

Governor Edmund G. Brown Jr.  
State of California

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and Housing Agency

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Thomas Wagner, BS, RRT, FAARC  
Vice-President

Mary Ellen Early  
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Rebecca F. Franzoia  
Member

Mark Goldstein, MBA, BS, RRT  
Member

Michael Hardeman  
Member

Ronald H. Lewis, MD  
Member

Judy McKeever, RCP  
Member

Laura C. Romero, PhD  
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  
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# Respiratory Care Board of California

3750 Rosin Court, Suite 100, Sacramento, CA 95834

## Board Meeting Agenda March 11, 2016

Hilton San Diego Mission Valley  
901 Camino Del Rio South, Kensington 2 Room  
San Diego, CA 92108  
(619) 767-5521

8:00 a.m. **Call to Order and Establishment of Quorum** (Alan Roth)

**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 November 6, 2015 Minutes** (Alan Roth)

**ACTION ITEM**

**3. Executive Officer's Report** (Stephanie Nunez)

- a. Sunset review 2016/2017
- b. Staffing ratios

**4. 2013-2016 Strategic Plan Review** (Alan Roth)

**5. California Exam Statistics** (Alan Roth)

**6. Enforcement Performance Measures** (Mary Ellen Early)

**7. Presentation and Discussion on the North Carolina State Board of Dental Examiners vs. Federal Trade Commission Decision and Attorney General Opinion** (Kelsey Pruden, Attorney)

**8. RCP Workforce Study Update/Scope of Work** (Alan Roth) **ACTION ITEM**

- a. National-level positions on baccalaureate degree

**9. Little Hoover Commission Review: Occupational Licensing** (Alan Roth)

**10. Discussion of 2015 California Society for Respiratory Care (CSRC) Position Statement Pertaining to Concurrent Therapy** (Alan Roth)

**11. Legislative Action**

- a. 2016 legislation of interest (Christine Molina) **ACTION ITEM**  
SB 66, SB 547, SB 1155, SB 1334, SB 1348, AB 1939, AB 2079, AB 2606, AB 2701, and any other bills of interest.
- b. 2015/16 board-cosponsored legislation: AB 923 (Stephanie Nunez)

• **Closed Session** •

The Board will convene into Closed Session, as authorized by Government Code section 11126(c), subdivision (3), to deliberate on disciplinary matters including petitions for reconsideration, stipulations, and proposed decisions.

**\*\* Return to Open Session \*\***

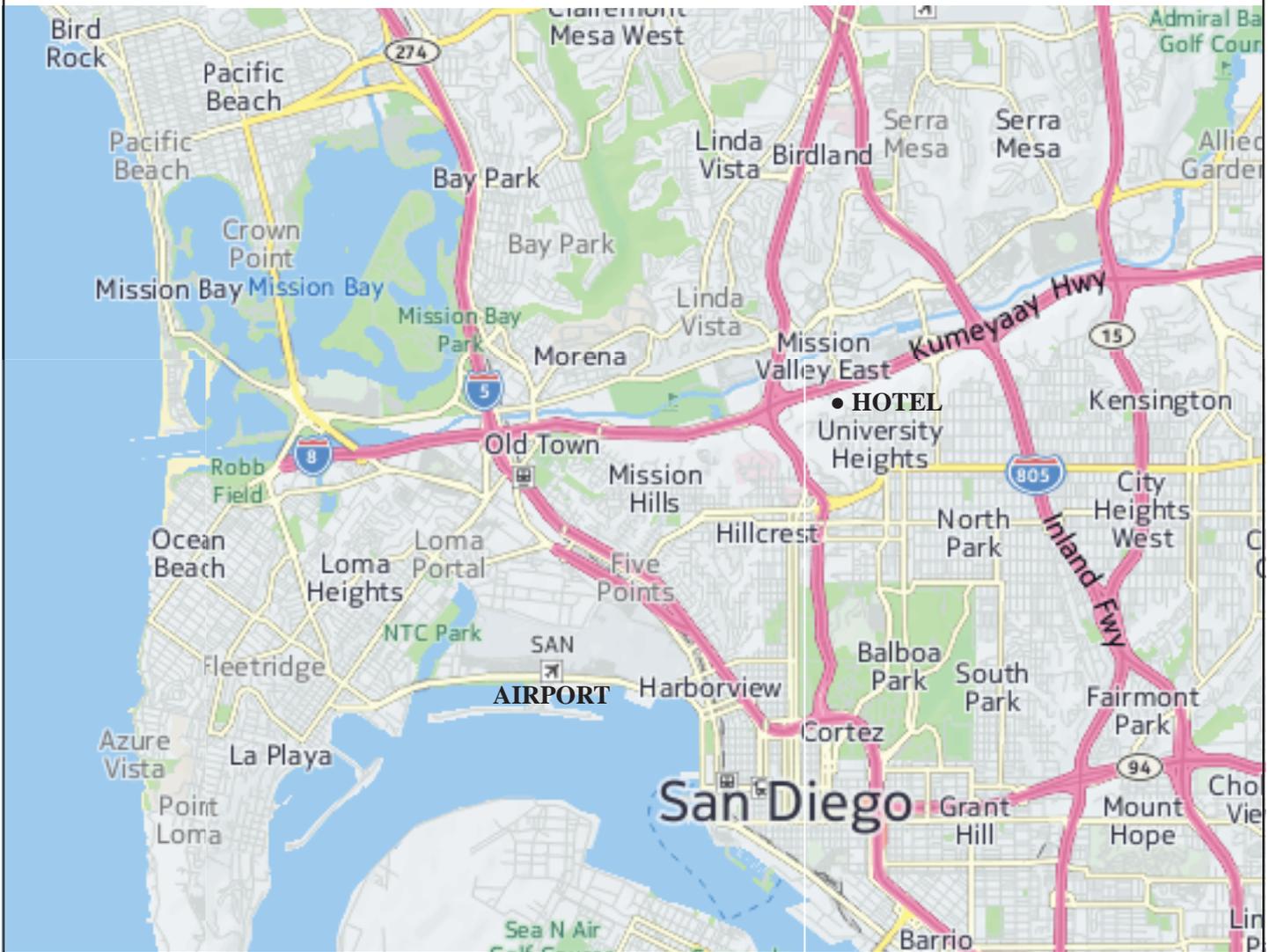
**12. 2016 Remaining Meeting Dates: June 24th; October 7th**

