

Governor Edmund G. Brown Jr.  
State of California

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and Housing Agency

Awet Kidane, Director  
Department of Consumer Affairs



Alan Roth, MS, MBA, RRT-NPS, FAARC  
Acting President/Vice President

Mary Ellen Early  
Member

Rebecca F. Franzoia  
Member

Mark Goldstein, BS, RRT, RCP  
Member

Michael Hardeman  
Member

Ronald H. Lewis, MD  
Member

Judy McKeever, RCP  
Member

Laura C. Romero, PhD  
Member

Thomas Wagner, BS, RRT, FAARC  
Member

#### Mission

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

Toll Free: (866) 375-0386  
Website: [www.rcb.ca.gov](http://www.rcb.ca.gov)

# Respiratory Care Board of California

3750 Rosin Court, Suite 100, Sacramento, CA 95834

## Board Meeting Agenda

**November 7, 2014**

**10:30 a.m. - 3:00 p.m.**

**1625 North Market Blvd.  
South Building, Room S-102  
(First Floor Hearing Room)  
Sacramento, CA 95834  
(800) 952-5210**

10:30 a.m. **Call to Order** (Alan Roth)

*Introduction of new member, Thomas Wagner, BS, RRT, RCP*

**1. Public Comment** (Alan Roth)

*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.*

**2. Approval of April 4, 2014 Minutes** (Alan Roth)

**3. RCP Workforce Study Presentation** (Mark Goldstein)

*Joanne Spetz, PhD, Professor, Philip R. Lee Inst. for Health Policy Studies  
Associate Director of Research Strategy, Center for the Health Professions  
University of California, San Francisco*

**4. Fiscal Review** (Stephanie Nunez)

**5. Consideration for Approval of RCP Workforce Study** (Mark Goldstein)

**6. Vote to Adopt/Non Adopt Final Regulatory Package Including New and Amended Sections of the California Code of Regulations Concerning Continuing Education, Military and O-O-S Practitioner Exemptions, Sponsored Free Health Care Events, and Fee Schedule**  
(Stephanie Nunez)

**7. RCB Resolution Approval: Delegation to Department of Consumer Affairs for the Review and Registration of Sponsoring Entities**  
(Stephanie Nunez)

**8. Pulmonary Function Testing: Request for Attorney General Legal Opinion - Status/Action** (Stephanie Nunez)

**9. Legislative Action**

- a. 2014 Legislation of Interest (Christine Molina)
- b. 2015 Board Legislative Proposals for Approval (Stephanie Nunez)

**10. Enforcement Statistics**

**11. Election of Officers for 2015**

**12. 2015 Meeting Dates: Calendar**

1:00 p.m. **Break**

## • Closed Session •

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

- I. **Reconsideration of ALJ Proposed Decision: Simon C. Mata, RCP 29344**
- II. **Consideration of Proposed Stipulated Decision: James Ryan Bonacorso, RCP 28772**
- III. **Consideration of Proposed Stipulated Decision: Jason B. Ketchem, RCP 22983**

### 13. Public Comment on Items Not on the Agenda

### 14. Future Agenda Items

3:00 p.m. 15. **Adjournment**

#### **DIRECTIONS FROM AIRPORT**

From the Sacramento International Airport:  
(approximately 9 miles/15 min. from airport)

Exit Airport

Take I-5 South towards Sacramento

Take the Arena Blvd. Exit

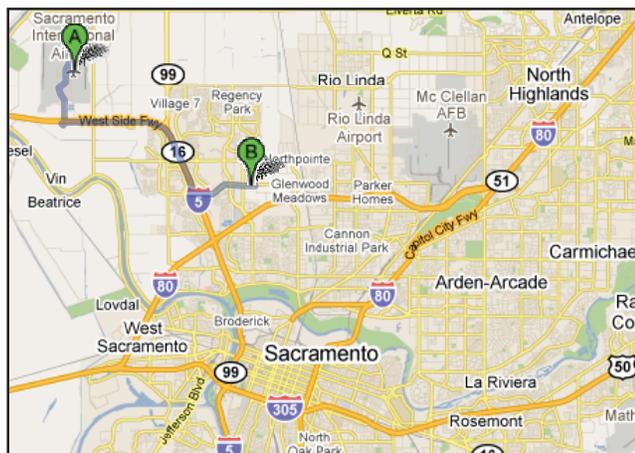
Turn Left onto Arena Blvd.

Continue onto N. Market Blvd.

(Arena turns into N. Market)

Make a U-turn at Sierra Point Drive

Destination is a three-story building on right



#### **NOTICE**

This meeting will be Webcast, provided there are no unforeseen technical difficulties. To view the Webcast, please visit <http://www.dca.ca.gov/publications/multimedia/webcast.shtml>

Action may be taken on any item on the agenda. Time and order of agenda items are subject to change at the discretion of the President. Meetings of the Respiratory Care Board are open to the public except when specifically noticed otherwise in accordance with the Open Meeting Act. In addition to the agenda item which addresses public comment, the audience will be given appropriate opportunities to comment on any issue before the Board, but the President may, at his discretion, apportion available time among those who wish to speak. Contact person: Paula Velasquez, telephone: (916) 999-2190 or (866) 375-0386.

The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Paula Velasquez at (916) 999-2190/ (866) 375-0386 or sending a written request to: Paula Velasquez, Respiratory Care Board, 3750 Rosin Court, Suite 100, Sacramento, CA 95834. Providing your request at least nine (9) business days before the meeting will help ensure availability of the requested accommodation.



**PUBLIC SESSION MINUTES**

**Friday, April 4, 2014**

**Ronald Reagan UCLA Medical Center  
De Neve Commons  
351 Charles E. Young Dr. Salon B  
Los Angeles, CA 90095**

**Members Present:** Charles B. Spearman, MEd, RCP, RRT, President  
Alan Roth, MS MBA RRT-NPS FAARC, Vice President  
Mary Ellen Early  
Rebecca Franzoia  
Mark Goldstein, BS, RRT, RCP  
Michael Hardeman  
Ronald Lewis, M.D.  
Judy McKeever, RCP, RRT  
Laura Romero, Ph.D.

**Staff Present:** Dianne Dobbs, Legal Counsel  
Stephanie Nunez, Executive Officer  
Christine Molina, Staff Services Manager  
Stephanie Aguirre, Associate Governmental Program Analyst

**CALL TO ORDER**

The Public Session was called to order at 9:04 a.m. by President Spearman. A quorum was present.

**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 Ms. McKeever introduced herself stating she is honored to be appointed into this position and looking  
2 forward to learning more about the RCB and serving and protecting the public.

3  
4 Ms. McKeever stated there is interest with the RCPs in the baccalaureate program. The issue is  
5 availability. She believes if more programs were available, people would choose to attend. She  
6 added this is the direction the profession should be taking, but does not believe this should be a  
7 requirement until programs are available.

8  
9 **c. Consideration to Contract Services for a Baccalaureate Degree Impact Study**

10 The Board directed staff to seek the services of a contractor to present a proposal at the next meeting  
11 on the scope of the study.

12  
13  
14  
15 **6. FISCAL REVIEW**

16  
17 Ms. Nunez stated revenues are projected to exceed expenditures by nearly \$100,000 after factoring in  
18 reimbursements. She alerted the board that some procedures are changing in the AG's office that  
19 may make it more expensive to process cases, possibly increasing AG expenditures.

20  
21  
22 **7. CONSIDERATION TO INCREASE CONTINUING EDUCATION HOURS REQUIRED FOR**  
23 **RENEWAL** *(Strategic Plan Goal No. 2.6)*

24  
25 President Spearman reviewed the information provided which shows the RCB's current required  
26 continuing education units (of 15 CEUs) as below most other professions.

27  
28 Vice President Roth stated with all the changes to protocols, ventilators, acute care and care outside  
29 of the hospital, it is incumbent upon the practitioner to seek out education. The Board should ensure  
30 the continuing competency of therapists through approved, qualified continuing education programs.

31  
32 Dr. Lewis inquired if there are core areas in respiratory care that therapists should focus on for  
33 continuing education and suggested that specific topics might be identified.

34  
35 Discussion ensued in the following areas:

- 36  
37 - Should units be increased? If yes, when and by how much?  
38 - RCPs are not always permitted time to participate in continued education.  
39 - Will more education allow for stronger patient safety and outcomes?  
40 - What would be the effective date?  
41 - Should the Board require core courses?  
42 - Should internet based units be limited?  
43 - Impact study should include information on benefits of categories.

44  
45 Dr. Lewis moved to increase continuing education units to 30 hours biennially by January 1, 2016. An  
46 impact study will be performed to determine if core courses should be identified.

47  
48 **Public Comment:**

49 Jeffery Davis, Director of Respiratory Therapy, UCLA Medical Center. Mr. Davis spoke in support of  
50 increased CEUs stating he has worked with two other states that have increased CE requirements.  
51 He suggested the Board take into consideration the professional organizations that will be providing  
52 the CEUs. He added the Board should also consider the cost of increasing CEU's to the practitioner.

1 Mr. Davis believes it is important to have categories in order to get practitioners out there among other  
2 RCPs.

3  
4 M/Lewis /S/Goldstein

5 Unanimous: Early, Franzoia, Goldstein, Hardeman, Lewis, McKeever, Roth, Romero, Spearman  
6 MOTION PASSED

7  
8  
9 **8. CONSIDERATION OF ENFORCEMENT HISTORY WEB RETENTION POLICY**  
10 *(Strategic Plan Goal No. 1.3)*

11  
12 Ms. Nunez opened the discussion on the proposed policy concerning the retention of discipline  
13 information posted on the Board's website:

14  
15 Upon request, the Board will consider the removal of disciplinary information as follows:

- 16  
17 • Decisions resulting in a Public Reprimand: Five years from the date the decision was  
18 effective or the date conditions were fulfilled, whichever is the latter.
- 19 • Issuance of Citation and Fines: Five years from the date the decision was effective  
20 including the resolution of any appeal or the date the fine was paid in full, whichever is  
21 the latter.
- 22 • Decisions containing orders for suspension, probation, revocation or surrender are not  
23 eligible for removal. In addition, citation and fines involving unlicensed individuals or  
24 employers of unlicensed activity are not eligible for removal. Further, the Board  
25 reserves the right to retain any administrative or disciplinary information or  
26 documentation on its website, when it believes it serves the best interest of the public.

27  
28 Ms. Nunez added, only discipline where the Board believes the licensee poses no risk to the public  
29 may be removed from its website.

30  
31 Discussion ensued.

32  
33 Mr. Goldstein moved to adopt the policy and remove the lesser offenses (Public Reprimand & Cite  
34 and Fines) off of the RCB's website after five years.

35  
36 M/Goldstein /S/Romero

37 Unanimous: Early, Franzoia, Goldstein, Hardeman, Lewis, McKeever, Roth, Romero, Spearman  
38 MOTION PASSED

39  
40  
41 **9. LIMITS OF RCP'S RESPONSIBILITY ON HOME DELIVERY**  
42 **OF EQUIPMENT AND PATIENT CARE DISCUSSION**  
43 *(Strategic Plan Goal No. 2.4)*

44  
45 Mr. Goldstein expressed his concern that most RCPs responsible for the home delivery of equipment  
46 must perform their job by the limits of their employer yet are held to a clinical care standard even  
47 when their job function is primarily educational and training.

48  
49 Discussion ensued.

1 **10. PROPOSED REGULATORY AMENDMENTS CONCERNING: CONTINUING EDUCATION,**  
2 **MILITARY AND O-O-S PRATITIONER EXEMPTIONS, AND FEE SCHEDULE**  
3 (Nunez)  
4

5 Mr. Hardeman moved to proceed with the regulatory process for the proposed language concerning  
6 education, military and out of state practitioner exemptions, and fee schedule.  
7

8 M/Hardeman/S/Lewis

9 Unanimous: Early, Franzoia, Goldstein, Hardeman, Lewis, McKeever, Roth, Romero, Spearman  
10 MOTION PASSED  
11

12 **11. LEGISLATIVE REPORT**  
13 (Molina/Nunez)  
14

15 Ms. Molina reviewed and provided updates regarding the 2014 Legislation of Interest. The Board's  
16 positions are as follows:  
17

- 18 AB 186: Professions and Vocations: Military Spouses: Temporary Licenses  
19 Status: Hearing to be set before the Senate Committee on Business, Professions  
20 and Economic Development  
21 Board's Position: Watch
- 22 AB 259: Health and Care Facilities: CPR  
23 Status: Referred to Senate Committee on Health and Senate Committee on Rules.  
24 Board's Position: Watch
- 25 AB 809: Healing Arts: Telehealth  
26 Status: Hearing before the Assembly Health Committee cancelled at the request of  
27 the author. This is a 2 year bill.  
28 Board's Position: Watch
- 29 AB 1827: State Bodies: Administrative and Civil Penalties  
30 Status: In Assembly –pending referral to appropriate committee(s)  
31 Board's Position: Watch
- 32 AB 1972: Respiratory Care Practitioners  
33 Status: Referred to Assembly Business, Professions, and Consumer Protection  
34 Committee.  
35 Board's Position: Support
- 36 AB 2102: Licensees: Data Collection  
37 Status: Referred to Assembly Business, Professions & Consumer Protection  
38 Committee.  
39 Board's Position: Watch
- 40 AB 2484: Healing arts: Telehealth  
41 Status: Referred to Assembly Committee on Business, Professions and Consumer  
42 Protection, and Assembly Health Committee  
43 Board's Position: Watch
- 44 AB 2720: State Agencies: Meetings: Record of Action Taken  
45 Status: Referred to Assembly Committee on Governmental Organization  
46 Board's Position: Watch
- 47 AB 2396: Convictions: expungement: licenses  
48 Board's Position: Oppose
- 49 SB 850: Public postsecondary education: community college districts: baccalaureate degree  
50 pilot program  
51 Status: Referred to Senate Committee on Education (was set for hearing 3/19/14,  
52 however, the hearing was cancelled at the request of the author).  
53 Board's Position: Support

1  
2 Mr. Goldstein moved to Support AB 1972 (RRT Bill) and SB 850 (Baccalaureate Degree Pilot  
3 Program Bill), Oppose AB 2396 (Expungement), and Watch the remaining bills.  
4

5 M/Goldstein /S/Roth  
6 In favor: Early, Franzoia, Goldstein, Hardeman, Lewis, McKeever, Roth, Romero, Spearman  
7 Unanimous  
8 MOTION PASSED  
9

10  
11 =====  
12 **CLOSED SESSION**  
13

14 The Board convened into Closed Session, as authorized by Government Code Section 11126c,  
15 subdivision (3) at 11:15 a.m. and reconvened into Public Session at 11:30 a.m.  
16 =====

17  
18  
19 **PUBLIC COMMENT ON ITEMS NOT ON THE AGENDA**  
20

21 No public comment was provided at this time.  
22

23  
24 **FUTURE AGENDA ITEMS**  
25

26 No future items were identified.  
27

28  
29 **ADJOURNMENT**  
30

31 The Public Session Meeting was adjourned by President Spearman at 12:15 p.m.  
32  
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37

38  
39 \_\_\_\_\_  
40 CHARLES B. SPEARMAN  
41 President  
42

38  
39 \_\_\_\_\_  
40 STEPHANIE A. NUNEZ  
41 Executive Officer  
42



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October 8, 2014

P0504321

Stephanie Nunez, Director  
Respiratory Care Board of California  
3750 Rosin Court, Suite 100  
Sacramento, CA 9583424

Dear Ms. Nunez,

We are presenting for your review a request for support of the following project:

PROJECT TITLE: California Respiratory Care Workforce Study  
PRINCIPAL INVESTIGATOR: Joanne Spetz, PhD  
TYPE OF PROPOSAL: New, Contract, Other Activity  
INDIRECT COST RATE: 10% total direct costs

In the event of an award, the Regents of the University of California reserve the right to negotiate the terms of the award with the Respiratory Care Board of California. Your favorable consideration will be appreciated.

In the event of an award, please send checks or wires as follows:

Please make checks payable to:

**The Regents of the University of California**  
**UCSF Controller's Office**  
**1855 Folsom Street, MCB 425, Box 0897**  
**San Francisco, CA 94143-0897 (94103 for courier services)**

For wires:

**Bank of America NA**  
**100 West 33<sup>rd</sup> Street**  
**New York, NY 10001**  
**Account No. BofA #12335-23601**  
**Routing No. 026009593**  
**Swift Code BOFAUS3N**

Any Award documentation or correspondence should be sent directly to:

John Radkowski, Director  
UCSF – Office of Sponsored Research | Government and Business Contracts  
3333 California Street, Suite 315  
San Francisco, CA 94118  
Telephone: (415) 502-4029 | e-Mail: [john.radkowski@ucsf.edu](mailto:john.radkowski@ucsf.edu)

Please direct questions to Linda Pham by phone at 415-502-8756 or by email to [linda.pham@ucsf.edu](mailto:linda.pham@ucsf.edu).

Sincerely,

Digitally signed by John Radkowski  
DN: cn=John Radkowski, o=Regents of the  
University of California, San Francisco Campus,  
ou=Director, Government & Business  
Contracts, email=john.radkowski@ucsf.edu,  
c=US  
Date: 2014.10.08 14:06:01 -0700

John Radkowski  
Director



University of California  
San Francisco

Philip R. Lee Institute for  
Health Policy Studies  
3333 California Street  
Suite 265  
San Francisco, CA 94118  
<http://healthpolicy.ucsf.edu>

Stephanie Nunez, Director  
Respiratory Care Board of California  
3750 Rosin Court, Suite 100  
Sacramento, CA 9583424

September 30, 2014

Dear Ms. Nunez:

Please find attached a proposal for a **California Respiratory Care Workforce Study**, for the period January 1, 2015, through June 30, 2016. This work would be done through a contract between the University of California and the Respiratory Care Board (Department of Consumer Affairs). You will find attached a detailed proposal with work plan, deliverables, timeline, and a detailed budget. Per your instructions, the facilities and administration charges are limited to 10% of total costs.

I look forward to hearing from you regarding this proposed contract.

Sincerely,

A handwritten signature in black ink that reads 'Joanne Spetz'.

**Joanne Spetz**

Professor, Philip R. Lee Institute for Health Policy Studies  
& Associate Director of Research Strategy, Center for the Health Professions  
3333 California Street, Suite 265  
University of California, San Francisco  
San Francisco, CA 94118  
tel: 415/502-4443  
fax: 415/476-0705  
email: [joanne.spetz@ucsf.edu](mailto:joanne.spetz@ucsf.edu)

## **California Respiratory Care Workforce Study**

**January 1, 2015 – June 30, 2016**

*Principal Investigator: Joanne Spetz, PhD, Philip R. Lee Institute for Health Policy Studies, UCSF*

The University of California, San Francisco, under the direction of Dr. Joanne Spetz, Professor, Philip R. Lee Institute for Health Policy Studies, will complete a comprehensive analysis of key issues regarding California's Respiratory Care workforce. Five research questions will be addressed in this study:

- 1) What is the feasibility and what would be the impact of establishing the requirement that respiratory therapists have a baccalaureate degree in California?
- 2) What are the curricular needs and implications of allowing RCPs to exercise prescriptive authority under protocol?
- 3) Are the current requirements regarding clinical supervision of RCP students adequate? Should there be modifications?
- 4) How effective are the Professional Ethics and Law courses that RCPs are currently required to take? Should they continue to be mandated?
- 5) Should the number of continuing education (CE) hours be increased or should the curricular requirements be changed?

To answer these five questions, we propose the following activities.

1. Conduct and summarize interviews with 10 Respiratory Care / Pulmonary Services Directors at selected general acute care hospitals.
2. Conduct and analyze a survey of Directors of Respiratory Care / Pulmonary Services at general acute care hospitals in California.
3. Complete a comprehensive literature review of scholarly work that examines the relationship between the education level of respiratory care practitioners (RCPs) and patient outcomes.
4. Collect and analyze the curricula currently used to train RCPs and other health care professionals (such as registered nurses, nurse practitioners, and physician assistants) to identify content related to the potential for RCPs to have prescriptive authority.
5. Conduct and summarize 10 interviews with Respiratory Care education program Directors.
6. Conduct and analyze 5 focus groups with RCPs at different locations in California.

As Principal Investigator of the project, Dr. Spetz will be involved in all aspects of the research design, interview and survey analyses, organization of the project, and publications.

The activities required to complete each of these tasks are outlined below, as are the deliverables associated with each task. An integrated timeline and budget are provided for all six tasks.

The period for this project is January 1, 2015 through June 30, 2016.

The budget for this contract period is \$159,091.

## **1. Conduct and summarize interviews with 10 Respiratory Care / Pulmonary Services Directors at selected general acute care hospitals.**

### *Scope of Work*

In consultation with the Respiratory Care Board, we will conduct semi-structured interviews with 10 selected Directors of respiratory care/pulmonary services at general acute care hospitals in California. The interview subjects will be recruited to capture information that represents a diverse set of facilities, such as by rural/urban geography, facility size, and demographics of population served.

Key issues addressed by the interviews would include:

- Are newly hired RCPs adequately prepared in terms of clinical skills/knowledge?
- What deficiencies in skills/knowledge of new RCP hires do employers have to address through on-board training programs?
- What kind of training is needed to qualify RCPs to exercise prescriptive authority under protocol?
- Can the level of clinical skill/knowledge currently required of RCPs to provide effective care be adequately covered in a two-year associate degree program?
- How is supervision over RCP students participating in clinical education exercised?
- What is the process used to evaluate students in terms of demonstrating clinical competencies?
- Are there components of the clinical training experience that need to be improved?
- Should the number of continuing education (CE) hours be increased? If so, by how much? Why do CE hours need to be increased?
- Should there be restrictions on the extent to which CE courses can be delivered online rather than in person?
- Should there be core CE courses taken by all RCPs? If so, why?
- How effective are the Professional Ethics and Law courses that RCPs are currently required to take? What is their impact on the practice of respiratory care? Should they continue to be mandated?

The specific steps to be undertaken are:

1. An interview guide will be developed in collaboration with the Respiratory Care Board to address the questions identified above.
2. A list of acute-care hospitals will be generated using California Office of Statewide Health Planning and Development records.
3. The respiratory care / pulmonary services directors of each hospital will be identified through web searches, phone calls, and personal contacts. Names, addresses, phone numbers, and email addresses will be obtained (to the extent they are available).
4. Criteria will be developed to select the 10 interview subjects. These may include hospital size and geographic location

5. The list of hospitals will be stratified into groupings aligned with the selection criteria. Hospitals will be selected based on the criteria / groupings, and a list of alternate hospitals will be identified in case some of the originally-selected hospitals choose to not participate.
6. The respiratory care / pulmonary services directors will be contacted by telephone and email to invite them to participate in the study. The study will be described to them, along with information aligned with protection of human subjects. If they agree to participate, a one-hour time period will be scheduled for the interview.
7. Interviews will be conducted as scheduled. Interviews will be recorded and notes will be taken. The recordings will be used only to verify information in the event notes are unclear.
8. All interview notes will be analyzed to identify common themes and issues pertaining to each of the study questions.
9. A summary of the thematic analysis and interview findings will be written and delivered to the Respiratory Care Board.

*Deliverables*

The thematic analysis and interview findings will be provided to the Respiratory Care Board as a short report intended for internal use.

## **2. Conduct and analyze a survey of Directors of Respiratory Care / Pulmonary Services at general acute care hospitals in California.**

### *Scope of Work*

In consultation with the Respiratory Care Board, UCSF will conduct and analyze a survey of Directors of Respiratory Care / Pulmonary Services at general acute care hospitals in California. The survey will be conducted primarily online, with options for Directors to respond by completing a PDF form or a paper form. If the email addresses of Directors cannot be identified, then the survey will be delivered by mail. At least two follow-up telephone calls per hospital will be conducted to encourage participation in the survey.

Key issues addressed by the survey will be drawn from the findings of the interviews with respiratory care / pulmonary services directors (described above).

The specific steps to be undertaken are:

1. A survey questionnaire will be developed in collaboration with the Respiratory Care Board, based on the findings from the interviews with respiratory care / pulmonary services directors. The questionnaire will be no longer than 6 printed pages.
2. The survey will include questions about facility size, staff mix of the respiratory care / pulmonary services department, and quantity and scope of services provided, in order to categorize respondents. The list of respiratory care / pulmonary services directors of each hospital developed for the interviews will be updated as needed.
3. The Respiratory Care Board may recommend the contractor develop the survey with assistance from a work group or consultation from specific stakeholders.
4. The draft survey will be tested on a small group of respiratory care / pulmonary services directors.
5. The survey will be prepared for online administration.
6. A paper version of the survey will be prepared as a fillable PDF that can be returned by email, fax, or mail.
7. Surveys will be sent to all respiratory care / pulmonary services directors of California general acute-care hospitals. The survey will be sent as an email explaining the survey and inviting participation, and include both the PDF version of the survey and a link to the online survey.
8. A follow-up email will be sent approximately weekly after the initial survey is sent.
9. Follow-up telephone calls will begin approximately two weeks after the initial survey is sent. Each non-responding hospital will be called up to 2 times.
10. The contractor will analyze the data to answer the research questions identified by the Respiratory Care Board. If necessary, data will be weighted to ensure results represent all hospitals in California.

11. A report will be prepared summarizing the findings of the survey, with tables and figures as appropriate.

*Deliverables*

The findings will be compiled into a report that includes descriptive information from the survey. This report also can include, at the Respiratory Care Board's discretion, the findings from the interviews of respiratory care / pulmonary services directors. UCSF will produce a PDF version of the report suitable for posting on the Board's website.

**3. Complete a comprehensive literature review of scholarly work that examines the relationship between the education level of respiratory care practitioners (RCPs) and patient outcomes.**

*Scope of Work*

The contractor will conduct a literature review to identify scholarly work that addresses the relationship between education level of RCPs and patient outcomes. The literature review also will examine the relationship between continuing education and the skills of RCPs. The literature review will include scholarly work that addresses the relationship between degree-level of RCPs, continuing education, and formal disciplinary action related to skills deficiencies and/or patient outcomes.

The specific steps to be undertaken are:

1. Search terms will be identified by the contractor in consultation with the Respiratory Care Board.
2. PubMed and Google Scholar will be searched using the selected terms. Related terms will be identified and used in the search process. Potentially relevant papers will be downloaded and catalogued in a bibliographic database. The references of each identified paper will be reviewed, and potentially relevant papers will be downloaded and catalogued.
3. The papers will be reviewed to assess the degree to which they are truly relevant to the research questions. Those that are relevant will be retained for the review.
4. All relevant literature will be reviewed, and a summary report will be developed that describes the key findings of each paper, along with ratings of the rigor and generalizability of each paper.

*Deliverables*

A report will be provided to the Respiratory Care Board that summarizes the literature as a whole, as well as each relevant paper. This report will be intended for internal use.

