, updating application materials, and modifying internal business processes to assist the DCA in ensuring a smooth transition to the new system. (Important)

4.4 Further clarify Active Military Exemptions pursuant to AB 1904 and AB 1588 (*statutes of 2012*).

4.5 Establish out-of-state practitioner exemption from licensure for sponsored event. (*Establish minimum education, training and other requirements via regulation for practitioners licensed in good standing, in another state to provide respiratory care services through a sponsored event.*) (Reference B&P sections 900 and 901; AB 2699, *Statutes of 2010*). (Beneficial)

4.6 Amend regulations to clarify authority to request driving history records for licensed RCPs and individuals applying for licensure. (Beneficial)

4.7 Complete Record Retention Project as outlined in the Board's policy adopted February 2011. (Beneficial)

4.8 Complete Department of Justice Project: By destroying remaining records and notifying the Department of Justice of "No Longer Interested" in rap sheets, as required by law (secure temporary help to address this project). (Beneficial)

California Department of Consumer Affairs
1625 North Market Boulevard, Suite S-308 , Sacramento, CA 95834
P (916) 574-8200 F (916) 574-8613 | <http://www.dca.ca.gov/>

Memorandum of Understanding

Bureau for Private Postsecondary Education Respiratory Care Board of California (RCB)

Within the California Department of Consumer Affairs (DCA), the Bureau for Private Postsecondary Education (BPPE) and the Respiratory Care Board of California (RCB) enter into this Memorandum of Understanding (MOU) to provide mutual cooperation in the review and approval of respiratory care education program providers.

Premises

1. The highest priority of both BPPE and RCB is to protect the public in accordance with CEC §94875 and Business and Professions Code §3710.1, respectively.
2. State statutes and regulations require that, unless exempt, private postsecondary education institutions must be approved by the BPPE. RCB requires that applicants for licensure under their jurisdiction complete an education program for respiratory care that is accredited by the Commission on Accreditation for Respiratory Care and hold an earned associate degree from an institution that is regionally accredited or accredited by an association recognized by the United States Department of Education.
3. Where there is reason to believe that unlawful activity exists, BPPE and RCB will use resources to ensure minimum educational operating standards are met and quality services are provided to the general public.
4. RCB has no obligation or authority to enforce any provisions of Chapter 8 of Part 59 of Division 10 of the California Education Code (CEC) or Division 7.5 of Title 5 of the California Code of Regulations.
5. BPPE has no obligation or authority to enforce any provisions of Chapter 8.3, Division 2 of the Business & Professions Code or Division 13.6 of Title 16 of the California Code of Regulations.

Agreement

RCB agrees:

1. To not accept a degree from an institution that is not approved by the BPPE unless that institution is otherwise exempt.
2. To promptly inform the BPPE Licensing and Enforcement Units of any institution found to be operating without a valid approval to operate from the BPPE.
3. To provide the BPPE Enforcement Unit with relevant information regarding complaint investigations performed by the RCB on private postsecondary educational institutions.
4. To provide the BPPE Enforcement Unit, upon request, the lists of licensees and/or licensing applicants identified by RCB as attending an institution that is under inspection or investigation by BPPE, as data is available.

BPPE Agrees:

1. That the BPPE has the authority and responsibility to approve a non-exempt private postsecondary educational institution's education programs, including an institution's degree, diploma and certificate programs.
2. To not accept any private postsecondary education institution's respiratory care degree program or any new institution offering such a program prior to the institution documenting that the program is accredited by the Commission on Accreditation for Respiratory Care and accredited by an accrediting associate that is recognized by the United States Department of Education. The BPPE Licensing Unit may issue an institution a letter of intent to approve pending accreditation of the program. The BPPE Licensing Unit will notify RCB of the issuance of a letter of intent to approve any respiratory care degree program.
3. The BPPE Enforcement Unit will advise RCB in any instance where BPPE is aware of a non-accredited respiratory care degree program being offered.
4. That the BPPE Licensing Unit and/or Enforcement Unit will provide RCB with information when BPPE has taken final action to deny or rescind an approval to operate of an institution offering respiratory care degree programs.

RCB and BPPE Jointly Agree:

1. To conduct mutual on-site compliance inspections or investigations when deemed necessary by both parties, within the limits of each jurisdiction and available staffing.
2. To the degree feasible, to share information on complaints and coordinate confidential investigations related to private postsecondary educational institutions that offer respiratory care degree education programs. BPPE and RCB agree to ensure the confidentiality of any information shared. In the event of a request by an agency or person for information obtained from the other party, unless otherwise required by law, BPPE and RCB agree to rely on the other party's characterization about the privileged or confidential nature of the information.
3. To work together within jurisdictional limits, in a spirit of cooperation, to ensure approved institutions provide the promised and required quality of education and student protection.
4. To implement and follow the agreements listed in this Memorandum of Understanding which will become effective on the date on which both parties have signed the agreement.
5. This agreement may be amended by the mutual written consent of the parties.
6. This agreement will remain in effect unless terminated by BPPE, RCB, the Department of Consumer Affairs, or an act of law.

Laura Metune, Bureau Chief
Bureau for Private Postsecondary Education

Stephanie Nunez, Executive Officer
Respiratory Care Board of California

Date

Date

Professional Qualifications Committee Report

Mark Goldstein, Chair
Charles B. Spearman, Vice Chair

7a. Coalition for Baccalaureate and Graduate Respiratory Therapy Education

www.cobgrte.org

Round Table Discussion

Saturday, November 16

6:30 pm

7b. California Community Colleges, Baccalaureate Degree Study Group

<http://extranet.cccco.edu/Divisions/AcademicAffairs.aspx>

OR

<http://extranet.cccco.edu/Divisions/AcademicAffairs/BaccalaureateDegreeStudyGroup.aspx>

Next meeting: Friday, November 22

More information location/webcast availability will be provided online as the meeting nears.

REVENUE

Revenue Category	2011/12 Actual	2012/13 Actual	2013/14 Projected
Application (CA)	\$284,900		
Application (Foreign)	\$0	\$497,005	\$510,000
Application (O-O-S)	\$33,800		
Initial License	\$115,068	n/a	n/a
Renewal	\$2,095,565	\$2,079,053	\$2,185,000
Delinquent Fees	\$43,930	\$45,540	\$47,380
Endorsement	\$24,470	\$11,145	\$11,250
Duplicate License	\$2,075	\$2,375	\$2,625
Cite and Fine	\$28,646	\$24,702	\$25,000
Miscellaneous	\$30,360	\$28,615	\$22,740
Total Revenue	\$2,658,814	\$2,688,435	\$2,803,995

Projected Workload 2013/14	Current Fees 2013/14
1,700	\$300
n/a	n/a
9,500	\$230
170 / 18	\$230 / \$460
450	\$25
105	\$25
var	var
var	var

EXPENDITURES

Expenditure Items	2011/12 Actual	2012/13 Actual	2013/14 Projected
Salary & Benefits	\$1,281,348	\$1,318,199	\$1,422,520
Training	\$1,038	\$240	\$2,000
Travel	\$25,631	\$19,063	\$20,000
Printing	\$11,974	\$39,012	\$40,000
Postage	\$31,124	\$33,525	\$40,000
Equipment	\$86,103	\$19,212	\$10,000
ProRata ¹	\$438,489	\$459,814	\$535,588
Fingerprints	\$5,707	\$5,978	\$5,000
All Other Fixed Expenses ²	\$230,629	\$291,540	\$240,500
Investigations	\$31,803	\$43,469	\$0
Attorney General	\$384,651	\$351,293	\$450,000
Office of Admin Hearings	\$105,342	\$76,306	\$100,000
Court Reporter Services	\$11,577	\$3,689	\$7,500
Evidence and Witness	\$34,756	\$30,274	\$30,000
Total Expenditures	\$2,680,172	\$2,691,614	\$2,903,108

Actual Exp. thru 09/30/13	Budgeted 2013/14
\$339,940	\$1,390,185
\$0	\$11,227
\$970	\$41,805
\$1,144	\$26,515
\$10,818	\$39,952
\$0	\$0
\$133,819	\$535,588
\$1,078	\$55,000
\$44,225	\$537,382
\$0	\$0
\$132,850	\$462,214
\$0	\$137,082
\$0	\$0
\$750	\$32,050
\$665,594	\$3,269,000

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

	2012/13*	2013/14	2014/15	2015/16
Beginning Reserve, July 1	\$2,401,036	\$2,597,136	\$2,716,009	2,903,928
Prior Year Adjustments	\$10,755			
Revenues	\$2,688,435	\$2,803,995	\$2,959,540	2,959,540
Interest		\$12,986	\$13,580	14,520
TOTAL RESOURCES	\$5,100,226	\$5,414,117	\$5,689,129	5,877,987
Budget Expenditure	\$2,691,614	\$2,903,108	\$2,990,201	2,990,201
Disbursements ¹	\$17,640			
Reimbursements	(\$206,164)	(\$205,000)	(\$205,000)	(\$205,000)
TOTAL EXPENDITURES	\$2,503,090	\$2,698,108	\$2,785,201	2,785,201
RESERVE, JUNE 30	\$2,597,136	\$2,716,009	\$2,903,928	\$3,092,786

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

¹Represents State Controller Operations and Financial Information System for California disbursements

ENFORCEMENT STATISTICS

Agenda Item: 9
Meeting Date: 11/15/13

Data through June 30, 2013

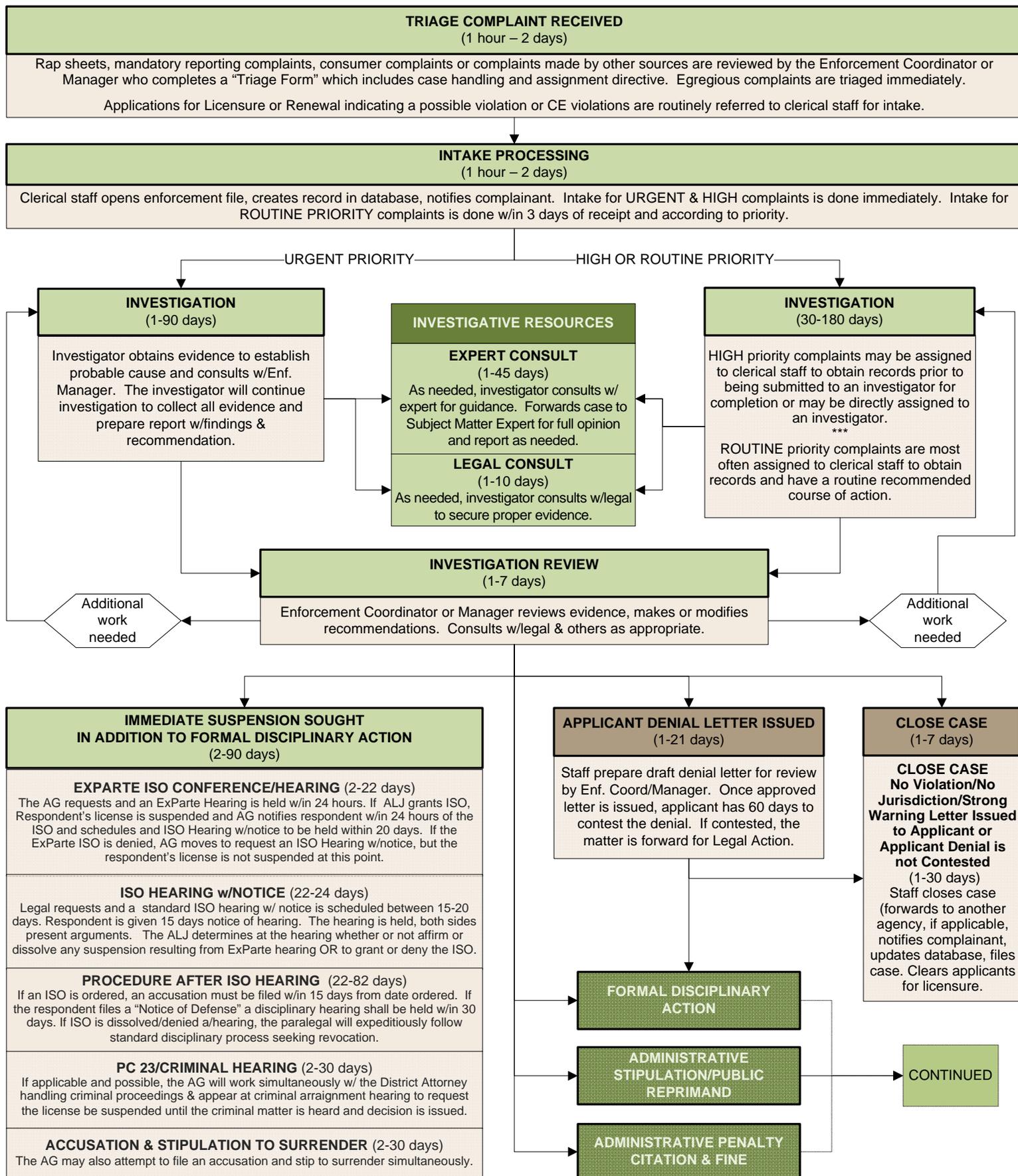
Applicant Licensed Unlicensed	CASELOAD	FY 03/04	FY 04/05	FY 05/06	FY 06/07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13
A	Applications Received	713	853	1003	1283	1359	1360	1443	1357	1593	1655
L	Total Licensed	23,674	24,408	25,246	26,338	27,545	28,847	30,120	31,511	32,825	34,499
A L U	Enforcement Budget	\$436,421	\$494,771	\$514,365	\$557,312	\$584,409	\$579,161	\$640,576	\$661,077	\$664,403	\$675,023
L	Licenses Active	15,367	15,503	15,835	16,511	17,202	18,077	18,803	19,658	20,390	21,473
A	Applicants Investigated (RCB Staff)	113	141	205	238	269	270	311	260	254	272
A	Applicants Denied/Initial	19	11	23	19	31	46	35	21	12	26
L U	Complaints Received	521	515	495	476	472	493	583	575	621	590
A L U	Cases to Investigation (sworn investigators)	0	4	3	9	5	11	3	6	1	6
L U	Citations Issued	68	99	57	71	63	102	75	96	69	68
A L	Cases to the DAG	125	46	56	71	64	99	69	80	69	83
L	Prob. Cases to AG for Revocation	15	13	13	10	9	17	23	9	10	13
A L U	Cases to the DA	1	0	1	0	1	0	0	1	0	0
L	Accusations Filed	102	60	34	51	51	46	42	58	51	60
A	Statement of Issues Filed	17	9	15	21	22	40	29	20	13	16
L	Petitions to Revoke Probation Filed	12	11	18	8	9	11	21	9	10	15
A L	Stipulated Settlements	85	71	34	46	59	61	57	50	47	47
A L	Disciplinary Hearings Completed/Final Decisions	19	11	13	7	14	9	20	17	16	21
L	Revocations/Surrenders	36	31	27	24	29	30	45	32	39	39
A	Applications Denied (Final Decision)	2	0	3	2	3	1	6	5	4	1
A L	Public Reprimands	50	20	5	6	9	6	4	10	4	3
A L	Probationers (New)	38	53	27	32	40	48	39	29	36	34
L	Probationers (Active)	81	100	80	77	84	108	92	84	86	84
L U	Fines Imposed	\$51,600	\$61,050	\$33,600	\$33,413	\$32,450	\$60,950	\$123,975	\$51,450	\$25,950	\$24,800
L U	Fines Reduced, Withdrawn, Dismissed	\$1,550	\$1,350	\$900	\$900	\$1,225	\$2,715	\$400	\$3,500	\$75,325	\$250
L U	Fines Collected	\$23,386	\$41,942	\$37,941	\$31,919	\$31,061	\$30,121	\$41,863	\$41,378	\$28,646	\$24,702
A L	Cost Recovery Requested	\$213,720	\$233,873	\$198,758	\$183,032	\$208,563	\$198,892	\$263,848	\$267,310	\$328,341	\$313,422
A L	Cost Recovery Awarded	\$195,354	\$223,996	\$173,771	\$174,142	\$168,976	\$184,082	\$214,040	\$245,009	\$259,648	\$250,655
A L	Cost Recovery Collected	\$130,994	\$130,378	\$142,061	\$120,820	\$96,454	\$55,820	\$81,483	\$84,285	\$92,673	\$98,285
L	Probation Monitoring Costs Collected	\$83,447	\$100,746	\$102,596	\$81,613	\$79,748	\$85,176	\$90,316	\$87,604	\$89,714	\$79,708
A L U	Franchise Tax Board Collected	\$16,064	\$13,676	\$20,288	\$13,542	\$17,697	\$10,440	\$8,796	\$8,826	\$29,755	\$21,684
A L U	Collection Agency Collected *	\$17,402	\$32,285	\$56,826	\$19,414	\$22,568	\$2,292	\$1,100	\$11,216	\$5,584	\$12,752