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

**14. Future Agenda Items**

**Adjournment**

**Hilton Hotel located at: 901 Camino Del Rio South, San Diego, CA 92108**



### **NOTICE**

This meeting will be Webcast, provided there are no unforeseen technical difficulties. To view the Webcast, please visit <http://thedcapage.wordpress.com/webcasts/>

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, November 6, 2015**

**1625 North Market Blvd.  
South Building, Room S-102  
Sacramento, CA 95834**

**Members Present:** Alan Roth, MS MBA RRT-NPS FAARC, President  
Mary Ellen Early  
Rebecca Franzoia  
Michael Hardeman  
Ronald Lewis, M.D.  
Laura Romero, Ph.D.  
Thomas Wagner, BS, RRT, FAARC

**Staff Present:** Norine Marks, Supervising Attorney  
Ravinder S. Kapoor, Staff Attorney  
Stephanie Nunez, Executive Officer  
Christine Molina, Staff Services Manager

### **CALL TO ORDER**

The Public Session was called to order at 10:02 a.m. by President Roth. A quorum was present.

### **PUBLIC COMMENT**

Ms. Nunez explained that public comment would be allowed on agenda items, as those items are discussed by the Board during the meeting. She 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. Public comment may be limited in order to allow sufficient time for the Board to conduct its scheduled business.

There was no public comment.

1 **APPROVAL OF MAY 15, 2015 MINUTES**

2  
3 Dr. Lewis moved to approve the May 15, 2015 Public Session minutes as written.

4  
5 M/Lewis /S/Wagner

6 In favor: Early, Hardeman, Lewis, Roth, Romero, Wagner

7 Abstain: Franzoia,

8 MOTION PASSED

9  
10  
11 **APPROVAL OF JUNE 23, 2015 MINUTES**

12  
13 Dr. Lewis moved to approve the June 23, 2015 Public Session minutes as written.

14  
15 M/Lewis /S/Hardeman

16 In favor: Early, Franzoia, Hardeman, Lewis, Roth, Romero, Wagner

17 Unanimous

18 MOTION PASSED

19  
20  
21 **EXECUTIVE OFFICER'S REPORT**

22 *(Nunez)*

23  
24 **a. Continuing Education Hours Increase Effective July 1, 2015:**

25  
26 Ms. Nunez reminded the Board of the implementation of increased continuing education hours.  
27 Licensees expiring on or after July 31, 2017 are required to complete 30 hours of continuing  
28 education. Ms. Nunez advised the Board that since July of this year, notices regarding the increase  
29 are being included with all renewed licenses to ensure adequate time (a full renewal cycle) for  
30 licenses to meet the increased requirement.