**4. Collect and analyze the curricula currently used to train RCPs and other health care professionals (such as registered nurses, nurse practitioners, and physician assistants) to identify content related to the potential for RCPs to have prescriptive authority.**

*Scope of Work*

In collaboration with the Respiratory Care Board, the contractor will conduct an analysis of the curriculum currently used to train respiratory care practitioners to address the issue(s) concerned with RCPs having prescriptive authority under protocol. The contractor also will examine the curricula of other health professions – such as registered nurses, nurse practitioners, and physician assistants – to identify curricular components that prepare those professionals to exercise prescriptive authority under protocol. Finally, the contractor will identify other countries (if they exist) that currently allow RCPs to prescribe under protocol.

The specific steps to be undertaken are:

1. The Respiratory Care Board will provide information about any curricular requirements for respiratory care education programs. These will be reviewed to identify components that could potentially serve as a basis for RCPs having prescriptive authority under protocol.
2. The curricula of selected California respiratory care education programs will be obtained and reviewed to identify components related to potential prescriptive authority under protocol (beyond those required by the Board). The selected programs will include baccalaureate, associate degree, and vocational programs.
3. The curricula of selected other professions will be obtained and reviewed to identify components related to potential prescriptive authority under protocol. These other professions will be selected in consultation with the Respiratory Care Board.
4. A web search will be used to identify other countries (if any exist) that allow RCPs to prescribe under protocol. The educational requirements and, if possible, the curricula for RCPs in those countries will be obtained and analyzed to identify components related to potential prescriptive authority under protocol.
5. A written report will be produced that summarizes the findings of the curricular review.

*Deliverables*

A report will be provided to the Respiratory Care Board that summarizes the curricular review. This report will be intended for internal use.

## **5. Conduct and summarize 10 interviews with Respiratory Care education program Directors.**

### *Scope of Work*

In consultation with the Respiratory Care Board, we will conduct semi-structured interviews with 10 selected Directors of respiratory care education programs in California. The interview subjects will be recruited to capture information that represents a diverse set of programs, including type of educational institution and geographic location.

Key issues addressed by the interviews would include:

- How is supervision over RCP students participating in clinical education exercised?
- What is the process used to evaluate students in terms of demonstrating clinical competencies?
- Are there components of the clinical training experience that need to be improved?
- Identify curricular components of RCP education programs in California that could serve as the basis to prepare RCPs to exercise prescriptive authority under protocol.
- What additional training is needed to prepare RCPs to exercise prescriptive authority under protocol?
- Can the level of clinical skill/knowledge currently required of RCPs to provide effective care be adequately covered in a two-year associate degree program?
- Identify specific challenges of providing a baccalaureate program within the two-year institutional setting.

The specific steps to be undertaken are:

1. An interview guide will be developed in collaboration with the Respiratory Care Board to address the questions identified above.
2. A list of respiratory care education programs will be generated using Respiratory Care Board records.
3. The deans/directors of each education program will be identified through web searches, phone calls, and personal contacts. Names, addresses, phone numbers, and email addresses will be obtained (to the extent they are available).
4. Criteria will be developed to select the 10 interview subjects. These may include type of educational institution and geographic location.
5. The list of education programs will be stratified into groupings aligned with the selection criteria. Programs will be selected based on the criteria / groupings, and a list of alternate programs will be identified in case some of the originally-selected programs choose to not participate.
6. The deans/directors will be contacted by telephone and email to invite them to participate in the study. The study will be described to them, along with information aligned with protection of human subjects. If they agree to participate, a one-hour time period will be scheduled for the interview.

7. Interviews will be conducted as scheduled. Interviews will be recorded and notes will be taken. The recordings will be used only to verify information in the event notes are unclear.
8. All interview notes will be analyzed to identify common themes and issues pertaining to each of the study questions.
9. A summary of the thematic analysis and interview findings will be written and delivered to the Respiratory Care Board.

*Deliverables*

The thematic analysis and interview findings will be provided to the Respiratory Care Board as a short report intended for internal use.

## **6. Conduct and analyze 5 focus groups with RCPs at different locations in California.**

### *Scope of Work*

With consultation from the Respiratory Care Board, the contractor will conduct focus groups with a selected group of currently employed respiratory care practitioners. Key issues addressed by the focus groups would include:

- Can the level of clinical skill/knowledge currently required of RCPs to provide effective care be adequately covered in a two-year associate degree program?
- Are there components of the clinical training experience that need to be improved?
- How effective are the Professional Ethics and Law courses that RCPs are currently required to take? What is their impact on the practice of respiratory care? Should they continue to be mandated?
- Should the number of continuing education (CE) hours be increased? If so, by how much? Why do CE hours need to be increased? Should there be restrictions on the extent to which CE courses can be delivered online rather than in person? Should there be core CE courses taken by all RCPs? If so, why?

The specific steps to be undertaken are:

1. A focus group discussion guide will be developed in collaboration with the Respiratory Care Board.
2. The contractor will propose five communities in which to conduct focus groups. These sites will be distributed across California and will be selected in consultation with the Respiratory Care Board.
3. The contractor will identify local organizations in each community that has expertise in recruiting focus group participants and/or identifying facilities appropriate for focus groups, for potential assistance in planning the focus groups. If such local organizations do not exist or are not affordable, the contractor will communicate with local employers to recruit participants, and will identify facilities directly.
4. Focus group participants, who are licensed RCPs, will be recruited, with a target of 10 people per group. Participants will be offered an incentive of a \$75 gift card for participation in a 2-hour focus group.
5. At least two members of the UCSF team will travel to the focus group site to conduct the focus group. Focus group participants will be offered light snacks and will be led through the focus group discussion guide by one UCSF team member, while another team member takes notes. Focus groups will be recorded for verification purposes, in the event notes are unclear.
6. The focus group notes will be analyzed for key themes.
7. A summary of the thematic analysis will be written and delivered to the Respiratory Care Board.

*Deliverables*

The findings from the focus groups will be summarized in a report that will be provided to the Respiratory Care Board as a short report intended for internal use.

**Timeline: California Respiratory Care Workforce Study.**

Activity	Jan 15	Feb 15	Mar 16	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	
Start-up activities: IRB approval, kick-off meeting, etc.	X																		
1. Interviews with hospital directors of respiratory care / pulmonary services		X	X	X	X														
2. Survey of hospital directors of respiratory care / pulmonary services						X	X	X	X	X	X								
3. Literature review		X	X	X	X														
4. Curriculum review						X	X	X	X	X	X	X							
5. Interviews with education program directors													X	X	X	X			
6. Focus groups with RCPs												X	X	X	X	X	X	X	X

**Budget**

<b>DETAILED BUDGET</b>				FROM		THROUGH
				01/01/15		06/30/16
NAME	ROLE ON PROJECT	Cal Mths	INST.BASE SALARY	SALARY REQUESTED	FRINGE BENEFITS	TOTAL
Joanne Spetz	PD/PI	1.20	174,840	26,882	9,075	35,957
Timothy Bates	Project Analyst	3.00	76,864	29,256	12,217	41,473
SRA 2	SRA 2	2.40	48,000	14,616	6,104	20,720
Admin	Admin	2.16	46,000	12,606	5,264	17,870
Financial Analyst	Financial Analyst	1.32	115,022	19,263	8,044	27,307
<b>SUBTOTALS</b>				<b>102,624</b>	<b>40,704</b>	<b>143,328</b>
SUPPLIES ( <i>Itemize by category</i> )						
Project-related supplies: \$1433.28						1,433
TRAVEL						
Focus group travel, travel to respiratory care board						3,318
OTHER EXPENSES ( <i>Itemize by category</i> )						
Focus group facility rentals, incentives						6,250
Communications costs						1,210
Computing & data processing costs						1,983
Other expenses						1,569
<b>SUBTOTAL DIRECT COSTS FOR BUDGET PERIOD</b>						<b>\$159,091</b>
FACILITIES & ADMINISTRATION COSTS (10%)						15,909
<b>TOTAL COSTS FOR BUDGET PERIOD</b>						<b>\$175,000</b>

## Budget Justification

### Salary and benefits

Per UCSF policy, salaries are based on current rates, escalated by published increase schedules depending on title code and the incumbent's placement on the salary rate scale. Merit increases and cost of living adjustments are included at the time they are due according to UC guidelines. Fringe benefits are estimated based on standard rates of faculty and staff, other standardized scales for other classifications, or actual rates as appropriate.

#### Fringe Benefits:

	7/1/14-6/30/15	7/1/15-6/30/16
ACADEMIC	33.72%	33.80%
STAFF	41.72%	41.80%

Joanne Spetz, PhD, Professor, is Principal Investigator of this contract. She will be responsible for all aspects of the work and will supervise all team members in the project. She will dedicate 10% of her time to this contract.

Timothy Bates, MPH, Senior Research Analyst, is Project Manager of this contract. He will manage all aspects of the work, supervise other personnel, and be directly engaged and have a leading role in conducting all components of the contract. He will dedicate 25% of his time to this contract.

Staff Research Associate, to be named, will dedicate 20% of time to this contract. The Research Associate will help to develop the survey questionnaires, interview guides, and focus group guides. The Research Associate also will help to conduct the literature review and curriculum review. This person will maintain databases of surveys responses, merge data from the online survey with the paper surveys, and edit and format reports.

Administrative Analyst, to be named, will dedicate 18% of time to this contract. The Administrative Analyst will support all components of the project, including literature searches, preparing survey questionnaires, identifying survey respondents and interview subjects, identifying focus group sites, coordinating focus groups, preparing reports, and other tasks.

Financial Analyst, to be named, will support the project by managing all project finances, handling payments to printers and other vendors, and ensure that all accounting practices are followed. This person is budgeted at 11% of time in each year.

### Other Expenses

*Project Supplies.* This includes various expenses specifically related to project activities, such as computer supplies, presentation materials, centralized research support expenses, software, office supplies, etc. The budgeted amount is based on past experience with similar projects (1% of personnel costs).

*Travel.* This includes travel to the Respiratory Care Board for project consultation and travel to focus groups.

*Focus group facility rentals and incentives.* This includes an estimated \$500 rental cost per focus group site, and \$75 incentives for 50 participants.

*Communications.* Includes costs related to telephone services (line, local, and long distance expenses). The cost is based on an estimate of a standard per month per phone line cost per FTE, plus an estimate of long distance charges (including conference calls). An additional cost is associated with maintenance of a toll-free line for people who have received surveys to contact the project team to answer questions.

*Data Network Recharge.* This recharge provides funding for critical network equipment and services. The funding model for data network services includes a UCSF-wide per capita rate of \$41/FTE/month.

*Computing and Communication Device Support Services (CCDSS).* This recharge provides integral support to campus voice and data technology functions. CCDSS includes software installation/updates, internet security, hardware setup/configuration, and centrally managed patching, storage and backup. The university charges these expenses to all funding sources based on a monthly recharge rate of \$48.50 per FTE, consistent with the university's current methodology used for data network services. The recharge rates are provided for under our approved DS-2, will be computed in accordance with applicable OMB requirements, including 2 CFR Part 220 (formerly Circular A-21), and will be reviewed and adjusted annually.

*Computing and Data Processing.* Personnel in this project are affiliated with and receive computing and data processing support from the Philip R. Lee Institute for Health Policy Studies under an approved recharge. The UCSF Philip R. Lee Institute for Health Policy Studies (PRL-IHPS) is an organized research unit comprised of researchers whose work involves policy-oriented research and analysis on a wide range of health issues. The PRL-IHPS network was created to provide a sophisticated, reliable and highly secure network specifically designed to accommodate the data intensive work requirements of PRL-IHPS researchers. The PRL-IHPS network is part of the UCSF domain (ucsf.edu), but is separate from the main University network managed by UCSF Enterprise Network Services (ENS). ENS services supported by federal indirect cost recovery are limited to support of network hardware and software that is owned and operated by ENS. The PRL-IHPS network infrastructure is separate from ENS and is therefore treated as a direct expense.

PRL-IHPS network support staff is responsible for maintaining and upgrading the PRL-IHPS network and for the provision of desktop support, which facilitates standardization and uniformity at PRL-IHPS. Desktop support is provided by PRL-IHPS network support staff at the end user level, and this support is available to all PRL-IHPS employees. PRL-IHPS network support staff provide ongoing maintenance of and upgrades to network hardware (switches, cables and servers), purchase computer supplies, install hardware and software to assure integrity and security, and expand and upgrade the quality of cabling, servers and server software in order to maintain the technical capacity required to support expanding research needs at the PRL-IHPS. The budgeted amount is based on a rate of \$90.10/FTE/month.

*Other Expenses.* This includes General, Automobile, and Employee Liability Insurance, which is an University approved campus recharge for liability assessment. Costs are calculated monthly at the rate of \$0.72/\$100 of salaries and are projected to increase 9% each future year.

*Indirect Costs* are charged at the 10% stipulated by the Respiratory Care Board.

# FISCAL REVIEW

Agenda Item: 4  
Meeting Date: 11/7/14

## REVENUE

Revenue Category	2012/13 Actual	2013/14 Actual	2014/15 Projected	Projected Workload 2014/15	Current Fees 2013/14
Application (CA)	\$497,005	\$483,323	\$480,000	1,600	\$300
Application (Foreign)					
Application (O-O-S)					
Renewal	\$2,079,053	\$2,119,434	\$2,162,000	9,400	\$230
Delinquent Fees	\$45,540	\$41,400	\$48,300	210	\$230
Endorsement	\$11,145	\$12,640	\$13,750	550	\$25
Duplicate License	\$2,375	\$3,050	\$3,750	150	\$25
Cite and Fine	\$24,702	\$23,593	\$25,000	var	var
Miscellaneous	\$28,615	\$27,841	\$23,880	var	var
<b>Total Revenue</b>	<b>\$2,688,435</b>	<b>\$2,711,281</b>	<b>\$2,756,680</b>		

## EXPENDITURES

Expenditure Items	2012/13 Actual	2013/14 Actual	2014/15 Projected	Actual Exp. thru 09/30/14	Budgeted 2014/15
Salary & Benefits	\$1,318,199	\$1,477,424	\$1,556,500	\$391,638	\$1,493,312
Training	\$240	\$579	\$2,000	\$0	\$12,227
Travel	\$19,063	\$24,942	\$30,000	\$1,762	\$41,805
Printing	\$39,012	\$36,231	\$40,000	\$2,778	\$27,515
Postage	\$33,525	\$32,694	\$35,000	\$4,206	\$40,952
Equipment	\$19,212	\$17,301	\$10,000	\$0	\$8,000
ProRata <sup>1</sup>	\$459,814	\$556,040	\$613,619	\$153,405	\$613,619
Fingerprints	\$5,978	\$5,794	\$6,000	\$1,274	\$55,000
All Other Fixed Expenses <sup>2</sup>	\$291,540	\$252,056	\$271,500	\$43,760	\$498,224
Division of Investigation	\$43,469	\$0	\$0	\$0	\$0
Attorney General	\$351,293	\$401,214	\$450,000	\$91,567	\$462,214
Office of Admin Hearings	\$76,306	\$74,528	\$75,000	\$6,972	\$137,082
Court Reporter Services	\$3,689	\$4,947	\$6,000	\$308	\$0
Evidence and Witness	\$30,274	\$38,563	\$50,000	\$3,788	\$32,050
<b>Total Expenditures</b>	<b>\$2,691,614</b>	<b>\$2,922,313</b>	<b>\$3,145,619</b>	<b>\$701,458</b>	<b>\$3,422,000</b>

<sup>1</sup> ProRata includes departmental and central administrative services.

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

## FUND CONDITION

	2013/14*	2014/15	2015/16	2016/17
Beginning Reserve, July 1	\$2,596	\$2,613	\$2,386	\$2,121
Prior Year Adjustments	\$76			
Revenues	\$2,711	\$2,757	\$2,810	\$2,810
<b>TOTAL RESOURCES</b>	<b>\$5,383</b>	<b>\$5,370</b>	<b>\$5,196</b>	<b>\$4,931</b>
Budget Expenditure	\$2,922	\$3,146	\$3,240	\$3,240
Disbursements <sup>1</sup>	\$14	\$3		
Reimbursements	(\$166)	(\$165)	(\$165)	(\$165)
<b>TOTAL EXPENDITURES</b>	<b>\$2,770</b>	<b>\$2,984</b>	<b>\$3,075</b>	<b>\$3,075</b>
<b>RESERVE, JUNE 30</b>	<b>\$2,613</b>	<b>\$2,386</b>	<b>\$2,121</b>	<b>\$1,856</b>

\* Actual

FY 15/16 expenditures reflect a 3% projected increase in overall expenditures.

<sup>1</sup> Represents State Controller Operations and Financial Information System for California disbursements

California Code of Regulations. Title 16. Division 13.6 Respiratory Care Board  
Continuing Education, Military and O-O-S Practitioner Exemptions, and Fee Schedule

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## ORDER OF ADOPTION

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

### **§1399.301. Location of Office.**

The principal office of the Respiratory Care Board of California is located at ~~444 North 3rd Street, Suite 270, Sacramento, CA 95811~~ 3750 Rosin Court, Suite 100, Sacramento, CA 95834.

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

*Adopt Section 1399.326 of Division 13.6 of Title 16 of the California Code of Regulations as follows:*

### **1399.326. Driving Record**

The board shall review the driving history for each applicant as part of its investigation prior to licensure.

Note: Authority cited: Section 3722, Business and Professions Code. Reference: Section 3730 and 3732, Business and Professions Code.

*Adopt Section 1399.329 of Division 13.6 of Title 16 of the California Code of Regulations as follows:*

### **1399.329. Military Renewal Application Exemptions**

Pursuant to subdivision (c) of Section 114.3 of the B&P, the board shall prorate the renewal fee and the number of CE hours required in order for a licensee to engage in any activities requiring licensure, upon discharge from active duty service as a member of the United States Armed Forces or the California National Guard.

Note: Authority cited: Sections 114.3 and 3722, Business and Professions Code. Reference: Section 114.3, Business and Professions Code and Sections 1399.350 and 1399.395 of the California Code of Regulations.

*Retitle Article 4 of Division 13.6 of Title 16 of the California Code of Regulations as follows:*

### **ARTICLE 4. EXAMINATIONS** **SPONSORED FREE HEALTH CARE EVENTS - EXEMPTION REQUIREMENTS**

*Adopt Section 1399.343 of Division 13.6 of Title 16 of the California Code of Regulations as follows:*

### **§ 1399.343. Definitions.**

For the purposes of section 901 of the code:

(a) "Community-based organization" means a public or private nonprofit organization that is representative of a community or a significant segment of a community, and is engaged in meeting human, educational, environmental, or public safety community needs.

(b) “Out-of-state practitioner” means a person who is not licensed in California to engage in the practice of respiratory care, but who holds a current valid license or certificate in good standing in another state, district, or territory of the United States to practice respiratory care.

Note: Authority cited: Sections 901 and 3722, Business and Professions Code. Reference: Section 901, Business and Professions Code.

*Adopt Section 1399.344 of Division 13.6 of Title 16 of the California Code of Regulations as follows:*

**§ 1399.344. Sponsoring Entity Registration and Recordkeeping Requirements.**

(a) Registration. A sponsoring entity that wishes to provide, or arrange for the provision of, respiratory care services at a sponsored event under section 901 of the code shall register with the board not later than 90 calendar days prior to the date on which the sponsored event is scheduled to begin. A sponsoring entity shall register with the board by submitting to the board a completed “Registration of Sponsoring Entity under Business & Professions Code Section 901,” Form 901-A (DCA/2014), which is hereby incorporated by reference.

(b) Determination of Completeness of Form. The board may, by resolution, delegate to the Department of Consumer Affairs the authority to receive and process “Registration of Sponsoring Entity under Business & Professions Code Section 901,” Form 901-A (DCA/2014) on behalf of the board. The board or its delegatee shall inform the sponsoring entity in writing within 15 calendar days of receipt of the form that the form is either complete and the sponsoring entity is registered or that the form is deficient and what specific information or documentation is required to complete the form and be registered. The board or its delegatee shall reject the registration if all of the identified deficiencies have not been corrected at least 30 days prior to the commencement of the sponsored event.

(c) Recordkeeping Requirements. Regardless of where it is located, a sponsoring entity shall maintain at a physical location in California a copy of all records required by section 901 as well as a copy of the authorization for participation issued by the board to an out-of-state practitioner. The sponsoring entity shall maintain these records for a period of at least five years after the date on which a sponsored event ended. The records may be maintained in either paper or electronic form. The sponsoring entity shall notify the board at the time of registration as to the form in which it will maintain the records. In addition, the sponsoring entity shall keep a copy of all records required by section 901(g) of the code at the physical location of the sponsored event until that event has ended. These records shall be available for inspection and copying during the operating hours of the sponsored event upon request of any representative of the board.

(d) A sponsoring entity shall place a notice visible to patients at every station where patients are being seen by a respiratory care practitioner. The notice shall be in at least 48-point type in Arial font and shall include the following statement and information:

NOTICE

Respiratory Care Practitioners providing respiratory care services at this health fair are either licensed and regulated by the Respiratory Care Board of California or hold a current valid license from another state and have been authorized to provide respiratory care services in California only at this specific health fair.

Respiratory Care Board of California

(866) 375-0386

www.rcb.ca.gov

(e) Requirement for Prior Board Approval of Out-of-State Practitioner. A sponsoring entity shall not permit an out-of-state practitioner to participate in a sponsored event unless and until the sponsoring entity has received written approval of such practitioner from the board.

(f) Report. Within 15 calendar days after a sponsored event has concluded, the sponsoring entity shall file a report with the board summarizing the details of the sponsored event. This report may be in a form of the sponsoring entity's choosing, but shall include, at a minimum, the following information:

(1) The date(s) of the sponsored event;

(2) The location(s) of the sponsored event;

(3) The type(s) and general description of all respiratory care services provided at the sponsored event; and

(4) A list of each out-of-state practitioner granted authorization pursuant to this article who participated in the sponsored event, along with the license number of that practitioner.

Note: Authority cited: Sections 901 and 3722, Business and Professions Code. Reference: Section 901, Business and Professions Code.

*Adopt Section 1399.345 of Division 13.6 of Title 16 of the California Code of Regulations as follows:*

**§ 1399.345. Out-of-State Practitioner Authorization to Participate in Sponsored Event.**

(a) Request for Authorization to Participate. An out-of-state practitioner ("applicant") may request authorization from the board to participate in a sponsored event and provide such respiratory care services at the sponsored event as would be permitted if the applicant were licensed by the board to provide those services. Authorization must be obtained for each sponsored event in which the applicant seeks to participate.

(1) An applicant shall request authorization by submitting to the board a completed "Request for Authorization to Practice Without a California License at a Sponsored Free Health Care Event," Form 901-RCB (RCB/2014), which is hereby incorporated by reference, accompanied by a non-refundable, non-transferable processing fee of \$25.

(2) The applicant also shall furnish either a full set of fingerprints or submit a Live Scan inquiry to establish the identity of the applicant and to permit the board to conduct a criminal

history record check. The applicant shall pay any costs for furnishing the fingerprints and conducting the criminal history record check.

(b) Response to Request for Authorization to Participate. Within 20 calendar days of receiving a completed request for authorization, the board shall notify the sponsoring entity or local government entity whether that request is approved or denied.

(c) Denial of Request for Authorization to Participate.

(1) The board shall deny a request for authorization to participate if:

(A) The submitted form is incomplete and the applicant has not responded within 7 calendar days to the board's request for additional information; or

(B) The applicant has not completed a respiratory care program which complies with B&PC section 3740; or

(C) The applicant has failed to comply with a requirement of this article or has committed any act that would constitute grounds for denial of an application for licensure by the board; or

(D) The applicant does not possess a current valid active license in good standing. The term "good standing" means the applicant:

i. Has not been charged with an offense for any act substantially related to the practice for which the applicant is licensed by any public agency;

ii. Has not entered into any consent agreement or been subject to an administrative decision that contains conditions placed upon the applicant's professional conduct or practice, including any voluntary surrender of license;

iii. Has not been the subject of an adverse judgment resulting from the practice for which the applicant is licensed that the board determines constitutes evidence of a pattern of negligence or incompetence.

(E) The board has been unable to obtain a timely report of the results of the criminal history check.

(2) The board may deny a request for authorization to participate if:

(A) The request is received less than 20 calendars days before the date on which the sponsored event will begin; or

(B) The applicant has been previously denied a request for authorization by the board to participate in a sponsored event; or

(C) The applicant has previously had an authorization to participate in a sponsored event terminated by the board.

(d) Appeal of Denial. An applicant requesting authorization to participate in a sponsored event may appeal the denial of such request by following the procedures set forth in section 1399.346(d).

(e) An out-of-state practitioner who receives authorization to practice respiratory care at an event sponsored by a local government entity shall place a notice visible to patients at every station at which that person will be seeing patients. The notice shall be in at least 48-point type in Arial font and shall include the following statement and information:

## NOTICE

I hold a current valid license to practice respiratory care in a state other than California. I have been authorized by the Respiratory Care Board of California to provide respiratory care services in California only at this specific health fair.

Respiratory Care Board of California

(866) 375-0386

www.rcb.ca.gov

Note: Authority cited: Sections 144, 901 and 3722, Business and Professions Code. Reference: Section 901, Business and Professions Code.

*Adopt Section 1399.346 of Division 13.6 of Title 16 of the California Code of Regulations as follows:*

### **§ 1399.346. Termination of Authorization and Appeal.**

(a) Grounds for Termination. The board may terminate an out-of-state practitioner's authorization to participate in a sponsored event for any of the following reasons:

(1) The out-of-state practitioner has failed to comply with any applicable provision of this article, or any applicable practice requirement or regulation of the board.

(2) The out-of-state practitioner has committed an act that would constitute grounds for discipline if done by a licensee of the board.

(3) The board has received a credible complaint indicating that the out-of-state practitioner is unfit to practice at the sponsored event or has otherwise endangered consumers of the practitioner's services.

(b) Notice of Termination. The board shall provide both the sponsoring entity or local government entity and the out-of-state practitioner with a written notice of the termination, including the basis for the termination. If the written notice is provided during a sponsored event, the board may provide the notice to any representative of the sponsored event on the premises of the event.

(c) Consequences of Termination. An out-of-state practitioner shall immediately cease his or her participation in a sponsored event upon receipt of the written notice of termination. Termination of authority to participate in a sponsored event shall be deemed a disciplinary measure reportable to the national practitioner data banks. In addition, the board shall provide a copy of the written notice of termination to the licensing authority of each jurisdiction in which the out-of-state practitioner is licensed.

(d) Appeal of Termination. An out-of-state practitioner may appeal the board's decision to terminate an authorization in the manner provided by section 901(j)(2) of the code. The request for an appeal shall be considered a request for an informal hearing under the Administrative Procedure Act.

(e) Informal Conference Option. In addition to requesting a hearing, the out-of-state practitioner may request an informal conference with the executive officer regarding the

reasons for the termination of authorization to participate. The executive officer shall, within 30 days from receipt of the request, hold an informal conference with the out-of-state practitioner. At the conclusion of the informal conference, the Executive Director or his/her designee may affirm or dismiss the termination of authorization to participate. The executive officer shall state in writing the reasons for his or her action and mail a copy of his or her findings and decision to the out-of-state practitioner within ten days from the date of the informal conference. The out-of-state practitioner does not waive his or her request for a hearing to contest a termination of authorization by requesting an informal conference. If the termination is dismissed after the informal conference, the request for a hearing shall be deemed to be withdrawn.