* Amount recovered by the Board's collection agency. This amount is also reflected in Fines, Cost Recovery, or Probation Monitoring Costs Collected depending on the account in which the money was ordered.

Respiratory Care Board of California
DISCIPLINARY PROCESS MODEL

(Revised 1/1/13)

Agenda Item: 10
Meeting Date: 11/15/13



FORMAL DISCIPLINARY ACTION

**ADMINISTRATIVE STIPULATION
IN-HOUSE PUBLIC REPRIMAND**

**ADMINISTRATIVE PENALTY
CITATION AND FINE**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FORMAL HEARING PHASE

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

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

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

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

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

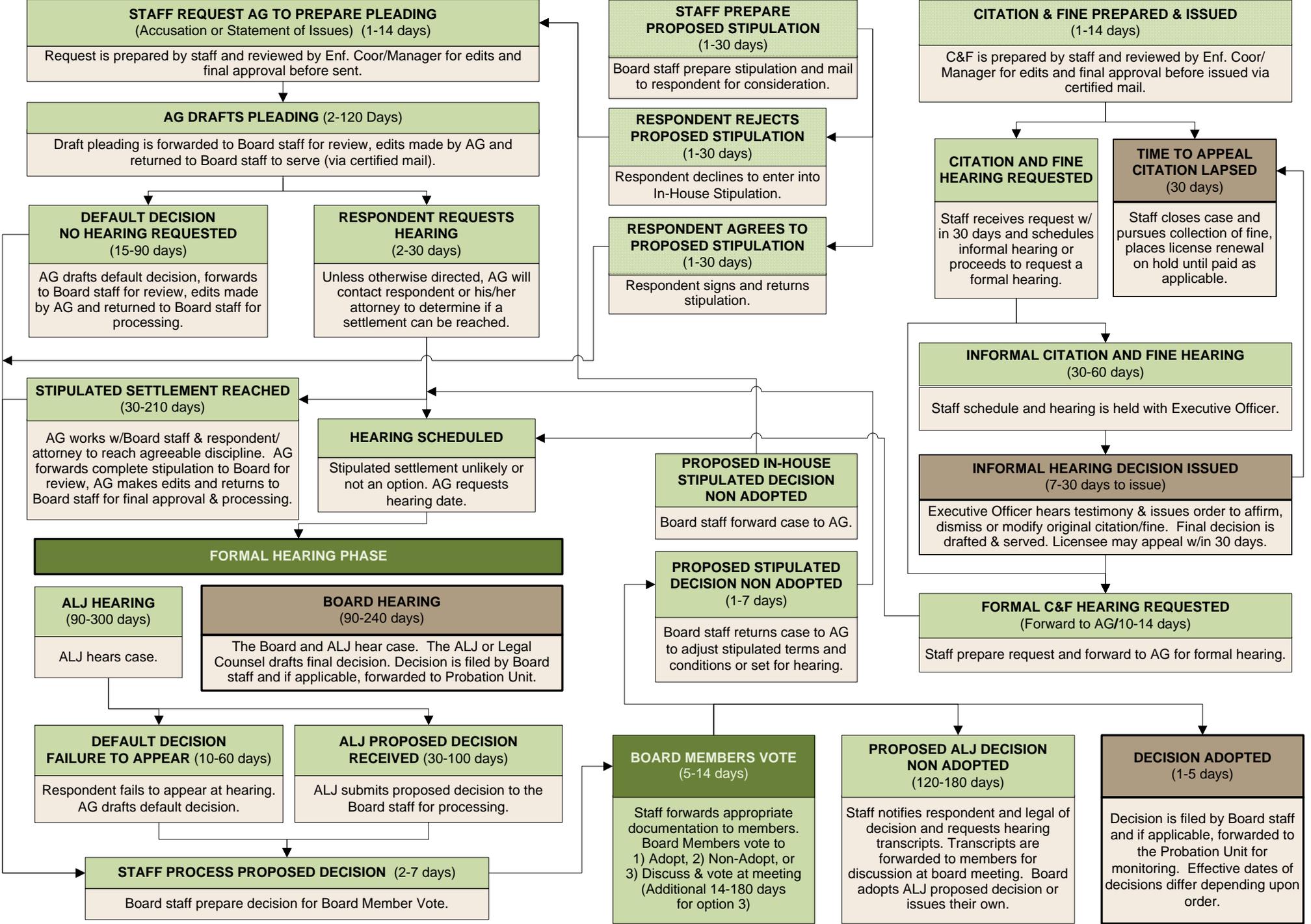
ALJ PROPOSED DECISION RECEIVED (30-100 days)
ALJ submits proposed decision to the Board staff for processing.

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

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

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

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



MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 7, 2013
ATTENTION: Board Members
SUBJECT: Medical Assistants Performing Basic
Pulmonary Function Testing
FROM: Kerrie Webb, Staff Counsel

REQUESTED ACTION:

Staff Counsel recommends the Medical Board of California (Board) approve Option 1 as a way to obtain a definitive answer from the Attorney General's Office (AG). This would be a joint effort between the Respiratory Care Board (RCB) and the Board, so that the AG may make a well-informed decision that the respective parties will stand behind and respect.

ISSUE:

Are medical assistants legally permitted to perform basic pulmonary function testing, such as spirometry? The RCB has taken a position that they are not allowed to perform such basic screening tests. Staff at the Board, in consultation with a medical consultant, disagree.

BACKGROUND:

On June 28, 2013, Stephanie Nunez, Executive Officer for the RCB, wrote a letter to Ms. Kirchmeyer to inform the Board that the RCB has instructed its staff to begin educating the health care community that medical assistants are not allowed to perform spirometry and other basic pulmonary function tests. The Board was informed that this educational push was being instituted as a precursor to citation and fine of medical assistants performing these tests. As part of this educational effort, Ms. Nunez asked the Board to post a Frequently Asked Question and Answer on its Web site stating the following:

Question: Are medical assistants allowed to conduct any level of pulmonary function testing, including, but not limited to, the most basic and limited type of testing, such as spirometry, peak flows, and lung volumes?

Response: No. Pulmonary function testing is a component of the respiratory care practitioner scope of practice. The Respiratory Care Practice Act (Business and Professions Code, Section 3700, et seq.) provides that only licensed respiratory care practitioners may perform pulmonary function testing with limited exemptions provided to other *licensed* personnel. In addition, all levels of pulmonary function testing

require assessment. Even the more basic and limited type of testing such as spirometry and peak flow are effort-dependent, as well as technically-dependent upon instruction and coaching patients for reliable results. Personnel performing these tests must assess whether the patient is providing the correct effort. Because pulmonary function testing requires assessment, and the Respiratory Care Practice Act prohibits this practice by unlicensed personnel, it must be performed by licensed and qualified personnel pursuant to the Respiratory Care Practice Act.

In response to the request, Board counsel, executive staff, and a medical consultant reviewed the matter. Based on this review, Board staff did not agree with the RCB's request for the reasons discussed below.

16 CCR 1366 RULEMAKING PROCESS

16 California Code of Regulations (CCR) section 1366 was adopted more than 20 years ago in response to thousands of inquiries from medical assistants, and the physicians who employed them, about what they are legally permitted to do. The Board noted that there were many simple tasks which were routinely performed in medical offices by medical assistants, but which were technically illegal. Throughout the rulemaking process, there was considerable controversy among other health professions about an appropriate scope of practice for medical assistants. In light of the controversy, it took several attempts over an approximate two-year period to adopt 16 CCR 1366.

Part of the rulemaking process included the recognition that many tasks are common to more than one health occupation. Such coincidental overlapping scopes of practice are accepted throughout the health care community. For example, the fact that a service may be performed by registered nurses does not automatically preclude its inclusion in the scope of practice for medical assistants.

Many comments were received and considered regarding scope of practice issues. Members of the Respiratory Care Examining Committee and RCB expressed opposition to the addition of the phrase "by inhalation" to a list of routes by which medical assistants may administer medications as part of additional supportive services. They argued that the inclusion of this phrase was in opposition to the Respiratory Care Practice Act (RCPA), section 3760, which states in part, "Except as otherwise provided in this chapter, no person shall engage in the practice of respiratory care, respiratory therapy or inhalation therapy..."

The Board did not agree that the administration of medications by inhalation constituted the practice of respiratory therapy any more than the administration of medications by injection constituted the practice of nursing. Moreover, since the law specifically allowed medical assistants to administer medications by the most potentially hazardous route – injections – it was not logical to prohibit administration by the less hazardous routes included in the regulation.

Members of the Respiratory Care Examining Committee and RCB also objected to the provision in 16 CCR 1366(b)(2) permitting medical assistants to perform plethysmography tests, stating that this could be interpreted to permit body plethysmography, which requires extensive training. The Board agreed to prohibit medical assistants from performing full body plethysmography, but found that other forms of plethysmography were reasonable tasks for medical assistants to perform.

Plethysmography is frequently used to measure extremities, but can also be used to measure lung volume without employing full body testing. This is further evidence of an overlapping scope of practice between respiratory care therapists and medical assistants specifically permitted by law.

With the adoption of 16 CCR 1366, the Board did not attempt, nor would it have been feasible, to identify every simple, non-hazardous task, and variations thereof, that a medical assistant could perform. Through the rulemaking process, the Board worked to strike a balance between those who objected to rigid regulations, and the need to establish parameters in setting forth and describing the technical services that can be safely performed by a medical assistant. The applicable statutes and regulations provide structure so that procedures that are more complicated and invasive than those specifically permitted should be performed by licensed practitioners, and those that are in the equivalent range may be performed by appropriately-trained and supervised medical assistants, provided all the other requirements are met.

APPLICATION

Considering the tasks that medical assistants are specifically allowed to perform pursuant to statute and regulations, including, but not limited to, electrocardiograms, electroencephalograms, plethysmography tests, applying orthopedic appliances, drawing blood, and giving injections, the Board's counsel, consultant, and staff find that trained medical assistants are capable of performing basic pulmonary function tests, such as screening spirometry.

The Board's medical consultant pointed out that while not all office-based practices have the capacity for performing these pulmonary function tests, many offices do. Thus, to require patients needing a peak flow or spirometry test to see a respiratory care therapist would place an undue burden on patients, and create an unnecessary hurdle to access to care.

In order for a medical assistant to be able to perform any technical supportive service under 16 CCR 1366, the service has to be a usual and customary part of the medical practice where the medical assistant is employed. Accordingly, it is conceivable that a medical assistant may not perform such testing in a dermatologist's office, but may routinely do so in a primary care physician's or a pulmonologist's office. This provides another layer of quality assurance, to ensure proper training, experience, and oversight.

CURRENT STATUS OF DISCUSSIONS

Following initial discussions, the RCB agreed that medical assistants are capable of performing peak flow tests, but the Board and RCB have not yet reached an agreement on other types of basic pulmonary function tests.

OPTIONS:

Board staff have identified options for the members to consider, including the following:

- 1) Seek a joint, formal legal opinion from the Attorney General's Office with the RCB.
- 2) In the alternative, if Board members agree with the RCB that medical assistants should not perform basic pulmonary function tests, the members can instruct Board staff to assist the RCB in educating physicians and medical assistants, such as by posting a FAQ on the topic on the Board's Web site.



RESPIRATORY CARE BOARD OF CALIFORNIA

June 26, 2013

Kimberly Kirchmeyer,
Interim Executive Director
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

RE: Pulmonary Function Testing/Medical Assistants

Dear Ms. Kirchmeyer,

In response to reports of unlicensed personnel (e.g. medical assistants) conducting pulmonary function tests, the Respiratory Care Board of California (**RCB**) conducted a review of this matter over a period spanning several years. The RCB affirmed at its May 6, 2013 meeting that in the interest of public protection, pulmonary function testing must be performed by qualified and licensed personnel, pursuant to the Respiratory Care Practice Act (Business and Professions Code, Section 3700 seq. et.). The RCB is moving forward to begin public notice to achieve state-wide compliance and is requesting assistance from the Medical Board of California (**MBC**) by way of providing additional information on its website.

Pulmonary function testing (**PFT**) is a component of the respiratory care scope of practice (B&P, §3702), requiring licensure as a respiratory care practitioner (**RCP**), or other qualified licensure (pursuant to the Respiratory Care Practice Act). PFT is useful in: (1) identifying and classifying certain types of lung disease, (2) evaluating the effectiveness of treatment, (3) documenting the progress of pulmonary disease, (4) providing a yardstick for compensating the disabled, and (5) assessing risk factors prior to surgery. In order for pulmonary function tests to be useful, there must be assurance that they have been properly performed on accurate, well-calibrated equipment by educated and trained personnel.