31  
32 **b. Unauthorized Practice of Respiratory Care Notice:**

33  
34 Ms. Nunez shared the Education Advisory Notice that the RCB intends to mail next week. She stated  
35 this is an attempt to halt a recurring trend of sub-acute facilities using LVN's and other unlicensed  
36 personnel to care for ventilators patients.

37  
38 Ms. Nunez introduced Mr. John Brook, Acting Executive Officer of the Board of Vocational Nursing &  
39 Psychiatric Technicians (BVNPT), and stated she and Mr. Brooks are in agreement that this issue has  
40 a lengthy history which was believed to be resolved around 2005 or 2006 in which it was made known  
41 that LVN's were not to provide respiratory care. Both boards would like to get together to work out a  
42 resolution jointly before other avenues are explored. In the meantime, because of a paramount  
43 concern for patient safety, the education advisory mailer will be sent out in accordance with existing  
44 law, including the possibility of a citation and fine. Ms. Nunez further stated she was contacted by the  
45 Medi-Cal Sub-acute Unit from the Department of Health Services with concerns on the same issue.

46  
47 Mr. Wagner asked who would be the recipients of this advisory.

48  
49 Ms. Nunez stated it will be going out to all sub-acute facilities of which there are approximately 150.

50  
51 Dr. Lewis questioned what specific objections were voiced by the Department of Health Services,  
52 Medi-Cal staff. Ms. Nunez responded that generally there was a concern that LVN's were performing

1 respiratory care functions. She added, some days LVNs would perform nursing duties while other  
2 days the LVN may be responsible entirely for respiratory care duties.  
3

4 **Public Comment:**

5 Mr. John Brook, Acting Executive Officer, BVNPT, stated that he has been in contact with Ms. Nunez  
6 for the past two weeks concerning the issue of LVN's possibly performing duties outside of their  
7 scope. He indicated that he believes that there may be some overlap on some of the items listed on  
8 the notice which are indicated as being purely within the purview of Respiratory Care Practitioners. He  
9 stated that perhaps there may be certain circumstances in which LVN's could perform some of these  
10 functions on a limited basis but that LVN's should not be taking on respiratory duties as part of a shift.  
11 He also expressed his concerns on the items brought to Ms. Nunez's attention by the Medi-Cal Staff  
12 of the Department of Health. Mr. Brook proposes that the two boards work jointly to better define the  
13 scope of practice for licensed vocational nurses to better determine what LVNs can or cannot do  
14 within the respiratory care professional arena.  
15

16 Mr. Wagner inquired as to the length and breadth of education the LVN's have in providing respiratory  
17 care. Mr. Brook indicated that he could not answer that question but questioned if possibly there were  
18 some functions that LVNs could perform under the direction of an RN or MD.  
19

20 President Roth then asked Mr. Brook if the title of LVN was the same as that of an LPN.  
21

22 Mr. Brook indicated that it was a different designation.  
23

24 Dr. Romero questioned, since there were concerns from Medi-Cal, if there were any implications at all  
25 surrounding the Affordable Care Act (ACA) and if there was any type of impact or concerns that the  
26 Board might have considering that there are populations served under that Act.  
27

28 Ms. Nunez responded that RCB does not currently know of any, but it is definitely a concern that  
29 patients are going to receive substandard care.  
30

31 **c. Sunset Review 2016/2017**

32  
33 Ms. Nunez stated that every four years, the Respiratory Care Board undergoes Sunset Review. With  
34 the Respiratory Care Act set to expire in 2018, during 2016 the Board will be required to compile a  
35 rather lengthy report which provides data on the Board's workload, as well as pending issues and  
36 accomplishments. This report goes to the Legislature which then compiles a list of questions and/or  
37 concerns on how the Board is operating and holds hearings in which it is hoped that legislation will be  
38 introduced to extend the existence of the RCB for another four years.  
39

40 Dr. Lewis asked if any roadblocks or issues were expected with this Sunset Review. Ms. Nunez  
41 stated that she did not expect any and that the RCB has always done a very good job and has always  
42 put consumers first, which has been a paramount issue. She also mentioned that there will be other  
43 issues that will be relevant this time which involve military legislation among others, but that all of the  
44 implementation needed has already been addressed. She stated that the Board has always been very  
45 responsive to military members regardless of legislation. Ms. Nunez added, there may be other items  
46 to discuss and explore further.  
47