Note: Authority cited: Sections 901 and 3722, Business and Professions Code. Reference: Section 901, Business and Professions Code.

*Amend Section 1399.350 of Division 13.6 of Title 16 of the California Code of Regulations as follows:*

**§ 1399.350. Continuing Education Required.**

(a) Each respiratory care practitioner (RCP) is required to complete ~~15~~ 30 hours of approved continuing education (CE) every 2 years. At least two-thirds of the required CE hours shall be directly related to clinical practice.

(b) To renew the license, each RCP shall report compliance with the CE requirement. Supporting documentation, showing evidence of compliance with each requirement under this Article, shall be submitted if requested by the board.

(c) CE supporting documentation shall be retained by the licensee for a period of four years.

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

*Amend Section 1399.351 of Division 13.6 of Title 16 of the California Code of Regulations as follows:*

**§1399.351. Approved CE Programs.**

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

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

- ~~(1) Registered Respiratory Therapist (RRT) - 15 CE hours if not taken for licensure;~~  
Adult Critical Care Specialty Examination (ACCS) - 15 hours
- (2) Certified Pulmonary Function Technologist (CPFT) - 15 CE hours;
- (3) Registered Pulmonary Function Technologist (RPFT) - 15 CE hours;
- (4) Neonatal/Pediatric Respiratory Care Specialist (NPS) - 15 CE hours;
- (5) Sleep Disorders Testing and Therapeutic Intervention Respiratory Care Specialist (SDS) - 15 hours

~~(5)~~ (6) Advanced Cardiac Life Support (ACLS) - number of CE hours to be designated by the provider;

~~(6)~~ (7) Neonatal Resuscitation Program (NRP) - number of CE hours to be designated by

the provider; and

~~(7)~~ (8) Pediatrics Advanced Life Support (PALS) - number of CE hours to be designated by the provider.

~~(8)~~ (9) Advanced Trauma Life Support (ATLS) - number of CE hours to be designated by the provider

(c) Any course including training regarding the characteristics and method of assessment and treatment of acquired immune deficiency syndrome (AIDS) meeting the criteria set for in this Article, will be accepted by the board for CE credit.

~~(e)~~ (d) Examinations listed in subdivisions (b)(1) through (b)4(5) of this section shall be those offered by the National Board for Respiratory Care and each successfully completed examination may be counted only once for credit.

~~(d)~~ (e) Successful completion of each examination listed in subdivisions (b)~~(5)~~(6) through (b) ~~(8)~~(9) of this section may be counted only once for credit and must be for the initial certification. See section 1399.352 for re-certification CE. These programs and examinations shall be provided by an approved entity listed in subdivision (h) of Section 1399.352.

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

Note: Authority cited: Sections 3719 and 3722, Business and Professions Code. Reference: Sections 32 and 3719, Business and Professions Code.

*Amend Section 1399.352 of Division 13.6 of Title 16 of the California Code of Regulations as follows:*

**§1399.352. Criteria for Acceptability of Courses.**

Acceptable courses and programs shall meet the following criteria:

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

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

(2) Health care cost containment or cost management.

(3) Preventative health services and health promotion.

(4) Required abuse reporting.

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

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

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

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

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

subject matter, or

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

(c) Educational objectives shall be listed.

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

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

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

(g) Each course or provider shall hold approval from one of the entities listed in subdivision

(h) from the time the course is distributed or instruction is given through the completion of the course.

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

(1) Any post-secondary institution accredited by a regional accreditation agency or association recognized by the United States Department of Education.

(2) A hospital or health-care facility licensed by the California Department of Health Services.

(3) The American Association for Respiratory Care.

(4) The California Society for Respiratory Care (and all other state societies directly affiliated with the American Association for Respiratory Care).

(5) The American Medical Association.

(6) The California Medical Association.

(7) The California Thoracic Society.

(8) The American College of Surgeons.

(9) The American College of Chest Physicians.

(10) Any entity approved or accredited by the California Board of Registered Nursing or the Accreditation Council for Continuing Medical Education.

(i) Course organizers shall maintain a record of attendance of participants, documentation of participant's completion, and evidence of course approval for four years.

(j) All program information by providers of CE shall state: "This course meets the requirements for CE for RCPs in California."

(k) All course providers shall provide documentation to course participants that includes participants name, RCP number, course title, course approval identifying information, number of hours of CE, date(s), and name and address of course provider.

(l) For quarter or semester-long courses (or their equivalent), completed at any post-secondary institution accredited by a regional accreditation agency or association recognized by the United States Department of Education, an official transcript showing successful completion of the course accompanied by the catalog's course description shall fulfill the requirements in subdivisions (i), (j) and (k).

(m) The board may audit providers offering CE for compliance with the criteria set forth in this Article.

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

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

**§1399.395. Fee Schedule.**

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

(a) Application fee		\$ 300
(b) Examination fee	<u>Actual cost</u>	<del>\$ 190</del>
(c) Re-examination fee	<u>Actual cost</u>	<del>\$ 150</del>
(d) Renewal fee for licenses expiring on or after January 1, 2002		\$ 230
(e) Delinquency fee (not more than 2 years after expiration)		\$ 230
(f) Delinquency fee (after 2 years but not more than 3 years after expiration)		\$ 460
(g) Inactive license fee.		\$ 230
(h) Duplicate license fee		\$ 25
(i) Endorsement fee		\$ 25

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

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STEPHANIE NUNEZ, Executive Officer  
Respiratory Care Board of California

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Date

## **NOTICE OF PROPOSED CHANGES**

### **Continuing Education, Military and O-O-S Practitioner Exemptions, and Fee Schedule Respiratory Care Board of California**

NOTICE IS HEREBY GIVEN that the Respiratory Care Board of California (Board) is proposing to take the action described in the Informative Digest. Any person interested may present statements or arguments orally or in writing relevant to the action proposed at a hearing to be held:

**Friday, August 15, 2014**  
**11:00 AM**  
**Department of Consumer Affairs**  
**1625 North Market Blvd.**  
**El Dorado Room**  
**Sacramento, CA 95834**

Written comments, including those sent by mail, facsimile, or e-mail to the addresses listed under "Contact Person" in this Notice, must be received by the Board at its office not later than **5:00 p.m. on August 14, 2014**, or must be received by the Board at the hearing. The Board, upon its own motion or at the instance of any interested party, may thereafter adopt the proposals substantially as described below or may modify such proposals if such modifications are sufficiently related to the original text. With the exception of technical or grammatical changes, the full text of any modified proposal will be available for 15 days prior to its adoption from the person designated in this Notice as contact person and will be mailed to those persons who submit written or oral testimony related to this proposal or who have requested notification of any changes to the proposal.

#### **AUTHORITY AND REFERENCE**

Pursuant to the authority vested by Sections 114.3, 115.5, 901, 3719, and 3722 of the Business and Professions Code, and to implement, interpret or make specific sections 32, 114.3, 115.5, 901, 3719, 3730, 3732, 3775, and 3775.5 of said Code, the Board is considering changes to Division 13.6 of Title 16 of the California Code of Regulations as follows:

#### **INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW**

Business and Professions Code (B&P), section 3701 provides the Board's mandate is to "protect the public from the unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care." B&P, section 3710.1 provides that "Protection of the public shall be the highest priority for the [Board] in exercising its licensing, regulatory, and disciplinary functions."

In effectuating its mandate, the Board is responsible for screening applicants to ensure education, criminal background checks, and competency requirements are met. This regulation proposal clarifies that the Board shall review the driving history for each applicant as part of its application screening process.

The Board is also increasing the number of continuing education hours from 15 to 30 hours to align its hours with other similar allied health professional requirements and as a matter of increasing public protection. The Board is also proposing to modify courses recognized for continuing education credit including 1) eliminating recognition of the passage of the Registered Respiratory Therapist examination as it is currently being proposed through legislation (AB 1972, Jones) to be the exam required for licensure; 2) new recognition of the Adult Critical Care Specialty examination and Sleep Disorders Testing and Therapeutic Intervention Respiratory Care Specialist examination, both relatively new examinations recognized nationally and offered by the National Board for Respiratory Care; and 3) recognizing education related to acquired immune deficiency syndrome (AIDS) in line with section 32 of the B&P. Amendments are being made to the fee structure to revert to a method that more accurately reflects fees imposed by the national testing vendor. The Board is proposing to change the actual dollar amount of the examination fee to “actual cost” as was previously done, thereby eliminating the need for the Board to modify its regulations when the vendor modifies its fee structure.

The Board is also adding regulatory sections to effectuate new laws to provide greater consumer protection, and/or promote fairness or social equity by: 1) providing preference to applications from active military personnel and their spouses or domestic partners; 2) exempting military personnel who are called to active duty from continuing education and renewal fee requirements as applicable; and 3) establishing a process for temporary licensure for out-of-state entities and personnel to practice respiratory care in California at a community event (sponsored-free health care events) of not more than 10 days.

During the process of developing these regulations and amendments, the Board has conducted a search of any similar regulations on this topic and has concluded that these regulations are neither inconsistent nor incompatible with existing state regulations.

At its April 4, 2014 meeting, the Board reviewed this final regulation proposal in detail, and approved moving forward with the rulemaking package.

### **INCORPORATION BY REFERENCE**

The following documents are incorporated by reference:

1. “Registration of Sponsoring Entity under Business & Professions Code Section 901” Form 901-A (DCA/2014 - revised)
2. “Request for Authorization to Practice Without a California License at a Sponsored Free Health Care Event” Form 901-RCB (RCB/2014)

### **FISCAL IMPACT ESTIMATES**

Fiscal Impact on Public Agencies Including Costs or Savings to State Agencies or Costs/Savings in Federal Funding to the State: Minor. The Board estimates a potential net loss of revenue of up to \$2,000 per year as a result of prorating/waiving renewal fees for military personnel called to active duty.

Nondiscretionary Costs/Savings to Local Agencies: None.

Local Mandate: None.

Cost to Any Local Agency or School District for Which Government Code Sections 17500-17630 Requires Reimbursement: None.

Business Impact: The Board has made an initial determination that the proposed regulatory action would have no significant statewide *adverse* economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states.

However, the amendments contained in section 1399.350 to increase the number of continuing education hours required for renewal of a respiratory care practitioner license from 15 hours to 30 hours every two years will impact businesses. Businesses may be impacted by greater demand for courses which may result in higher attendance at existing courses or the desire to offer additional courses. This economic impact is estimated to be up to \$1,118,250 annually.

Impact on Jobs/New Businesses: The Board has determined that this regulatory proposal will not have any impact on the creation of jobs or new businesses or the elimination of jobs or existing businesses or the expansion of businesses in the State of California.

Cost Impact on Representative Private Person or Business:

The cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action and that are known to the Board are costs associated with increasing the number of continuing education hours required for renewal of a respiratory care practitioner license. Those costs are estimated to be \$0-\$225 every renewal cycle (two years) for each active licensed respiratory care practitioner.

Effect on Housing Costs: None

### **EFFECT ON SMALL BUSINESS**

The amendments contained in section 1399.350 to increase the number of continuing education hours required for renewal of a respiratory care practitioner license from 15 hours to 30 hours every two years will impact small businesses as well. There may be a greater demand for courses which may result in higher attendance at existing courses or the desire to offer additional courses. The overall economic impact to businesses (including small businesses) is estimated to be up to \$1,118,250 annually.

### **RESULTS OF ECONOMIC IMPACT ANALYSIS**

#### **IMPACT ON JOBS/BUSINESSES**

The Board has determined that this regulatory proposal will not have a significant impact on the creation of jobs or new businesses or the elimination of jobs or existing businesses or the expansion of businesses in the State of California.

#### **BENEFITS OF REGULATION**

The Board has determined that this regulatory proposal will increase consumer protection and promote fairness or social equity.

**CONSIDERATION OF ALTERNATIVES**

The Board must determine that no reasonable alternative it considered to the regulation or that has otherwise been identified and brought to its attention would either be more effective in carrying out the purpose for which the action is proposed or would be as effective and less burdensome to affected private persons than the proposal described in this Notice, or would be more cost effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

Any interested person may present statements or arguments orally or in writing relevant to the above determinations at the above-mentioned hearing.

**INITIAL STATEMENT OF REASONS AND INFORMATION**

The Board has prepared an initial statement of the reasons for the proposed action and has available all the information upon which the proposal is based.

**TEXT OF PROPOSAL**

Copies of the exact language of the proposed regulations and any document incorporated by reference, and of the initial statement of reasons, and all of the information upon which the proposal is based, may be obtained at the hearing or prior to the hearing, upon request to the Board at 3750 Rosin Court, Suite 100, Sacramento, CA 95834 or on the Board’s website at [www.rcb.ca.gov](http://www.rcb.ca.gov).

**AVAILABILITY AND LOCATION OF THE FINAL STATEMENT OF REASONS AND RULEMAKING FILE**

All the information upon which the proposed regulations are based is contained in the rulemaking file which is available for public inspection by contacting the person named below.

You may obtain a copy of the final statement of reasons once it has been prepared, by making a written request to the contact person named, or by accessing the website listed, on the following page.

**CONTACT PERSON**

Inquiries or comments concerning the proposed rulemaking action may be addressed to:

Name: Christine Molina  
Address: 3750 Rosin Court, Suite 100  
Sacramento, CA 95834  
Telephone No.: (916) 999.2190  
Fax No.: (916) 263.7311  
E-Mail Address: [rcbinfo@dca.ca.gov](mailto:rcbinfo@dca.ca.gov)

The backup contact person is:

Name: Stephanie Nunez  
Address: 3750 Rosin Court, Suite 100  
Sacramento, CA 95834  
Telephone No.: (916) 999.2190  
Fax No.: (916) 263.7311  
E-Mail Address: [rcbinfo@dca.ca.gov](mailto:rcbinfo@dca.ca.gov)

Website Access: Materials regarding this proposal can be found at [www.rcb.ca.gov](http://www.rcb.ca.gov).

**RESPIRATORY CARE BOARD**  
**Department of Consumer Affairs**  
**California Code of Regulations. Title 16. Division 13.6 Respiratory Care Board**  
**Continuing Education, Military and O-O-S Practitioner Exemptions, and Fee Schedule**

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# **PROPOSED LANGUAGE**

## **ARTICLE 1. GENERAL PROVISIONS**

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

### **§1399.301. Location of Office.**

The principal office of the Respiratory Care Board of California is located at ~~444 North 3rd Street, Suite 270, Sacramento, CA 95811~~ 3750 Rosin Court, Suite 100, Sacramento, CA 95834.

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

## **ARTICLE 2. APPLICATIONS**

*Adopt Section 1399.326 of Division 13.6 of Title 16 of the California Code of Regulations as follows:*

### **1399.326. Driving Record**

The board shall review the driving history for each applicant as part of its investigation prior to licensure.

Note: Authority cited: Section 3722, Business and Professions Code. Reference: Section 3730 and 3732, Business and Professions Code.

*Adopt Section 1399.328 of Division 13.6 of Title 16 of the California Code of Regulations as follows:*

### **1399.328. Military Initial Application Handling**

The board shall expedite the initial licensure process for an applicant that provides evidence, satisfactory to the board, that the applicant himself/herself is, or the applicant is married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in this state under official active duty military orders, or the California National Guard.

Note: Authority cited: Sections 115.5 and 3722, Business and Professions Code. Reference: Section 115.5, Business and Professions Code.

*Adopt Section 1399.329 of Division 13.6 of Title 16 of the California Code of Regulations as follows:*

### **1399.329. Military Renewal Application Exemptions**

Pursuant to subdivision (c) of Section 114.3 of the B&P, the board shall prorate the renewal fee and the number of CE hours required in order for a licensee to engage in any activities requiring licensure, upon discharge from active duty service as a member of the United States Armed Forces or the California National Guard.

Note: Authority cited: Sections 114.3 and 3722, Business and Professions Code. Reference: Section 114.3, Business and Professions Code and Sections 1399.350 and 1399.395 of the California Code of Regulations.

*Retitle Article 4 of Division 13.6 of Title 16 of the California Code of Regulations as follows:*

**ARTICLE 4. EXAMINATIONS**  
**SPONSORED FREE HEALTH CARE EVENTS - EXEMPTION REQUIREMENTS**

*Adopt Section 1399.343 of Division 13.6 of Title 16 of the California Code of Regulations as follows:*

**§ 1399.343. Definitions.**

For the purposes of section 901 of the code:

(a) "Community-based organization" means a public or private nonprofit organization that is representative of a community or a significant segment of a community, and is engaged in meeting human, educational, environmental, or public safety community needs.

(b) "Out-of-state practitioner" means a person who is not licensed in California to engage in the practice of respiratory care, but who holds a current valid license or certificate in good standing in another state, district, or territory of the United States to practice respiratory care.

Note: Authority cited: Sections 901 and 3722, Business and Professions Code. Reference: Section 901, Business and Professions Code.

*Adopt Section 1399.344 of Division 13.6 of Title 16 of the California Code of Regulations as follows:*

**§ 1399.344. Sponsoring Entity Registration and Recordkeeping Requirements.**

(a) Registration. A sponsoring entity that wishes to provide, or arrange for the provision of, respiratory care services at a sponsored event under section 901 of the code shall register with the board not later than 90 calendar days prior to the date on which the sponsored event is scheduled to begin. A sponsoring entity shall register with the board by submitting to the board a completed "Registration of Sponsoring Entity under Business & Professions Code Section 901," Form 901-A (DCA/2014), which is hereby incorporated by reference.

(b) Determination of Completeness of Form. The board may, by resolution, delegate to the Department of Consumer Affairs the authority to receive and process "Registration of Sponsoring Entity under Business & Professions Code Section 901," Form 901-A (DCA/2014) on behalf of the board. The board or its delegatee shall inform the sponsoring entity in writing within 15 calendar days of receipt of the form that the form is either complete and the sponsoring entity is registered or that the form is deficient and what specific information or documentation is required to complete the form and be registered. The board or its delegatee shall reject the registration if all of the identified deficiencies have not been corrected at least 30 days prior to the commencement of the sponsored event.

(c) Recordkeeping Requirements. Regardless of where it is located, a sponsoring entity shall maintain at a physical location in California a copy of all records required by section 901 as well as a copy of the authorization for participation issued by the board to an out-of-state practitioner. The sponsoring entity shall maintain these records for a period of at least five years after the date on which a sponsored event ended. The records may be maintained in either paper or electronic form. The sponsoring entity shall notify the board at the time of registration.

as to the form in which it will maintain the records. In addition, the sponsoring entity shall keep a copy of all records required by section 901(g) of the code at the physical location of the sponsored event until that event has ended. These records shall be available for inspection and copying during the operating hours of the sponsored event upon request of any representative of the board.

(d) A sponsoring entity shall place a notice visible to patients at every station where patients are being seen by a respiratory care practitioner. The notice shall be in at least 48-point type in Arial font and shall include the following statement and information:

#### NOTICE

Respiratory Care Practitioners providing respiratory care services at this health fair are either licensed and regulated by the Respiratory Care Board of California or hold a current valid license from another state and have been authorized to provide respiratory care services in California only at this specific health fair.

Respiratory Care Board of California

(866) 375-0386

[www.rcb.ca.gov](http://www.rcb.ca.gov)

(e) Requirement for Prior Board Approval of Out-of-State Practitioner. A sponsoring entity shall not permit an out-of-state practitioner to participate in a sponsored event unless and until the sponsoring entity has received written approval of such practitioner from the board.

(f) Report. Within 15 calendar days after a sponsored event has concluded, the sponsoring entity shall file a report with the board summarizing the details of the sponsored event. This report may be in a form of the sponsoring entity's choosing, but shall include, at a minimum, the following information:

(1) The date(s) of the sponsored event;

(2) The location(s) of the sponsored event;

(3) The type(s) and general description of all respiratory care services provided at the sponsored event; and

(4) A list of each out-of-state practitioner granted authorization pursuant to this article who participated in the sponsored event, along with the license number of that practitioner.

Note: Authority cited: Sections 901 and 3722, Business and Professions Code. Reference: Section 901, Business and Professions Code.

*Adopt Section 1399.345 of Division 13.6 of Title 16 of the California Code of Regulations as follows:*

**§ 1399.345. Out-of-State Practitioner Authorization to Participate in Sponsored Event.**

(a) Request for Authorization to Participate. An out-of-state practitioner (“applicant”) may request authorization from the board to participate in a sponsored event and provide such respiratory care services at the sponsored event as would be permitted if the applicant were licensed by the board to provide those services. Authorization must be obtained for each sponsored event in which the applicant seeks to participate.

(1) An applicant shall request authorization by submitting to the board a completed “Request for Authorization to Practice Without a California License at a Sponsored Free Health Care Event,” Form 901-RCB (RCB/2014), which is hereby incorporated by reference, accompanied by a non-refundable, non-transferable processing fee of \$25.

(2) The applicant also shall furnish either a full set of fingerprints or submit a Live Scan inquiry to establish the identity of the applicant and to permit the board to conduct a criminal history record check. The applicant shall pay any costs for furnishing the fingerprints and conducting the criminal history record check.

(b) Response to Request for Authorization to Participate. Within 20 calendar days of receiving a completed request for authorization, the board shall notify the sponsoring entity or local government entity whether that request is approved or denied.

(c) Denial of Request for Authorization to Participate.

(1) The board shall deny a request for authorization to participate if:

(A) The submitted form is incomplete and the applicant has not responded within 7 calendar days to the board’s request for additional information; or

(B) The applicant has not completed a respiratory care program which complies with B&PC section 3740; or

(C) The applicant has failed to comply with a requirement of this article or has committed any act that would constitute grounds for denial of an application for licensure by the board; or

(D) The applicant does not possess a current valid active license in good standing. The term “good standing” means the applicant:

i. Has not been charged with an offense for any act substantially related to the practice for which the applicant is licensed by any public agency;

ii. Has not entered into any consent agreement or been subject to an administrative decision that contains conditions placed upon the applicant’s professional conduct or practice, including any voluntary surrender of license;

iii. Has not been the subject of an adverse judgment resulting from the practice for which the applicant is licensed that the board determines constitutes evidence of a pattern of negligence or incompetence.

(E) The board has been unable to obtain a timely report of the results of the criminal history check.

- (2) The board may deny a request for authorization to participate if:
- (A) The request is received less than 20 calendars days before the date on which the sponsored event will begin; or
- (B) The applicant has been previously denied a request for authorization by the board to participate in a sponsored event; or
- (C) The applicant has previously had an authorization to participate in a sponsored event terminated by the board.
- (d) Appeal of Denial. An applicant requesting authorization to participate in a sponsored event may appeal the denial of such request by following the procedures set forth in section 1399.346(d).
- (e) An out-of-state practitioner who receives authorization to practice respiratory care at an event sponsored by a local government entity shall place a notice visible to patients at every station at which that person will be seeing patients. The notice shall be in at least 48-point type in Arial font and shall include the following statement and information:

NOTICE

I hold a current valid license to practice respiratory care in a state other than California. I have been authorized by the Respiratory Care Board of California to provide respiratory care services in California only at this specific health fair.

Respiratory Care Board of California

(866) 375-0386

[www.rcb.ca.gov](http://www.rcb.ca.gov)

Note: Authority cited: Sections 144, 901 and 3722, Business and Professions Code. Reference: Section 901, Business and Professions Code.

*Adopt Section 1399.346 of Division 13.6 of Title 16 of the California Code of Regulations as follows:*

**§ 1399.346. Termination of Authorization and Appeal.**

- (a) Grounds for Termination. The board may terminate an out-of-state practitioner's authorization to participate in a sponsored event for any of the following reasons:
- (1) The out-of-state practitioner has failed to comply with any applicable provision of this article, or any applicable practice requirement or regulation of the board.
- (2) The out-of-state practitioner has committed an act that would constitute grounds for discipline if done by a licensee of the board.
- (3) The board has received a credible complaint indicating that the out-of-state practitioner is unfit to practice at the sponsored event or has otherwise endangered consumers of the practitioner's services.
- (b) Notice of Termination. The board shall provide both the sponsoring entity or local government entity and the out-of-state practitioner with a written notice of the termination,

including the basis for the termination. If the written notice is provided during a sponsored event, the board may provide the notice to any representative of the sponsored event on the premises of the event.

(c) Consequences of Termination. An out-of-state practitioner shall immediately cease his or her participation in a sponsored event upon receipt of the written notice of termination. Termination of authority to participate in a sponsored event shall be deemed a disciplinary measure reportable to the national practitioner data banks. In addition, the board shall provide a copy of the written notice of termination to the licensing authority of each jurisdiction in which the out-of-state practitioner is licensed.

(d) Appeal of Termination. An out-of-state practitioner may appeal the board's decision to terminate an authorization in the manner provided by section 901(j)(2) of the code. The request for an appeal shall be considered a request for an informal hearing under the Administrative Procedure Act.

(e) Informal Conference Option. In addition to requesting a hearing, the out-of-state practitioner may request an informal conference with the executive officer regarding the reasons for the termination of authorization to participate. The executive officer shall, within 30 days from receipt of the request, hold an informal conference with the out-of-state practitioner. At the conclusion of the informal conference, the Executive Director or his/her designee may affirm or dismiss the termination of authorization to participate. The executive officer shall state in writing the reasons for his or her action and mail a copy of his or her findings and decision to the out-of-state practitioner within ten days from the date of the informal conference. The out-of-state practitioner does not waive his or her request for a hearing to contest a termination of authorization by requesting an informal conference. If the termination is dismissed after the informal conference, the request for a hearing shall be deemed to be withdrawn.

Note: Authority cited: Sections 901 and 3722, Business and Professions Code. Reference: Section 901, Business and Professions Code.

## **ARTICLE 5. CONTINUING EDUCATION**

*Amend Section 1399.350 of Division 13.6 of Title 16 of the California Code of Regulations as follows:*

### **§ 1399.350. Continuing Education Required.**

(a) Each respiratory care practitioner (RCP) is required to complete ~~15~~ 30 hours of approved continuing education (CE) every 2 years. At least two-thirds of the required CE hours shall be directly related to clinical practice.

(b) To renew the license, each RCP shall report compliance with the CE requirement. Supporting documentation, showing evidence of compliance with each requirement under this Article, shall be submitted if requested by the board.

(c) CE supporting documentation shall be retained by the licensee for a period of four years.

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

Amend Section 1399.351 of Division 13.6 of Title 16 of the California Code of Regulations as follows:

**§1399.351. Approved CE Programs.**

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

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

- (1) ~~Registered Respiratory Therapist (RRT) - 15 CE hours if not taken for licensure;~~  
Adult Critical Care Specialty Examination (ACCS) - 15 hours
- (2) Certified Pulmonary Function Technologist (CPFT) - 15 CE hours;
- (3) Registered Pulmonary Function Technologist (RPFT) - 15 CE hours;
- (4) Neonatal/Pediatric Respiratory Care Specialist (NPS) - 15 CE hours;
- (5) Sleep Disorders Testing and Therapeutic Intervention Respiratory Care Specialist (SDS) - 15 hours

~~(5)~~ (6) Advanced Cardiac Life Support (ACLS) - number of CE hours to be designated by the provider;

~~(6)~~ (7) Neonatal Resuscitation Program (NRP) - number of CE hours to be designated by the provider; and

~~(7)~~ (8) Pediatrics Advanced Life Support (PALS) - number of CE hours to be designated by the provider.