PFT has historically been performed primarily in hospitals or independent laboratories and is occurring more often within physician offices. Patients are coherent and alert during testing except in extremely rare instances when specialized PFT is needed in critical cases, such as in an intensive care unit or when the PFT causes an adverse reaction (generally caused by inappropriate testing techniques).

The California Thoracic Society (**CTS**) issued a position paper in 1987 with revisions made as recent as 2004, titled "Pulmonary Physiology Laboratory Personnel Qualifications" [<http://www.calthoracic.org/sites/default/files/pulm-phys-lab-personnel-qualif.pdf>].

The position paper provides:

"High quality testing provided in a safe manner requires properly functioning and standardized equipment operated by qualified personnel, who perform under the medical direction of a physician who is knowledgeable in pulmonary physiology and its testing procedures. Such personnel might include pulmonary technologists, respiratory care practitioners, registered nurses or others with similar training. Technical personnel in such a laboratory must meet minimum standards of competence, and should achieve this through standardized education and training, followed by appropriately supervised clinical experience. Continuing proficiency is assured by continuing education and ongoing assessment of skills by the Medical Director of the laboratory."

Many physician offices and some pulmonary laboratories are under the false presumption that medical assistants are qualified and/or legally authorized to perform PFT, when in fact they are not.

Great technological advancements have been made with pulmonary function equipment which is a major contributor to the trend of medical assistants performing PFT. A number can be produced from the equipment with minimal instruction to the operator. The trend today with many pulmonary function instruments and tests performed by unlicensed personnel is to produce a number...never minding its source. What results, in many cases where tests are performed by unqualified personnel that lack education in physiology, are erroneous numbers.

An article published in the Medical Board of California's October 2001 *Action Report* titled, "Is Your Medical Assistant Practicing Beyond His or Her Scope of Training?" states,

"An unlicensed person may not diagnose or treat or perform any task that is invasive or *requires assessment* [emphasis added]....

In summary, medical assistants are not licensed, and it is not legal to use them to replace highly trained, licensed professionals. The medical assistant is present to assist and perform support services in the physician's office.

Those duties must be appropriate with the medical assistant's required training, which cannot be compared with licensed nurses or other health professionals who meet rigorous educational and examination requirements."

Many medical assistants have little, if any, understanding that test results are effort-dependent, as well as technically-dependent, upon instruction and coaching patients for reliable results. Even spirometry testing, one of the most common basic and limited type of PFT performed by unlicensed personnel, requires quality **assessment** of maneuvers to obtain reliable results as outlined in the ATS' *Standardization of Spirometry* guidelines (revised 2005) [<http://www-archive.thoracic.org/sections/publications/statements/pages/pfet/pft2.html>].

Over the years there has been a marked increase in unlicensed and unqualified personnel performing PFT, as well as complaints of inaccurate and unreliable PFT results and infection control guidelines not being followed. ***Inaccurate and unreliable PFT results has been the primary concern among the respiratory medical community.*** Inaccurate test results can

lead to the improper diagnosis and treatment of a patient if not detected, as well as add to health care costs. Another concern is the technician's inability to recognize hazards and properly intervene if necessary. Though it is an extremely rare occurrence, failure to react and react properly could lead to permanent patient injury or even death.

In 1989, the California Thoracic Society (CTS) implemented an educational program for hospital-based pulmonary function laboratories in California. The goal of the program was to enhance patient care through quality control for measurements of spirometry, flow-volume loops, and diffusing capacity. The program was short-lived due to limited CTS resources. Currently, however, hospital-based pulmonary laboratories appear to be of least concern as some control measures do exist (i.e. accrediting bodies, California Department of Public Health). Whereas, independent laboratories and physician offices have no facility oversight.

In the September 2001 issue of the American College of Chest Physicians' quarterly scientific publication, *Pulmonary Perspectives*, an article entitled, "Is This Pulmonary Function Test Interpretable?" notes that while the ATS has made it easier to verify tests are of enough quality to interpret, there is still "a tendency to neglect the details of quality assurance and just 'eyeball' the tests" leading to misinterpretation and potentially misdiagnosis. The article notes that while criteria for performing a test is very helpful, it is important to recognize they "are not a substitute for checking the internal consistency among tests, **good technical expertise on the part of the person performing the test**, visually examining the graphical results, **and clinical judgement**". The article also notes that "most pulmonologists are not present at the time of the testing..."

In various "clinical guidelines" issued by the American Association for Respiratory Care (AARC), several risks and/or hazards are associated with various types of PFT [<http://www.rcjournal.com/cpgs/index.cfm>].

- ▶ Infant/Toddler Pulmonary Function Tests (ITPFTs) (1995): vomiting with aspiration with consequent apnea and laryngospasm and/or bronchospasm (the forced deflation technique requires tracheal intubation); pneumothorax (collapse of the lung); increased intracranial pressure; loss of airway patency; transmission of contagion via improperly cleaned equipment or as a consequence of the inadvertent spread of droplet nuclei or body fluids (patient-to-patient or patient-to-technologist); oxygen desaturation due to a worsening of ventilation-to-perfusion mismatch and hypoventilation as a consequence of sedation and/or positioning or interruption of oxygen therapy or failure to preoxygenate the patient prior to performing the forced deflation technique; temporary loss of distending pressure.
- ▶ Pulmonary Rehabilitation (2002): During exercise the cardiovascular and ventilatory systems must be able to respond to increased demands. Exercise can lead to muscle or ligament injuries.
- ▶ Body Plethysmography (2001): Improper panting technique may result in excessive intrathoracic (innerchest) pressures; prolonged confinement in the plethysmograph chamber could result in hypercapnia or hypoxia; transmission of infection through improperly cleaned equipment.

- ▶ Exercise Testing for Evaluation of Hypoxemia and/or Desaturation (2001): electrocardiographic abnormalities, severe desaturation, angina (a heart condition marked by uncontrollable attacks of chest pain due to reduced oxygen to the heart), hypotensive responses drop in blood pressure, lightheadedness, rise in blood pressure, mental confusion or headache, cyanosis, nausea or vomiting, muscle cramping; hazards associated with arterial puncture, arterial cannulation, and pulse oximetry; tissue injury as a result of probe misuse.
- ▶ Assessing Response to Bronchodilator Therapy at Point of Care (1995): bronchoconstriction; airway collapse; paroxysmal (uncontrollable attack) coughing with or without syncope (loss of consciousness caused by insufficient blood to the brain); inherent hazards or complications of specific assessment procedures (i.e. arterial puncture, esophageal balloons, forced exhalations).
- ▶ Methacholine Challenge Testing (2001): bronchoconstriction, hyperinflation, severe coughing; hazards associated with spirometry, such as dizziness, light-headedness, chest pain; possible exposure of testing personnel to provocative substance.
- ▶ Static Lung Volumes (2001): Infection may be contracted from improperly cleaned tubing, mouthpieces, manifolds, valves, and pneumotachometers; hypoxemia may result from interruption of oxygen therapy in the body box; ventilatory drive may be depressed in susceptible subjects as a consequence of breathing 100% oxygen during the nitrogen washout; hypercapnia (abnormally high level of carbon dioxide in circulating blood) and/or hypoxemia (below normal oxygen content in arterial blood) may occur during helium-dilution FRC determinations as a consequence of failure to adequately remove carbon dioxide or oxygen to the rebreathed gas.
- ▶ Incentive Spirometry (1991) : also referred to as sustained maximal inspiration (SMI), is a component of bronchial hygiene therapy. Ineffective unless closely supervised or performed as ordered; hyperventilation; barotrauma (emphysematous lungs); discomfort secondary to inadequate pain control; hypoxia secondary to interruption of prescribed oxygen therapy if face mask or shield is being used; exacerbation of bronchospasm; fatigue.
- ▶ Spirometry (1996): pneumothorax (collapse of the lung); increased intracranial pressure; syncope, dizziness, light-headedness; chest pain; paroxysmal coughing; contraction of nosocomial infections; oxygen desaturation due to interruption of oxygen therapy; bronchospasm.

After careful review and consideration, the Respiratory Care Board of California affirmed at its May 6, 2013 meeting, that in the interest of public protection, pulmonary function testing must be done by licensed and skilled professionals as authorized by the Respiratory Care Practice Act. Unlicensed personnel including medical assistants, are not authorized to perform any pulmonary function testing including, peak flow, spirometry, lung volume, and whole body plethysmography testing, or any other pulmonary function test.

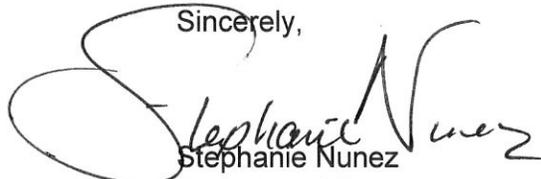
The RCB intends to provide public notice of this decision to gain state-wide compliance and is requesting the assistance of the Medical Board of California. Specifically, the RCB is requesting the MBC add an additional question to its "Medical Assistants - Frequently Asked Questions" website page that will clarify that Medical Assistants are not authorized to perform PFT. Following is suggested language for your consideration:

Question: Are medical assistants allowed to conduct any level of pulmonary function testing including but not limited to, the most basic and limited type of testing such as spirometry, peak flows, and lung volumes?

Response: No. Pulmonary function testing is a component of the respiratory care practitioner scope of practice. The Respiratory Care Practice Act (Business and Professions Code, Section 3700 et. seq.) provides that only licensed respiratory care practitioners may perform pulmonary function testing with limited exemptions provided to other licensed personnel. In addition, all levels of pulmonary function testing require assessment. Even the more basic and limited type of testing such as spirometry and peak flow are effort-dependent, as well as technically dependent upon instruction and coaching patients for reliable results. Personnel performing these tests must assess whether the patient is providing the correct effort. Because pulmonary function testing requires assessment and the Respiratory Care Practice Act prohibits this practice by unlicensed personnel, it must be performed by licensed and qualified personnel pursuant to the Respiratory Care Practice Act.

Please give me a call at your earliest convenience to discuss how we may proceed in this matter. My telephone number is 916.999.2212. The RCB sincerely appreciates your consideration in providing this clarification in the interest of consumer protection.

Sincerely,



Stephanie Nunez
Executive Officer

cc: The Honorable Anna M. Caballero, Secretary
State and Consumer Services Agency

Resources Needed to Identify Highest Earned Credential for Respondents Disciplined

ACTIVE LICENSEES with ACTIVE CREDENTIAL STATUS 2008 ESTIMATE		
Based on Cross Comparison of Names of Active Licensees and Active NBRC Credentials in California**		
8/31/2008		
	No.	%
Active Licensees	16,003	100%
RRT Credentials Issued	4,891	30.56%
CRT Credentials Issued*	4,910	30.68%
Subtotal	9,801	61.24%
Non Credentialed	6,202	38.76%
Total	16,003	100.00%

* The actual number of CRT credentials issued is the figure shown PLUS the number of RRT credentials issued for each year. The CRT credential is represented in this manner to help narrow and identify licensees holding the highest level of credential.

CASELOAD	FY 09/10	FY 10/11	FY 11/12	FY 12/13	TOTAL
Accusations Filed	42	58	51	45	196
Statement of Issues Filed	29	20	13	12	74

TASKS	Time in Hours	
	<u>Minimum</u>	<u>Maximum</u>
Identify and compile list of applicants and licensees	4	6
Look up 270 names and record credentials (+different spellings) in NBRC databse	10	18
Pull file for 105 people expected to not have current credential to identify if they were grandfathered in or passed CRT but let expire	18	22
Compile report	8	12

Total hours	40	58
--------------------	-----------	-----------

2013 LEGISLATION OF INTEREST

SB 305	Author:	Price [D]
	Title:	Healing arts: boards. [RCB SUNSET EXTENSION BILL]
	Last Amended:	9/6/13
	Status:	10/3/13: Signed by the Governor [Chapter 516, Statutes of 2013].
	Summary:	This bill extends the sunset, until January 1, 2018, of several licensing boards within the Department of Consumer Affairs (DCA) and makes certain statutory changes to those boards' responsibilities. Provisions specific to the Respiratory Care Board include: 1) Extending, until January 1, 2018, (1) the provisions establishing the RCB, and (2) the term of the executive officers of the RCB; 2) Specifying that the RCB is subject to be reviewed by the appropriate policy committees of the Legislature; and 3) Exempting individuals who have performed pulmonary function tests in Los Angeles County facilities for at least 15 years, from licensure as a respiratory care practitioner. The bill also specifies that any board under the DCA is authorized to receive certified records from a local or state agency of all arrests and convictions, certified records regarding probation, and any and all other related documentation needed to complete an applicant or licensee investigation; and specifies that a local or state agency is authorized to provide those records to a board upon receipt of such a request.
	Position:	SUPPORT

SB 690	Author:	Price [D]
	Title:	Licenses.
	Last Amended:	N/A
	Status:	3/11/13: Referred to Senate Committee on Rules. Has become a 2 year bill.
	Summary:	Existing law provides for the licensing of various professions and vocations by boards within the Department of Consumer Affairs. Existing law defines license to mean a license, certificate, registration, or other means to engage in a business or profession, as provided. This bill would expand the definition of license to include a permit.
	Position:	WATCH

AB 186	Author:	Maienschein [R]
	Title:	Professions and vocations: military spouses; temporary licenses.
	Last Amended:	6/24/13
	Status:	7/1/13: Further hearing to be set before the Senate Business, Professions & Economic Development Committee. Has become a 2-year bill.
	Summary:	This bill requires all licensing entities under the Department of Consumer Affairs to provide military spouses and domestic partners, who hold a valid professional license in another state, an 18 month provisional license to practice in California.
	Position:	WATCH

AB 258	Author:	Chavez [R]
	Title:	State agencies: veterans.
	Last Amended:	4/23/13
	Status:	9/6/13: Signed by the Governor [Chapter 227, Statutes of 2013].
	Summary:	This bill requires, on or after July 1, 2014, every state agency that requests on any written form or written publication, or through its Internet Web site, whether a person is a veteran, to request that information in a specified manner.
	Position:	WATCH