48 Mr. Kapoor asked if the Board has a Sunset Review Committee. Ms. Nunez responded that they  
49 generally utilize the Executive Committee comprised of the President and Vice President.  
50

51 There was no public comment.  
52  
53

1 **2013-2016 STRATEGIC PLAN REVIEW**

2 *(Roth )*

3  
4 President Roth stated, at the previous Board meeting there was vigorous discussion concerning items  
5 relative to the strategic plan that were achievable as well as the longer range goals for the Board and  
6 the profession. He believes the Board has done a very good job focusing on what is important relative  
7 to patient safety and the goals of the Board moving forward. He also stated that he looks forward to  
8 input from Board Members as to what the Board will look like in the next three years. President Roth  
9 stated he believes the research project currently being performed by UCSF will help guide the Board  
10 in future decision making.

11  
12 Ms. Nunez called attention to page six of the Strategic Plan and indicated that she has updated each  
13 goal to bring the Board up to speed on the current status of each. She stated that the Board plans on  
14 completing a new strategic plan in 2017.

15  
16 Dr. Romero commented that the Board and Department have done a very good job. She asked for  
17 clarification of the meaning of each type of indicator used next to each goal.

18  
19 Ms. Nunez explained the legend as follows:

- 20  
21 ✓ = Complete  
22 ○ = Not Complete  
23 **WS** = Awaiting Work Force Study Information  
24

25 Ms. Nunez pointed out that the work force study is in the process of researching item #2.6 to see if  
26 continuing education hours need to be increased further and if there should be a restriction on the  
27 extent to which CE courses can be delivered on-line rather than in person.

28  
29 President Roth added that there was much discussion concerning the number of CE hours required  
30 for other professional boards relative to those required by the Board and that this information would  
31 help the Board get more “in-line” with other professions.

32  
33 There was no public comment.

34  
35 **ENFORCEMENT PERFORMANCE MEASURES AND STATISTICS**

36 *(Nunez)*

37  
38  
39 Ms. Nunez reviewed the first section of the Quarterly Statistics for this Fiscal Year and stated the  
40 Board is on target for everything with the exception of Formal Discipline which goes through the  
41 Attorney General’s Office. She added that this is still a vast improvement. Ms. Nunez further  
42 discussed the Annual Report which is also listed on DCA’s website and provides additional statistics.

43  
44 President Roth commended Ms. Nunez and her staff for working hard to achieve these goals. He  
45 highlighted improvements in the categories of “Intake & Investigation” and “Intake” which is the  
46 average cycle time from complaint to the date the complaint was assigned to an investigator. He  
47 indicated that those were very aggressive goals and that staff worked very hard to have high numbers  
48 and get cases moving along.

49  
50 Dr. Lewis requested clarification on how to read the Summary of Enforcement Activity. He questioned  
51 that in the “Consumer Complaint Intake” section it lists 326 cases received and 307 of those moved  
52 onward to investigation. Additionally, he inquired if he was correct in his understanding that all 534  
53 complaints in the “Conviction /Arrest” section moved forward to investigation.

1  
2 Ms. Nunez replied that they moved on to investigation or closure.  
3  
4 Dr. Lewis inquired if this report shows the Board receives less than 900 complaints in volume between  
5 these two areas per year.  
6  
7 Ms. Nunez confirmed it does.  
8  
9 President Roth questioned whether there has been a decrease in the number of applicants because  
10 of the new RRT requirement for licensing He added the NBRC's last quarter review indicated the  
11 pass rate has edged up to 68% for those taking the exam for the first time.  
12  
13 Ms. Nunez replied a projection was done on the impact and it was believed there would be a drop in  
14 applicants. She continued that it now seems there will be a less significant drop than initially believed  
15 however, more data is needed before making an assessment.  
16  
17 Ms. Molina reported, according to the Board's Licensing Technician, from July 1 to October 30, she  
18 has issued 500 new licenses. Ms. Molina believes because the exams have posed additional  
19 difficulty, there were more applications pending at the end of June than the Board generally has in  
20 that timeframe. However, those individuals seem to have since passed the secondary portion of the  
21 exam resulting in the Board licensing more people in the first four months of this year.  
22  
23 There was no public comment.