~~(8)~~ (9) Advanced Trauma Life Support (ATLS) - number of CE hours to be designated by the provider

(c) Any course including training regarding the characteristics and method of assessment and treatment of acquired immune deficiency syndrome (AIDS) meeting the criteria set for in this Article, will be accepted by the board for CE credit.

~~(e)~~ (d) Examinations listed in subdivisions (b)(1) through (b)4(5) of this section shall be those offered by the National Board for Respiratory Care and each successfully completed examination may be counted only once for credit.

~~(d)~~ (e) Successful completion of each examination listed in subdivisions (b)~~(5)~~(6) through (b)~~(8)~~(9) of this section may be counted only once for credit and must be for the initial certification. See section 1399.352 for re-certification CE. These programs and examinations shall be provided by an approved entity listed in subdivision (h) of Section 1399.352.

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

Note: Authority cited: Sections 3719 and 3722, Business and Professions Code. Reference: Sections 32 and 3719, Business and Professions Code.

*Amend Section 1399.352 of Division 13.6 of Title 16 of the California Code of Regulations as follows:*

**§1399.352. Criteria for Acceptability of Courses.**

Acceptable courses and programs shall meet the following criteria:

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

- (1) Those activities relevant to specialized aspects of respiratory care, which activities include education, supervision, and management.
- (2) Health care cost containment or cost management.
- (3) Preventative health services and health promotion.
- (4) Required abuse reporting.
- (5) Other subject matter which is directed by legislation to be included in CE for licensed healing arts practitioners.
- (6) Re-certification for ACLS, NRP, PALS, and ATLS.
- (7) Review and/or preparation courses for credentialing examinations provided by the National Board for Respiratory Care, excluding those courses for entry-level or advance level respiratory therapy certification.

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

- (1) A degree from an accredited college or university and verifiable experience in the subject matter, or
- (2) Teaching and/or clinical experience in the same or similar subject matter.

(c) Educational objectives shall be listed.

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

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

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

(g) Each course or provider shall hold approval from one of the entities listed in subdivision

(h) from the time the course is distributed or instruction is given through the completion of the course.

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

- (1) Any post-secondary institution accredited by a regional accreditation agency or association recognized by the United States Department of Education.
- (2) A hospital or health-care facility licensed by the California Department of Health Services.
- (3) The American Association for Respiratory Care.
- (4) The California Society for Respiratory Care (and all other state societies directly affiliated with the American Association for Respiratory Care).
- (5) The American Medical Association.
- (6) The California Medical Association.

(7) The California Thoracic Society.

(8) The American College of Surgeons.

(9) The American College of Chest Physicians.

(10) Any entity approved or accredited by the California Board of Registered Nursing or the Accreditation Council for Continuing Medical Education.

(i) Course organizers shall maintain a record of attendance of participants, documentation of participant's completion, and evidence of course approval for four years.

(j) All program information by providers of CE shall state: "This course meets the requirements for CE for RCPs in California."

(k) All course providers shall provide documentation to course participants that includes participants name, RCP number, course title, course approval identifying information, number of hours of CE, date(s), and name and address of course provider.

(l) For quarter or semester-long courses (or their equivalent), completed at any post-secondary institution accredited by a regional accreditation agency or association recognized by the United States Department of Education, an official transcript showing successful completion of the course accompanied by the catalog's course description shall fulfill the requirements in subdivisions (i), (j) and (k).

(m) The board may audit providers offering CE for compliance with the criteria set forth in this Article.

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

## ARTICLE 9. FEES

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

### **§1399.395. Fee Schedule.**

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

(a) Application fee		\$ 300
(b) Examination fee	<u>Actual cost</u>	<del>\$ 190</del>
(c) Re-examination fee	<u>Actual cost</u>	<del>\$ 150</del>
(d) Renewal fee for licenses expiring on or after January 1, 2002		\$ 230
(e) Delinquency fee (not more than 2 years after expiration)		\$ 230
(f) Delinquency fee (after 2 years but not more than 3 years after expiration)		\$ 460
(g) Inactive license fee.		\$ 230
(h) Duplicate license fee		\$ 25
(i) Endorsement fee		\$ 25

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



## SPONSORED FREE HEALTH CARE EVENTS

### REGISTRATION OF SPONSORING ENTITY UNDER BUSINESS & PROFESSIONS CODE SECTION 901

In accordance with California Business and Professions Code section 901(d), a non-government organization administering an event to provide health-care services to uninsured and underinsured individuals at no cost, may include participation by certain health-care practitioners licensed outside of California if the organization registers with the California licensing authorities having jurisdiction over those professions. This form shall be completed and submitted by the sponsoring organization **at least 90 calendar days prior to the sponsored event**. *Note that the information required by Business and Professions Code section 901(d) must also be provided to the county health department having jurisdiction in each county in which the sponsored event will take place.*

#### PART 1 – ORGANIZATIONAL INFORMATION

1. Organization Name: \_\_\_\_\_

2. Organization Contact Information (*use principal office address*):

\_\_\_\_\_  
 Address Line 1

\_\_\_\_\_  
 Phone Number of Principal Office

\_\_\_\_\_  
 Address Line 2

\_\_\_\_\_  
 Alternate Phone

\_\_\_\_\_  
 City, State, Zip

\_\_\_\_\_  
 Website

\_\_\_\_\_  
 County

Organization Contact Information in California (*if different*):

\_\_\_\_\_  
 Address Line 1

\_\_\_\_\_  
 Phone Number

\_\_\_\_\_  
 Address Line 2

\_\_\_\_\_  
 Alternate Phone

\_\_\_\_\_  
 City, State, Zip

\_\_\_\_\_  
 County

3. Type of Organization:

Is the organization operating pursuant to section 501(c)(3) of the Internal Revenue Code?     Yes     No

If not, is the organization a community-based organization\*?

\_\_\_\_\_ Yes    \_\_\_\_\_ No

Organization's Tax Identification Number \_\_\_\_\_

If a community-based organization, please describe the mission, goals, and activities of the organization (*attach separate sheet(s) if necessary*): \_\_\_\_\_

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\* A "community-based organization" means a public or private nonprofit organization that is representative of a community or a significant segment of a community, and is engaged in meeting human, educational, environmental, or public safety community needs.

<b>PART 2 – RESPONSIBLE ORGANIZATION OFFICIALS</b>
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Please list the following information for each of the principal individual(s) who is the officer(s) or official(s) of the organization responsible for operation of the sponsoring entity.

Individual 1:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address Line 1

\_\_\_\_\_  
Address Line 2

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
County

\_\_\_\_\_  
Title

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Alternate Phone

\_\_\_\_\_  
E-mail address

Individual 2:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address Line 1

\_\_\_\_\_  
Address Line 2

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
County

\_\_\_\_\_  
Title

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Alternate Phone

\_\_\_\_\_  
E-mail address

Individual 3:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address Line 1

\_\_\_\_\_  
Address Line 2

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
County

\_\_\_\_\_  
Title

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Alternate Phone

\_\_\_\_\_  
E-mail address

*(Attach additional sheet(s) if needed to list additional principal organizational individuals)*

**PART 3 – EVENT DETAILS**

1. Name of event, if any: \_\_\_\_\_

2. Date(s) of event (not to exceed ten calendar days): \_\_\_\_\_

3. Location(s) of the event (be as specific as possible, including address):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Describe the intended event; including a list of all types of healthcare services intended to be provided (*attach additional sheet(s) if necessary*): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Attach a list of all out-of-state health-care practitioners who you currently believe intend to apply for authorization to participate in the event. The list should include the name, profession, and state of licensure of each identified individual.

\_\_\_ *Check here to indicate that list is attached.*

**Note:**

- Each individual out-of-state practitioner must request authorization to participate in the event by submitting an application to the applicable licensing Board or Committee.
- The organization will be notified in writing whether authorization for an individual out-of-state practitioner has been granted.

This form, any attachments, and all related questions shall be submitted to:

Department of Consumer Affairs  
Attn: Sponsored Free Health-Care Events  
Complaint Resolution Program  
1625 North Market Blvd., Ste. 202  
Sacramento, CA 95834

Tel: (916) 574-7950  
Fax: (916) 574-8676  
E-mail: CRP2@dca.ca.gov

- I understand that I must maintain records in either electronic or paper form both at the sponsored event and for five (5) years in California, per the recordkeeping requirements imposed by California Business and Professions Code section 901 and the applicable sections of Title 16, California Code of Regulations, for the regulatory bodies with jurisdiction over the practice to be engaged in by out-of-state practitioners
- I understand that our organization must file a report with each applicable Board or Committee within fifteen (15) calendar days of the completion of the event.

I certify under penalty of perjury under the laws of the State of California that the information provided on this form and any attachments is true and current, and that I am authorized to sign this form on behalf of the organization:

\_\_\_\_\_  
Name Printed

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**PERSONAL INFORMATION COLLECTION, ACCESS AND DISCLOSURE**

Disclosure of your personal information is mandatory. The information on this form is required pursuant to Business and Professions Code section 901. Failure to provide any of the required information will result in the form being rejected as incomplete. The information provided will be used to determine compliance with the requirements promulgated pursuant to Business and Professions Code section 901. The information collected may be transferred to other governmental and enforcement agencies. Individuals have a right of access to records containing personal information pertaining to that individual that are maintained by the applicable Board or Committee, unless the records are exempted from disclosure by section 1798.40 of the Civil Code. An individual may obtain information regarding the location of his or her records by contacting the Complaint Resolution Program at the address and telephone number listed above.



# Respiratory Care Board of California

## REQUEST FOR AUTHORIZATION TO PRACTICE WITHOUT A CALIFORNIA LICENSE AT A SPONSORED FREE HEALTH CARE EVENT

In accordance with California Business and Professions Code Section 901 any respiratory care practitioner licensed and in good standing in another state, district, or territory in the United States may request authorization from the Respiratory Care Board of California (Board) to participate in a free health care event offered by a local government entity or a sponsoring entity, registered with the Board pursuant to Section 901, for a period not to exceed ten (10) days.

### PART 1 - APPLICATION INSTRUCTIONS

An application must be complete and must be accompanied by all of the following:

- A processing fee of \$25, made payable to the board.
- A copy of each valid, current active license and/or certificate authorizing the applicant to engage in the practice of respiratory care issued by any state, district, or territory of the United States.
- A copy of a valid photo identification of the applicant issued by one of the jurisdictions in which the applicant holds a license or certificate to practice.
- A full set of fingerprints or a Live Scan inquiry. This will be used to establish your identity and to conduct a criminal history record check. The applicant shall pay any costs for furnishing the fingerprints and conducting the criminal history record check.
- Educational records to prove you meet the education requirements provided for in Section 3740 of the Business and Professions Code.

The board will not grant authorization until this form has been completed in its entirety, all required enclosures have been received by the board, and any additional information requested by the Board has been provided by the applicant and reviewed by the board, and a determination made to grant authorization.

The board shall process this request and notify the sponsoring entity or the local government entity listed on this form whether the request is approved or denied within 20 calendar days of receipt. If the board requires additional or clarifying information, the board will contact you directly, but **written approval or denial of requests will be provided directly to the sponsoring entity or local government entity.** It is the applicant's responsibility to maintain contact with the sponsoring entity or the local government entity.



**PART 3 – LICENSURE INFORMATION**

1. Do you hold a valid, current active license in good standing issued by a state, district, or territory of the United States authorizing the unrestricted practice of respiratory care in your jurisdiction(s)? The term “good standing” means you:

- Have not been charged with an offense for any act substantially related to the practice for which the applicant is licensed by any public agency;
- Have not entered into any consent agreement or been subject to an administrative decision that contains conditions placed upon the applicant’s professional conduct or practice, including any voluntary surrender of license; and
- Have not been the subject of an adverse judgment resulting from the practice for which the applicant is licensed that the board determines constitutes evidence of a pattern of negligence or incompetence.

No  If no, you are not eligible to participate as an out-of-state practitioner in the sponsored event.

Yes  If yes, list every license, certificate, and registration authorizing you to engage in the practice of respiratory care in the following table. If there are not enough boxes to include all the relevant information please attach an addendum to this form. Please also attach a copy of each of your current licenses, certificates, and registrations.

<b>State/ Jurisdiction</b>	<b>Issuing Agency/Authority</b>	<b>License Number</b>	<b>Expiration Date</b>

2. Have you ever had a license to practice respiratory care revoked or suspended?  
\_\_\_ Yes \_\_\_ No

3. Have you ever been subject to any disciplinary action or proceeding by any licensing body?  
\_\_\_ Yes \_\_\_ No

4. Have you ever committed any act or been convicted of a crime constituting grounds for denial of licensure?  
\_\_\_ Yes \_\_\_ No

5. If you answered “Yes” to any of questions 2 – 4, above, please explain (*attach additional page(s) if necessary*):

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**PART 4 – SPONSORED EVENT**

1. Name and address of local government entity, non-profit, or community-based organization hosting the free healthcare event (the “sponsoring entity”):

\_\_\_\_\_  
Name of Entity

\_\_\_\_\_  
Address Line 1

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Address Line 2

\_\_\_\_\_  
Alternate Phone

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
E-mail address

2. Name of event: \_\_\_\_\_

3. Date(s) & location(s) of the event: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Date(s) & location(s) applicant will be performing healthcare services (if different):

\_\_\_\_\_  
\_\_\_\_\_

5. Please specify the healthcare services you intend to provide: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Name and phone number of contact person with sponsoring entity or local government entity:

\_\_\_\_\_  
\_\_\_\_\_

**PART 5 – ACKNOWLEDGMENT/CERTIFICATION**

I, the undersigned, declare under penalty of perjury under the laws of the State of California and acknowledge that:

- I have not committed any act or been convicted of a crime constituting grounds for denial of licensure by the board.
- I am in good standing with the licensing authority or authorities of all jurisdictions in which I hold licensure and/or certification to practice respiratory care.
- I am responsible for knowing and will comply with all applicable practice requirements required of licensed respiratory care practitioners and all regulations of the Board.
- In accordance with Business and Professions Code Section 901(i), I will only practice within the scope of practice for California-licensed respiratory care practitioners.
- I will provide the services authorized by this request and Business and Professions Code Section 901 to uninsured and underinsured persons only and shall receive no compensation for such services.
- I will provide the services authorized by this request and Business and Professions Code Section 901 only in association with the sponsoring entity or local government entity listed herein and only on the dates and at the locations listed herein for a period not to exceed 10 calendar days.
- I must post the notice required by 16 CCR 1399.345 if the event is sponsored by a local government entity.
- Practice of a regulated profession in California without proper licensure and/or authorization may subject me to potential criminal penalties.
- The Board may notify the licensing authority of my home jurisdiction and/or other appropriate law enforcement authorities of any potential grounds for discipline associated with my participation in the sponsored event.
- All information provided by me in this application is true and complete. By submitting this application and signing below, I am granting permission to the Board to verify the information provided and to perform any investigation pertaining to the information I have provided as the board deems necessary.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

# INITIAL STATEMENT OF REASONS

**HEARING DATE**

August 15, 2014

**SUBJECT MATTER OF PROPOSED REGULATIONS**

Continuing Education, Military and Out-of-State Practitioner Exemptions and Fee Schedule

**SECTIONS AFFECTED**

1399.301, 1399.326, 1399.328, 1399.329, 1399.343, 1399.344, 1399.345, 1399.346, 1399.350, 1399.351, 1399.352, and 1399.395 of Division 13.6, Title 16 of the California Code of Regulations (CCR).

**SPECIFIC PURPOSE OF EACH ADOPTION, AMENDMENT OR REPEAL / FACTUAL BASIS/ RATIONALE**

**1399.301** (Amendment): This amendment changes the Respiratory Care Board (Board) office address as a result of an office move in May 2012. This amendment will accurately reflect, in regulation, the Board’s office address.

**1399.326** (Adoption): This Section provides that the Board shall review the driving history of each applicant as part of its investigation prior to licensure. The adoption of this Section provides clarity to the Board’s existing application process and promotes social equity.

**1399.328** (Adoption): This Section provides that military personnel or spouses of military personnel called to active duty shall receive preferential treatment and such applications for licensure shall be expedited by the Board. The adoption of this Section codifies section 115.5 of the Business and Professions Code and promotes social equity for our military personnel and their families.

**1399.329** (Adoption): This Section provides the Board shall prorate the renewal fee and continuing education hours for licensees called to active military duty. The adoption of this Section codifies section 114.3 of the Business and Professions Code and promotes social equity in that it provides a means to waive fees and continuing education for military personnel who are not using their license or do not have the means to obtain continuing education because they are actively serving our country. It also ensures that respiratory care practitioner licenses of military personnel are not ultimately cancelled as a result of being called to active duty.

**1399.343** (Adoption): This Section provides definitions for a newly developed process concerning “Sponsored Free Health Care Events – Exemptions Requirements.” These definitions will help the reader understand their reference more clearly as used throughout Article 4. This section, in addition to all the Sections proposed in Article 4 of this package (Sections 1399.343-1399.346), are necessary and required to codify section 901 of the Business and Professions Code.

**1399.344** (Adoption): This Section provides information for sponsoring entity registration and recordkeeping requirements for a newly developed process concerning “Sponsored Free Health Care Events – Exemptions Requirements.” This Section provides that a sponsoring entity shall register with the Board 90 days prior to the event to provide the Board sufficient processing time of the application. This Section

provides requirements for maintaining records for a period of at least five years in the event an issue arises with services provided or other issues surrounding the event that must be reviewed or investigated. This Section provides that the sponsoring entity must also provide a detailed report following the event for the Board to have on file should an issue arise thereafter. This Section also provides that the sponsoring entity must post a notice at the event so that consumers are aware that some of the respiratory care practitioners may not be licensed in California. This Section, in addition to all the sections proposed in Article 4 of this package (Sections 1399.343-1399.346), are necessary and required to codify section 901 of the Business and Professions Code.

**1399.345 (Adoption):** This Section provides information for out-of-state practitioner authorization to participate for a newly developed process concerning “Sponsored Free Health Care Events – Exemptions Requirements.” This section also includes a \$25 fee to cover expenses associated with processing these requests (as further identified in the underlying data of this document). This Section provides reasons an application may be denied to give an applicant notice of cause to deny an applicant that provide concern for patient safety or insufficient processing time. This Section requires an out-of-state practitioner to post a notice at the event so that consumers are aware that the practitioner is licensed in a state other than California. This Section, in addition to all the sections proposed in Article 4 of this package (Sections 1399.343-1399.346), are necessary and required to codify section 901 of the Business and Professions Code.

**1399.346 (Adoption):** This Section provides information to terminate an authorization and appeal for a newly developed process concerning “Sponsored Free Health Care Events – Exemptions Requirements.” This Section provides applicants notice of causes that would terminate an authorization all of which are listed, provide consumer protection. This Section also addresses how an practitioner could appeal an authorization that is terminated. This Section, in addition to all the sections proposed in Article 4 of this package (Sections 1399.343-1399.346,) are necessary and required to codify section 901 of the Business and Professions Code.

**1399.350 (Amendment):** The proposed amendment in this Section increases the number of continuing education (CE) hours required for renewal of a respiratory care practitioner license from 15 to 30 hours every two years. At its April 4, 2014 meeting, the Board reviewed the number of CE hours required by other professions regulated by the California Department of Consumer Affairs as well as other respiratory care boards across the nation. As a result of this review, the Board moved to increase the number of CE hours from 15 to 30 and conduct a more in-depth study to determine if additional hours should be required. Existing law (section 3719 of the Business and Professions Code) was amended in 1998 to allow for a maximum of 30 hours of CE. This amendment provides greater clinical and technical relevance and provides greater consumer protection.

**1399.351 (Amendment):** The proposed amendments in this Section update respiratory-related credentialing examinations that qualify for CE and recognize courses in the assessment and treatment of the acquired immune deficiency syndrome (AIDS) as provided for in Section 32 of the Business and Professions Code. These amendments provide current references to approved CE courses promoting fairness for Respiratory Care Practitioners (RCPs) in obtaining CE, greater protection of the public health and safety, and worker safety.

**1399.352 (Amendment):** The proposed amendment in this Section recognizes preparation courses for the advanced level credential as qualified CE not directly related to the practice. As the Board is moving forward with legislation establishing the advance level credential as the minimum qualification for licensure, it is appropriate to then only recognize preparation courses for the exam as CE that is not directly related to the practice as is done for the entry level credential. This amendment provides a current reference to approved CE courses promoting fairness for RCPs in obtaining CE and greater protection of the public health and safety.

**1399.395 (Amendment):** The amendment in this Section eliminates the specific dollar amount required for the exam and replaces it with the “actual cost” as was previously cited. Since the Board does not control these costs that are set by the national examination provider, the Board is proposing to again cite “actual cost,” so that applicants and interested parties will have an accurate representation of costs. This amendment promotes greater transparency.

#### **UNDERLYING DATA**

As identified above, the increase in continuing education hours is based on the following materials presented to the Board on April 4, 2014 as Agenda Item 7:

- California Continuing Education Requirements – Various Professions
- RCP Continuing Education/State Comparison

The Board also prepared the following to establish the \$25 application fee for practitioners as noted in section 1399.345 above:

- Data Supporting Application Fee for Out-of-State Practitioner Authorization to Participate in Sponsored Event

#### **BUSINESS IMPACT**

These regulations will not have a significant adverse economic impact on businesses. Most of these regulations only impact respiratory care practitioners (RCPs) and those regulations that do affect businesses such as the temporary work authorization or increase in CE required provide a means to have a positive economic impact on businesses.

#### **ECONOMIC IMPACT ASSESSMENT**

This regulatory proposal will have the following effects:

- It will not create or eliminate jobs within the State of California because these regulations do not make any changes or provide for any new provisions that would affect the creation or elimination of jobs.
- It will not create new business or eliminate existing businesses within the State of California because these regulations do not make any changes or provide for any new provisions that would result in the creation or elimination of new businesses.
- It may affect the expansion of businesses currently doing business within the State of California because the increase in continuing education hours required may lead to additional enrollment or courses provided by existing CE providers.
- This regulatory proposal benefits the health and welfare of California residents because it provides for the increase in CE hours which may result in better care or service by RCPs. These regulations may also result in more representation by RCPs at free sponsored health care events in California giving consumers access to respiratory care and assessment.
- This regulatory proposal may benefit worker safety because it provides for increases in the number of CE hours required which may include courses in worker safety.
- This regulatory proposal does not affect the state’s environment because the regulations do not make any changes or provide for any new provisions that would have any impact on the environment.

### **SPECIFIC TECHNOLOGIES OR EQUIPMENT**

This regulation does not mandate the use of specific technologies or equipment.

### **CONSIDERATION OF ALTERNATIVES**

No reasonable alternative to the regulatory proposal would be either more effective in carrying out the purpose for which the action is proposed or would be as effective or less burdensome to affected private persons and equally effective in achieving the purposes of the regulation in a manner that ensures full compliance with the law being implemented or made specific.

Set forth below are the alternatives which were considered and the reasons each alternative was rejected:

1. Not adopt the regulations. This alternative was rejected because this regulatory proposal includes many amendments necessary to effectuate existing laws or amendments necessary to maintain current relevancy in the workforce that may improve consumer protection.
2. Adopt the regulations. The Board determined that this alternative is the most feasible because the regulatory proposal provides a means to effectuate several existing laws as well as update and enhance continuing education requirements for RCPs, necessary for current relevancy in the workforce.

## CALIFORNIA CONTINUING EDUCATION REQUIREMENTS VARIOUS PROFESSIONS

**Strategic Plan Goal No. 2.6:** Consider whether or not continuing education hour requirements are sufficient to ensure clinical and technical relevance.

**§ 3719. Continuing education requirements; Submission of examination by licensee**

Each person renewing his or her license shall submit proof satisfactory to the board that, during the preceding two-year period, he or she completed the required number of continuing education hours established by regulation of the board. Required continuing education shall not exceed 30 hours every two years.

Successful completion of an examination approved by the board may be submitted by a licensee for a designated portion of continuing education credit. The board shall determine the hours of credit to be granted for the passage of particular examinations.

**§1399.350. Continuing Education Required.**

(a) Each respiratory care practitioner (RCP) is required to complete 15 hours of approved continuing education (CE) every 2 years. At least two-thirds of the required CE hours shall be directly related to clinical practice.

(b) To renew the license, each RCP shall report compliance with the CE requirement. Supporting documentation, showing evidence of compliance with each requirement under this Article, shall be submitted if requested by the board.

(c) CE supporting documentation shall be retained by the licensee for a period of four years.