AB 291	Author:	Nestande [R]
	Title:	California Sunset Review Commission.
	Last Amended:	N/A
	Status:	4/15/13: Referred to Assembly Accountability & Administrative Review, and Business, Professions & Consumer Protection Committees. However, hearings were cancelled at the request of the author. Has become a 2 year bill.
	Summary:	This bill would abolish the Joint Sunset Review Committee on January 1 or an unspecified year. The bill would, commencing on that same January 1, establish the California Sunset Review Commission within the executive branch to assess the continuing need for any agency, as defined, to exist. The commission would consist of 10 members, with 8 members appointed by the Governor and 2 Members of the Legislature each appointed by the Senate Committee on Rules and the Speaker of the Assembly, subject to specified terms. The commission would be under the direction of a director appointed by the commission members. The bill would require the commission to meet regularly and to work with each agency subject to review to evaluate the need for the agency to exist, identify required statutory, regulatory, or management changes, and develop legislative proposals to enact those changes. The bill would require the commission to prepare a report, containing legislative recommendations based on its agency review, to be submitted to the Legislature and would also require the commission to meet certain cost-savings standards within 5 years.
	Position:	WATCH

AB 512	Author:	Rendon [D]
	Title:	Healing arts: licensure exemption.
	Last Amended:	N/A
	Status:	8/16/13: Signed by the Governor [Chapter 111, Statutes of 2013].
	Summary:	This bill extends the sunset date, from January 2014, to January 2018, on existing law permitting qualified, out-of-state health care practitioners to volunteer their services on a limited basis at health care events designed to provide free services for underinsured and uninsured individuals in California.
	Position:	WATCH

AB 809	Author:	Logue [R]
	Title:	Healing arts: telehealth.
	Last Amended:	6/25/13
	Status:	7/1/13: Hearing before the Assembly Health Committee cancelled at the request of the author. Has become a 2 year bill.
	Summary:	This bill is an urgency measure which repeals the Telehealth Advancement Act of 2011 requiring a physician to obtain oral consent prior to each delivery of telehealth services. This bill: 1) Specifies that the health care provider initiating the use of telehealth at the originating site shall verbally inform the patient about the use of telehealth and request the patient's verbal consent, which may apply in that instance and for any subsequent use of telehealth; 2) Specifies that verbal consent shall be documented in the patient's medical record; and 3) Contains an urgency clause allowing the bill to take effect immediately upon enactment in order to protect the health and safety of the public due to a lack of access to health care providers in rural and urban medically underserved areas of California, the increasing strain on existing providers expected to occur with the implementation of the federal Patient Protection and Affordable Care Act and the assistance that further implementation of telehealth can provide to help relieve these burdens.
	Position:	WATCH

AB 1013	Author:	Gomez [D]
	Title:	Consumer affairs.
	Last Amended:	N/A
	Status:	3/7/13: Referred to Assembly Committee on Business, Professions and Consumer Protection. Has become a 2 year bill.
	Summary:	Existing law authorizes the DCA Director or the Attorney General (AG) to intervene in a matter pending before any state agency, or any court, which the director finds may affect substantially the interests of CA consumers, to represent the interests of consumers, and authorizes the director, or any officer or employee designated by the director, or the AG to present evidence and argument to the agency or court for the effective protection of the interests of consumers. This bill would also add authorization to any employee designated by the AG.
	Position:	WATCH

AB 1057	Author:	Medina [D]
	Title:	Professions and vocations: licenses: military service.
	Last Amended:	4/9/13
	Status:	10/10/13: Signed by the Governor [Chapter 693, Statutes of 2013].
	Summary:	This bill requires every licensing board under the Department of Consumer Affairs to inquire in every license application if the applicant is serving in, or has previously served in, the military, commencing January 1, 2015.
	Position:	WATCH

Senate Bill No. 305

CHAPTER 516

An act to amend Sections 1000, 2450, 2450.3, 2530.2, 2531, 2531.06, 2531.75, 2532.6, 2533, 2570.19, 3010.5, 3014.6, 3046, 3056, 3057, 3110, 3685, 3686, 3710, 3716, and 3765 of, and to add Sections 144.5 and 3090.5 to, the Business and Professions Code, relating to healing arts.

[Approved by Governor October 3, 2013. Filed with
Secretary of State October 3, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

SB 305, Lieu. Healing arts: boards.

(1) Existing law requires specified regulatory boards within the Department of Consumer Affairs to require an applicant for licensure to furnish to the board a full set of fingerprints in order to conduct a criminal history record check.

This bill would additionally authorize those boards to request and receive from a local or state agency certified records of all arrests and convictions, certified records regarding probation, and any and all other related documentation needed to complete an applicant or licensee investigation and would authorize a local or state agency to provide those records to the board upon request.

(2) The Chiropractic Act, enacted by an initiative measure, provides for the licensure and regulation of chiropractors in this state by the State Board of Chiropractic Examiners. Existing law specifies that the law governing chiropractors is found in the act.

This bill would require that the powers and duties of the board, as provided, be subject to review by the appropriate policy committees of the Legislature as if these provisions were scheduled to be repealed on January 1, 2018. This bill would also make nonsubstantive changes to conform with the Governor's Reorganization Plan No. 2.

(3) Existing law, the Osteopathic Act, provides for the licensure and regulation of osteopathic physicians and surgeons by the Osteopathic Medical Board of California.

This bill would require that the powers and duties of the board, as provided, be subject to review by the appropriate policy committees of the Legislature. The bill would require that the review be performed as if these provisions were scheduled to be repealed as of January 1, 2018.

(4) Existing law, the Speech-Language Pathologists and Audiologists and Hearing Aid Dispensers Licensure Act, provides for the licensure and regulation of speech-language pathologists, audiologists, and hearing aid dispensers by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board. The act authorizes the board to appoint an executive

officer. Existing law repeals these provisions on January 1, 2014, and subjects the board to review by the Joint Committee on Boards, Commissions, and Consumer Protection.

This bill would extend the operation of these provisions until January 1, 2018, and provide that the repeal of these provisions subjects the board to review by the appropriate policy committees of the Legislature.

The Speech-Language Pathologists and Audiologists and Hearing Aid Dispensers Licensure Act also authorizes the board to refuse to issue, or issue subject to terms and conditions, a license on specified grounds, including, among others, securing a license by fraud or deceit.

This bill would additionally authorize the board to refuse to issue, or issue subject to terms and conditions, a license for a violation of a term or condition of a probationary order of a license or a term or condition of a conditional license issued by the board, as provided. The bill would also delete an obsolete provision and make other technical changes.

(5) Existing law, the Occupational Therapy Practice Act, provides for the licensure and regulation of occupational therapists, as defined, by the California Board of Occupational Therapy. Existing law repeals those provisions on January 1, 2014, and subjects the board to review by the Joint Committee on Boards, Commissions, and Consumer Protection.

This bill would extend the operation of these provisions until January 1, 2018, and provide that the repeal of these provisions subjects the board to review by the appropriate policy committees of the Legislature.

(6) Existing law, the Naturopathic Doctors Act, until January 1, 2014, provides for the licensure and regulation of naturopathic doctors by the Naturopathic Medicine Committee within the Osteopathic Medical Board of California. Existing law also specifies that the repeal of the committee subjects it to review by the appropriate policy committees of the Legislature.

This bill would extend the operation of these provisions until January 1, 2018, and make conforming changes.

(7) Existing law, the Optometry Practice Act, provides for the licensure and regulation of optometrists by the State Board of Optometry. The Respiratory Care Act provides for the licensure and regulation of respiratory care practitioners by the Respiratory Care Board of California. Each of those acts authorizes the board to employ an executive officer. Existing law repeals these provisions on January 1, 2014, and subjects the boards to review by the Joint Committee on Boards, Commissions, and Consumer Protection.

This bill would extend the operation of these provisions until January 1, 2018, and provide that the repeal of these provisions subjects the boards to review by the appropriate policy committees of the Legislature.

(8) The Optometry Practice Act prescribes license eligibility requirements, including, but not limited to, not having been convicted of a crime, as specified. The act defines unprofessional conduct to include, committing or soliciting an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of an optometrist. Under the act, the board may take action against a licensee who is charged with unprofessional conduct, and may deny an application

for a license if the applicant has committed an act of unprofessional conduct. Under existing law, commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action against any healing arts licensee, subject to a specified exception for a physician and surgeon.

This bill would add to the license eligibility requirements under the act that the applicant is not currently required to register as a sex offender, as specified. The bill would make conviction of a crime that currently requires a licensee to register as a sex offender unprofessional conduct and would expressly specify that commission of an act of sexual abuse or misconduct, as specified, constitutes unprofessional conduct, subject to an exception for an optometrist treating his or her spouse or person in an equivalent domestic relationship. The bill would also state that those acts of unprofessional conduct shall be considered crimes substantially related to the qualifications, functions, or duties of a licensee. The bill would also expressly specify that the board may revoke a license if the licensee has been found, in an administrative proceeding, as specified, to have been convicted of sexual misconduct or convicted of a crime that currently requires the licensee to register as a sex offender.

(9) The Respiratory Care Act also prohibits a person from engaging in the practice of respiratory care unless he or she is a licensed respiratory care practitioner. However, the act does not prohibit specified acts, including, among others, the performance of respiratory care services in case of an emergency or self-care by a patient.

This bill would additionally authorize the performance of pulmonary function testing by persons who are currently employed by Los Angeles County hospitals and have performed pulmonary function testing for at least 15 years.

This bill would make legislative findings and declarations as to the necessity of a special statute for the persons described above.

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

SECTION 1. Section 144.5 is added to the Business and Professions Code, to read:

144.5. Notwithstanding any other law, a board described in Section 144 may request, and is authorized to receive, from a local or state agency certified records of all arrests and convictions, certified records regarding probation, and any and all other related documentation needed to complete an applicant or licensee investigation. A local or state agency may provide those records to the board upon request.

SEC. 2. Section 1000 of the Business and Professions Code is amended to read:

1000. (a) The law governing practitioners of chiropractic is found in an initiative act entitled “An act prescribing the terms upon which licenses may be issued to practitioners of chiropractic, creating the State Board of

SEC. 20. Section 3686 of the Business and Professions Code is amended to read:

3686. This chapter shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

SEC. 21. Section 3710 of the Business and Professions Code is amended to read:

3710. (a) The Respiratory Care Board of California, hereafter referred to as the board, shall enforce and administer this chapter.

(b) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date. Notwithstanding any other law, the repeal of this section renders the board subject to review by the appropriate policy committees of the Legislature.

SEC. 22. Section 3716 of the Business and Professions Code is amended to read:

3716. The board may employ an executive officer exempt from civil service and, subject to the provisions of law relating to civil service, clerical assistants and, except as provided in Section 159.5, other employees as it may deem necessary to carry out its powers and duties.

This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

SEC. 23. Section 3765 of the Business and Professions Code is amended to read:

3765. This act does not prohibit any of the following activities:

(a) The performance of respiratory care that is an integral part of the program of study by students enrolled in approved respiratory therapy training programs.

(b) Self-care by the patient or the gratuitous care by a friend or member of the family who does not represent or hold himself or herself out to be a respiratory care practitioner licensed under the provisions of this chapter.

(c) The respiratory care practitioner from performing advances in the art and techniques of respiratory care learned through formal or specialized training.

(d) The performance of respiratory care in an emergency situation by paramedical personnel who have been formally trained in these modalities and are duly licensed under the provisions of an act pertaining to their specialty.

(e) Respiratory care services in case of an emergency. "Emergency," as used in this subdivision, includes an epidemic or public disaster.

(f) Persons from engaging in cardiopulmonary research.

(g) Formally trained licensees and staff of child day care facilities from administering to a child inhaled medication as defined in Section 1596.798 of the Health and Safety Code.

(h) The performance by a person employed by a home medical device retail facility or by a home health agency licensed by the State Department

of Public Health of specific, limited, and basic respiratory care or respiratory care related services that have been authorized by the board.

(i) The performance of pulmonary function testing by persons who are currently employed by Los Angeles County hospitals and have performed pulmonary function testing for at least 15 years.

SEC. 24. The Legislature finds and declares that a special law, as set forth in Section 18 of this act, is necessary and that a general law cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution because of the unique circumstances relating to persons who are currently employed by Los Angeles County hospitals and have performed pulmonary function testing for at least 15 years.

Assembly Bill No. 258

CHAPTER 227

An act to add Section 11019.11 to the Government Code, relating to state agencies.

[Approved by Governor September 6, 2013. Filed with
Secretary of State September 6, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

AB 258, Chávez. State agencies: veterans.

Existing law provides for the governance and regulation of state agencies, as defined. Existing law provides certain benefits and protections for members of the Armed Forces of the United States.

This bill would require, on or after July 1, 2014, every state agency that requests on any written form or written publication, or through its Internet Web site, whether a person is a veteran, to request that information in a specified manner.

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

SECTION 1. Section 11019.11 is added to the Government Code, to read:

11019.11. (a) Every state agency that requests on any written form or written publication, or through its Internet Web site, whether a person is a veteran, shall request that information only in the following format: "Have you ever served in the United States military?"

(b) This section shall apply only to a written form or written publication that is newly printed on or after July 1, 2014.

Assembly Bill No. 512

CHAPTER 111

An act to amend Section 901 of the Business and Professions Code, relating to healing arts.

[Approved by Governor August 16, 2013. Filed with
Secretary of State August 16, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

AB 512, Rendon. Healing arts: licensure exemption.

Existing law provides for the licensure and regulation of various healing arts practitioners by boards within the Department of Consumer Affairs. Existing law provides an exemption from these requirements for a health care practitioner licensed in another state who offers or provides health care for which he or she is licensed during a state of emergency, as defined, and upon request of the Director of the Emergency Medical Services Authority, as specified.

Existing law provides, until January 1, 2014, an exemption from the licensure and regulation requirements for a health care practitioner, as defined, licensed or certified in good standing in another state or states, who offers or provides health care services for which he or she is licensed or certified through a sponsored event, as defined, (1) to uninsured or underinsured persons, (2) on a short-term voluntary basis, (3) in association with a sponsoring entity that registers with the applicable healing arts board, as defined, and provides specified information to the county health department of the county in which the health care services will be provided, and (4) without charge to the recipient or a 3rd party on behalf of the recipient, as specified. Existing law also requires an exempt health care practitioner to obtain prior authorization to provide these services from the applicable licensing board, as defined, and to satisfy other specified requirements, including payment of a fee as determined by the applicable licensing board.

This bill would delete the January 1, 2014, date of repeal, and instead allow the exemption to operate until January 1, 2018.

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

SECTION 1. Section 901 of the Business and Professions Code is amended to read:

901. (a) For purposes of this section, the following provisions apply:

(1) “Board” means the applicable healing arts board, under this division or an initiative act referred to in this division, responsible for the licensure or regulation in this state of the respective health care practitioners.

(2) “Health care practitioner” means any person who engages in acts that are subject to licensure or regulation under this division or under any initiative act referred to in this division.

(3) “Sponsored event” means an event, not to exceed 10 calendar days, administered by either a sponsoring entity or a local government, or both, through which health care is provided to the public without compensation to the health care practitioner.