24  
25  
26 **RCP WORKFORCE STUDY**  
27 *(Roth)*  
28

29 President Roth reviewed the progress on the work force study being conducted by UCSF covering the  
30 goals and the proposed activities of the study. President Roth stated the advisory group for this study  
31 has already accomplished six goals towards their extended project.  
32  
33 UCSF research is looking into specifics about the kinds of continuing education that respiratory  
34 requires in order to be viewed as competent and have continued competency relative to their scope of  
35 practice.  
36  
37 Because of the multiple iterations of the research, UCSF has proposed a revised timeline to complete  
38 the study. UCSF plans to come to future meetings to provide updates in the process.  
39  
40 Dr. Lewis stated it looks like they will delay interviews with the program directors and inquired when  
41 the Board may receive a full update.  
42  
43 President Roth estimated that within the next nine months the Board should receive more information.  
44 He added the two programs for respiratory care that have been approved for baccalaureate programs  
45 in California as the pilot project will be starting soon; one in the fall of 2016 and one in the spring of  
46 2017. Both schools have yet to establish admission criteria and are waiting to identify the makeup of  
47 the class.  
48  
49 Dr. Romero stated it is great to see that the core advisory group has been established and inquired  
50 who these six individuals are.  
51  
52 President Roth indicated he was one of the advisors along with Rick Ford, UCSD; Ray Hernandez,  
53 Skyline College; Mike Madison, CSRC President, and Joe Garcia from Doctor's Medical Center.

1  
2 Dr. Romero questioned why no females were on the advisory committee.

3  
4 Ms. Nunez explained the respiratory care field is predominately male at the level of director and  
5 above. They were looking for key experts with the education and “hands on” experience to assist  
6 UCSF in this study. She added she does not believe there are any gender specific issues as part of  
7 the study

8  
9 There was no public comment.

10  
11  
12 **CONSIDERATION OF CSRC REQUEST: MANDATE HALF OF CONTINUING EDUCATION BE**  
13 **ACCUMULATED THROUGH LIVE CONTACT HOURS**

14  
15 President Roth stated the Board was looking at whether or not there needed to be a quality of  
16 continuing education that is currently not being met and added there are several groups around the  
17 State that have put out continuing education programs that are less than optimal. It is a thought that  
18 having live contact CEUs would allow for debate, interaction and knowledge transfer. The advisory  
19 group for the UCSF study is looking into exactly what, as a profession, should be required for  
20 continuing education. President Roth suggested this item be discussed further after the UCSF study  
21 is complete and there is more information in this area.

22  
23 Mr. Hardeman commented, since continuing education is often being completed during the RCP’s  
24 own time as opposed to on the job, it is more convenient to offer the choice of online training.

25  
26 President Roth replied opportunities are available at the institutions where RCPs work.

27  
28 Ms. Nunez stated that was a good point and suggested as the Board move forward developing the  
29 criteria for continuing education, it keep in mind that not all RCP’s work in facilities and have those  
30 opportunities. Possible allowance such as extra credit for those doing the live courses might be  
31 included.

32  
33 Ms. Early stated one of the other things that needs to be taken into consideration is that a computer  
34 class does not offer the opportunity for hands on training and demonstration with frequently changing  
35 equipment.

36  
37 Dr. Lewis stated, in medicine most of the CE credits can be taken online and do not necessarily need  
38 to be hands on. He added however, as medical technology advances, so will the need for more on-  
39 site training. We need to find a way to make it easier and less of a financial burden to obtain the  
40 hands on training needed.

41  
42 Discussion ensued.

43  
44 **Public Comments:**

45  
46 Written testimony was received by Michael Monasky highlighting reasons why he believes the  
47 CSRC’s request to have at least half of the required CE credits earned for license renewal be “live  
48 contact hours” should be rejected.

49  
50  
51

1 **FISCAL REVIEW**

2  
3 Ms. Nunez highlighted the increase in expenditures of about \$340,000 stating these are primarily  
4 onetime costs. Of this year's budget, these include \$117,000 towards the UCSF Workforce Study;  
5 \$98,000 towards BreEZe and \$80,000 for Division of Investigation. Overall, the fund condition is  
6 lower but remains steady. She added there is still a reserve just not as large as in past years  
7 because of these one-time costs.  
8

9 Dr. Romero inquired if the Board's redesign of the website was included in this budget and when that  
10 was expected to take place.  
11

12 Ms. Nunez replied the website redesign would be conducted by staff and expects it to be complete by  
13 the end of 2016.  
14