License Type	Required # of CEUs	Units Required to be directly related to clinical practice	%
Acupuncturist	50	45	90%
Dentist	50		
Optometrists (TPA-Certified)	50	35	70%
Physician & Surgeon	50		
Physician Assistant (PA)	50		
Midwives	36	36	100%
Psychologist	36		
Psychological Assistant	36		
Veterinarian	36		
<b>Licensed Vocational Nurse (LVN)</b>	<b>30</b>	<b>30</b>	<b>100%</b>
Physical Therapist	30		
Physical Therapist Assistant	30		
Psychiatric Technician (PT)	30	30	100%
<b>Registered Nurse (RN)</b>	<b>30</b>	<b>30</b>	<b>100%</b>
Registered Dental Assistant (RDA)	25		
Dental Hygienist	25		
Occupational Therapist	24	12	50%
Veterinary Technician	20		
<b>Respiratory Care Practitioner (RCP)</b>	<b>15</b>	<b>10</b>	<b>67%</b>

<b>CE Analysis</b>
<b>Mean/Average: 34.37    Median: 30    Mode: 30 &amp; 50</b>

**RCP Continuing Education / State Comparison  
CE Order**

# of Licenses	Renewal Period	C.E. Hours	Fee	State	Converston to Biennial	
					CE Hours	Renewal Fee
2,686	Biennial	0	\$76	Colorado	0	\$76
447	Triennial	0	\$285	Hawaii	0	\$190
619	Annual	0	\$65	Maine	0	\$130
5,219	Biennial	0	\$150	Michigan	0	\$150
1,320	Biennial	0	\$52	Utah	0	\$52
2,692	Biennial	0	\$141	Wisconsin	0	\$141
1,731	Annual	6	\$100	Connecticut	12	\$200
2,166	Biennial	12	\$100	Oklahoma	12	\$100
514	Biennial	12	\$60	Rhode Island	12	\$60
299	Biennial	12	\$200	Vermont	12	\$200
21,270	Biennial	15	\$230	California	15	\$230
4,599	Biennial	15	\$50	Indiana	15	\$50
2,872	Biennial	15	\$110	Massachusetts	15	\$110
1,692	Annual	7.5	\$50	Oregon	15	\$100
792	Biennial	16	\$169	District of Columbia	16	\$169
2,837	Biennial	16	\$176	Maryland	16	\$176
338	Annual	8	\$100	Wyoming	16	\$200
4,017	Biennial	20	\$120	Arizona	20	\$120
747	Biennial	20	\$95	Delaware	20	\$95
3,558	Annual	10	\$85	Louisiana	20	\$170
2,264	Biennial	20	\$100	Mississippi	20	\$100
1,281	Biennial	20	\$118	Nebraska	20	\$118
1,515	Biennial	20	\$200	Nevada	20	\$200
993	Biennial	20	\$150	New Mexico	20	\$150
7,146	Triennial	30	\$207	New York	20	\$138
530	Annual	10	\$60	North Dakota	20	\$120
7,845	Biennial	20	\$100	Ohio	20	\$100
440	Biennial	20	\$60	South Dakota	20	\$60
4,613	Biennial	20	\$120	Tennessee	20	\$120
3,739	Biennial	20	\$135	Virginia	20	\$135
1,652	Annual	10	\$65	West Virginia	20	\$130
2,738	Biennial	24	\$75	Alabama	24	\$75
1,934	Annual	12	\$30	Arkansas	24	\$60
10,012	Biennial	24	\$126	Florida	24	\$126
855	Annual	12	\$60	Idaho	24	\$120
6,553	Biennial	24	\$120	Illinois	24	\$120
1,609	Biennial	24	\$60	Iowa	24	\$60
1,872	Annual	12	\$75	Kansas	24	\$150
3,500	Biennial	24	\$75	Kentucky	24	\$75
1,855	Annual	12	\$99	Minnesota	24	\$198
4,093	Biennial	24	\$50	Missouri	24	\$50
584	Annual	12	\$75	Montana	24	\$150
547	Biennial	24	\$110	New Hampshire	24	\$110
4,569	Annual	12	\$75	North Carolina	24	\$150
13,918	Biennial	24	\$106	Texas	24	\$106
5,133	Biennial	30	\$105	Georgia	30	\$105
3,344	Biennial	30	\$160	New Jersey	30	\$160
7,179	Biennial	30	\$25	Pennsylvania	30	\$25
2,665	Biennial	30	\$80	South Carolina	30	\$80
2,617	Biennial	30	\$165	Washington	30	\$165

**CE ANALYSIS**

Mean/Average: 18.44      Median: 20      Mode: 20 & 24

**Respiratory Care Board of California  
Data Supporting Application Fee for Out-of-State Practitioner Authorization to Participate in Sponsored Event**

[Reference: B&P, Section 901 and CCR, Title 16, Division 13.6, Article 4, Section 1399.345]

<b>Tasks Associated with Processing "REQUEST FOR AUTHORIZATION TO PRACTICE WITHOUT A CALIFORNIA LICENSE AT A SPONSORED FREE HEALTH CARE EVENT" (Form 901-RCB)</b>	<b>Anticipated Applicants/ Tasks Per Year</b>	<b>Minutes Per Unit</b>	<b>Total Minutes (MST)</b>
Receive and disseminate request for application (prepare/copy packet)	1	8	8
Cashier Application Fee	1	5	5
Review application materials and documentation	1	9	9
Verify licensure, fingerprint processing, National Practitioner Databank	1	15	15
Prepare authorization letter/approval by Management	1	5	5
Track Authorizations	1	3	3
<b>Total Projected MST Minutes Annually</b>			<b>45</b>
<b>MST Hourly Rate (per cost book)</b>			<b>\$33.81</b>
<b>Total Projected Cost per Applicant</b>			<b>\$25.36</b>

**RESPIRATORY CARE BOARD**  
**Department of Consumer Affairs**  
**California Code of Regulations. Title 16. Division 13.6 Respiratory Care Board**  
**Continuing Education, Military and O-O-S Practitioner Exemptions, and Fee Schedule**

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## **UPDATED INFORMATIVE DIGEST**

The informative digest published on June 27, 2014 by the Respiratory Care Board is updated as follows:

Section 1399.328 was removed from the originally proposed text. This section had inadvertently added “military personnel” themselves when in fact Section 115.5 of the Business and Professions Code only provides for the spouse, domestic partner, or other legally unified person of the military personnel to receive expedited licensure. The remaining text simply repeats the statute (B&P section 115.5) and is therefore unnecessary.

### **Originally Proposed Text**

*Adopt Section 1399.328 of Division 13.6 of Title 16 of the California Code of Regulations as follows:*

#### **1399.328. Military Initial Application Handling**

The board shall expedite the initial licensure process for an applicant that provides evidence, satisfactory to the board, that the applicant himself/herself is, or the applicant is married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in this state under official active duty military orders, or the California National Guard.

Note: Authority cited: Sections 115.5 and 3722, Business and Professions Code. Reference: Section 115.5, Business and Professions Code.

### **As written initially in the Notice of Proposed Changes**

**1399.328** (Adoption): This Section provides that military personnel or spouses of military personnel called to active duty shall receive preferential treatment and such applications for licensure shall be expedited by the Board. The adoption of this Section codifies section 115.5 of the Business and Professions Code and promotes social equity for our military personnel and their families.

### **Business and Professions Code, Section 115.5.**

(a) A board within the department shall expedite the licensure process for an applicant who meets both of the following requirements:

(1) Supplies evidence satisfactory to the board that the applicant is married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in this state under official active duty military orders.

(2) Holds a current license in another state, district, or territory of the United States in the profession or vocation for which he or she seeks a license from the board.

(b) A board may adopt regulations necessary to administer this section.

(Added by Stats. 2012, Ch. 399, Sec. 1. Effective January 1, 2013.)

# **FINAL STATEMENT OF REASONS**

**HEARING DATE**

August 15, 2014

**SUBJECT MATTER OF PROPOSED REGULATIONS**

Continuing Education, Military and Out-of-State Practitioner Exemptions, Sponsored Free Health Care Events, and Fee Schedule

**SECTIONS AFFECTED**

1399.301, 1399.326, 1399.328, 1399.329, 1399.343, 1399.344, 1399.345, 1399.346, 1399.350, 1399.351, 1399.352, and 1399.395 of Division 13.6, Title 16 of the California Code of Regulations (CCR).

**UPDATED INFORMATION**

The Initial Statement of Reasons is included in the file. The information contained therein is updated as follows:

Section 1399.328 was removed from the originally proposed text. This section had inadvertently added "military personnel" themselves when in fact Section 115.5 of the Business and Professions Code only provides for the spouse, domestic partner, or other legally unified person of the military personnel to receive expedited licensure. The remaining text simply repeats the statute (B&P section 115.5) and is therefore unnecessary.

Also on the document incorporated by reference, form number 901-A (DCA/2014-revised), page 4, the underlining of text was inadvertently dropped a line in both the original and modified text as follows:

**PERSONAL INFORMATION COLLECTION, ACCESS AND DISCLOSURE**

Disclosure of your personal information is mandatory. The information on this form is required pursuant to Business and Professions Code section 901. Failure to provide

The final version approved by the Board on November 9, 2014, was corrected and the text now appears as follows:

**PERSONAL INFORMATION COLLECTION, ACCESS AND DISCLOSURE**

Disclosure of your personal information is mandatory. The information on this form is required pursuant to Business and Professions Code section 901. Failure to provide

**LOCAL MANDATE**

A mandate is not imposed on local agencies or school districts.

### **SMALL BUSINESS IMPACT**

This action will not have a significant adverse economic impact on small businesses.

However, subdivision (f) of section 1399.344 does require those private or not profit organizations that apply to allow an out-of-state practitioner to provide respiratory services at a sponsored event, to provide a report to the board within 15 days after the conclusion of the event. The report is necessary as a means to monitor activity for the purpose of consumer protection.

Overall, the provisions to authorize such practice benefits these community-based organizations by allowing them to retain personnel when traveling to different states and is necessary to codify section 901 of the Business and Professions Code.

### **CONSIDERATION OF ALTERNATIVES**

No reasonable alternative which was considered or that has otherwise been identified and brought to the attention of the board would be more effective in carrying out the purpose for which it was proposed or would be as effective and less burdensome to affected private persons than the adopted regulation or would be more cost effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

### **OBJECTIONS OR RECOMMENDATIONS/RESPONSES**

There were no objections, recommendations or comments regarding the proposed action. There were also no comments concerning the modified proposal.

### **FINDING OF NECESSITY**

The Respiratory Care Board of California hereby finds that it is necessary for the public health, safety, and welfare of the people of California that these regulations apply to business.

### **INCORPORATION BY REFERENCE**

The incorporation by reference method was used because it would be impractical and cumbersome to publish the application forms in the California Code of Regulations (CCR). The forms are intended to allow only what is anticipated to be only a handful of parties interested in applying for authorization to allow out-of-state practitioners to provide services for a very limited time. The application forms are extensive. If the application forms were incorporated into the CCR, it would increase the size of Division 13.6 and would cause confusion to the user. The application forms will be made available on the board's website immediately, should the regulations be approved.

RESOLUTION

**Delegation to Department of Consumer Affairs for the  
Review and Registration of Sponsoring Entities**

Whereas, section 901 of the Business and Professions Code (section 901), which relates to sponsored health care events, requires that an entity desiring to sponsor such an event must first register with the appropriate board within the Department of Consumer Affairs (Department); and,

Whereas, the Respiratory Care Board of California (Board) is the appropriate board to register sponsored health care events utilizing the services of respiratory care practitioners; and,

Whereas, the Board, to implement the provisions of section 901, has adopted proposed regulations that will authorize the Board by resolution to delegate to the Department the authority to receive registration forms and register sponsoring entities; and,

Whereas, a sponsored event may utilize many healthcare license disciplines, including physicians, respiratory care practitioners, registered nurses, licensed vocational nurses and other professionals; and,

Whereas, the Department would therefore serve as the optimal central point to receive registration forms and to register sponsoring entities;

THEREFORE, BE IT RESOLVED that the Board hereby delegates to the Department the authority to receive sponsored entity registration forms and to register sponsoring entities for sponsored health care events that utilize the services of respiratory care practitioners upon the effective date of the proposed regulations.

Adopted this 7<sup>th</sup> day of November 2014

By

Alan Roth, MS MBA RRT-NPS FAARC  
Acting President

## 2014 LEGISLATION OF INTEREST

ASSEMBLY BILL 186	
Author:	Maienschein [R]
Title:	Professions and Vocations: Military Spouses: Temporary Licenses
Introduced:	1/28/2013 [last amended 8/20/2014]
Status:	9/27/14: Approved by the Governor [Chapter 640, Statutes of 2014]
Summary:	Requires <b>specified</b> licensing entities under the Department of Consumer Affairs (DCA) to provide military spouses and domestic partners, who hold a valid professional license in another state, an 12 month provisional license to practice in California. <b>The bill does not include respiratory care practitioner applicants.</b>
Position:	<b>WATCH</b>

ASSEMBLY BILL 259	
Author:	Logue [R]
Title:	Health and Care Facilities: CPR
Introduced:	2/7/2013 [last amended 04/16/2013]
Status:	Bill has died.
Summary:	Existing law regulates long-term health care facilities, community care facilities, adult day health care centers, and residential care facilities. A person who violates these provisions is guilty of a crime, except as specified. This bill would make it a misdemeanor for those facilities to have a policy that prohibits any employee from administering cardiopulmonary resuscitation, except as specified.
Position:	<b>WATCH</b>

 Indicates bill is attached.

<b>ASSEMBLY BILL 809</b> <b>[URGENCY BILL]</b>	
Author:	Logue [R]
Title:	Healing Arts: Telehealth
Introduced:	2/21/2013 [last amended 8/7/2014]
Status:	9/18/14: Approved by the Governor [Chapter 404, Statutes of 2014]
Summary:	Existing law requires a health care provider, as defined, prior to the delivery of health care services via telehealth, as defined, to verbally inform the patient that telehealth may be used and obtain verbal consent from the patient for this use. Existing law also provides that failure to comply with this requirement constitutes unprofessional conduct. This bill would require the health care provider initiating the use of telehealth to obtain verbal or written consent from the patient for the use of telehealth, as specified. The bill would require that health care provider to document the consent.
Position:	<b>WATCH</b>

<b>ASSEMBLY BILL 1827</b>	
Author:	Patterson [R]
Title:	State Bodies: Administrative and Civil Penalties
Introduced:	02/18/14 [amended 3/28/14 to <b>only</b> impact environmental agencies]
Status:	Bill has died.
Summary:	This bill would require an agency, board, commission, department, division, or office within the California Environmental Protection Agency or the Natural Resources Agency, prior to the imposition of an administrative or civil penalty for a minor violation, to allow a business with 50 or fewer employees an opportunity to cure the violation.
Position:	<b>WATCH</b>

ASSEMBLY BILL 1972	
Author:	Jones [R]
Title	Respiratory Care Practitioners
Introduced:	2/19/2014 [amended 3/28/14]
Status:	7/23/14: Approved by the Governor [Chapter 179, Statutes of 2014]
Summary:	The Respiratory Care Practice Act requires an applicant to successfully pass the national respiratory therapist examination conducted in accordance with Board regulations. This bill would, instead, require an applicant to pass all parts of the Registered Respiratory Therapist (RRT) examination, unless an applicant provides evidence that he or she passed the National Board for Respiratory Care's Certified Respiratory Therapist (CRT) exam prior to January 1, 2015, and there is no evidence of prior license or job-related discipline, as determined by the Board in its discretion. This bill would also authorize the Board to extend the dates an applicant may perform as a respiratory care practitioner applicant for up to 6 months when the applicant is unable to complete the application process due to causes outside his/ her control, or when the applicant provides evidence that he/she has successfully passed the CRT examination and has otherwise completed the application process and has not previously been authorized to practice as a respiratory care practice applicant.
Position:	<b>SUPPORT</b>

ASSEMBLY BILL 2102	
Author:	Ting [D]
Title:	Licensees: Data Collection
Introduced:	2/20/2014 [last amended 8/4/14]
Status:	9/18/14: Approved by the Governor [Chapter 420, Statutes of 2014]
Summary:	Existing law requires the Board of Registered Nursing, the Physician Assistant Board, the Respiratory Care Board of California, and the Board of Vocational Nursing and Psychiatric Technicians of the State of California to regulate and oversee the practice of healing arts within their respective jurisdictions. This bill would require these boards to collect and report specific demographic data relating to its licensees, subject to a licensee's discretion to report his or her race or ethnicity, to the Office of Statewide Health Planning and Development. The bill would require these boards to collect this data at least biennially, at the times of both issuing an initial license and issuing a renewal license.
Position:	<b>WATCH</b>

ASSEMBLY BILL 2396	
Author:	Bonta [D]
Title:	Convictions: Expungement: Licenses
Introduced:	2/21/14 [last amended 8/19/14]
Status:	9/28/14: Approved by the Governor [Chapter 737, Statutes of 2014]
Summary:	This bill would prohibit licensing boards under DCA from denying a license based solely on a conviction that has been dismissed pursuant to Penal Code sections 1203.4, 1203.4(a), or 1203.41.
Position:	<b>OPPOSE</b>

ASSEMBLY BILL 2484	
Author:	Gordon [D]
Title:	Healing Arts: Telehealth
Introduced:	2/21/2014
Status:	Bill has died.
Summary:	Existing law provides for the licensure and regulation of various healing arts professions by various boards within the Department of Consumer Affairs. A violation of specified provisions is a crime. Existing law defines telehealth for the purpose of its regulation and requires a health care provider, as defined, prior to the delivery of health care via telehealth, to verbally inform the patient that telehealth may be used and obtain verbal consent from the patient and to document that verbal consent in the patient's medical record. This bill would alternatively allow a health care provider to obtain written consent from the patient before telehealth may be used and would require that written consent to be documented in the patient's medical record.
Position:	<b>WATCH</b>

ASSEMBLY BILL 2720	
Author:	Ting [D]
Title:	State Agencies: Meetings: Record of Action Taken
Introduced:	02/21/2014 [last amended 8/7/14]
Status:	9/20/14: Approved by the Governor [Chapter 510, Statutes of 2014]
Summary:	The Bagley-Keene Open Meeting Act requires, with specified exceptions, that all meetings of a state body, as defined, be open and public and all persons be permitted to attend any meeting of a state body. The act defines various terms for its purposes, including “action taken,” which means a collective decision made by the members of a state body, a collective commitment or promise by the members of the state body to make a positive or negative decision, or an actual vote by the members of a state body when sitting as a body or entity upon a motion, proposal, resolution, order, or similar action. This bill would require a state body to publicly report any action taken and the vote or abstention on that action of each member present for the action.
Position:	<b>WATCH</b>

**SENATE BILL 850**

Author:	Block [D]
Title:	Public postsecondary education: community college districts: baccalaureate degree pilot program
Introduced:	1/09/2014 [last amended 8/18/14]
Status:	9/28/14: Approved by the Governor [Chapter 747, Statutes of 2014]
Summary:	<p>Existing law establishes the California Community Colleges, under the administration of the Board of Governors of the California Community Colleges, as one of the segments of public postsecondary education in this state. Existing law requires the board of governors to appoint a chief executive officer, to be known as the Chancellor of the California Community Colleges. Existing law establishes community college districts, administered by governing boards, throughout the state, and authorizes these districts to provide instruction to students at the community college campuses maintained by the districts. Existing law requires community colleges to offer instruction through, but not beyond, the 2nd year of college and authorizes community colleges to grant associate degrees in arts and science.</p> <p>This bill would, commencing January 1, 2015, authorize the board of governors, in consultation with the California State University and the University of California, to establish a statewide baccalaureate degree pilot program at not more than 15 community college districts, with one baccalaureate degree program each, to be determined by the chancellor and approved by the board of governors. The bill would prohibit each participating district from offering more than one baccalaureate degree program within the district, as specified. The bill would require a district baccalaureate degree pilot program to commence by the beginning of the 2017–18 academic year, and would require a student participating in a baccalaureate degree pilot program to complete his or her degree by the end of the 2022–23 academic year. The bill would require participating community college districts to meet specified requirements, including, but not limited to, offering baccalaureate degree programs and program curricula not offered by the California State University or the University of California, and in subject areas with unmet workforce needs, as specified.</p> <p>This bill would also require the governing board of a participating community college district to submit certain items for review by the chancellor and approval by the board of governors, including, among other things, the administrative plan for the baccalaureate degree pilot program and documentation of consultation with the California State University and the University of California. The bill would provide that the Legislative Analyst’s Office shall conduct both a statewide interim evaluation and a statewide final evaluation of the statewide baccalaureate degree pilot program implemented under this article, as specified, and report to the Legislature and Governor, in writing, the results of the interim evaluation on or before July 1, 2018, and the results of the final evaluation on or before July 1, 2022. The bill would provide that on or before March 31, 2015, the board of governors shall develop, and adopt by regulation, a funding model for the support of the statewide baccalaureate degree pilot program, as specified.</p> <p>This bill would make these provisions inoperative on July 1, 2023, and would repeal the provisions on January 1, 2024.</p>
Position:	<b>SUPPORT</b>

# Assembly Bill No. 809

## CHAPTER 404

An act to amend Section 2290.5 of the Business and Professions Code, relating to telehealth, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor September 18, 2014. Filed with Secretary of State September 18, 2014.]

### LEGISLATIVE COUNSEL'S DIGEST

AB 809, Logue. Healing arts: telehealth.

Existing law requires a health care provider, as defined, prior to the delivery of health care services via telehealth, as defined, to verbally inform the patient that telehealth may be used and obtain verbal consent from the patient for this use. Existing law also provides that failure to comply with this requirement constitutes unprofessional conduct.

This bill would require the health care provider initiating the use of telehealth to obtain verbal or written consent from the patient for the use of telehealth, as specified. The bill would require that health care provider to document the consent.

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

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

SECTION 1. Section 2290.5 of the Business and Professions Code is amended to read:

2290.5. (a) For purposes of this division, the following definitions shall apply:

(1) "Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient.

(2) "Distant site" means a site where a health care provider who provides health care services is located while providing these services via a telecommunications system.

(3) "Health care provider" means a person who is licensed under this division.

(4) "Originating site" means a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.

(5) "Synchronous interaction" means a real-time interaction between a patient and a health care provider located at a distant site.

(6) “Telehealth” means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

(b) Prior to the delivery of health care via telehealth, the health care provider initiating the use of telehealth shall inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health. The consent shall be documented.

(c) Nothing in this section shall preclude a patient from receiving in-person health care delivery services during a specified course of health care and treatment after agreeing to receive services via telehealth.

(d) The failure of a health care provider to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

(e) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

(f) All laws regarding the confidentiality of health care information and a patient’s rights to his or her medical information shall apply to telehealth interactions.

(g) This section shall not apply to a patient under the jurisdiction of the Department of Corrections and Rehabilitation or any other correctional facility.

(h) (1) Notwithstanding any other provision of law and for purposes of this section, the governing body of the hospital whose patients are receiving the telehealth services may grant privileges to, and verify and approve credentials for, providers of telehealth services based on its medical staff recommendations that rely on information provided by the distant-site hospital or telehealth entity, as described in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

(2) By enacting this subdivision, it is the intent of the Legislature to authorize a hospital to grant privileges to, and verify and approve credentials for, providers of telehealth services as described in paragraph (1).

(3) For the purposes of this subdivision, “telehealth” shall include “telemedicine” as the term is referenced in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

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

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 that occurred 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, it is necessary for this act to take effect immediately.



RESPIRATORY CARE BOARD OF CALIFORNIA

March 25, 2014

The Honorable Brian Jones  
Assemblymember, District 71  
State Capitol, Room 3141  
Sacramento, CA 95814

RE: AB 1972: Respiratory Care Practitioners

Dear Assemblymember Jones:

The Respiratory Care Board of California (Board) is in support of AB 1972 which will require an applicant for licensure as a Respiratory Care Practitioner to pass all parts of the national registered respiratory therapist (RRT) examination, unless otherwise specified.

Business and Professions Code section 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.

AB 1972 will align the minimum examination requirements for licensure with the natural progression made in the respiratory field, and with accreditation standards and examination delivery. Evidence of competency, at what was once considered the advance level, proves greater consumer protection, improved job performance as a whole, and the ability to measure school outcomes.

The Board fully supports this bill which will increase the minimum exam threshold to the RRT to provide better consumer protection by ensuring new graduates meet the competency threshold that is now expected through all educational programs. Moreover, AB 1972 will align the licensure examination with changes made to the structure of the national exams and the standards of the national respiratory care accrediting agency.

Sincerely,

A handwritten signature in black ink that reads "Charles B. Spearman".

Charles B. Spearman, MSED, RRT, RCP  
President

# Assembly Bill No. 1972

## CHAPTER 179

An act to amend Sections 3730, 3735, and 3739 of, and to repeal Section 3735.5 of, the Business and Professions Code, relating to respiratory care.

[Approved by Governor July 23, 2014. Filed with  
Secretary of State July 23, 2014.]

### LEGISLATIVE COUNSEL'S DIGEST

AB 1972, Jones. Respiratory care practitioners.

(1) Under the Respiratory Care Practice Act, the Respiratory Care Board of California licenses and regulates the practice of respiratory care and therapy. The act requires an applicant to successfully pass the national respiratory therapist examination conducted in accordance with board regulations.

This bill would, instead, require an applicant to pass all parts of the national registered respiratory therapist examination, unless an applicant provides evidence that he or she passed the national certified respiratory therapist examination prior to January 1, 2015, and there is no evidence of prior license or job-related discipline, as determined by the board in its discretion. The bill would make conforming changes.

(2) The act authorizes a person who has filed an application for licensure with the board to perform as a respiratory care practitioner applicant under the direct supervision of a respiratory care practitioner, if the applicant has met education requirements and passed the national respiratory therapist examination, if he or she ever attempted the examination. Those privileges automatically cease if the applicant fails that examination.

This bill would authorize the board to extend the dates an applicant may perform as a respiratory care practitioner applicant for up to 6 months when the applicant is unable to complete the application for licensure process due to causes outside his or her control, or when the applicant provides evidence that he or she has successfully passed the national certified respiratory therapist examination, and the applicant has otherwise completed the application for licensure process and has not previously been authorized to practice as a respiratory care practitioner applicant.

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

SECTION 1. Section 3730 of the Business and Professions Code is amended to read:

3730. (a) 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.”

(b) 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 one or more examinations.

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

SEC. 2. Section 3735 of the Business and Professions Code is amended to read:

3735. (a) Except as otherwise provided in this chapter, an applicant shall not receive a license under this chapter without first successfully passing all parts of the national registered respiratory therapist examination.

(b) Notwithstanding subdivision (a), any person applying for licensure who provides evidence that he or she passed the national certified respiratory therapist examination prior to January 1, 2015, shall not be required to pass the national registered respiratory therapist examination, if there is no evidence of prior license or job-related discipline, as determined by the board in its discretion.

SEC. 3. Section 3735.5 of the Business and Professions Code is repealed.

SEC. 4. Section 3739 of the Business and Professions Code is amended to read:

3739. (a) 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 if he or she has met education requirements for licensure as may be certified by his or her respiratory care program.

(b) The board may extend the dates an applicant may perform as a respiratory care practitioner applicant under either of the following circumstances:

(1) When the applicant is unable to complete the licensure application due to causes completely outside his or her control.

(2) When the applicant provides evidence that he or she has successfully passed the national certified respiratory therapist examination, and the applicant has otherwise completed the application for licensure process and has not previously been authorized to practice as a respiratory care practitioner applicant under this subdivision.

(c) Authorization to practice as a respiratory care practitioner applicant pursuant to paragraph (2) of subdivision (b) shall not exceed six months from the date of graduation or the date the application was filed, whenever is later.

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

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

(f) This section shall not be construed to 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.

(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.



RESPIRATORY CARE BOARD OF CALIFORNIA

April 21, 2014

The Honorable Rob Bonta  
California State Assembly, District 18  
State Capitol, Room 6025  
Sacramento, CA 95814

RE: AB 2396: Convictions: Expungement: Licenses.

Dear Assemblyman Bonta:

The Respiratory Care Board (Board) has reviewed AB 2396 which would prohibit licensing boards under the Department of Consumer Affairs from denying a license based solely on a conviction that has been dismissed pursuant to Penal Code sections 1203.4, 1203.4(a), or 1203.41, and has respectfully taken an oppose position on the bill.

Pursuant to Business and Profession Code section 3710.1, "Protection of the public shall be the highest priority for the Respiratory Care Board in exercising its licensing, regulatory, and disciplinary functions." As proposed, AB 2396 threatens to take away the Board's discretion to deny a license, even when it is in the best interest of California's consumers, and may ultimately place patients at risk, and jeopardize protection of the public.

Dismissal of a conviction pursuant to specified sections of the Penal Code is available to those who have successfully completed probation and paid all restitution and fines. However, dismissal of a conviction is not indicative of rehabilitation, although AB 2396 creates a presumption of such and could result in a risk to consumers by prohibiting the denial of a license based on convictions that have been dismissed. For such cases, evidence of rehabilitation should still be considered as a condition that must be demonstrated prior to the granting of a license. This is especially true given the vulnerability of respiratory care patients.

Based on the foregoing, the Board is opposing AB 2396 to maintain vital authority to continue to pursue appropriate action, in support of its consumer protection mandate. Should you have any questions, please feel free to contact me at (916) 999-2190.

Respectfully,

A handwritten signature in black ink that reads "Stephanie Nunez". The signature is written in a cursive, flowing style.