(4) “Sponsoring entity” means a nonprofit organization organized pursuant to Section 501(c)(3) of the Internal Revenue Code or a community-based organization.

(5) “Uninsured or underinsured person” means a person who does not have health care coverage, including private coverage or coverage through a program funded in whole or in part by a governmental entity, or a person who has health care coverage, but the coverage is not adequate to obtain those health care services offered by the health care practitioner under this section.

(b) A health care practitioner licensed or certified in good standing in another state, district, or territory of the United States who offers or provides health care services for which he or she is licensed or certified is exempt from the requirement for licensure if all of the following requirements are met:

(1) Prior to providing those services, he or she does all of the following:

(A) Obtains authorization from the board to participate in the sponsored event after submitting to the board a copy of his or her valid license or certificate from each state in which he or she holds licensure or certification and a photographic identification issued by one of the states in which he or she holds licensure or certification. The board shall notify the sponsoring entity, within 20 calendar days of receiving a request for authorization, whether that request is approved or denied, provided that, if the board receives a request for authorization less than 20 days prior to the date of the sponsored event, the board shall make reasonable efforts to notify the sponsoring entity whether that request is approved or denied prior to the date of that sponsored event.

(B) Satisfies the following requirements:

(i) The health care practitioner has not committed any act or been convicted of a crime constituting grounds for denial of licensure or registration under Section 480 and is in good standing in each state in which he or she holds licensure or certification.

(ii) The health care practitioner has the appropriate education and experience to participate in a sponsored event, as determined by the board.

(iii) The health care practitioner shall agree to comply with all applicable practice requirements set forth in this division and the regulations adopted pursuant to this division.

(C) Submits to the board, on a form prescribed by the board, a request for authorization to practice without a license, and pays a fee, in an amount determined by the board by regulation, which shall be available, upon appropriation, to cover the cost of developing the authorization process and processing the request.

(2) The services are provided under all of the following circumstances:

(A) To uninsured or underinsured persons.

(B) On a short-term voluntary basis, not to exceed a 10-calendar-day period per sponsored event.

(C) In association with a sponsoring entity that complies with subdivision (d).

(D) Without charge to the recipient or to a third party on behalf of the recipient.

(c) The board may deny a health care practitioner authorization to practice without a license if the health care practitioner fails to comply with this section or for any act that would be grounds for denial of an application for licensure.

(d) A sponsoring entity seeking to provide, or arrange for the provision of, health care services under this section shall do both of the following:

(1) Register with each applicable board under this division for which an out-of-state health care practitioner is participating in the sponsored event by completing a registration form that shall include all of the following:

(A) The name of the sponsoring entity.

(B) The name of the principal individual or individuals who are the officers or organizational officials responsible for the operation of the sponsoring entity.

(C) The address, including street, city, ZIP Code, and county, of the sponsoring entity's principal office and each individual listed pursuant to subparagraph (B).

(D) The telephone number for the principal office of the sponsoring entity and each individual listed pursuant to subparagraph (B).

(E) Any additional information required by the board.

(2) Provide the information listed in paragraph (1) to the county health department of the county in which the health care services will be provided, along with any additional information that may be required by that department.

(e) The sponsoring entity shall notify the board and the county health department described in paragraph (2) of subdivision (d) in writing of any change to the information required under subdivision (d) within 30 calendar days of the change.

(f) Within 15 calendar days of the provision of health care services pursuant to this section, the sponsoring entity shall file a report with the board and the county health department of the county in which the health care services were provided. This report shall contain the date, place, type, and general description of the care provided, along with a listing of the health care practitioners who participated in providing that care.

(g) The sponsoring entity shall maintain a list of health care practitioners associated with the provision of health care services under this section. The sponsoring entity shall maintain a copy of each health care practitioner's current license or certification and shall require each health care practitioner to attest in writing that his or her license or certificate is not suspended or revoked pursuant to disciplinary proceedings in any jurisdiction. The sponsoring entity shall maintain these records for a period of at least five years following the provision of health care services under this section and shall, upon request, furnish those records to the board or any county health department.

(h) A contract of liability insurance issued, amended, or renewed in this state on or after January 1, 2011, shall not exclude coverage of a health care practitioner or a sponsoring entity that provides, or arranges for the provision of, health care services under this section, provided that the practitioner or entity complies with this section.

(i) Subdivision (b) shall not be construed to authorize a health care practitioner to render care outside the scope of practice authorized by his or her license or certificate or this division.

(j) (1) The board may terminate authorization for a health care practitioner to provide health care services pursuant to this section for failure to comply with this section, any applicable practice requirement set forth in this division, any regulations adopted pursuant to this division, or for any act that would be grounds for discipline if done by a licensee of that board.

(2) The board shall provide both the sponsoring entity and the health care practitioner with a written notice of termination including the basis for that termination. The health care practitioner may, within 30 days after the date of the receipt of notice of termination, file a written appeal to the board. The appeal shall include any documentation the health care practitioner wishes to present to the board.

(3) A health care practitioner whose authorization to provide health care services pursuant to this section has been terminated shall not provide health care services pursuant to this section unless and until a subsequent request for authorization has been approved by the board. A health care practitioner who provides health care services in violation of this paragraph shall be deemed to be practicing health care in violation of the applicable provisions of this division, and be subject to any applicable administrative, civil, or criminal fines, penalties, and other sanctions provided in this division.

(k) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

(l) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

Assembly Bill No. 1057

CHAPTER 693

An act to add Section 114.5 to the Business and Professions Code, relating to professions and vocations.

[Approved by Governor October 10, 2013. Filed with
Secretary of State October 10, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1057, Medina. Professions and vocations: licenses: military service.

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs. Existing law authorizes a licensee or registrant whose license expired while the licensee or registrant was on active duty as a member of the California National Guard or the United States Armed Forces to, upon application, reinstate his or her license without penalty and without examination, if certain requirements are satisfied, unless the licensing agency determines that the applicant has not actively engaged in the practice of his or her profession while on active duty, as specified.

This bill would require each board, commencing January 1, 2015, to inquire in every application for licensure if the individual applying for licensure is serving in, or has previously served in, the military.

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

SECTION 1. Section 114.5 is added to the Business and Professions Code, to read:

114.5. Commencing January 1, 2015, each board shall inquire in every application for licensure if the individual applying for licensure is serving in, or has previously served in, the military.

Senate Business, Professions and Economic Development Committee
COMMITTEE BILL: PROPOSED LEGISLATION

Note: Submit the completed form to the Committee electronically by email **and** as a hardcopy by mail. Attach additional information or documentation as necessary.

REQUESTOR & CONTACT INFORMATION

Stephanie Nunez, Executive Officer
Respiratory Care Board of California
3750 Rosin Court, Suite 100
Sacramento, CA 95834
T: 916.999.2232
E: Stephanie.nunez@dca.ca.gov
W: rcb.ca.gov

**Respiratory Care Board
Legislative Proposal #1**
Substantive
RRT Minimum Exam Threshold
Sections 3730, 3735,
3735.5, and 3739

DATE SUBMITTED November 18, 2013

SUMMARY Since the Board's inception in 1985, the National Board for Respiratory Care, Inc. (NBRC) has offered two credentials specific to respiratory care that are both nationally recognized: 1) The Certified Respiratory Therapist (CRT) - entry level credential and 2) the Registered Respiratory Therapist (RRT) credential - advanced level credential. For approximately 25 years, the Board has recognized the passage of the CRT examination as the minimum exam requirement for licensure as a respiratory care practitioner (RCP). Changes made by the national exam provider and oversight accreditation agency, makes this proposal to require the passage of the RRT examination for licensure a natural progression, raising the bar for consumer protection.

IDENTIFICATION OF PROBLEM

Advancements in technology and accreditation standards coupled with the restructuring of nationally recognized exams (effective 1/1/15), will make the current requirement to pass the CRT examination for licensure as an RCP inadequate, outdated and insufficient in meeting the Board's consumer protection mandate.

NBRC Examinations

Following grandfather provisions that expired in 1985, the Board has required and continues to require the passage of the NBRC's CRT examination to demonstrate competency prior to licensure. The CRT examination has always been designed to objectively measure essential knowledge, skills and abilities required of entry level therapists. Whereas NBRC's RRT examination was developed to objectively measure essential knowledge, skills and abilities required of advanced level respiratory therapists. The differentiation between "entry" and "advanced" has been identified in the requirements to sit for each of the exams. Over the years, the "CRT" exam admittance requirement has been graduation from an "entry" level (a.k.a. "100-level") educational program and the "RRT" exam admittance requirement has been graduation from an "advanced" level educational program OR graduation from an "entry" level program with additional education and/or experience thereafter. Following are the current admission requirements for each examination:

Current CRT Admission Requirements

Applicants shall satisfy ONE of the following educational requirements:

- a. Applicants shall have a minimum of an associate degree from a respiratory therapist education program 1) supported or accredited by the Commission on Accreditation for Respiratory Care (CoARC), or 2) accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and graduated on or before November 11, 2009.
- b. Applicants enrolled in an accredited respiratory therapy program in an institution offering a baccalaureate degree may be admitted to the CRT Examination with a "special certificate of completion" issued by a sponsoring educational institution. The CoARC will authorize such institutions to issue the "special certificate of completion" at the advanced-level following completion of the science, general academic and respiratory therapy coursework commensurate with the requirements for accreditation.
- c. Applicants shall hold the Canadian Society of Respiratory Therapists (CSRT) RRT credential.

Current RRT Admission Requirements

Applicants shall satisfy ONE of the following educational requirements:

- a. Be a CRT having earned a minimum of an associate degree* from a respiratory therapist educational program 1) supported or accredited by the Commission on Accreditation for Respiratory Care (CoARC), or 2) accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and graduated on or before November 11, 2009. Graduates of accredited 100-level respiratory therapist education programs are not eligible for admission to the RRT Examination under this admission provision.
- b. Be a CRT having been enrolled in an accredited respiratory therapy program in an institution offering a baccalaureate degree offering a "special certificate of completion" issued by a sponsoring educational institution. The CoARC will authorize such institutions to issue the "special certificate of completion" at the advanced level following completion of the science, general academic and respiratory therapy coursework commensurate with the requirements for accreditation.
- c. Be a therapist Certified (CRT) by the NBRC who has four years* of full-time clinical experience in respiratory therapy under licensed medical supervision following Certification and prior to applying for the Registry Examination. In addition, the applicant shall have at least 62 semester hours of college credit from a college or university accredited by its regional association or its equivalent. The 62 semester hours of college credit must include the following courses: anatomy and physiology, chemistry, microbiology, physics, and mathematics.
- d. Be a CRT having earned a minimum of an associate degree from an accredited entry-level respiratory therapist educational program with two years of full-time, clinical experience in respiratory care under licensed medical supervision following Certification and prior to applying for the examination.

- e. Be a CRT with a baccalaureate degree in an area other than respiratory care, including college credit level courses in anatomy and physiology, chemistry, mathematics, microbiology and physics. In addition, they shall have two years of full-time clinical experience** in respiratory care under licensed medical supervision following Certification and before applying for the examination. In addition, the applicant shall have at least 62 semester hours of college credit from a college or university accredited by its regional association or its equivalent.
- f. Be a CRT and hold the Canadian Society of Respiratory Therapists (CSRT) RRT credential.

*Individuals certified (CRT) prior to January 1, 1983, are required to complete only three years of clinical experience.

**Clinical experience in respiratory care under licensed medical supervision is interpreted as a minimum of 21 hours per week. Clinical experience must be completed before the candidate applies for this examination.

The current exam admission requirements no longer make multiple references to entry or advanced level programs, because the entry level educational programs were phased out as of December 2012. However, you will note that in subdivision (a) of the RRT (advanced) admission requirements it clearly states that “*Graduates of accredited 100-level respiratory therapist education programs [the CRT entry-level programs] are not eligible for admission to the RRT Examination under this admission provision.*”

In light of numerous states, including California’s consideration to require the passage of the RRT exam, coupled with the new accreditation standards, the National Board for Respiratory Care, Inc. (NBRC) recently announced in 2012 that it was making “conceptual” changes to its CRT and RRT examinations. Currently, the CRT examination consists of a one part written examination and the RRT examination consists of a one part written examination and one part clinical simulation examination. Each “part” carries a separate fee: CRT exam \$190; RRT written exam \$190; RRT clinical exam \$200).

Effective January 1, 2015 (the same time these proposed changes would take effect), the new exam structure will consist of one part written exam for both the CRT and RRT examinations and one part clinical simulation for the remainder of the RRT exam. The new structure will identify if the test taker qualifies to sit for the clinical simulated RRT exam if he/she achieves the RRT-level passing score required on the CRT/RRT written examination. This new structure eliminates the duplicative fee and there are no anticipated fee increases in the near future (CRT/RRT written exam \$190 and RRT clinical exam \$200).

CoARC Accreditation

Following is a very high level and brief review of educational programs and requirements that have been in place, largely due to revisions in accreditation standards over the years:

Prior to 2002: Two types of respiratory educational programs existed: One year+ entry level programs (a.k.a. 100-level programs) and two year+ advanced level programs. *[While programs were referenced as one year and two year programs, the educational content grew with advancements in the profession and technology to a point that programs were 18 months to three years in length for full time students]*

After 2002: Accreditation requirements are changed to require an associate degree as part of any educational program. All programs become two+ years long, but are still differentiated by entry level (aka 100-level programs) and advanced level based on content.

January 2011: Entry level programs begin to teach out graduating classes through December 2012, the last month a student could graduate from an entry level program. *[This proposal provides two full years for these graduates to take and pass the CRT examination for licensure without being affected by the new requirements.]*

January 2013: Only one type of educational program exists: the advanced level program offering an associate degree.

All current graduates meet the minimum admissions requirements for the RRT examination.

In addition, the accreditation status of educational programs hinges upon the RRT passage rate. According to the most recent accreditation standards (June 2010), each respiratory care educational program is required to have the following goal: "To prepare graduates with demonstrated competence in the cognitive (knowledge), psychomotor (skills), and affective (behavior) learning domains of respiratory care practice as performed by registered respiratory therapists (RRTs)."

As part of the reaccreditation process, CoARC assesses whether the program has met this goal by several factors, including the pass rate of the program's graduates of the RRT examination. Since the RRT examination is not required to be taken for licensure, many programs receive a negative assessment in this area and it is believed this attributed to few students applying for the exam. With this proposal, the RRT exam would be required for new graduates which will in turn, also provide for more reliable outcome measurements not only for accreditation, but for consumers.

There are no longer any barriers to increasing the minimum exam threshold to the RRT level. Failure to require the passage of the once considered "advanced" exam would be a disservice to consumers.