15  
16 **LEGISLATIVE ACTION**  
17 (Molina/Nunez)  
18

19 **a. 2015 Legislation of Interest:**  
20

21 Ms. Molina reviewed and provided updates regarding the 2015 Legislation of Interest. The Board's  
22 positions are as follows:  
23

- 24 AB 12: State government: administrative regulations: review  
25 Status: 8/27/15: Referred to Appropriations suspense file. May become a 2 year bill  
26 Board's Position: Watch
- 27 AB 85: Open Meetings  
28 Status: Vetoed by the Governor  
29 Board's Position: Opposed
- 30 AB 333: Healing Arts: continuing education  
31 Status: Signed by the Governor, Chapter 360, Statutes of 2015.  
32 Board's Position: Watch
- 33 AB 507: Department of Consumer Affairs: BreEZe system: annual report  
34 Status: Hearing before Senate BP&ED cancelled at the request of the author. May  
35 become a 2 year bill  
36 Board's Position: Watch
- 37 AB 611: Controlled Substances: prescription reporting  
38 Status: Hearing before the Assembly cancelled at the request of the author. May  
39 become a 2 year bill.  
40 Board's Position: Watch
- 41 AB 860: Sex crimes: professional services  
42 Status: Referred to Senate Appropriations suspense file. May become a 2 year bill.  
43 Board's Position: Watch
- 44 AB 1060: Cancer clinical trails  
45 Status: As amended, no longer a bill of interest to the Board  
46 Board's Position: Watch
- 47 SB 390: Home health agencies: skilled nursing services  
48 Status: 4/14/15 hearing before Senate Health cancelled at the request of the author.  
49 May become a 2 year bill.  
50 Board's Position: Watch
- 51 SB 467: Professions and Vocations  
52 Status: Signed by the Governor, chapter 656, Statutes of 2015  
53 Board's Position: Watch

1 SB 800: Committee on Business, Professions and Economic Development  
2 Status: Signed by the Governor, Chapter 426, Statutes of 2015.  
3 Board's Position: Watch  
4

5 **b. 2015 Board-Cosponsored Legislation**  
6

7 Ms. Nunez reviewed Board Cosponsored Legislation:  
8

9 SB 525: Respiratory care practice  
10 Status: Signed by the Governor, Chapter 247, Statutes of 2015.  
11 Board's Position: Support  
12

13 AB 923: Respiratory care practitioners  
14 Status: has become a 2 year bill  
15 Board's Position: Support  
16

17 Ms. Nunez stated the Board is still working on AB 923 and she has had numerous meetings with the  
18 Assembly Business and Professions Committee regarding this bill. One of the sections being  
19 removed (which received a lot of objection) deals with the posting of arrests on the Board's website.  
20 The Assembly B&P Committee agreed to submit this issue as crosscutting for all DCA boards and  
21 bureaus to determine if a resolution such as public notice might be achieved. Ms. Nunez added that  
22 the other provisions of the bill are on track.  
23

24  
25 **ATTORNEY GENERAL LEGAL OPINION: SPIROMETRY BY MEDICAL ASSISTANTS**  
26

27 Ms. Nunez reviewed the legal opinion stating a medical assistant may lawfully perform spirometric  
28 pulmonary function testing if the test is a usual and customary part of the medical practice where the  
29 medical assistant is employed. Ms. Nunez also noted that this opinion is not binding,, but does carry  
30 weight.  
31

32 Mr. Wagner stated he understands the difficulty with this issue and expressed that his concern is  
33 those doing the spirometry are not doing it under the appropriate criteria. He is concerned that many  
34 of these tests are being put into the record as fact when they are actually not being performed  
35 properly. Mr. Wagner questioned who will police them to make sure the tests are being done  
36 properly.  
37

38 Discussion ensued.  
39

40 Dr. Lewis stated he is not sure how much more energy should be put into this because as he reads  
41 the opinion, the last line states "and supervision are satisfied." If it is not an isolated test without  
42 supervision and the entity is satisfied with the training and supervision, he does not see an issue.  
43

44 President Roth agreed that the physician in charge needs to have confidence in the medical assistant  
45 but that is not always the case. He gave an example of his last physical where the medical assistant  
46 performing the spirometry did not do the test correctly. He further stated that he feels that the Board  
47 needs to broaden the knowledge base to the physicians through either an educational effort or some  
48 other new technology to be more aware of what spirometry actually means.  
49

50 Dr. Lewis suggested using one of the avenues of communication already at hand, such as the  
51 Medical Board's newsletter, and include a reminder to physicians that they may be held responsible  
52 for any negative outcome due to improper education or oversight.  
53

1 Ms. Nunez inquired if Dr. Lewis would be interested in communicating with the Medical Board.

2  
3 Dr. Lewis responded he would have no problem opening an avenue of conversation with the Medical  
4 Board and added this is all about public outreach and that there may be many ideas that have not  
5 been thought of yet.