Stephanie Nunez, Executive Officer  
Respiratory Care Board

# Assembly Bill No. 2396

## CHAPTER 737

An act to amend Section 480 of the Business and Professions Code, relating to expungement.

[Approved by Governor September 28, 2014. Filed with Secretary of State September 28, 2014.]

### LEGISLATIVE COUNSEL'S DIGEST

AB 2396, Bonta. Convictions: expungement: licenses.

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 board to deny, suspend, or revoke a license on various grounds, including, but not limited to, conviction of a crime if the crime is substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued. Existing law prohibits a board from denying a license on the ground that the applicant has committed a crime if the applicant shows that he or she obtained a certificate of rehabilitation in the case of a felony, or that he or she has met all applicable requirements of the criteria of rehabilitation developed by the board, as specified, in the case of a misdemeanor.

Existing law permits a defendant to withdraw his or her plea of guilty or plea of nolo contendere and enter a plea of not guilty in any case in which a defendant has fulfilled the conditions of probation for the entire period of probation, or has been discharged prior to the termination of the period of probation, or has been convicted of a misdemeanor and not granted probation and has fully complied with and performed the sentence of the court, or has been sentenced to a county jail for a felony, or in any other case in which a court, in its discretion and the interests of justice, determines that a defendant should be granted this or other specified relief and requires the defendant to be released from all penalties and disabilities resulting from the offense of which he or she has been convicted.

This bill would prohibit a board within the Department of Consumer Affairs from denying a license based solely on a conviction that has been dismissed pursuant to the above provisions. The bill would require an applicant who has a conviction that has been dismissed pursuant to the above provisions to provide proof of the dismissal.

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

SECTION 1. Section 480 of the Business and Professions Code is amended to read:

480. (a) A board may deny a license regulated by this code on the grounds that the applicant has one of the following:

(1) Been convicted of a crime. A conviction within the meaning of this section means a plea or verdict of guilty or a conviction following a plea of nolo contendere. Any action that a board is permitted to take following the establishment of a conviction may be taken when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4, 1203.4a, or 1203.41 of the Penal Code.

(2) Done any act involving dishonesty, fraud, or deceit with the intent to substantially benefit himself or herself or another, or substantially injure another.

(3) (A) Done any act that if done by a licentiate of the business or profession in question, would be grounds for suspension or revocation of license.

(B) The board may deny a license pursuant to this subdivision only if the crime or act is substantially related to the qualifications, functions, or duties of the business or profession for which application is made.

(b) Notwithstanding any other provision of this code, a person shall not be denied a license solely on the basis that he or she has been convicted of a felony if he or she has obtained a certificate of rehabilitation under Chapter 3.5 (commencing with Section 4852.01) of Title 6 of Part 3 of the Penal Code or that he or she has been convicted of a misdemeanor if he or she has met all applicable requirements of the criteria of rehabilitation developed by the board to evaluate the rehabilitation of a person when considering the denial of a license under subdivision (a) of Section 482.

(c) Notwithstanding any other provisions of this code, a person shall not be denied a license solely on the basis of a conviction that has been dismissed pursuant to Section 1203.4, 1203.4a, or 1203.41 of the Penal Code. An applicant who has a conviction that has been dismissed pursuant to Section 1203.4, 1203.4a, or 1203.41 of the Penal Code shall provide proof of the dismissal.

(d) A board may deny a license regulated by this code on the ground that the applicant knowingly made a false statement of fact that is required to be revealed in the application for the license.

# Assembly Bill No. 2720

## CHAPTER 510

An act to amend Section 11123 of the Government Code, relating to public meetings.

[Approved by Governor September 20, 2014. Filed with Secretary of State September 20, 2014.]

### LEGISLATIVE COUNSEL'S DIGEST

AB 2720, Ting. State agencies: meetings: record of action taken.

The Bagley-Keene Open Meeting Act requires, with specified exceptions, that all meetings of a state body, as defined, be open and public and all persons be permitted to attend any meeting of a state body. The act defines various terms for its purposes, including "action taken," which means a collective decision made by the members of a state body, a collective commitment or promise by the members of the state body to make a positive or negative decision, or an actual vote by the members of a state body when sitting as a body or entity upon a motion, proposal, resolution, order, or similar action.

This bill would require a state body to publicly report any action taken and the vote or abstention on that action of each member present for the action.

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

SECTION 1. Section 11123 of the Government Code is amended to read:

11123. (a) All meetings of a state body shall be open and public and all persons shall be permitted to attend any meeting of a state body except as otherwise provided in this article.

(b) (1) This article does not prohibit a state body from holding an open or closed meeting by teleconference for the benefit of the public and state body. The meeting or proceeding held by teleconference shall otherwise comply with all applicable requirements or laws relating to a specific type of meeting or proceeding, including the following:

(A) The teleconferencing meeting shall comply with all requirements of this article applicable to other meetings.

(B) The portion of the teleconferenced meeting that is required to be open to the public shall be audible to the public at the location specified in the notice of the meeting.

(C) If the state body elects to conduct a meeting or proceeding by teleconference, it shall post agendas at all teleconference locations and

conduct teleconference meetings in a manner that protects the rights of any party or member of the public appearing before the state body. Each teleconference location shall be identified in the notice and agenda of the meeting or proceeding, and each teleconference location shall be accessible to the public. The agenda shall provide an opportunity for members of the public to address the state body directly pursuant to Section 11125.7 at each teleconference location.

(D) All votes taken during a teleconferenced meeting shall be by rollcall.

(E) The portion of the teleconferenced meeting that is closed to the public may not include the consideration of any agenda item being heard pursuant to Section 11125.5.

(F) At least one member of the state body shall be physically present at the location specified in the notice of the meeting.

(2) For the purposes of this subdivision, “teleconference” means a meeting of a state body, the members of which are at different locations, connected by electronic means, through either audio or both audio and video. This section does not prohibit a state body from providing members of the public with additional locations in which the public may observe or address the state body by electronic means, through either audio or both audio and video.

(c) The state body shall publicly report any action taken and the vote or abstention on that action of each member present for the action.



RESPIRATORY CARE BOARD OF CALIFORNIA

April 18, 2014

The Honorable Marty Block  
California State Senate, District 39  
State Capitol, Room 4090  
Sacramento, CA 95814

RE: SB 850: Public postsecondary education: community college districts:  
baccalaureate degree pilot program.

Dear Senator Block:

The Respiratory Care Board of California (Board) is in support of SB 850 which would establish a baccalaureate degree pilot program within community college districts.

The field of respiratory care has expanded significantly over the last few decades with practitioners working in intensive care and acute care units, as well as home care, sleep labs and pulmonary laboratories. In addition, technology and advancements in medicine has broadened this field requiring extensive education and the development of critical thinkers in order to be successful. Currently the minimum education required for licensure as a Respiratory Care Practitioner is an associate degree. There are currently 37 programs in California with one offering a baccalaureate degree. The Board has long grappled with the fact that the "two-year" program which consistently takes three plus years (with full-time attendance) to complete, is falling short in providing the in-depth education that is really necessary to be prepared for employment at graduation. Furthermore, the Board has noticed significant workforce shortages over the last decade that it believes correlates more with the lack of education and qualified candidates, rather than the lack of available practitioners. Employers are demanding more and few therapists are meeting this demand.

The Board fully supports this bill, which has the potential to afford respiratory therapy students with an opportunity to earn a baccalaureate degree at the community college level, in support of the Board's mandate to protect and serve California's respiratory care consumers.

Sincerely,

  
Charles B. Spearman, MSEd, RRT, RCP  
President

## Senate Bill No. 850

### CHAPTER 747

An act to add and repeal Article 3 (commencing with Section 78040) of Chapter 1 of Part 48 of Division 7 of Title 3 of the Education Code, relating to public postsecondary education.

[Approved by Governor September 28, 2014. Filed with Secretary of State September 28, 2014.]

#### LEGISLATIVE COUNSEL'S DIGEST

**SB 850, Block.** Public postsecondary education: community college districts: baccalaureate degree pilot program.

Existing law establishes the California Community Colleges, under the administration of the Board of Governors of the California Community Colleges, as one of the segments of public postsecondary education in this state. Existing law requires the board of governors to appoint a chief executive officer, to be known as the Chancellor of the California Community Colleges. Existing law establishes community college districts, administered by governing boards, throughout the state, and authorizes these districts to provide instruction to students at the community college campuses maintained by the districts.

Existing law requires community colleges to offer instruction through, but not beyond, the 2nd year of college and authorizes community colleges to grant associate degrees in arts and science.

This bill would, commencing January 1, 2015, authorize the board of governors, in consultation with the California State University and the University of California, to establish a statewide baccalaureate degree pilot program at not more than 15 community college districts, with one baccalaureate degree program each, to be determined by the chancellor and approved by the board of governors. The bill would prohibit each participating district from offering more than one baccalaureate degree program within the district, as specified. The bill would require a district baccalaureate degree pilot program to commence by the beginning of the 2017–18 academic year, and would require a student participating in a baccalaureate degree pilot program to complete his or her degree by the end of the 2022–23 academic year. The bill would require participating community college districts to meet specified requirements, including, but not limited to, offering baccalaureate degree programs and program curricula not offered by the California State University or the University of California, and in subject areas with unmet workforce needs, as specified.

This bill would also require the governing board of a participating community college district to submit certain items for review by the chancellor and approval by the board of governors, including, among other

things, the administrative plan for the baccalaureate degree pilot program and documentation of consultation with the California State University and the University of California. The bill would provide that the Legislative Analyst's Office shall conduct both a statewide interim evaluation and a statewide final evaluation of the statewide baccalaureate degree pilot program implemented under this article, as specified, and report to the Legislature and Governor, in writing, the results of the interim evaluation on or before July 1, 2018, and the results of the final evaluation on or before July 1, 2022. The bill would provide that on or before March 31, 2015, the board of governors shall develop, and adopt by regulation, a funding model for the support of the statewide baccalaureate degree pilot program, as specified.

This bill would make these provisions inoperative on July 1, 2023, and would repeal the provisions on January 1, 2024.

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

SECTION 1. The Legislature finds and declares all of the following:

(a) California needs to produce one million more baccalaureate degrees than the state currently produces to remain economically competitive in the coming decades.

(b) The 21st century workplace increasingly demands a higher level of education in applied fields.

(c) There is demand for education beyond the associate degree level in specific academic disciplines that is not currently being met by California's four-year public institutions.

(d) Community colleges can help fill the gaps in our higher education system by granting baccalaureate degrees in a limited number of areas in order to meet a growing demand for a skilled workforce.

(e) These baccalaureate programs will be limited and will not in any way detract from the community colleges' traditional mission to advance California's economic growth and global competitiveness through education, training, and services that contribute to continuous workforce improvement, nor will these programs unnecessarily duplicate similar programs offered by nearby public four-year institutions.

(f) Community colleges can provide a quality baccalaureate education to their students, enabling place-bound local students and military veterans the opportunity to earn the baccalaureate degree needed for new job opportunities and promotion.

(g) Twenty-one other states, from Florida to Hawaii, already allow their community colleges to offer baccalaureate degrees. California is one of the most innovative states in the nation, and the California Community Colleges will use that same innovative spirit to produce more professionals in health, biotechnology, public safety, and other needed fields.

SEC. 2. Article 3 (commencing with Section 78040) is added to Chapter 1 of Part 48 of Division 7 of Title 3 of the Education Code, to read:

## Article 3. Baccalaureate Degree Pilot Program

78040. For purposes of this article, “district” means any community college district identified by the Chancellor of the California Community Colleges as participating in the statewide baccalaureate degree pilot program. Each participating district may establish one baccalaureate degree pilot program pursuant to Section 78041.

78041. Notwithstanding Section 66010.4, and commencing January 1, 2015, the Board of Governors of the California Community Colleges, in consultation with the California State University and the University of California, may authorize the establishment of district baccalaureate degree pilot programs that meet all of the eligibility requirements set forth in Section 78042. A district pilot program established pursuant to this article shall commence no later than the 2017–18 academic year. A student participating in a baccalaureate degree pilot program shall complete his or her degree by the end of the 2022–23 academic year. For purposes of this section, a pilot program commences when the first class of students begins the program. The statewide baccalaureate degree pilot program shall consist of a maximum of 15 districts, with one baccalaureate degree program each, to be determined by the Chancellor of the California Community Colleges and approved by the Board of Governors of the California Community Colleges.

78042. (a) A district shall seek approval to offer a baccalaureate degree program through the appropriate accreditation body.

(b) When seeking approval from the Board of Governors of the California Community Colleges, a district shall maintain the primary mission of the California Community Colleges specified in paragraph (3) of subdivision (a) of Section 66010.4. The district, as part of the baccalaureate degree pilot program, shall have the additional mission to provide high-quality undergraduate education at an affordable price for students and the state.

(c) As a condition of eligibility for consideration to participate in the statewide baccalaureate degree pilot program, a district shall have a written policy that requires all potential students who wish to apply for a Board of Governors Fee Waiver pursuant to Section 76300 to complete and submit either a Free Application for Federal Student Aid or a California Dream Act application in lieu of completing the Board of Governors Fee Waiver application.

(d) A district shall not offer more than one baccalaureate degree program, as determined by the governing board of the district and approved by the Board of Governors of the California Community Colleges, and subject to the following limitations:

(1) A district shall identify and document unmet workforce needs in the subject area of the baccalaureate degree to be offered and offer a baccalaureate degree at a campus in a subject area with unmet workforce needs in the local community or region of the district.

(2) A baccalaureate degree pilot program shall not offer a baccalaureate degree program or program curricula already offered by the California State University or the University of California.

(3) A district shall have the expertise, resources, and student interest to offer a quality baccalaureate degree in the chosen field of study.

(4) A district shall not offer more than one baccalaureate degree program within the district, which shall be limited to one campus within the district.

(5) A district shall notify a student who applies to the district's baccalaureate degree pilot program that the student is required to complete his or her baccalaureate degree by the end of the 2022–23 academic year, as specified in Section 78041.

(e) A district shall maintain separate records for students who are enrolled in courses classified in the upper division and lower division of a baccalaureate program. A student shall be reported as a community college student for enrollment in a lower division course and as a baccalaureate degree program student for enrollment in an upper division course.

(f) A governing board of a district seeking authorization to offer a baccalaureate degree pilot program shall submit all of the following for review by the Chancellor of the California Community Colleges and approval by the Board of Governors of the California Community Colleges:

(1) Documentation of the district's written policy required by subdivision (c).

(2) The administrative plan for the baccalaureate degree pilot program, including, but not limited to, the governing board of the district's funding plan for its specific district.

(3) A description of the baccalaureate degree pilot program's curriculum, faculty, and facilities.

(4) The enrollment projections for the baccalaureate degree pilot program.

(5) Documentation regarding unmet workforce needs specifically related to the proposed baccalaureate degree pilot program, and a written statement supporting the necessity of a four-year degree for that program.

(6) Documentation of consultation with the California State University and the University of California regarding collaborative approaches to meeting regional workforce needs.

(g) (1) On or before March 31, 2015, the Board of Governors of the California Community Colleges shall develop, and adopt by regulation, a funding model for the support of the statewide baccalaureate degree pilot program that is based on a calculation of the number of full-time equivalent students enrolled in all district pilot programs.

(2) Funding for each full-time equivalent student shall be at a marginal cost calculation, as determined by the Board of Governors of the California Community Colleges, that shall not exceed the community college credit instruction marginal cost calculation for a full-time equivalent student, as determined pursuant to paragraph (2) of subdivision (d) of Section 84750.5.

(3) A student in a baccalaureate degree pilot program authorized by this article shall not be charged fees higher than the mandatory systemwide fees charged for baccalaureate degree programs at the California State University.

(4) Fees for coursework in a baccalaureate degree pilot program shall be consistent with Article 1 (commencing with Section 76300) of Chapter 2 of Part 47.

(5) A district shall, in addition to the fees charged pursuant to paragraph (4), charge a fee for upper division coursework in a baccalaureate degree pilot program of eighty-four dollars (\$84) per unit.

(h) (1) The Legislative Analyst's Office shall conduct both an interim and a final statewide evaluation of the statewide baccalaureate degree pilot program implemented pursuant to this article.

(2) The results of the interim evaluation shall be reported as a progress report, in writing, to the Legislature and the Governor on or before July 1, 2018. The interim evaluation shall include, but is not limited to, all of the following:

(A) How many, and which specific, districts applied for a baccalaureate degree pilot program, and the baccalaureate degree pilot programs they applied for.

(B) Which potential four-year baccalaureate degrees were denied and why they were denied.

(C) Baccalaureate degree pilot program costs and the funding sources that were used to finance these programs.

(D) Current trends in workforce demands that require four-year degrees in the specific degree programs being offered through the statewide baccalaureate degree pilot program.

(E) Current completion rates, if available, for each cohort of students participating in a baccalaureate degree pilot program.

(F) Information on the impact of baccalaureate degree pilot program on underserved and underprepared students.

(3) The results of the final evaluation shall be reported, in writing, to the Legislature and the Governor on or before July 1, 2022. The final evaluation shall include, but is not limited to, all of the following:

(A) The number of new district baccalaureate degree pilot programs implemented, including information identifying the number of new programs, applicants, admissions, enrollments, and degree recipients.

(B) The extent to which the baccalaureate degree pilot programs established under this article fulfill identified workforce needs for new baccalaureate degree programs, including statewide supply and demand data that considers capacity at the California State University, the University of California, and in California's independent colleges and universities.

(C) Information on the place of employment of students and the subsequent job placement of graduates.

(D) Baccalaureate degree program costs and the funding sources that were used to finance these programs, including a calculation of cost per degree awarded.

(E) The costs of the baccalaureate degree programs to students, the amount of financial aid offered, and student debt levels of graduates of the programs.

(F) Time-to-degree rates and completion rates for the baccalaureate degree pilot programs.

(G) The extent to which the programs established under this article are in compliance with the requirements of this article.

(H) Information on the impact of baccalaureate degree pilot program on underserved and underprepared students.

(I) Recommendations on whether and how the statewide baccalaureate degree pilot program can or should be extended and expanded.

(4) A district shall submit the information necessary to conduct the evaluations required by paragraph (1), as determined by the Legislative Analyst's Office, to the Chancellor of the California Community Colleges, who shall provide the information to the Legislative Analyst's Office upon request.

(5) A report to be submitted pursuant to paragraph (2) or (3) shall be submitted in compliance with Section 9795 of the Government Code.

78043. This article shall become inoperative on July 1, 2023, and as of January 1, 2024, is repealed, unless a later enacted statute that is enacted before January 1, 2024, deletes or extends that date.

## **Respiratory Care Board of California** **2015 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**

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**Respiratory Care Board**  
**Legislative Proposal #1**  
**SUBSTANTIVE**  
Interim Suspension Order  
Sections 494 & 3769.7

**DATE SUBMITTED** November 18, 2014

### **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 non-consenting 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 – Only if suspension is ordered can the board take steps to notify the public at this stage.

### **IDENTIFICATION OF PROBLEM**

Licensed RCPs who are arrested 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 and sometimes even after conviction. 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 a licensee’s arrest, 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 when an actual suspension (PC 23/ISO) order is issued wherein those details are provided. Unless the subject is arrested at work or the media provides coverage, the public and employers are not likely to gain knowledge of the 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 “pure clear and convincing” evidence will be presented at 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 continued to practice legally. 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.<sup>1</sup>

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, depending on whether the RCP waives time and there are other delays of the hearing. The criminal trial could take months and even years to initiate. During this time the RCP is often out on bail with no practice restrictions and therefore there is no protection of the public.

### *Evidentiary Showing*

Again, the Gray case was not specific in what constitutes an evidentiary showing, only that citing the fact that charges were filed, was not sufficient. District Attorneys are reluctant to release any evidence or allow any testimony until such time that 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

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<sup>1</sup> 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.

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. If the RCP appeals the conviction, there are no means through PC 23 to continue or request another suspension while the 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 exparte or standard hearing. As with the PC 23 suspension, notice and evidentiary requirements still apply. 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. Through years of experience, we have found that 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 and discretion.

The standard of proof for criminal cases is beyond 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 494 of the Business and Professions Code to extend the time to file an accusation after securing an ISO from 15 days to 30 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 certain substantially related criminal arrests for a period of up to 60 days after the matter has been adjudicated and all appeals exhausted.

### **RCP 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 the unauthorized and/or unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care.

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. The Board also pursues discipline for violations of its Act. Over 36,000 licenses have been issued to date.

An RCP is a specialized healthcare practitioner who has graduated from a college or university, passed a national board certifying examination and holds state licensure. RCPs work most often in intensive care units (ICUs) and operating rooms, but are also commonly found in acute care settings, outpatient clinics, sleep clinics and home-health environments. RCPs work with patients of all ages from newborn infants to the elderly.

RCPs are specialists and educators in cardiology and pulmonology. RCPs are also advanced-practice clinicians in airway management; establishing and maintaining the airway during management of trauma, intensive care, and may administer medications or pharmacological agents for conscious sedation.

RCPs educate, diagnose, and treat people who are suffering from heart and lung problems. Specialized in both cardiac and pulmonary care, RCPs often collaborate with specialists in pulmonology and anesthesia in various aspects of clinical care of patients. RCPs provide a vital role in both medicine and nursing. A vital role in ICUs and emergency departments is the initiation and management of mechanical ventilation and the care of artificial airways.

RCPs with advanced education or credentialing evaluate and treat patients with a great deal of autonomy under the direction of a pulmonologist. In facilities that maintain critical care transport teams, RCPs are a preferred addition to all types of surface or air transport.

RCPs serve as clinical providers in pulmonary rehabilitation programs, cardiology clinics and catheterization labs. They are also primary clinicians in conducting tests to measure lung function and teaching people to manage asthma, chronic obstructive pulmonary disease among many other cardiac and lung functions.

Outside of clinics and hospitals, RCPs often manage home oxygen needs of patients and their families, providing around the clock support for home ventilators and other equipment for conditions like sleep apnea.

RCPs in the United States are migrating toward a role with autonomy similar to the nurse practitioner, or as an extension of the physician like the physician assistant. RCPs are frequently utilized as complete cardiovascular specialists being utilized to place and manage arterial accesses along with peripherally-inserted central catheters.

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 174,000 “active” respiratory therapists in the United States with California contributing 14% 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 and appropriate notice to the public. 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 protect children and other vulnerable patients from becoming victims of sexual or other bodily injury offenses at the hands of licensees. A licensee arrested for one of the noted crimes would no longer have pathways that would allow him/her to continue to practice respiratory care while resolution of the crime is pending.

Con: *The subject of the arrest may be falsely accused and innocent.* By limiting the crimes to certain egregious crimes, the section seeks to strike a balance between consumer protection and individual rights. This is also balanced against the fact that the arresting agency must have some belief in the evidence and/or testimony to make the arrest. The more unacceptable scenario would be adding an additional child or vulnerable patient, to the list of the licensee’s victims with the State knowing of the licensee’s criminal arrest. The Board has given consideration to due process rights weighted against the potential severity for gross negligence or malicious and potential harm to patients. The Board believes this proposal strikes an appropriate balance between consumer protection and due process.

## **PROBABLE SUPPORT & OPPOSITION**

*California Society for Respiratory Care (CSRC)*: The Board anticipates the CSRC will take a **neutral** or **support** 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 and would only affect licensees (private parties) 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.

## **APPOINTMENTS**

### *Governor*

Mary Ellen Early, Public Member, 4/13/13  
Rebecca F. Franzoia, Public Member, 7/21/12  
Mark D. Goldstein, BS, RRT, RCP, Professional Member, 6/9/12

### *Assembly Speaker*

Michael Hardeman, Public Member, 7/3/13  
Judy McKeever, RCP, RRT, Professional Member, 2/19/14  
Alan Roth, MS MBA RRT-NPS FAARC, Professional Member, 9/12/12

### *Senate Rules*

Ronald H. Lewis, M.D., Physician Member, 6/9/13  
Laura C. Romero, Ph.D, Public Member, 5/8/13  
Thomas Wagner, BS, RRT, RCP, Professional Member, 6/4/14

## **PROPOSED LANGUAGE**

Section 494 of the Business and Professions Code is amended to read:

### **494. Administrative Interim Suspension Order**

(a) A board or an administrative law judge sitting alone, as provided in subdivision (h), may, upon petition, issue an interim order suspending any licentiate or imposing license restrictions, including, but not limited to, mandatory biological fluid testing, supervision, or remedial training. The petition shall include affidavits that demonstrate, to the satisfaction of the board, both of the following:

(1) The licentiate has engaged in acts or omissions constituting a violation of this code or has been convicted of a crime substantially related to the licensed activity.

(2) Permitting the licentiate to continue to engage in the licensed activity, or permitting the licentiate to continue in the licensed activity without restrictions, would endanger the public health, safety, or welfare.

(b) No interim order provided for in this section shall be issued without notice to the licentiate unless it appears from the petition and supporting documents that serious injury would result to the public before the matter could be heard on notice.

(c) Except as provided in subdivision (b), the licentiate shall be given at least 15 days' notice of the hearing on the petition for an interim order. The notice shall include documents submitted to the board in support of the petition. If the order was initially issued without notice as provided in subdivision (b), the licentiate shall be entitled to a hearing on the petition within 20 days of the issuance of the interim order without notice. The licentiate shall be given notice of the hearing within two days after issuance of the initial interim order, and shall receive all documents in support of the petition. The failure of the board to provide a hearing within 20 days following the issuance of the interim order without notice, unless the licentiate waives his or her right to the hearing, shall result in the dissolution of the interim order by operation of law.

(d) At the hearing on the petition for an interim order, the licentiate may:

(1) Be represented by counsel.

(2) Have a record made of the proceedings, copies of which shall be available to the licentiate upon payment of costs computed in accordance with the provisions for transcript costs for judicial review contained in Section 11523 of the Government Code.

(3) Present affidavits and other documentary evidence.

(4) Present oral argument.

(e) The board, or an administrative law judge sitting alone as provided in subdivision (h), shall issue a decision on the petition for interim order within five business days following submission of the matter. The standard of proof required to obtain an interim order pursuant to this section shall be a preponderance of the evidence standard. If the interim order was previously issued without notice, the board shall determine whether the order shall remain in effect, be dissolved, or modified.

(f) The board shall file an accusation within ~~45~~30 days of the issuance of an interim order 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 later. In the case of an interim order issued without notice, the time shall run from the date of the order issued after the noticed hearing. If the licentiate files a Notice of Defense, the hearing shall be held within 30 days of the agency's receipt of the Notice of Defense. A decision shall be rendered on the accusation no later than 30 days after submission of the matter. Failure to comply with any of the requirements in this subdivision shall dissolve the interim order by operation of law.

(g) Interim orders shall be subject to judicial review pursuant to Section 1094.5 of the Code of Civil Procedure and shall be heard only in the superior court in and for the Counties of Sacramento, San Francisco, Los Angeles, or San Diego. The review of an interim order shall be limited to a determination of whether the board abused its discretion in the issuance of the interim order. Abuse of discretion is established if the respondent board has not proceeded in the manner required by law, or if the court determines that the interim order is not supported by substantial evidence in light of the whole record.