PROPOSED SOLUTION

Amend section 3730 of the Business and Professions Code (B&P) to identify that one or more examinations may be required for licensure in the event the national exam structure is modified or the RRT exam is perceived to be two separate examinations (e.g. written, clinical simulation).

Amend section 3735 of the B&P to identify the RRT examination is required prior to licensure. Also provide that any person in any state who passed the CRT examination prior to January 1, 2015 may not be required to pass the RRT examination, even if he/she applies for licensure after January 1, 2015.

Repeal section 3735.5 of the B&P as the new language in section 3735 makes section 3735.5 obsolete.

Amend section 3739 of the B&P to align "work permit" privileges with the changes made in the exam requirements and provide a mechanism to allow a period up to six months for new applicants to pass both parts of the RRT examination.

PROPOSED LANGUAGE

§ 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 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 all parts of the national registered 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 who provides evidence that he or she passed the National Board for Respiratory Care’s certified respiratory therapist examination prior to January 1, 2015, may not be required to pass the registered respiratory therapist examination, provided there is no evidence of prior license or job-related discipline, as determined and at the discretion of the board.

-continued-

§ 3735.5. Equivalent examination for credentialing

~~The requirements to pass the written examination 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 that is, in the opinion of the board, equivalent to the examination 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 national respiratory therapist examination.~~

(b) The board may extend the dates an applicant may perform as a respiratory care practitioner applicant:

(i) for causes completely outside the control of an applicant, to complete the application for licensure process;

(ii) in cases where the applicant can provide evidence that he or she has successfully passed the national certified respiratory therapist examination and has otherwise, completed the application for licensure process and has not previously been authorized to practice as a respiratory care practice applicant under this subdivision.

(c) Authorization to practice as a respiratory care practitioner applicant pursuant to subdivision (b) (ii) shall not exceed six months from the date of graduation or the date the application was filed, whichever is later.

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

~~(3) (e) 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 the national respiratory therapist examination, all privileges under this section shall automatically cease on the date specified by the board.~~

(c) (f) 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. Nothing in this section shall prohibit the board from denying or rescinding the privilege to work as a respiratory care practitioner applicant for any reason, including but not limited to, failure to pass the registered respiratory therapist examination or if cause exists to deny the license.

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

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 August 2013, 35,000 licenses have been issued (21,723 are active). 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 subacute facilities, physicians' offices, home health agencies, specialized care hospitals, medical equipment supply companies, and patients' homes.

The respiratory care profession is relatively young 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 founded in 1947. This Association estimates that there are over 150,000 respiratory therapists in the United States with California contributing 12% of this figure.

JUSTIFICATION

Over the last ten years there have been legislative amendments, and modifications in accreditation and credentialing requirements to such a point, that all current graduates of respiratory care educational programs qualify to take the NBRC's RRT exam. The NBRC will complete its "conceptual" changes to the CRT and RRT exams at the same time this proposal would take effect.

The Board has also taken into consideration other factors including staff resources, new BreEZe database modifications, out-of-state reciprocity and workforce impact.

The Board estimates there will be an insignificant impact on its resources that will result from one-time tasks related to outreach with students and educators and updating forms, its website and the new BreEZe database. The Board has already sought and gained confirmation that the BreEZe database could be modified if new legislation was enacted.

The proposed language also takes great care in developing a means to support reciprocity in an equitable manner by providing a provision to not require passage of the RRT exam if an applicant passed the CRT exam prior to January 1, 2015. It also allows the Board to extend a

work permit (one time) for up to six months from the date of graduation or the date an application was filed (whichever is later) if a scenario develops where an applicant may need additional time to pass the RRT exam.

The Board also took into account the impact this proposal may have on its existing workforce. The Board estimates that initially, the number of new licenses issued may be reduced by 30%.

The Board conducted a formal workforce study in 2007 that indicated the number of licensees it would need in coming years:

16,665 licensees by 2015
18,000 licensees by 2020
19,000 licensees by 2025
21,000 licensees by 2030

While the workforce study was prepared prior to the Affordable Care Act, the Board believes it has an ample workforce supply. At the time the study was completed, the Board had approximately 15,000 active licensees. Currently, the Board has over 21,700 active licensees, a figure well over the number of licensees needed by the year 2030. Further, the number of new applicants received each year continues to exceed the number of applications received in prior years.

Ultimately, there were no other factors or threats that outweighed the need to ensure competency in connection with the Board's consumer protection mandate.

B&P §3701 states, "The Legislature finds and declares that the practice of respiratory care in California affects the public health, safety, and welfare and is to be subject to regulation and control in the public interest to protect the public from the unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care." As such, licenses are issued in accordance with the Board's mandate to protect and serve the consumer in the interest of the safe practice of respiratory care.

B&P §3710.1 provides "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."

The proposed language will align the minimum examination requirements for licensure with the natural progression made in the respiratory field, accreditation standards and examination delivery. Evidence of competency at what was once considered the advanced level, provides greater consumer protection, improved job performance as a whole, and the ability to measure school outcomes.

ARGUMENTS PRO & CON

Pro: *Consumer Protection Strengthened and Alignment with National Movement.* Increasing the minimum exam threshold to the RRT will provide better consumer protection by ensuring new graduates meet the competency threshold that is now expected through all educational programs and will also provide an even playing field in which students can evaluate educational programs. This proposal also aligns with changes made to the structure of the national exams and the standards of the national accrediting agency.

Con: *Consumer Protection Weakened.* Failure to require passage of the RRT exam places an unnecessary deficiency in the level of consumer protection that the Board could afford. There are no factors or threats with any significance, that would outweigh the higher level of consumer protection that would be afforded through this proposal.

PROBABLE SUPPORT & OPPOSITION

- California Society for Respiratory Care (CSRC): The CSRC supports this proposal.

FISCAL IMPACT None.

ECONOMIC IMPACT The economic impact is expected to be insignificant. This proposal allows the last graduating class from an entry level program two years to take and pass the CRT examination. This proposal also has a provision to extend a work permit an additional six months for applicants who need additional time to pass the RRT examination.

FINDINGS FROM OTHER STATES In April 2013, the state of Ohio's Joint Committee on Agency Rule Review allowed the Ohio Respiratory Care Board to file a rule to require successful completion of the RRT exam in order to obtain a new license to practice respiratory care in Ohio. The new rule will take effect January 1, 2015.

Senate Business, Professions and Economic Development Committee
COMMITTEE BILL: PROPOSED LEGISLATION

Note: Submit the completed form to the Committee electronically by email **and** as a hardcopy by mail. Attach additional information or documentation as necessary.

REQUESTOR & CONTACT INFORMATION

Stephanie Nunez, Executive Officer
Respiratory Care Board of California
3750 Rosin Court, Suite 100
Sacramento, CA 95834
T: 916.999.2232
E: Stephanie.nunez@dca.ca.gov
W: rcb.ca.gov

Respiratory Care Board
Legislative Proposal #2
Substantive
Interim Suspension Order
Sections 3753 & 3769.7

DATE SUBMITTED November 18, 2013

SUMMARY

Licensed RCPs who are arrested or convicted for malicious and egregious crimes such as lewd and lascivious acts against a child under 14, possession of child pornography, and attempted murder, to name a few, are often permitted to continue practicing while awaiting criminal adjudication. RCPs work in many settings, including homes and children's hospitals, and with all types of vulnerable patients, including children and the elderly. While the Board vigorously pursues avenues to suspend a license in these circumstances, these RCPs often continue to work for weeks, months, even years, all the while with no public notice, placing the public health, welfare, and safety at immediate and significant risk. The current processes to obtain a suspension, prevents early public disclosure and includes several barriers to secure a suspension. The goals of this proposed legislation are to 1) provide a means to swiftly secure an Interim Suspension Order without threat of manifesting an estoppel effect and 2) provide authority for the Board to inform employers and the public of such an arrest.

CURRENT PROCESS OVERVIEW

In accordance with the Board's ISO Policy, it aggressively pursues an immediate suspension for any of the following scenarios involving a licensed RCP (the list is not all inclusive):

- Under the influence of drugs or alcohol while at work.
- Charged with Driving Under the Influence on the way directly to a work shift.
- Allegations of engaging in a lewd act, sexual misconduct, or sexual assault involving a child, patient or unconsenting adult.
- Allegations of engaging in or attempting to engage in murder, rape, or other violent assault.

Once a suspension is secured, the Board aggressively pursues avenues to provide public notice, as well.

Following is a summary of the Board's current process when it learns an RCP has been arrested for an egregious crime (sexually-related/murder) to which the Board believes poses an immediate threat to the public:

- Complaint Received - Generally, the Board is notified via a rap sheet or the media within one to five days of the arrest.

- Arrest Verified - Staff immediately contact the arresting agency to verify the arrest and charges verbally and request “certified” copies of the arrest. The Board generally receives an “uncertified” copy of the arrest report within 24 hours. A “certified” copy is generally received within two to ten days. Board staff will also request personnel documentation to determine if there are any other circumstances or actions that should be included in the record.
- Office of the Attorney General (OAG) Contact - At the same time staff are verifying the arrest, the appropriate supervising deputy attorney general (DAG) is contacted to begin steps to pursue a suspension, either through the Administrative Procedures Act (interim suspension order) or criminal justice system (Penal Code 23). The DAG will provide assistance if needed to obtain the “certified” arrest report and begin to make contact with the district attorney who will prosecute the case criminally.
- Suspension – Most often, a suspension through the criminal justice system (PC 23) is pursued (for reasons given later) and is usually obtained in six weeks to three months, with two months being the mode. Some cases can take up to two years (discussed later).
- Public Notice – Once a suspension is ordered, public notification is made.

IDENTIFICATION OF PROBLEM

Licensed RCPs who are arrested or convicted for malicious and egregious crimes such as lewd and lascivious acts against a child under 14, possession of child pornography, and attempted murder, to name a few, are often permitted to continue practicing while awaiting criminal adjudication. RCPs work in many settings, including homes and children’s hospitals, and with all types of vulnerable patients, including children and the elderly. While the Board vigorously pursues avenues to suspend a license in these circumstances, RCPs who have been arrested for malicious and egregious crimes often continue to work for weeks, months, even years, all the while with no public notice, placing the public health, welfare, and safety at immediate and significant risk. The current processes to obtain a suspension, prevents early public disclosure and includes several barriers to secure a suspension.

The two problems that this proposal addresses are 1) The Board’s lack of clear authority to provide public notice of licensee arrests, and more predominately 2) The limitations in securing a license suspension swiftly.

Public Notice

The Board has no authority to make public disclosure of any arrests until such time a formal legal pleading (i.e. Accusation) or suspension (PC 23/ISO) order is filed wherein those details are provided. Unless the subject is arrested at work or the media provides coverage, the public and employers do not have any knowledge of an arrest.

As part of its investigation, the Board will request employer documentation (usually within two days from learning of the arrest). However, it is not authorized to divulge the basis for the request, based on legal advice and concerns for allegations of harassment that could ultimately thwart efforts for discipline.

In addition, the OAG cannot file an Accusation against a person, just for the sake of making a public record. There must be some evidence that a violation has taken place, and a reasonable certainty that sufficient “clear and convincing” evidence will be present prior to an administrative hearing.

In reviewing the history of serious cases the Board has had over the last six years, we found that public notice usually takes anywhere from six weeks to three months. Even this success is based on “chance” that various factors align in the Board’s favor. In all cases, the RCPs have been employed — several at children’s hospitals — and have been authorized to practice.

In one record-setting case, the DAG was exceptional and visited the subject and obtained a stipulation to suspend his license, the same day the Board learned of the arrest. In contrast, another case with allegations of lewd conduct with a child under 14, took two years to make a public record via an Accusation. However, there are several cases that fall in between, where criminal prosecution can take months, even years, to adjudicate, which in turn, affects the Board’s ability to discipline the license. The barriers present in securing an order of suspension, directly correlate, to delays in making public notice.

Securing an Order of Suspension

There are two means by which the Board can secure an order of suspension: Through criminal proceedings based on Penal Code 23 (PC 23) and through administrative proceedings to pursue an ISO. Both of these options, have numerous drawbacks and obstacles.

PC 23 Suspension/Criminal

Obtaining a PC 23 suspension is the preferred route to obtain a suspension when the complaint is based on an arrest with egregious criminal charges. A PC 23 suspension remains in effect until the criminal case is adjudicated and prevents a collateral estoppel effect.¹

Prior to “*Gray v. Superior Court of Napa County/Medical Board of California*,” filed on January 5, 2005, a PC 23 suspension was relatively easy to obtain. The Board’s counsel could appear at an arraignment (with or without notice to the defendant) and request the suspension based on the charges.

The Gray case changed this process by requiring “reasonable notice” to the defendant and an evidentiary showing that failure to take such action would result in serious injury to the public, citing that the mere fact that charges were filed was not sufficient. Given these requirements, the Board has difficulty with each and every egregious case, in pursuing a PC 23 suspension swiftly.

Reasonable Notice

Because no days were specified in the Gray case, “reasonable” is left open for interpretation. The opinion of the OAG varies from region to region, ranging anywhere from one to ten days. The purpose of the notice is to advise the RCP that a DAG will be present at the criminal arraignment, preliminary hearing, or trial and will be requesting suspension of his or her license pursuant to PC 23. The Board, nor the DAG, has any influence or control over when these criminal proceedings will take place. An arraignment can be held within days of learning of an arrest. A criminal “preliminary hearing” may be held within three to four months of an arrest, assuming the RCP does not waive or delay the hearing. The criminal trial could take months and even years to initiate.

1

Collateral estoppel: 1. The binding effect of a judgment as to matters actually litigated and determined in one action on later controversies between the parties involving a different claim from that on which the original judgment was based. 2. A doctrine barring a party from relitigating an issue determined against that party in an earlier action, even if the second action differs significantly from the first one. Source: Garner, Bryan A. “Collateral estoppel.” Black’s Law Dictionary, Eighth Edition, 2004.

Evidentiary Showing

Again, the Gray case was not specific in what constitutes an evidentiary showing, only that citing charges were filed, was not sufficient. District Attorneys are reluctant to release any evidence or allow any testimony until such time they must provide evidence to a criminal judge that grounds exist to pursue a criminal trial or at the actual trial itself. In most scenarios, an “evidentiary showing” cannot be achieved by the time of an arraignment. The next available opportunity to request a PC 23 suspension would be at a preliminary hearing, where a judge determines if there are sufficient grounds to pursue a criminal trial. A preliminary hearing is generally held three to four months following an arrest, but may take longer, if held at all. If the RCP waives the preliminary hearing, the next opportunity to request a PC 23 suspension, is when the trial is initiated, which can take months or even years.