6  
7 Dr. Romero then stated that she agrees with Dr. Lewis in that communication may be the answer to  
8 this issue.

9  
10 Ms. Franzoia questions, for clarification, if the Board is asking that Dr. Lewis contact the Medical  
11 Board requesting they place a reminder in their newsletter that whoever signs off on these tests  
12 should be responsible and aware of the consequences.

13  
14 Dr. Lewis stated it is not so much of a request, as it is opening up a dialog.

15  
16 Board discussion ensued.

17  
18 There was no public comment.

19  
20 President Roth moved to authorize Dr. Lewis to make contact with the Medical Board and open a  
21 dialog pertaining to educational information in regards to spirometry and bring any communication  
22 back to the Board for discussion.

23  
24 The motion was seconded by Mr. Wagner.

25  
26 M Roth/S Wagner

27 In favor: Early, Franzoia, Hardeman, Lewis, Roth, Romero, Wagner

28 Unanimous:

29 MOTION PASSED

30

31

32

### **RCP STAFFING RATIOS/VENTILATOR PATIENTS**

33

34 President Roth stated that currently there are staffing ratios in nursing that relate to acuity and the  
35 number of nurses to patients in a particular unit like the ICU. Different units of a facility or hospital  
36 have different ratios in each. He explained he wanted the Board to have a discussion as to whether or  
37 not they could come up with a way in which therapists across the State could view the acuity of a  
38 person on mechanical ventilation both within and outside the ICU. He further explained, unlike nurses  
39 who are assigned to a smaller area or unit of responsibility, therapists are commonly assigned to an  
40 entire floor of a hospital or even several floors. The result is that individuals in respiratory care  
41 administrative functions currently are not aware of the best way in which to staff departments for those  
42 areas that require both mechanical ventilation and other activities.

43

44 Mr. Wagner stated, having been a respiratory therapy department administrator for almost 40 years,  
45 he would in his departments, not normally assign more than 4 acute ventilators to any therapist for an  
46 8 hour shift, 5 if they were "long term stable" and stated his facility used the AARC's Uniform  
47 Reporting Guidelines to figure out the acuities for each of the patients which has turned out to be  
48 much of the standard. He added that this also depends upon the other types of procedures that the  
49 patient is receiving, how frequently the ventilator checks are being administered, and what is required  
50 of a therapist during a ventilator check. He believes that they have found a safe and effective staffing  
51 level to be no more than 4 acute ventilators patients per therapist.

52

1 Ms. Nunez inquired if currently there is an average number of patients per therapist for stable  
2 patients.  
3  
4 Mr. Wagner responded that it would be 5 stable ventilator patients per therapist because of the many  
5 procedures involved in a ventilator check.  
6  
7 Dr. Lewis then inquired if any of this equates into a time. He questioned if it is by CPT Code where it  
8 can tell you how much time is spent on that activity so that data can be gathered to assist in telling  
9 how much a therapist can be assigned.  
10  
11 Mr. Wagner answered that it was not by CPT Code but by the AARC's Uniform Reporting Guideline.  
12 In it there is a manual that describes the time required to perform each of the specific duties required  
13 of a respiratory therapist to perform ventilator care. It gives both a general timeframe or suggests that  
14 a time study be performed on a therapist performing all of the duties of a ventilator check. Mr. Wagner  
15 stated he agrees that there should be a standard.  
16  
17 Ms. Franzoia inquired, if a therapist has 4 acute patients, do they have any other patients?  
18  
19 Mr. Wagner responded that generally, they would not.  
20  
21 Discussion ensued.  
22  
23 Mr. Wagner stated it would be difficult to dictate a number of ventilator patients to therapists and  
24 should be left up to the department directors based on the acuities of the ventilator patients.  
25  
26 Ms. Early stated the staffing ratio developed for RN's was through the State Legislature. She believes  
27 it may have been an organization like the California Nurses Association that wrote the bill and got a  
28 legislator to carry it. It would be a similar process for therapist: to get a statewide organization to put  
29 something together and find a member of the Legislature to carry it. She added she believes this is  
30 beyond the purview of this Board and should be something taken up by a professional organization.  
31  
32 Dr. Lewis agreed but stated he believes that Board should set minimum standards if legislation is  
33 introduced by an organization.  
34  
35 Mr. Kapoor, Legal counsel, stated the Legislature would have to authorize the Board to regulate those  
36 ratios established. Further, a statement made by the Board would not be enforceable. He  
37 recommended, if the Board feels that ratios are something that need to be regulated, the Board  
38 pursue a statutory change. A guideline or policy statement might not be a good use of time.  
39  
40 Mr. Kapoor reviewed some of the options: the Board could make a motion to direct staff to put  
41 together a proposal, authorize staff to seek input, put this topic on a future agenda while getting more  
42 input, send the topic to a committee; or authorize staff to move forward on draft language to bring to a  
43 future board meeting.  
44  
45 Ms. Franzoia suggested staff look into whether other states have developed staffing ratios and how  
46 they established those ratios.  
47  
48 Mr. Wagner moved to have staff request an opinion and recommendation from the practitioners and  
49 the CSRC in regards to ventilator therapist ratios in acute and sub-acute care facilities.  
50  
51 The motion was seconded by Ms. Franzoia.  
52  
53