(h) The board may, in its sole discretion, delegate the hearing on any petition for an interim order to an administrative law judge in the Office of Administrative Hearings. If the board hears the noticed petition itself, an administrative law judge shall preside at the hearing, rule on the admission and exclusion of evidence, and advise the board on matters of law. The board shall exercise all other powers relating to the conduct of the hearing but may delegate any or all of them to the administrative law judge. When the petition has been delegated to an administrative law judge, he or she shall sit alone and exercise all of the powers of the board relating to the conduct of the hearing. A decision issued by an administrative law judge sitting alone shall be final when it is filed with the board. If the administrative law judge issues an interim order without notice, he or she shall preside at the noticed hearing, unless unavailable, in which case another administrative law judge may hear the matter. The decision of the administrative law judge sitting alone on the petition for an interim order is final, subject only to judicial review in accordance with subdivision (g).

(i) Failure to comply with an interim order issued pursuant to subdivision (a) or (b) shall constitute a separate cause for disciplinary action against any licentiate, and may be heard at, and as a part of, the noticed hearing provided for in subdivision (f). Allegations of noncompliance with the interim order may be filed at any time prior to the rendering of a decision on the accusation. Violation of the interim order is established upon proof that the licentiate was on notice of the interim order and its terms, and that the order was in effect at the time of the violation. The finding of a violation of an interim order made at the hearing on the accusation shall be reviewed as a part of any review of a final decision of the agency. If the interim order issued by the agency provides for anything less than a complete suspension of the licentiate from his or her business or profession, and the licentiate violates the interim order prior to the hearing on the accusation provided for in subdivision (f), the agency may, upon notice to the licentiate and proof of violation, modify or expand the interim order.

(j) A plea or verdict of guilty or a conviction after a plea of nolo contendere is deemed to be a conviction within the meaning of this section. A certified record of the conviction shall be

conclusive evidence of the fact that the conviction occurred. A board may take action under this section notwithstanding the fact that an appeal of the conviction may be taken.

(k) The interim orders provided for by this section shall be in addition to, and not a limitation on, the authority to seek injunctive relief provided in any other provision of law.

(l) In the case of a board, a petition for an interim order may be filed by the executive officer. In the case of a bureau or program, a petition may be filed by the chief or program administrator, as the case may be.

(m) "Board," as used in this section, shall include any agency described in Section 22, and any allied health agency within the jurisdiction of the Medical Board of California. Board shall also include the Osteopathic Medical Board of California and the State Board of Chiropractic Examiners. The provisions of this section shall not be applicable to the Medical Board of California, the Board of Podiatric Medicine, or the State Athletic Commission.

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

**3769.7. Public information; arrests**

Upon receipt of certified copies of arrest documents, the board may provide notice on its website and may additionally notify employers whenever a licensee or applicant of the board has been arrested for any crime noted in sections 3752.5, 3752.6 and 3752.7. Such notice shall be removed 60 days after the criminal matter is adjudicated or when all appeal rights have been exhausted, whichever is later.

## **Respiratory Care Board of California** **2015 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**

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**Respiratory Care Board**  
**Legislative Proposal #2**  
SUBSTANTIVE  
Probation Stipulations  
Sections 3769.5 & 3769.7

**DATE SUBMITTED** November 18, 2014

### **SUMMARY**

This proposal would grant the Respiratory Care Board (Board) the authority to *directly* issue “conditional probationary licenses” to applicants and enter into stipulated agreements to issue “probationary licenses” to licensees. This proposal aims to achieve significant cost savings and reduction in disciplinary processing times.

### **IDENTIFICATION OF PROBLEM**

It is standard practice for the Board to issue conditional probationary licenses to applicants and enter into stipulated agreements for probationary licenses with licensees, when grounds exist for disciplinary action. However, this process is currently performed by the Office of the Attorney General (OAG).

Currently, the Board issues an average of 24 stipulated decisions containing orders for probation each year. The Board estimates the average cost charged to the Board by the OAG is 1) \$1,800 for each conditional license (33%) and 2) \$3,000 for each probationary license (66%); an amount totaling \$62,400 accounting for approximately 16% of OAG expenses each year. The average time from the date the Board requests a pleading document (Statement of Issues or Accusation) from the OAG to the date a stipulated settlement is ordered is 320 days, 45 days shy of a year.

Given that the Board is charged with protecting consumers and continually strives to reduce disciplinary processing times and costs, coupled with the simple alternative posed in this proposal, these timeframes and costs are no longer acceptable.

### **PROPOSED SOLUTION**

- Add §3769.5 to grant the Board the authority to enter into a stipulation with an applicant to issue a conditional license.
- Add §3769.7 to grant the Board the authority to enter into a stipulation with a licensee to issue a probationary license.

## **RCP 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 the unauthorized and/or unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care.

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. The Board also pursues discipline for violations of its Act. Over 36,000 licenses have been issued to date.

An RCP is a specialized healthcare practitioner who has graduated from a college or university, passed a national board certifying examination and holds state licensure. RCPs work most often in intensive care units (ICUs) and operating rooms, but are also commonly found in acute care settings, outpatient clinics, sleep clinics and home-health environments. RCPs work with patients of all ages from newborn infants to the elderly.

RCPs are specialists and educators in cardiology and pulmonology. RCPs are also advanced-practice clinicians in airway management; establishing and maintaining the airway during management of trauma, intensive care, and may administer medications or pharmacological agents for conscious sedation.

RCPs educate, diagnose, and treat people who are suffering from heart and lung problems. Specialized in both cardiac and pulmonary care, RCPs often collaborate with specialists in pulmonology and anesthesia in various aspects of clinical care of patients. RCPs provide a vital role in both medicine and nursing. A vital role in ICUs and emergency departments is the initiation and management of mechanical ventilation and the care of artificial airways.

RCPs with advanced education or credentialing evaluate and treat patients with a great deal of autonomy under the direction of a pulmonologist. In facilities that maintain critical care transport teams, RCPs are a preferred addition to all types of surface or air transport.

RCPs serve as clinical providers in pulmonary rehabilitation programs, cardiology clinics and catheterization labs. They are also primary clinicians in conducting tests to measure lung function and teaching people to manage asthma, chronic obstructive pulmonary disease among many other cardiac and lung functions.

Outside of clinics and hospitals, RCPs often manage home oxygen needs of patients and their families, providing around the clock support for home ventilators and other equipment for conditions like sleep apnea.

RCPs in the United States are migrating toward a role with autonomy similar to the nurse practitioner, or as an extension of the physician like the physician assistant. RCPs are frequently utilized as complete cardiovascular specialists being utilized to place and manage arterial accesses along with peripherally-inserted central catheters.

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 174,000 "active" respiratory therapists in the United States with California contributing 14% 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. Since 2002, the Board has reduced enforcement processing timelines and timelines associated with obtaining initial licensure, while applications for licensure have nearly tripled, and several new programs or functions have been added. The Board has made this progress over the last 12 years without any augmentations in authorized personnel. Through continuous growth and reengineering, the Board strives to continue to evolve in this fashion.

The Board believes the delays in issuing conditional and probationary licenses can be completely averted while achieving cost savings.

Currently, when a case is transmitted to the OAG, Board staff prepares a very detailed memo that outlines all the sections to be pled; highlights all the details to include in the pleading, and identify any mitigating or aggravating facts. At this time, Board staff also prepares a "Proposed Probationary Terms and Conditions" sheet, should the Board be willing to seek discipline less than revocation. Additional documentation is prepared and/or attached including certified arrest and/or court records, a certificate of licensure and any other relevant back up documentation.

Once all evidence is received, the Board estimates the time to prepare the memo and certification of licensure and copy and package all the documentation takes approximately two weeks. Once the OAG receives the request, it takes approximately three and a half months to receive the initial pleading and another five-six months to produce a signed stipulated settlement. The average time from the date the Board requests a pleading document (Statement of Issues or Accusation) from the OAG to the date a stipulated settlement is ordered is 320 days, 45 days shy of a year, at an annual cost averaging \$62,400.

Nearly all of those cases where the Board is pursuing less than revocation result in a stipulated settlement and are most often straight forward cases (e.g. conviction of a crime). As provided in the proposed language stipulations would be modeled after existing pleading documents and would contain the authority, grounds and causes and circumstances for taking such action and before waiving certain rights, the affected applicant will be informed of the right to have the matter heard before an Administrative Law Judge in accordance with the Administrative Procedures Act. Essentially, Board staff already prepares these pleadings in their detailed memo requesting disciplinary action. Other boards like the MBC routinely negotiate probationary licenses in this manner and without the OAG completing the documents.

The adoption of this section would allow board staff to work directly with licensees (willing to stipulate) to the same end result with no Attorney General costs and in a more timely fashion. Should this section be enacted, the Board estimates that the average time to from the point of a complete investigation to the date a stipulated settlement is ordered will be 120 days; Reducing the average processing times by 200 days or nearly 7 months.

Workload for Board staff would be balanced by preparing stipulations instead of detailed requests and by contacting the respondent to negotiate a settlement instead of contacting the OAG regularly to follow up. The Board would achieve an average of \$62,400 in cost savings annually.

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 to reduce enforcement processing times made by the sunset overview review staff in 2013.

## **ARGUMENTS PRO & CON**

Pro: *Enforcement processing timelines will be significantly reduced and cost savings achieved.* This proposed language will reduce processing timelines from 320 days to 120 days, for over half of its total enforcement actions while achieving an annual cost savings of approximately \$62,400. This proposal is better for consumers and affected licensees.

Con: None.

## **PROBABLE SUPPORT & OPPOSITION**

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

## **FISCAL IMPACT**

Significant. The Board estimates an annual cost savings of approximately \$62,400 in OAG expenses.

## **ECONOMIC IMPACT**

None.

## **FINDINGS FROM OTHER STATES**

The Board is unaware of other states with similar statutes.

## **APPOINTMENTS**

### *Governor*

Mary Ellen Early, Public Member, 4/13/13  
Rebecca F. Franzoia, Public Member, 7/21/12  
Mark D. Goldstein, BS, RRT, RCP, Professional Member, 6/9/12

### *Assembly Speaker*

Michael Hardeman, Public Member, 7/3/13  
Judy McKeever, RCP, RRT, Professional Member, 2/19/14  
Alan Roth, MS MBA RRT-NPS FAARC, Professional Member, 9/12/12

### *Senate Rules*

Ronald H. Lewis, M.D., Physician Member, 6/9/13  
Laura C. Romero, Ph.D, Public Member, 5/8/13  
Thomas Wagner, BS, RRT, RCP, Professional Member, 6/4/14

## **PROPOSED LANGUAGE**

Section 3769.5 is added to the Business and Professions Code to read:

### **§ 3769.5. Applicant - Conditional License Stipulation**

(a) Notwithstanding any other provision, the board may, by stipulation with the affected applicant, issue a conditional probationary license, subject to terms and conditions, as provided in the board's disciplinary guidelines, in lieu of filing and prosecuting a formal statement of issues.

(b) The stipulation shall contain the authority, grounds and causes and circumstances for taking such action and by way of waiving the affected applicant's rights, inform him or her of their rights to have a formal statement of issues filed and stipulate to a settlement thereafter or have the matter in the statement of issues heard before an Administrative Law Judge in accordance with the Administrative Procedures Act.

(c) The stipulation shall be public information and may be used as the basis for or as evidence in any future disciplinary or penalty action taken by the board.

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

### **§ 3769.7. Licensee – Probationary License Stipulation**

(a) Notwithstanding any other provision, the board itself, may, by stipulation with the affected licensee, place his or her license on probation, subject to terms and conditions, as provided in the board's disciplinary guidelines, in lieu of filing and prosecuting a formal accusation.

(b) The stipulation shall contain the authority, grounds and causes and circumstances for taking such action and shall by way of waiving the affected licensee's rights, inform him or her of the right to have a formal accusation filed and stipulate to a settlement thereafter or have the matter in the accusation heard before an Administrative Law Judge in accordance with the Administrative Procedures Act.

(c) The stipulation and order shall be public information and shall be used as the basis for or as evidence in any future disciplinary or penalty action taken by the board.

## **Respiratory Care Board of California** **2015 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  
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**Respiratory Care Board**  
**Legislative Proposal #3**  
**SUBSTANTIVE**  
Sex Crimes/  
Unprofessional Conduct  
Sections 3752.7 & 3755

**DATE SUBMITTED** November 18, 2014

### **SUMMARY**

This proposal would add all crimes identified in the Sex Offender Registration Act (Penal Code 290) to section 3752.7 which requires an Administrative Law Judge (ALJ) who makes a finding of fact that a respondent has committed one or more of those acts, to issue a decision that includes an order for revocation.

This proposal would also amend section 3755 to include as unprofessional conduct any 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 of a person while in the health care setting.

### **IDENTIFICATION OF PROBLEM**

Currently, section 3752.7 provides and ALJ to include an order of revocation in any decision where there is a finding of fact of a violation of numerous sexually related crimes identified in section 44010 of the Education Code. However, the following sections (not all inclusive), which are referenced in Section 290 of the Penal Code, also known as the Sex Offender Registration Act, were inadvertently omitted:

Section 187 Murder  
Section 207 Kidnapping/Trafficking  
Section 209 Kidnapping for ransom/rape  
Section 266 (c) Rape no consent  
Section 266 (i)(b) Receiving financial gain from prostitute less than 16 years of age  
Section 269 Rape child under 14 years of age  
Section 288.2 Delivery of pornographic materials to minor  
Section 288.4 Arranges meeting with minor to expose genitals or engage in lewd conduct  
Section 288.7 Sexual intercourse or sodomy with child under 10 years of age  
Section 653(f)(c) Solicits another to commit rape, sodomy, or oral copulation by force.

In addition, the Board has encountered barriers within its existing statutory framework in pursuing discipline (not necessarily revocation) for acts of unprofessional conduct of a highly inappropriate nature.

The Board recently substantiated two complaints involving serious allegations of sexual harassment (that did not result in an arrest) but found that it has no basis to pursue disciplinary action in these types of cases.

Many DAGs believe the Board's existing codes do not allow it to pursue administrative suspension or discipline for some behavior or crimes that take place in the health care setting. Absent a criminal conviction, some DAGs have been reluctant to take action solely based on §3750(j) "a corrupt act" because "corrupt" has never been defined by the courts, and provide that the language in §3755, unprofessional conduct, is too broad.

### **PROPOSED SOLUTION**

- Amend §3752.7 to provide clarity of all sexually related crimes (and murder) that are grounds for revocation by referencing Penal Code Section 290, the Sex Offender Registration Act.
- 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.

### **RCP 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 the unauthorized and/or unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care.

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. The Board also pursues discipline for violations of its Act. Over 36,000 licenses have been issued to date.

An RCP is a specialized healthcare practitioner who has graduated from a college or university, passed a national board certifying examination and holds state licensure. RCPs work most often in intensive care units (ICUs) and operating rooms, but are also commonly found in acute care settings, outpatient clinics, sleep clinics and home-health environments. RCPs work with patients of all ages from newborn infants to the elderly.

RCPs are specialists and educators in cardiology and pulmonology. RCPs are also advanced-practice clinicians in airway management; establishing and maintaining the airway during management of trauma, intensive care, and may administer medications or pharmacological agents for conscious sedation.

RCPs educate, diagnose, and treat people who are suffering from heart and lung problems. Specialized in both cardiac and pulmonary care, RCPs often collaborate with specialists in pulmonology and anesthesia in various aspects of clinical care of patients. RCPs provide a vital role in both medicine and nursing. A vital role in ICUs and emergency departments is the initiation and management of mechanical ventilation and the care of artificial airways.

RCPs with advanced education or credentialing evaluate and treat patients with a great deal of autonomy under the direction of a pulmonologist. In facilities that maintain critical care transport teams, RCPs are a preferred addition to all types of surface or air transport.

RCPs serve as clinical providers in pulmonary rehabilitation programs, cardiology clinics and catheterization labs. They are also primary clinicians in conducting tests to measure lung function and teaching people to manage asthma, chronic obstructive pulmonary disease among many other cardiac and lung functions.

Outside of clinics and hospitals, RCPs often manage home oxygen needs of patients and their families, providing around the clock support for home ventilators and other equipment for conditions like sleep apnea.

RCPs in the United States are migrating toward a role with autonomy similar to the nurse practitioner, or as an extension of the physician like the physician assistant. RCPs are frequently utilized as complete cardiovascular specialists being utilized to place and manage arterial accesses along with peripherally-inserted central catheters.

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 174,000 “active” respiratory therapists in the United States with California contributing 14% 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, many of 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 has succumbed to flaws in the existing legal framework. 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. This proposed language rightfully strengthens consumer protection against some of the most egregious acts.

Con: None.

## **PROBABLE SUPPORT & OPPOSITION**

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

## **FISCAL IMPACT**

None.

## **ECONOMIC IMPACT**

Insignificant. All such cases, 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.

## **APPOINTMENTS**

### *Governor*

Mary Ellen Early, Public Member, 4/13/13  
Rebecca F. Franzoia, Public Member, 7/21/12  
Mark D. Goldstein, BS, RRT, RCP, Professional Member, 6/9/12

### *Assembly Speaker*

Michael Hardeman, Public Member, 7/3/13  
Judy McKeever, RCP, RRT, Professional Member, 2/19/14  
Alan Roth, MS MBA RRT-NPS FAARC, Professional Member, 9/12/12

### *Senate Rules*

Ronald H. Lewis, M.D., Physician Member, 6/9/13  
Laura C. Romero, Ph.D, Public Member, 5/8/13  
Thomas Wagner, BS, RRT, RCP, Professional Member, 6/4/14

## **PROPOSED LANGUAGE**

Section 3752.7 of the Business and Professions Code is amended to read:

### **3752.7. Sexual contact or acts 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 any act of sexual contact, as defined in Section 729, with a patient, or has committed, 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.

Section 3755 of the Business and Professions Code is amended to read:

### **§ 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, or verbally or physically abusive behavior, including but not limited to sexual harassment, abusive infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or any other conduct which is inimical to the health, morals, welfare, or safety of a person, whether or not the victim is a patient, a patient friend or family member or employee, ~~and~~ or 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.

## **Respiratory Care Board of California** **2015 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**

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**Respiratory Care Board**  
**Legislative Proposal #4**  
NON SUBSTANTIVE  
Endangering Vulnerable  
Population /Continuing Jurisdiction  
Sections 3750 & 3754.8

**DATE SUBMITTED** November 18, 2014

### **SUMMARY**

This proposal will make the commission of an act of abuse or neglect against a child, dependent adult, or the elderly, by a respiratory care practitioner (RCP) grounds for discipline. This proposal will also ensure the Board continues to maintain jurisdiction in all disciplinary matters that are finalized after a license has cancelled.

### **IDENTIFICATION OF PROBLEM**

The Board has encountered licensees who have committed acts of neglect or abuse against vulnerable individuals (e.g. children, dependent adults, elderly) and placing them in endangerment. Sometimes these acts result in convictions and other times they do not. The Board has had incidents where abuse or neglect has occurred, but could not pursue disciplinary action because it did not have the authority or have been advised that the acts would likely not be deemed to be substantially related. The Board believes that any act endangering a child, a dependent adult or the elderly causes grave concerns for RCPs' ability to care for another vulnerable population: respiratory care patients. Licensed RCPs regularly care for the vulnerable population without direct oversight and demonstration of neglect or abuse against these individuals causes serious concern for patient safety. The Board believes that such acts warrant discipline and to monitor the RCP more closely at a minimum.

This Board is also seeking a legislative change that is more administrative in nature, to ensure it maintains jurisdiction in disciplinary matters, should an RCP's license cancel before a disciplinary matter is finalized. Currently, the Board provides significant financial and personnel resources to pursue discipline. Should the discipline process not be completed because a license is cancelled, the discipline is null and void and may not be part of a public record. The person may then reapply for licensure but depending on other variables, discipline may not be able to be pursued or duplicative resources are exhausted to pursue discipline.

### **PROPOSED SOLUTION**

- Add subdivision (q) to §3750 to make the commission of an action of neglect, endangerment or abuse of a child, and elderly person or a dependent adult grounds for discipline.
- Add §3754.8 to give the board continuing jurisdiction of a disciplinary matter despite the expiration or cancellation of a license.

## **RCP 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 the unauthorized and/or unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care.

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. The Board also pursues discipline for violations of its Act. Over 36,000 licenses have been issued to date.

An RCP is a specialized healthcare practitioner who has graduated from a college or university, passed a national board certifying examination and holds state licensure. RCPs work most often in intensive care units (ICUs) and operating rooms, but are also commonly found in acute care settings, outpatient clinics, sleep clinics and home-health environments. RCPs work with patients of all ages from newborn infants to the elderly.

RCPs are specialists and educators in cardiology and pulmonology. RCPs are also advanced-practice clinicians in airway management; establishing and maintaining the airway during management of trauma, intensive care, and may administer medications or pharmacological agents for conscious sedation.

RCPs educate, diagnose, and treat people who are suffering from heart and lung problems. Specialized in both cardiac and pulmonary care, RCPs often collaborate with specialists in pulmonology and anesthesia in various aspects of clinical care of patients. RCPs provide a vital role in both medicine and nursing. A vital role in ICUs and emergency departments is the initiation and management of mechanical ventilation and the care of artificial airways.

RCPs with advanced education or credentialing evaluate and treat patients with a great deal of autonomy under the direction of a pulmonologist. In facilities that maintain critical care transport teams, RCPs are a preferred addition to all types of surface or air transport.

RCPs serve as clinical providers in pulmonary rehabilitation programs, cardiology clinics and catheterization labs. They are also primary clinicians in conducting tests to measure lung function and teaching people to manage asthma, chronic obstructive pulmonary disease among many other cardiac and lung functions.

Outside of clinics and hospitals, RCPs often manage home oxygen needs of patients and their families, providing around the clock support for home ventilators and other equipment for conditions like sleep apnea.

RCPs in the United States are migrating toward a role with autonomy similar to the nurse practitioner, or as an extension of the physician like the physician assistant. RCPs are frequently utilized as complete cardiovascular specialists being utilized to place and manage arterial accesses along with peripherally-inserted central catheters.

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 174,000 “active” respiratory therapists in the United States with California contributing 14% 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."

## **ARGUMENTS PRO & CON**

Pro: *Consumer protection provisions are strengthened.* This proposed language strengthens the legal framework to pursue disciplinary action for acts of negligence and abuse against our most vulnerable population and in turn increase patient safety. 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.

Con: None.

## **PROBABLE SUPPORT & OPPOSITION**

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

## **FISCAL IMPACT**

None.

## **ECONOMIC IMPACT**

Insignificant. Private parties subject to discipline are the only parties affected. 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.

## **APPOINTMENTS**

### *Governor*

Mary Ellen Early, Public Member, 4/13/13  
Rebecca F. Franzoia, Public Member, 7/21/12  
Mark D. Goldstein, BS, RRT, RCP, Professional Member, 6/9/12

### *Assembly Speaker*

Michael Hardeman, Public Member, 7/3/13  
Judy McKeever, RCP, RRT, Professional Member, 2/19/14  
Alan Roth, MS MBA RRT-NPS FAARC, Professional Member, 9/12/12

### *Senate Rules*

Ronald H. Lewis, M.D., Physician Member, 6/9/13  
Laura C. Romero, Ph.D, Public Member, 5/8/13  
Thomas Wagner, BS, RRT, RCP, Professional Member, 6/4/14

## **PROPOSED LANGUAGE**

Section 3750 of the Business and Professions Code is amended to read:

### **§ 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 an act of neglect, endangerment or abuse involving a 1) minor, any person under 18 years of age, or 2) an elder, any person 65 years of age or older, or 3) any dependent adult, as described in subdivision (a) of section 368 of the Penal Code, whether or not the person was a patient.

Section 3754.8 is added to the Business and Professions Code to read:

**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.

**Respiratory Care Board of California**  
**2015 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**

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**Respiratory Care Board**  
**Legislative Proposal #5**  
SUBSTANTIVE  
Scope of Practice  
Sections 3702.4 and 3702.7

**DATE SUBMITTED** November 18, 2014

**SUMMARY**

This proposal clarifies areas of the respiratory scope of practice that were not initially drafted to accommodate advancements in technology and changes in patient care for future interpretation. Those areas are: conscious/deep sedation, extracorporeal life support; cardiovascular system, respiratory care education, and overlapping functions.

**IDENTIFICATION OF PROBLEM**

Advancements in the medical field and the delivery of care have rapidly evolved since the Respiratory Care Practice Act was enacted 33 years ago in 1982. Since then, the Board has not made any legislative or regulatory amendments affecting its scope of practice with the exception of one in 2004. The Board is contacted frequently with various "scope of practice" questions. And while the Board has opined or even moved forward with expert opinions on many of these inquiries, confusion exists among facilities throughout California of which practices are authorized to be performed by licensed respiratory care practitioners (RCPs). Lack of clarity in the RCP scope of practice can often be a roadblock for facilities as they attempt to provide the most efficient and beneficial care to patients. Furthermore, the Board has received complaints of educators or persons providing clinical instruction that are not licensed to practice, placing the public at risk. While discipline is pursued for unlicensed practice, greater clarity would be beneficial to ensure the public clearly understands that such practice is a violation of law.

**PROPOSED SOLUTION**

Provide clarification for all facilities, educators and consumers of the tasks and functions that are authorized to be performed by RCPs.

- Add §3702.4 which further defines "overlapping functions" as used in section 3701 of the Legislature's intent to include the testing, managing, caring and educating of patients with non-respiratory care ailments provided the RCP is competent and authorized by his or her facility to provide such services.
- Amend §3702.7 to further define the respiratory care scope of practice to include administration of medications or pharmacological agents to induce conscious or deep sedation, all forms of extracorporeal life support, treatment and care for patients with ailments affecting the heart and cardiovascular system and education or clinical instruction of respiratory care educational courses or equipment.

## **RCP 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 the unauthorized and/or unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care.

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. The Board also pursues discipline for violations of its Act. Over 36,000 licenses have been issued to date.

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RCPs are specialists and educators in cardiology and pulmonology. RCPs are also advanced-practice clinicians in airway management; establishing and maintaining the airway during management of trauma, intensive care, and may administer medications or pharmacological agents for conscious sedation.

RCPs educate, diagnose, and treat people who are suffering from heart and lung problems. Specialized in both cardiac and pulmonary care, RCPs often collaborate with specialists in pulmonology and anesthesia in various aspects of clinical care of patients. RCPs provide a vital role in both medicine and nursing. A vital role in ICUs and emergency departments is the initiation and management of mechanical ventilation and the care of artificial airways.

RCPs with advanced education or credentialing evaluate and treat patients with a great deal of autonomy under the direction of a pulmonologist. In facilities that maintain critical care transport teams, RCPs are a preferred addition to all types of surface or air transport.

RCPs serve as clinical providers in pulmonary rehabilitation programs, cardiology clinics and catheterization labs. They are also primary clinicians in conducting tests to measure lung function and teaching people to manage asthma, chronic obstructive pulmonary disease among many other cardiac and lung functions.

Outside of clinics and hospitals, RCPs often manage home oxygen needs of patients and their families, providing around the clock support for home ventilators and other equipment for conditions like sleep apnea.