Finally, there is the matter of the RCP appealing a conviction. If ordered, a PC 23 suspension only remains in effect until the matter is adjudicated. There are no means through PC 23 to request another suspension while a criminal matter is being appealed.

Interim Suspension Order/Administrative

Obtaining an ISO through the Office of Administrative Hearings (OAH), can occur in as little as 24 hours to three weeks, from the date the OAG requests the ex parte or standard hearing. As with the PC 23 suspension, notice and evidentiary requirements still exist. While this process is beneficial in many instances, it has proven to be impractical in cases involving arrests of this magnitude.

The evidentiary showing is by far, the greatest hurdle. The opinion of the OAG has varied from region to region on what constitutes an evidentiary showing. Most DAGs will move forward with a declaration from an arresting officer/investigator, while others believe the victim must testify which has proved to be impossible. District Attorneys are reluctant to provide any evidence to the DAG or allow arresting officers/investigators to testify at an Administrative Hearing in fear of creating a collateral estoppel effect. And so far, we have not encountered a district attorney willing to allow victims to testify prior to an actual trial as a result of concerns of a collateral estoppel effect and the victims' mental wellness. It is crucial that the DAG work cooperatively with the district attorney handling the case to gain cooperation to obtain evidence which is always on the district attorney's timeline.

The standard of proof for criminal cases is clear and convincing evidence without a reasonable doubt. The standard of proof for administrative cases seeking revocation is clear and convincing evidence to a reasonable certainty (*Ettinger v. Board of Medical Quality Assurance, Department of Consumer Affairs (1982)*). The “clear and convincing” standard of proof previously applied even in the case of an interim license suspension authorized by Government Code section 11529 (*Silva v. Superior Court (1993) 14 Cal.App.4th 562, 569-571.*) However, the adoption of §494 of the B&P in 1993, reduced this standard for interim license suspensions to “a preponderance of the evidence.”

The evidentiary showing for an ISO is usually not the barrier. Usually, an ISO can be obtained with certified arrest records. Rather, the barrier comes from the requirement tied to the ISO process, in which the Board must file an Accusation within 15 days and if requested by the licensee, hold a hearing within 30 days to consider revocation of the license [*reference subdivisions (f) of section 11529 of the Administrative Procedures Act*]. At this point, the Board must have a key piece of evidence or testimony, in addition to the certified arrest records, to meet the “clear and convincing” threshold. The more egregious the crime, the more likely the criminal hearing will be drawn out and the evidence will remain limited based on those same

reasons previously discussed (e.g. collateral estoppel effect). So, the DAG will not pursue an ISO in these instances, as it would likely result in the ISO being lifted and a final order with no discipline.

PROPOSED SOLUTION

Amend section 3753 of the Business and Profession Code to reduce the standard of proof to obtain an ISO to “some credible evidence” to ensure certified arrest records are considered sufficient evidence in all cases to secure and ISO AND extend the time to file an accusation after securing an ISO from 15 days to 60 days from the time the ISO is ordered, or if applicable to 60 days after the criminal matter has been adjudicated and all appeals exhausted.

Add section 3769.7 to the Business and Professions Code to provide the Board clear authorization to publicly disclose any criminal arrest for a period of up to 60 days after the matter has been adjudicated and all appeals exhausted.

PROPOSED LANGUAGE

Section 3753 of the Business and Professions Code is amended to read:

§ 3753. Application of provisions of Administrative Procedure Act

(a) The procedure in all matters and proceedings relating to the denial, suspension, or revocation of licenses under this chapter shall be governed by the provisions of the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code).

(b) Notwithstanding *Ettinger v Board of Medical Quality Assurance*, Department of Consumer Affairs (1982) 135 Cal.App.3d 853, and section 494 of this code, the standard of proof applied in all proceedings requesting an Interim Suspension Order shall be by some credible evidence.

(c) Notwithstanding section 494 of this code, in all proceedings concerning an Interim Suspension Order, an accusation shall be filed within 60 days from the date an interim suspension is ordered or if the interim suspension order is issued based on an act that results in the filing of criminal charges, within 60 days after all criminal matters are adjudicated, all rights to an appeal are exhausted or all time periods to appeal have lapsed, whichever is greater.

Section 3769.7 is added to the Business and Professions Code to read:

3769.7. Public information; arrests

The board may inform all known employers, potential employers and the public and post on the Internet any information concerning an arrest of any applicant or licensee for a period of up to 60 days after any criminal matter has been adjudicated and all appeals have been exhausted or the time to appeal has elapsed. The board shall ensure it possesses certified copies of an arrest report or charging documents prior to making any such information available for public display.

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 August 2013, nearly 35,000 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 subacute facilities, physicians' offices, home health agencies, specialized care hospitals, medical equipment supply companies, and patients' homes.

The respiratory care profession is relatively young 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 founded in 1947. This Association estimates that there are over 150,000 respiratory therapists in the United States with California contributing 12% of this figure.

JUSTIFICATION

There is a recent movement in public awareness through the media and efforts by law enforcement agencies to put a halt to child sex predators and their horrific sexual acts against children. Moreover, a licensee arrested for rape, murder, or other egregious crimes is a direct threat to patients. This proposed language gives the Board the authority to prevent additional children and other vulnerable patients from becoming victims of sexual offenses and other egregious crimes.

In 2013, the Sunset Review Committee also made the following recommendation in regard to this problem, "The Board should seek to extend the timeframe placed on the AG to file an accusation. This will allow the AG to utilize the ISO process without being subject to the currently limited timeframe."

B&P §3701 states, "The Legislature finds and declares that the practice of respiratory care in California affects the public health, safety, and welfare and is to be subject to regulation and control in the public interest to protect the public from the unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care". As such, licenses are issued in accordance with the Board's mandate to protect and serve the consumer in the interest of the safe practice of respiratory care.

B&P §3710.1 provides “**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.”

The legislature’s intent is clear. The regulation of the respiratory care practice must be in the public interest of consumer protection. Egregious acts warrant immediate suspension. While there are a number of methods to achieve immediate suspension, the Board believes the proposals set forth, provide the necessary safeguards, while still providing due process.

ARGUMENTS PRO & CON

Pro: *Public’s immediate health and safety is protected.* This proposed language gives the Board the authority to prevent children and other vulnerable patients from becoming victims of sexual offenses and other egregious crimes. Any person arrested for an egregious crime would no longer have pathways that would allow him/her to continue to practice respiratory care while an egregious criminal matter is pending.

Con: *The subject of the arrest may be falsely accused and innocent.* However, keep in mind that the arresting agency must have some belief in the evidence and/or testimony to make the arrest. The more inconceivable scenario would be adding an additional child or vulnerable patient, to the list of the licensee's victims with the State knowing the licensee's criminal arrest/conviction. The Board has given consideration to due process rights weighted against the potential severity for gross negligence or malicious and potential harm to patients. It is much like a person who is held in jail or given bail while criminal charges are pending. The Board believes this proposal strikes an appropriate balance between consumer safeguards and due process rights.

PROBABLE SUPPORT & OPPOSITION

California Society for Respiratory Care (CSRC): The Board anticipates the CSRC will take a neutral position on this proposed legislation.

FISCAL IMPACT

Insignificant. Providing clarity and authority to move forward will reduce case handling by having a direct path to achieve suspension. However, the costs saving realized is expected to be insignificant. This measure is aimed at providing consumer protection, not cost savings.

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. Licensees arrested for an egregious crime may be prohibited from working and earning an income during a suspension period.

FINDINGS FROM OTHER STATES: The Board is unaware of other states with similar statutes. However the Department of Social Services may suspend the license of a child daycare worker on a single accusation (not vetted through an arresting agency) and without a hearing, for up to 30 days.

Senate Business, Professions and Economic Development Committee
COMMITTEE BILL: PROPOSED LEGISLATION

Note: Submit the completed form to the Committee electronically by email **and** as a hardcopy by mail. Attach additional information or documentation as necessary.

REQUESTOR & CONTACT INFORMATION

Stephanie Nunez, Executive Officer
Respiratory Care Board of California
3750 Rosin Court, Suite 100
Sacramento, CA 95834
T: 916.999.2232
E: Stephanie.nunez@dca.ca.gov
W: rcb.ca.gov

**Respiratory Care Board
Legislative Proposal #3**
Substantive
Enforcement/
Substantially Related Acts
Sections 3750, 3752.3, 3752.4,
3752.7, 3754.8, & 3755

DATE SUBMITTED November 18, 2013

SUMMARY This proposal will eliminate barriers that exist within the existing statutory framework to pursue discipline for acts of unprofessional conduct or the commission of crimes that may not result in a conviction. The goals of this proposed legislation are to 1) Substantially relate “acts” (not just convictions) for all egregious crimes and sexual misconduct violations; 2) Expand the definition of “unprofessional conduct” to include inappropriate behavior in a care setting; 3) Substantially relate any crime against a child, dependent adult, or the elderly; and 4) Ensure the Board continues to maintain jurisdiction in disciplinary matters that are finalized after a license has cancelled.

IDENTIFICATION OF PROBLEM:

The Board has encountered barriers within its existing statutory framework in pursuing discipline for acts of unprofessional conduct or the commission of crimes that may not result in a conviction.

Many DAGs believe the Board’s existing codes do not allow it to pursue administrative suspension or discipline for some egregious crimes (e.g. sexually related crimes, attempted murder, etc...) unless there is a conviction. In these cases, the administrative ISO is not even an option, as the DAG will only pursue administrative discipline upon a conviction. Sections 3752.5 and 3752.6 clearly show sexual misconduct and attempted bodily injury cases are substantially related to the practice. However, the authority to take action is limited to either §3750(d), conviction of a crime; §3750(j), a corrupt act; or §3755, unprofessional conduct. Absent a criminal conviction, some DAGs have been reluctant to take action solely based on §3750(j) and §3755 because the language is too broad. One example cited was that the term “corrupt” has never been defined by the courts.

Another roadblock can occur in cases where the DAG is relying upon a conviction to take action. The matter may be further delayed if the RCP appeals the conviction, as this would no longer meet the criteria of a “conviction” pursuant to B&P §3752.

The Board has also had cases arise from time to time involving a victim who may be a child, a dependent adult or an elderly person. In most cases, the Board has been able to pursue disciplinary action. But there have been some instances where the Board has had to pursue other avenues to address each scenario. The Board believes that any crime involving any of these persons as victims is grounds for discipline. RCPs are educated and trained to care for patients. A violation against any of these individuals shows the inability to care for or willingness to take advantage of, persons who may not be able to fully fend for themselves.

The Board has also recently received two complaints involving serious allegations of sexual harassment (that did not result in an arrest) and has since found that it has no basis to pursue disciplinary action in these types of cases. The proposed alternatives include amending §3755, Unprofessional Conduct to address this problem (separate from the Board's pursuit to immediately suspend licenses for more egregious serious acts).

PROPOSED SOLUTION:

- Amend §3750 to add that “Commission of any crime substantially related to the qualifications, functions, duties or practice of an RCP or the respiratory care practice” and “Commission of any act in violation of any provision of Division 2” are grounds to deny, suspend, revoke or impose probationary terms and conditions upon a license.
- Add §3752.3 to make the commission of a crime involving a minor, any person under 18 years of age, substantially related to the qualifications, functions or duties of an RCP.
- Add §3752.4 to make the commission of a crime involving an elder, any person 65 years of age or older, or dependent adult, as described in Section 368 of the Penal Code, substantially related to the qualifications, functions, or duties of an RCP.
- Amend §3752.7 to provide clarity of sexually related crimes that are grounds for revocation.
- Add §3754.8 to give the board continuing jurisdiction of a disciplinary matter despite the expiration or cancellation of a license.
- Amend §3755 to include inappropriate behavior, including but not limited to, verbally or physically abusive behavior, sexual harassment, or any other behavior that is inappropriate for any care setting.

PROPOSED LANGUAGE

§ 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.
- (q) Commission of, or the attempted commission of any crime substantially related to the qualifications, functions, duties or practice of a respiratory care practitioner or the respiratory care practice.
- (r) Commission or the attempted commission of any act in violation of any provision of Division 2, including, but not limited to, any act that if convicted, would be grounds for discipline.

§ 3752.3. Crime involving a minor

For purposes of Division 1.5 (commencing with Section 475) and this chapter, the commission of, or attempted commission of a crime involving a minor, any person under 18 years of age, whether or not the child was a patient, shall be considered a crime substantially related to the qualifications, functions or duties of a respiratory care practitioner.

§ 3752.4. Crime involving an elder/dependent adult

For purposes of Division 1.5 (commencing with Section 475) and this chapter, the commission of, or the attempted commission of a crime involving an elder, any person 65 years of age or older, or any dependent adult, as described in subdivision (a) of section 368 of the Penal Code, whether or not the elder or dependent adult was a patient, shall be considered a crime substantially related to the qualifications, functions or duties of a respiratory care practitioner.

3752.7. Sexual contact with patient; Conviction of sexual offense; Revocation

Notwithstanding Section 3750, any proposed decision or decision issued under this chapter in accordance with the procedures set forth in Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, that contains any finding of fact that the licensee or registrant engaged in or attempted to engage in, any act of sexual contact, as defined in Section 729, with a patient, or has committed, or attempted to commit an act or been convicted of a sex offense as defined in Section 44010 of the Education Code, or Section 290 of the Penal Code, shall contain an order of revocation. The revocation shall not be stayed by the administrative law judge. For purposes of this section, the patient shall no longer be considered a patient of the respiratory care practitioner when the order for respiratory procedures is terminated, discontinued, or not renewed by the prescribing physician and surgeon.

3754.8. Continuing Jurisdiction

The expiration, cancellation, forfeiture, or suspension of a license, practice privilege, or other authority to practice respiratory care by operation of law or by order or decision of the board or a court of law, the placement of a license on a retired status, or the voluntary surrender of a license by a licensee shall not deprive the board of jurisdiction to commence or proceed with any investigation of or action or disciplinary proceeding against the licensee, or to render a decision suspending or revoking the license.

§ 3755. Action for unprofessional conduct

The board may take action against any respiratory care practitioner who is charged with unprofessional conduct in administering, or attempting to administer, direct or indirect respiratory care or in any care setting. Unprofessional conduct includes, but is not limited to, repeated any acts of clearly administering directly or indirectly inappropriate or unsafe respiratory care procedures, protocols, therapeutic regimens, or diagnostic testing or monitoring techniques, inappropriate behavior, including but not limited to, verbally or physically abusive behavior, sexual harassment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or any other conduct which is inimical to the health, morals, welfare, or safety, whether or not the victim is a patient, a patient friend or family member or employee, and violation of any provision of Section 3750. The board may determine unprofessional conduct involving any and all aspects of respiratory care performed by anyone licensed as a respiratory care practitioner. Any person who engages in repeated acts of unprofessional conduct shall be guilty of a misdemeanor and shall be punished by a fine of not more than one thousand dollars (\$1,000), or by imprisonment for a term not to exceed six months, or by both that fine and imprisonment.