RCPs in the United States are migrating toward a role with autonomy similar to the nurse practitioner, or as an extension of the physician like the physician assistant. RCPs are frequently utilized as complete cardiovascular specialists being utilized to place and manage arterial accesses along with peripherally-inserted central catheters.

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 174,000 “active” respiratory therapists in the United States with California contributing 14% of this figure.

## **JUSTIFICATION**

In 1982, when the Respiratory Care Practice Act was enacted, the Legislature recognized, "**the practice of respiratory care to be a dynamic and changing art and science, the practice of which is continually evolving to include newer ideas and more sophisticated techniques in patient care**" (*Reference: Business and Professions Code Section 3701*). At the time of the enactment, section 3702 was drafted to include various procedures and services within the scope of respiratory care. The proposed amendments in section 3702.7 clarify section 3702 to coincide with advancements in technology and more sophisticated techniques in patient care:

### Conscious Sedation

Conscious or deep sedation is a medically controlled state of depressed consciousness and a safe and effective option to minimize pain, fear and anxiety for patients undergoing diagnostic or therapeutic procedures, from changing or cleaning a tube or cannula connected to a ventilator to minor surgeries. Conscious or deep sedation is administered in many areas of the hospital. The number and type of procedures that can be performed using conscious or deep sedation have increased significantly as a result of new technology and state of the art drugs. Conscious or deep sedation allows patients to recover quickly and resume normal daily activities in a short period of time. It has also been found as a means to control the levels of sedation, reduce adverse effects and reduce costs. In addition, in recent years, medical devices have advanced to such a degree that even greater control of inhaled sedation is achieved.

Medical facilities began instituting protocols for RCPs, and other personnel, to induce conscious sedation in the 1980s and deep sedation in the mid 1990s. Since most of the complications of conscious sedation relate to airway compromise, RCPs are uniquely qualified to safeguard patients and improve outcomes.

The Board is proposing to amend section 3702.7 to clarify that it is within the respiratory care scope of practice to administer medications or pharmacological agents for the purpose of inducing conscious or deep sedation and is very specific that the RCP's role in these procedures would be "under the medical supervision and the direct orders of the physician performing the procedure."

### Extracorporeal Life Support (Extracorporeal Membrane Oxygenation (EDMO) and Extracorporeal Carbon Dioxide Removal (ECCO(2)R)

Extracorporeal Membrane Oxygenation (ECMO) is a type of cardiopulmonary bypass that supports the lungs, heart, or both for days to weeks in patients in intensive care with reversible life threatening respiratory or cardiac disease. ECMO is used for babies, children and adults.

Some conditions that may require ECMO are:

- Congenital diaphragmatic hernia
- Heart malformations
- Meconium aspiration syndrome
- Severe pneumonia
- Severe air leak problems
- Severe pulmonary hypertension
- Lung Transplant
- Acute respiratory distress syndrome
- Hypoxic respiratory failure
- CO<sub>2</sub> retention on mechanical ventilation
- Immediate cardiac or respiratory collapse

Starting ECMO requires a large team of caregivers to stabilize the patient, as well as the careful set-up and priming of the ECMO pump with fluid and blood. Surgery is performed to attach the

ECMO pump to the patient through catheters that are placed into large blood vessels in the patient's neck or groin.

ECMO currently comes in two varieties: venoarterial (VA), and venovenous (VV). VA ECMO takes deoxygenated blood from a central vein or the right atrium, pumps it past the oxygenator, and then returns the oxygenated blood, under pressure, to the arterial side of the circulation (typically to the aorta). This form of ECMO partially supports the cardiac output as the flow through the ECMO circuit is in addition to the normal cardiac output. VV ECMO takes blood from a large vein and returns oxygenated blood back to a large vein. VV ECMO does not support the circulation. VA ECMO helps support the cardiac output and delivers higher levels of oxygenation support than does VV ECMO. VA ECMO carries a higher risk of systemic emboli than does VV. VV ECMO systems may actually recirculate previously oxygenated blood depending on the placement of the inflow and outflow catheters. Another variant of VV ECMO is extracorporeal CO<sub>2</sub> removal (ECCO<sub>2</sub>R). With this mode of support, oxygenation is provided by slow ventilation of the native lungs while CO<sub>2</sub> removal is accomplished by the ECMO circuit. In all forms of ECMO, CO<sub>2</sub> removal is more efficient than O<sub>2</sub> addition because of the solubility and diffusion properties of CO<sub>2</sub> relative to O<sub>2</sub>.

The goal of ECMO is to insure that the patient's body has enough oxygen by taking over the workload of reversible heart and/or lung disorders. ECMO will not heal the patient's heart or the lungs, but it will allow time for them to rest and recover. The patient can be on ECMO for several days to a few weeks. When the heart or the lungs have healed and can work on their own, the support from ECMO is gradually removed. Patients with severe but reversible heart or lung disorders that have not responded to the usual treatments of mechanical ventilation, medications and oxygen therapy are candidates for ECMO.

In 1990, the then Respiratory Care Examining Committee sought a legal opinion on whether the practice of ECMO was within the scope of practice of a respiratory care practitioner. In that opinion, it provides:

“The California Children Services Branch of the State Department of Health Services defines neonatal [ECMO] as ‘the use of a cardiopulmonary bypass circuit for temporary life support for term or near-term infants with potentially reversible cardiac or respiratory failure’...We are informed that while ECMO is typically a procedure used for infants with that medical condition, it may also be used for adults...”

On March 26, 1990, the Legislative Counsel of California issued its legal opinion, citing sections 3701 and 3702 of the B&P and provided:

“QUESTION

Is the practice of extracorporeal membrane oxygenation (ECMO) within the scope of practice of a respiratory care practitioner?

OPINION

The practice of extracorporeal membrane oxygenation is within the scope of practice of a respiratory care practitioner.”

Furthermore, in 2004, section 3702.7 was added to the Business and Professions Code supporting this position and provides, “Mechanical or physiological ventilatory support as used in subdivision (d) of Section 3702 includes, but is not limited to, any system, procedure, machine, catheter, equipment, or other device used in whole or in part, to provide ventilatory or oxygenating support.”

## Heart and Cardiovascular System

Dr. Linda J. Vorvick, Medical Director and Director of Didactic Curriculum, School of Medicine, University of Washington, provides that the cardiovascular system is composed of the heart and the network of arteries, veins, and capillaries and is responsible for delivering oxygen to all living cells in the body and transporting waste products from the tissues to the systems of the body through which they are eliminated.”<sup>1</sup>

Respiratory care educational programs provide extensive study of the heart, and both the cardiopulmonary and cardiovascular systems. Some references point to the cardiovascular system as being part of the respiratory system as follows.

The main parts of the respiratory system are the airways, the lungs, heart, blood vessels, and the muscles that enable breathing.<sup>2</sup>

### Airways

The airways are pipes that carry oxygen-rich air to your lungs. They also carry carbon dioxide, a waste gas, out of your lungs. The airways include your nose and nasal cavities, mouth, larynx, trachea and bronchial tubes or bronchi and their branches.

### Lungs and Blood Vessels

Your lungs and blood vessels deliver oxygen to your body and remove carbon dioxide from your body. Within the lungs, your bronchi branch into thousands of smaller, thinner tubes called bronchioles. These tubes end in bunches of tiny round air sacs called alveoli. Each of these air sacs is covered in a mesh of tiny blood vessels called capillaries. The capillaries connect to a network of arteries and veins that move blood through your body.

The pulmonary artery and its branches deliver blood rich in carbon dioxide (and lacking in oxygen) to the capillaries that surround the air sacs. Inside the air sacs, carbon dioxide moves from the blood into the air. At the same time, oxygen moves from the air into the blood in the capillaries.

The oxygen-rich blood then travels to the heart through the pulmonary vein and its branches. The heart pumps the oxygen-rich blood out to the body.

### Muscles Used for Breathing

Muscles near the lungs help expand and contract (tighten) the lungs to allow breathing. These muscles include the, diaphragm, intercostal muscles, abdominal muscles, and muscles in the neck and collarbone area.

While other references indicate them independently, yet working toward the same goal:

An understanding of how the respiratory and cardiovascular systems interact requires knowledge of how each of the systems functions independently.<sup>3</sup>

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<sup>1</sup> Linda J. Vorvick, MD, *Cardiovascular System*, Medline Plus, <http://www.nlm.nih.gov/medlineplus/ency/anatomyvideos/000023.htm>, (January 21, 2013)

<sup>2</sup> Neil K. Kaneshiro, MD, MHA, The Respiratory System, National Heart, Lung, and Blood Institute, <http://www.nhlbi.nih.gov/health/health-topics/topics/hlw/system.html>, (July 17, 2012)

<sup>3</sup> Adam Cloe, *How Does the Cardiovascular System Work With the Respiratory System?*, Livestrong, <http://www.livestrong.com/article/18606-cardiovascular-system-work-respiratory-system/> (August 16, 2013)

### Cardiovascular System

The cardiovascular system in the human body is made up of the heart and blood vessels, which are divided into arteries, veins and capillaries. The heart is responsible for pumping the blood throughout the blood vessels and is divided into four chambers, two of which are responsible for moving poorly oxygenated blood and two of which move highly oxygenated blood. Oxygenated blood, which is pumped through the body via the arteries, supplies the body's tissues with oxygen that they need to live. Blood in the arteries is under high pressure; however, which could damage the tissue, so this oxygenated blood first needs to go to the capillaries, which are very small and low-pressure blood vessels that are responsible for supplying the oxygenated blood to the tissues. Once the capillaries have delivered their oxygen, they also absorb excess carbon dioxide into the blood and then deliver it to the veins, which then supply the blood back to the heart.

### Respiratory System

The respiratory system is primarily comprised of the airways, the lungs and the structures (such as muscles) that help move air in and out of the lungs. The airway, which begins with the nose and mouth, continues down through the throat into the bronchi, which are small airways that eventually feed into the lungs, which are lined with cells called alveoli. The other part of the respiratory system is the muscles, such as the intercostals (muscles between the ribs) and the diaphragm, which cause the lungs to expand and contract. When the size of the lungs changes, so does the pressure inside, leading to air either coming in (inhalation) or being forced out (exhalation).

### Interaction

The cardiovascular and the respiratory systems both work toward the same goal: getting oxygen to tissues and getting carbon dioxide out. The respiratory system is involved in supplying oxygen to the blood and removing carbon dioxide. When the heart receives blood that is low in oxygen and high in carbon dioxide, it pumps it to the lungs via the pulmonary arteries. When the lungs expand and get fresh air from the environment, oxygen is transferred (via the alveoli) into the low-oxygen blood, which also then sends some of its carbon dioxide back into the lungs. Now that this blood has fresh oxygen in it, it returns to the heart and the heart then pumps it throughout the body.

Respiratory care by definition is an allied health specialty which provides a wide range of therapeutic and diagnostic services to patients with heart and lung disorders. As such, nearly every function of an RCP requires in depth knowledge and understanding of the cardiovascular system and often involves the treatment, management and rehabilitation of the cardiovascular system. The scope of practice needs to be further defined to clearly convey to all facilities that the heart and the cardiovascular system are indeed included in the respiratory care scope of practice so that RCPs can continue or be fully utilized in managing and caring for their patients.

### Education

The Board is proposing to clarify in its scope of practice that instruction and education of respiratory care educational courses or equipment is respiratory care. It has come to the Board's attention that this amendment is necessary to ensure students who are seeking a professional career in respiratory care are being provided reliable instruction by licensed RCPs. This includes both core respiratory education courses and clinical instruction. This will also better enable the Board to ensure that clinical instructors are providing appropriate oversight of and instruction to students who are working on patients as part of their clinical rotations.

Furthermore, the Board has learned there are a few manufacturing companies who are not using licensed RCPs to train health care professionals in the operation and application of respiratory care equipment, including the use of highly complex ventilators. Employees of the manufacturing companies may have past experience in a health care discipline, but without required licensure, the knowledge becomes quickly outdated since they are not required to complete continuing education and they are not practicing. This poses a serious threat to patient safety when new equipment is employed.

In fact, failure to use licensed RCPs in any of these forms of education is extremely threatening to the protection and safety of respiratory patients.

#### Overlapping Functions

In addition, B&P §3701 also enacted in 1982 states, “ **It is the intent also to recognize the existence of overlapping functions between physicians and surgeons, registered nurses, physical therapists, respiratory care practitioners, and other licensed health care personnel, and to permit additional sharing of functions within organized health care systems. ...**”

It is quite common for a respiratory care patient to also suffer from non-respiratory related ailments or need care that may be outside of the respiratory care scope of practice. Section 3702.4 of the proposed language is intended to clarify that RCPs may perform tasks that may not be directly related to respiratory care provided the RCP has demonstrated and maintained current competencies and the facility has authorized the RCP to provide such services. Provided conditions are met, the facility has the opportunity to provide more efficient and effective care to patients. In many facilities this practice already occurs, however, lack of clarity and fear of reprisal prevents some facilities from employing such practice.

#### **ARGUMENTS PRO & CON**

Pro: *Efficiency and consumer protection.* As the nation works diligently to rollout the Affordable Care Act, it is incumbent upon government agencies to review and update their laws to afford health care organizations greater flexibility to efficiently use their resources and provide consumers optimal care. Providing clarification in all these subjects will assist medical facilities and other organizations to put current and foreseen issues to rest and allow them to move forward and expend energies toward improving their operations. Furthermore, the Board believes the proposed legislative language will clarify the respiratory scope of practice that was not initially drafted to accommodate advancements in technology and changes in patient care for future interpretation, now some 20+ years later.

Con: There may be concerns that the language encroaches or limits the scope of practice of other health care professionals. As stated previously, the practice related amendments are practices already performed by RCPs. There is no intention to change or add disciplines, but rather enhance the care for respiratory care patients. In addition, the amendments will not limit any other professionals scope of practice because section 3762 provides, “Nothing in this chapter is intended to limit preclude, or otherwise interfere with the practices of other licensed personnel in carrying out authorized and customary duties and functions.” These proposed amendments compliment the Legislature’s intention for overlapping functions as provided in section 3701.

#### **PROBABLE SUPPORT & OPPOSITION**

Respiratory Care Board - support

California Society for Respiratory Care (CSRC) – possible support

California Hospital Association – possible support

**FISCAL IMPACT** None.

**ECONOMIC IMPACT**

The proposed changes simply codify existing practice at many facilities. The Board surmises that by providing clarification, it will lend to greater flexibility for facilities to increase efficiency and provide better patient care outcomes.

**FINDINGS FROM OTHER STATES**

**Extracorporeal Membrane Oxygenation (ECMO)**

Numerous states have a provision in their law which includes ECMO as part of the RCP scope of practice. The RCB also has a legal opinion issued by the Legislative Counsel of California on March 26, 1990 that provides that ECMO is within the scope of practice of an RCP.

**Conscious Sedation**

*Montana:* Established regulations in or before 2005 that provide guidelines for RCPs to “administer intravenous (IV) conscious sedation.”

*North Carolina:* Issued a “Declaratory Ruling” in 2007 concluding that “...Respiratory Care Practitioners may, with a physician’s order, administer conscious sedation to patients receiving care in North Carolina hospitals, Ambulatory Surgical facilities and Cardiac Rehabilitation Facilities which are licensed pursuant to... .”

*Oklahoma:* The state Medical Board issued a position statement in 2000, providing that, “The Assistant Attorney General to the Oklahoma Board of Medical Licensure and Supervision has reviewed the Respiratory Care Practice Act and subsequently has reported to the Respiratory Care Advisory Committee conscious sedation drug administration and monitoring are within the scope of practice of Respiratory Care Practitioners pursuant to the Act.”

*South Carolina:* Medical Board issued a position statement in 2002 that provides guidelines under which RCPs may administer controlled substances for sedation and analgesia.

*Tennessee:* Adopted a position statement in 2002, that provides: “The Tennessee Board of Respiratory Care strongly supports the fact Respiratory Care Practitioners can administer conscious sedation when administered under the supervision, control and responsibility of a licensed physician- and when administered for the sole purpose of diagnosing, implementing treatment, promoting disease prevention, and providing rehabilitation to the cardiorespiratory system.”

**APPOINTMENTS**

*Governor*

- Mary Ellen Early, Public Member, 4/13/13
- Rebecca F. Franzoia, Public Member, 7/21/12
- Mark D. Goldstein, BS, RRT, RCP, Professional Member, 6/9/12

*Assembly Speaker*

- Michael Hardeman, Public Member, 7/3/13
- Judy McKeever, RCP, RRT, Professional Member, 2/19/14
- Alan Roth, MS MBA RRT-NPS FAARC, Professional Member, 9/12/12

*Senate Rules*

- Ronald H. Lewis, M.D., Physician Member, 6/9/13
- Laura C. Romero, Ph.D, Public Member, 5/8/13
- Thomas Wagner, BS, RRT, RCP, Professional Member, 6/4/14

## **PROPOSED LANGUAGE**

Section 3702.4 is added to the Business and Professions Code to read:

### **§ 3702.4. Overlapping functions**

Overlapping functions as provided for in section 3701 includes but is not limited to, providing therapy, management, rehabilitation, diagnostic evaluation and care for non-respiratory related diagnoses or conditions provided 1) the facility has authorized the respiratory care practitioner to provide these services and 2) the respiratory care practitioner has maintained current competencies in the services provided.

Section 3702.7 of the Business and Professions Code is amended to read:

### **§ 3702.7. ~~Mechanical and ventilatory support defined~~ Scope of Practice Further Defined**

The respiratory care practice is further defined and includes, but is not limited to the following:

1) Mechanical or physiological ventilatory support as used in subdivision (d) of Section 3702 includes, but is not limited to, any system, procedure, machine, catheter, equipment, or other device used in whole or in part, to provide ventilatory or oxygenating support.

2) Administration of medical gases and pharmacological agents for the purpose of inducing conscious or deep sedation under medical supervision and the direct orders of the physician performing the procedure.

3) All forms of Extracorporeal Life Support including, but not limited to, Extracorporeal Membrane Oxygenation (ECMO) and Extracorporeal Carbon Dioxide Removal (ECCO(2)R).

4) "Associated aspects of cardiopulmonary and other systems functions" as used in section 3702 includes patients with deficiencies and abnormalities which affect the heart and cardiovascular system.

5) Educating students, health care professionals, or consumers about respiratory care for the purpose of employing the learned knowledge to care for patients including, but not limited to, education of respiratory core courses or clinical instruction provided as part of a respiratory educational program and educating health care professionals or consumers about the operation or application of respiratory care equipment and appliances.

## **QUICK B&P REFERENCES**

### **§ 3701. Legislative finding and declaration; Legislative intent**

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. The Legislature also recognizes the practice of respiratory care to be a dynamic and changing art and science, the practice of which is continually evolving to include newer ideas and more sophisticated techniques in patient care. It is the intent of the Legislature in this chapter to provide clear legal authority for functions and procedures which have common acceptance and usage.

It is the intent also to recognize the existence of overlapping functions between physicians and surgeons, registered nurses, physical therapists, respiratory care practitioners, and other licensed health care personnel, and to permit additional sharing of functions within organized health care systems. The organized health care systems include, but are not limited to, health facilities licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, clinics, home health agencies, physicians' offices, and public or community health services.

Added Stats 1982 ch 1344 § 1, operative July 1, 1983. Amended Stats 1991 ch 654 § 7 (AB 1893).

### **§ 3702. Practice of respiratory care; Components; "Respiratory care protocols"**

Respiratory care as a practice means a health care profession employed under the supervision of a medical director in the therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities which affect the pulmonary system and associated aspects of cardiopulmonary and other systems functions, and includes all of the following:

- (a) Direct and indirect pulmonary care services that are safe, aseptic, preventive, and restorative to the patient.
- (b) Direct and indirect respiratory care services, including but not limited to, the administration of pharmacological and diagnostic and therapeutic agents related to respiratory care procedures necessary to implement a treatment, disease prevention, pulmonary rehabilitative or diagnostic regimen prescribed by a physician and surgeon.
- (c) Observation and monitoring of signs and symptoms, general behavior, general physical response to respiratory care treatment and diagnostic testing and
  - (1) determination of whether such signs, symptoms, reactions, behavior or general response exhibits abnormal characteristics;
  - (2) implementation based on observed abnormalities of appropriate reporting or referral or respiratory care protocols, or changes in treatment regimen, pursuant to a prescription by a physician and surgeon or the initiation of emergency procedures.
- (d) The diagnostic and therapeutic use of any of the following, in accordance with the prescription of a physician and surgeon: administration of medical gases, exclusive of general anesthesia; aerosols; humidification; environmental control systems and baromedical therapy; pharmacologic agents related to respiratory care procedures; mechanical or physiological ventilatory support; bronchopulmonary hygiene; cardiopulmonary resuscitation; maintenance of the natural airways; insertion without cutting tissues and maintenance of artificial airways; diagnostic and testing techniques required for implementation of respiratory care protocols; collection of specimens of blood; collection of specimens from the respiratory tract; analysis of blood gases and respiratory secretions.
- (e) The transcription and implementation of the written and verbal orders of a physician and surgeon pertaining to the practice of respiratory care.

"Respiratory care protocols" as used in this section means policies and protocols developed by a licensed health facility through collaboration, when appropriate, with administrators,

physicians and surgeons, registered nurses, physical therapists, respiratory care practitioners, and other licensed health care practitioners.

Added Stats 1982 ch 1344 § 1, operative July 1, 1983. Amended Stats 2008 ch 179 (SB 1498).

**§ 3702.7. Mechanical and ventilatory support defined**

Mechanical or physiological ventilatory support as used in subdivision (d) of Section 3702 includes, but is not limited to, any system, procedure, machine, catheter, equipment, or other device used in whole or in part, to provide ventilatory or oxygenating support.

Added Stats 2004 ch 695 (SB 1913).

**§ 3703. Settings for respiratory care**

(a) The settings in which respiratory care may be practiced include licensed health care facilities, hospitals, clinics, ambulatory or home health care, physicians' offices, and public or community health services. Respiratory care may also be provided during the transportation of a patient, and under any circumstances where an emergency necessitates respiratory care.

(b) The practice of respiratory care shall be performed under the supervision of a medical director in accordance with a prescription of a physician and surgeon or pursuant to respiratory care protocols as specified in Section 3702.

Added Stats 1982 ch 1344 § 1, operative July 1, 1983. Amended Stats 1989 ch 645 § 1.

# ENFORCEMENT STATISTICS

Agenda Item: 10  
Meeting Date: 11/07/14

Data through June 30, 2014

Applicant Licensed Unlicensed	CASELOAD	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	FY 13/14
A	Applications Received	853	1003	1283	1359	1360	1443	1357	1593	1655	1560
L	Total Licensed	24,408	25,246	26,338	27,545	28,847	30,120	31,511	32,825	34,499	35,921
A L U	Enforcement Budget	\$494,771	\$514,365	\$557,312	\$584,409	\$579,161	\$640,576	\$661,077	\$664,403	\$675,023	\$631,346
L	Licenses Active	15,503	15,835	16,511	17,202	18,077	18,803	19,658	20,390	21,473	22,153
A	Applicants Investigated (RCB Staff)	141	205	238	269	270	311	260	254	272	273
A	Applicants Denied/Initial	11	23	19	31	46	35	21	12	26	9
L U	Complaints Received	515	495	476	472	493	583	575	621	590	584
A L U	Cases to Investigation (Sworn Investigators)	4	3	9	5	11	3	6	1	6	8
L U	Citations Issued	99	57	71	63	102	75	96	69	68	79
A L	Cases to OAG	46	56	71	64	99	69	80	69	83	58
L	Probation Cases to OAG for Revocation	13	13	10	9	17	23	9	10	13	9
A L U	Cases to the DA	0	1	0	1	0	0	1	0	0	2
L	Accusations Filed	60	34	51	51	46	42	58	51	60	45
A	Statement of Issues Filed	9	15	21	22	40	29	20	13	16	10
L	Petitions to Revoke Probation Filed	11	18	8	9	11	21	9	10	15	8
A L	Stipulated Settlements	71	34	46	59	61	57	50	47	47	43
A L	Disciplinary Hearings Completed/Final Decisions	11	13	7	14	9	20	17	16	21	14
L	Revocations/Surrenders	31	27	24	29	30	45	32	39	39	32
A	Applications Denied (Final Decision)	0	3	2	3	1	6	5	4	1	2
A L	Public Reprimands	20	5	6	9	6	4	10	4	3	7
A L	Probationers (New)	53	27	32	40	48	39	29	36	34	24
L	Probationers (Active)	100	80	77	84	108	92	84	86	84	69
L U	Fines Imposed	\$61,050	\$33,600	\$33,413	\$32,450	\$60,950	\$123,975	\$51,450	\$25,950	\$24,800	\$65,950
L U	Fines Reduced, Withdrawn, Dismissed	\$1,350	\$900	\$900	\$1,225	\$2,715	\$400	\$3,500	\$75,325	\$250	\$1,100
L U	<b>Fines Collected</b>	<b>\$41,942</b>	<b>\$37,941</b>	<b>\$31,919</b>	<b>\$31,061</b>	<b>\$30,121</b>	<b>\$41,863</b>	<b>\$41,378</b>	<b>\$28,646</b>	<b>\$24,702</b>	<b>\$23,593</b>
A L	Cost Recovery Requested	\$233,873	\$198,758	\$183,032	\$208,563	\$198,892	\$263,848	\$267,310	\$328,341	\$313,422	\$277,034
A L	Cost Recovery Awarded	\$223,996	\$173,771	\$174,142	\$168,976	\$184,082	\$214,040	\$245,009	\$259,648	\$250,655	\$236,091
A L	<b>Cost Recovery Collected</b>	<b>\$130,378</b>	<b>\$142,061</b>	<b>\$120,820</b>	<b>\$96,454</b>	<b>\$55,820</b>	<b>\$81,483</b>	<b>\$84,285</b>	<b>\$92,673</b>	<b>\$98,285</b>	<b>\$77,685</b>
L	<b>Probation Monitoring Costs Collected</b>	<b>\$100,746</b>	<b>\$102,596</b>	<b>\$81,613</b>	<b>\$79,748</b>	<b>\$85,176</b>	<b>\$90,316</b>	<b>\$87,604</b>	<b>\$89,714</b>	<b>\$79,708</b>	<b>\$65,745</b>
A L U	<b>Franchise Tax Board Collected</b>	<b>\$13,676</b>	<b>\$20,288</b>	<b>\$13,542</b>	<b>\$17,697</b>	<b>\$10,440</b>	<b>\$8,796</b>	<b>\$8,826</b>	<b>\$29,755</b>	<b>\$21,684</b>	<b>\$17,712</b>
A L U	<b>Collection Agency Collected *</b>	<b>\$32,285</b>	<b>\$56,826</b>	<b>\$19,414</b>	<b>\$22,568</b>	<b>\$2,292</b>	<b>\$1,100</b>	<b>\$11,216</b>	<b>\$5,584</b>	<b>\$12,752</b>	<b>\$24,700</b>

\* 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.

## Board Meeting - Scheduling

### 2015 Calendar

January	February	March																																																																																																																																					
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#### Proposed Locations

February (*tentative*): Sacramento / Los Angeles

May: Loma Linda

November: Sacramento