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 August 2013, nearly 35,000 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 subacute facilities, physicians' offices, home health agencies, specialized care hospitals, medical equipment supply companies, and patients' homes.

The respiratory care profession is relatively young 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 founded in 1947. This Association estimates that there are over 150,000 respiratory therapists in the United States with California contributing 12% of this figure.

JUSTIFICATION

Since the Board's inception, it has continued to evolve and lead the country in consumer protection as it relates to the regulation of respiratory care practitioners. With each disciplinary matter, the Board is open to learning how it can continue to evolve in this fashion.

This proposed language is a result of a handful of cases where the Board was unable to take appropriate disciplinary action as a result of its existing legal framework. In these instances, the acts were of a serious nature and the Board could not pursue disciplinary action or could not pursue it to the degree warranted.

This proposed language will fill the gaps in the existing legal framework to prevent future similar occurrences. It will also provide clarity and help alleviate delays in prosecution.

This proposal is in direct correlation with the legislature's intent to regulate the respiratory care practice in the public interest of consumer protection and with recommendations made by the sunset overview review staff in 2013.

B&P §3701 states, "The Legislature finds and declares that the practice of respiratory care in California affects the public health, safety, and welfare and is to be subject to regulation and control in the public interest to protect the public from the unauthorized and unqualified practice

of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care.” As such, licenses are issued in accordance with the Board’s mandate to protect and serve the consumer in the interest of the safe practice of respiratory care.

B&P §3710.1 provides “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.”

Sunset Overview Review Staff Recommendation in 2013: The Board should consider pursuing legislation that will help clarify the definition of unprofessional conduct and specify the Board’s ability to follow through with administrative suspension and discipline.

ARGUMENTS PRO & CON

Pro: *Consumer protection provisions are strengthened.* This proposed language strengthens the legal framework to pursue disciplinary action for acts and convictions that the Board has historically always pursued, but in some instances have succumbed to flaws in the existing legal framework. This proposed language also strengthens consumer protection for our most vulnerable population (i.e., children, dependent adults, and the elderly).

Con: Respondents who have averted disciplinary action as a result of various caveats in the Board’s existing legal framework, will no longer be able to do so.

PROBABLE SUPPORT & OPPOSITION

California Society for Respiratory Care (CSRC): The Board anticipates the CSRC will take a neutral position on this proposed legislation.

FISCAL IMPACT None.

ECONOMIC IMPACT

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.

FINDINGS FROM OTHER STATES: The Board is unaware of other states with similar statutes.

Board Meeting - Scheduling

2014 Calendar

January	February	March																																																																																																																																					
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><th>Su</th><th>Mo</th><th>Tu</th><th>We</th><th>Th</th><th>Fr</th><th>Sa</th></tr> <tr><td></td><td></td><td></td><td style="color: red;">1</td><td>2</td><td>3</td><td>4</td></tr> <tr><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td></tr> <tr><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td></tr> <tr><td>19</td><td style="color: red;">20</td><td>21</td><td>22</td><td>23</td><td>24</td><td>25</td></tr> <tr><td>26</td><td>27</td><td>28</td><td>29</td><td>30</td><td>31</td><td></td></tr> </table>	Su	Mo	Tu	We	Th	Fr	Sa				1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><th>Su</th><th>Mo</th><th>Tu</th><th>We</th><th>Th</th><th>Fr</th><th>Sa</th></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td>1</td></tr> <tr><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td style="background-color: yellow;">7</td><td>8</td></tr> <tr><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td><td style="background-color: yellow;">14</td><td>15</td></tr> <tr><td>16</td><td style="color: red;">17</td><td>18</td><td>19</td><td>20</td><td>21</td><td>22</td></tr> <tr><td>23</td><td>24</td><td>25</td><td>26</td><td>27</td><td>28</td><td></td></tr> </table>	Su	Mo	Tu	We	Th	Fr	Sa							1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><th>Su</th><th>Mo</th><th>Tu</th><th>We</th><th>Th</th><th>Fr</th><th>Sa</th></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td>1</td></tr> <tr><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td></tr> <tr><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td></tr> <tr><td>16</td><td>17</td><td>18</td><td>19</td><td>20</td><td>21</td><td>22</td></tr> <tr><td>23</td><td>24</td><td>25</td><td>26</td><td>27</td><td>28</td><td>29</td></tr> <tr><td>30</td><td style="color: red;">31</td><td></td><td></td><td></td><td></td><td></td></tr> </table>	Su	Mo	Tu	We	Th	Fr	Sa							1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31					
Su	Mo	Tu	We	Th	Fr	Sa																																																																																																																																	
			1	2	3	4																																																																																																																																	
5	6	7	8	9	10	11																																																																																																																																	
12	13	14	15	16	17	18																																																																																																																																	
19	20	21	22	23	24	25																																																																																																																																	
26	27	28	29	30	31																																																																																																																																		
Su	Mo	Tu	We	Th	Fr	Sa																																																																																																																																	
						1																																																																																																																																	
2	3	4	5	6	7	8																																																																																																																																	
9	10	11	12	13	14	15																																																																																																																																	
16	17	18	19	20	21	22																																																																																																																																	
23	24	25	26	27	28																																																																																																																																		
Su	Mo	Tu	We	Th	Fr	Sa																																																																																																																																	
						1																																																																																																																																	
2	3	4	5	6	7	8																																																																																																																																	
9	10	11	12	13	14	15																																																																																																																																	
16	17	18	19	20	21	22																																																																																																																																	
23	24	25	26	27	28	29																																																																																																																																	
30	31																																																																																																																																						
April	May	June																																																																																																																																					
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><th>Su</th><th>Mo</th><th>Tu</th><th>We</th><th>Th</th><th>Fr</th><th>Sa</th></tr> <tr><td></td><td></td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td></tr> <tr><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td></tr> <tr><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td></tr> <tr><td>20</td><td>21</td><td>22</td><td>23</td><td>24</td><td>25</td><td>26</td></tr> <tr><td>27</td><td>28</td><td>29</td><td>30</td><td></td><td></td><td></td></tr> </table>	Su	Mo	Tu	We	Th	Fr	Sa			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30				<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><th>Su</th><th>Mo</th><th>Tu</th><th>We</th><th>Th</th><th>Fr</th><th>Sa</th></tr> <tr><td></td><td></td><td></td><td></td><td>1</td><td>2</td><td>3</td></tr> <tr><td>4</td><td>5</td><td style="background-color: yellow;">6</td><td style="background-color: yellow;">7</td><td style="background-color: yellow;">8</td><td style="background-color: yellow;">9</td><td>10</td></tr> <tr><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td></tr> <tr><td>18</td><td>19</td><td>20</td><td>21</td><td>22</td><td>23</td><td>24</td></tr> <tr><td>25</td><td style="color: red;">26</td><td>27</td><td>28</td><td>29</td><td>30</td><td>31</td></tr> </table>	Su	Mo	Tu	We	Th	Fr	Sa					1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><th>Su</th><th>Mo</th><th>Tu</th><th>We</th><th>Th</th><th>Fr</th><th>Sa</th></tr> <tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td></tr> <tr><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td><td>14</td></tr> <tr><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td>20</td><td>21</td></tr> <tr><td>22</td><td>23</td><td>24</td><td>25</td><td>26</td><td>27</td><td>28</td></tr> <tr><td>29</td><td>30</td><td></td><td></td><td></td><td></td><td></td></tr> </table>	Su	Mo	Tu	We	Th	Fr	Sa	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30												
Su	Mo	Tu	We	Th	Fr	Sa																																																																																																																																	
		1	2	3	4	5																																																																																																																																	
6	7	8	9	10	11	12																																																																																																																																	
13	14	15	16	17	18	19																																																																																																																																	
20	21	22	23	24	25	26																																																																																																																																	
27	28	29	30																																																																																																																																				
Su	Mo	Tu	We	Th	Fr	Sa																																																																																																																																	
				1	2	3																																																																																																																																	
4	5	6	7	8	9	10																																																																																																																																	
11	12	13	14	15	16	17																																																																																																																																	
18	19	20	21	22	23	24																																																																																																																																	
25	26	27	28	29	30	31																																																																																																																																	
Su	Mo	Tu	We	Th	Fr	Sa																																																																																																																																	
1	2	3	4	5	6	7																																																																																																																																	
8	9	10	11	12	13	14																																																																																																																																	
15	16	17	18	19	20	21																																																																																																																																	
22	23	24	25	26	27	28																																																																																																																																	
29	30																																																																																																																																						
July	August	September																																																																																																																																					
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><th>Su</th><th>Mo</th><th>Tu</th><th>We</th><th>Th</th><th>Fr</th><th>Sa</th></tr> <tr><td></td><td></td><td>1</td><td>2</td><td>3</td><td style="color: red;">4</td><td>5</td></tr> <tr><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td></tr> <tr><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td></tr> <tr><td>20</td><td>21</td><td>22</td><td>23</td><td>24</td><td>25</td><td>26</td></tr> <tr><td>27</td><td>28</td><td>29</td><td>30</td><td>31</td><td></td><td></td></tr> </table>	Su	Mo	Tu	We	Th	Fr	Sa			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31			<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><th>Su</th><th>Mo</th><th>Tu</th><th>We</th><th>Th</th><th>Fr</th><th>Sa</th></tr> <tr><td></td><td></td><td></td><td></td><td></td><td>1</td><td>2</td></tr> <tr><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> <tr><td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td></tr> <tr><td>17</td><td>18</td><td>19</td><td>20</td><td>21</td><td>22</td><td>23</td></tr> <tr><td>24</td><td>25</td><td>26</td><td>27</td><td>28</td><td>29</td><td>30</td></tr> <tr><td>31</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </table>	Su	Mo	Tu	We	Th	Fr	Sa						1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31							<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><th>Su</th><th>Mo</th><th>Tu</th><th>We</th><th>Th</th><th>Fr</th><th>Sa</th></tr> <tr><td></td><td style="color: red;">1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td></tr> <tr><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td></tr> <tr><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td>20</td></tr> <tr><td>21</td><td>22</td><td>23</td><td>24</td><td>25</td><td>26</td><td>27</td></tr> <tr><td>28</td><td>29</td><td>30</td><td></td><td></td><td></td><td></td></tr> </table>	Su	Mo	Tu	We	Th	Fr	Sa		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30				
Su	Mo	Tu	We	Th	Fr	Sa																																																																																																																																	
		1	2	3	4	5																																																																																																																																	
6	7	8	9	10	11	12																																																																																																																																	
13	14	15	16	17	18	19																																																																																																																																	
20	21	22	23	24	25	26																																																																																																																																	
27	28	29	30	31																																																																																																																																			
Su	Mo	Tu	We	Th	Fr	Sa																																																																																																																																	
					1	2																																																																																																																																	
3	4	5	6	7	8	9																																																																																																																																	
10	11	12	13	14	15	16																																																																																																																																	
17	18	19	20	21	22	23																																																																																																																																	
24	25	26	27	28	29	30																																																																																																																																	
31																																																																																																																																							
Su	Mo	Tu	We	Th	Fr	Sa																																																																																																																																	
	1	2	3	4	5	6																																																																																																																																	
7	8	9	10	11	12	13																																																																																																																																	
14	15	16	17	18	19	20																																																																																																																																	
21	22	23	24	25	26	27																																																																																																																																	
28	29	30																																																																																																																																					
October	November	December																																																																																																																																					
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><th>Su</th><th>Mo</th><th>Tu</th><th>We</th><th>Th</th><th>Fr</th><th>Sa</th></tr> <tr><td></td><td></td><td></td><td>1</td><td>2</td><td>3</td><td>4</td></tr> <tr><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td></tr> <tr><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td></tr> <tr><td>19</td><td>20</td><td>21</td><td>22</td><td>23</td><td>24</td><td>25</td></tr> <tr><td>26</td><td>27</td><td>28</td><td>29</td><td>30</td><td style="color: red;">31</td><td></td></tr> </table>	Su	Mo	Tu	We	Th	Fr	Sa				1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><th>Su</th><th>Mo</th><th>Tu</th><th>We</th><th>Th</th><th>Fr</th><th>Sa</th></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td>1</td></tr> <tr><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td style="background-color: yellow;">7</td><td>8</td></tr> <tr><td>9</td><td>10</td><td style="color: red;">11</td><td>12</td><td>13</td><td style="background-color: yellow;">14</td><td>15</td></tr> <tr><td>16</td><td>17</td><td>18</td><td>19</td><td>20</td><td>21</td><td>22</td></tr> <tr><td>23</td><td>24</td><td>25</td><td>26</td><td style="color: red;">27</td><td style="color: red;">28</td><td>29</td></tr> <tr><td>30</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </table>	Su	Mo	Tu	We	Th	Fr	Sa							1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30							<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><th>Su</th><th>Mo</th><th>Tu</th><th>We</th><th>Th</th><th>Fr</th><th>Sa</th></tr> <tr><td></td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td></tr> <tr><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td></tr> <tr><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td>20</td></tr> <tr><td>21</td><td>22</td><td>23</td><td>24</td><td style="color: red;">25</td><td>26</td><td>27</td></tr> <tr><td>28</td><td>29</td><td>30</td><td>31</td><td></td><td></td><td></td></tr> </table>	Su	Mo	Tu	We	Th	Fr	Sa		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31			
Su	Mo	Tu	We	Th	Fr	Sa																																																																																																																																	
			1	2	3	4																																																																																																																																	
5	6	7	8	9	10	11																																																																																																																																	
12	13	14	15	16	17	18																																																																																																																																	
19	20	21	22	23	24	25																																																																																																																																	
26	27	28	29	30	31																																																																																																																																		
Su	Mo	Tu	We	Th	Fr	Sa																																																																																																																																	
						1																																																																																																																																	
2	3	4	5	6	7	8																																																																																																																																	
9	10	11	12	13	14	15																																																																																																																																	
16	17	18	19	20	21	22																																																																																																																																	
23	24	25	26	27	28	29																																																																																																																																	
30																																																																																																																																							
Su	Mo	Tu	We	Th	Fr	Sa																																																																																																																																	
	1	2	3	4	5	6																																																																																																																																	
7	8	9	10	11	12	13																																																																																																																																	
14	15	16	17	18	19	20																																																																																																																																	
21	22	23	24	25	26	27																																																																																																																																	
28	29	30	31																																																																																																																																				

Proposed Locations

February: Sacramento (*tentative*)

May: Long Beach (CSRC Conference scheduled for May 6-8 in Long Beach)

October: Sacramento