1 M Wagner/S Franzoia  
2 In favor: Early, Franzoia, Hardeman, Lewis, Roth, Romero, Wagner  
3 Unanimous:  
4 MOTION PASSED

5  
6  
7 =====  
8 **CLOSED SESSION**  
9

10 The Board convened into Closed Session, as authorized by Government Code Section 11126c,  
11 subdivision (3) at 11:57 a.m. and reconvened into Public Session at 12:34 a.m.  
12 =====

13  
14  
15 **ELECTION OF OFFICERS FOR 2016**

16  
17 **a. Vice President**

18  
19 President Roth opened the floor for nominations for Respiratory Care Board Vice President.

20  
21 A movement to nominate Mr. Wagner for RCB Vice President was made by Ms. Early and seconded  
22 by Mr. Hardeman. No other nominations were made.

23  
24 No public comment.

25  
26 M/Early /S/Hardeman

27 In favor: Early, Franzoia, Hardeman, Lewis, Roth, Romero, Wagner

28 Unanimous

29 MOTION PASSED

30  
31 **b. President**

32  
33 President Roth opened the floor for Nominations for Respiratory Care Board President.

34  
35 A movement to nominate Mr. Roth for RCB President was made by Dr. Lewis, and seconded by Dr.  
36 Romero. No other nominations were made.

37  
38 No public comment.

39  
40 M/Lewis/S/Romero

41 In favor: Early, Franzoia, Hardeman, Lewis, Roth, Romero, Wagner

42 Unanimous

43 MOTION PASSED

44  
45  
46 **2016 MEETING DATES: CALENDAR**

47  
48 The following Public Meetings were scheduled for 2016:

49  
50 March 11, 2016 in San Diego, California  
51 June 24, 2016 Teleconference Meeting  
52 October 7, 2016 in Sacramento, California  
53

1  
2 **PUBLIC COMMENT ON ITEMS NOT ON THE AGENDA**  
3

4 There was no public comment.  
5

6  
7 **FUTURE AGENDA ITEMS**  
8

9 President Roth requested that if available, information and recommendations from the CSRC with  
10 regards to ventilator to therapist ratio, be included on the next agenda.  
11

12  
13 **ADJOURNMENT**  
14

15 The Public Session Meeting was adjourned by President Roth at 12:52 p.m.  
16  
17  
18  
19  
20  
21

22  
23 \_\_\_\_\_  
24 ALAN ROTH  
President

22  
23 \_\_\_\_\_  
24 STEPHANIE A. NUNEZ  
Executive Officer

Agenda Item: 4  
Meeting Date: 3/11/16



# Strategic Plan

2013-2016

**Respiratory Care  
Board of California**

# MEMBERS OF THE RESPIRATORY CARE BOARD OF CALIFORNIA

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

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

MARY ELLEN EARLY, MEMBER

REBECCA F. FRANZOIA, MEMBER

MICHAEL HARDEMAN, MEMBER

RONALD H. LEWIS, MD, MEMBER

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

LAURA C. ROMERO, PHD, MEMBER

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

STEPHANIE NUNEZ, EXECUTIVE OFFICER

## **TABLE OF CONTENTS**

ABOUT THE RESPIRTORY CARE BOARD OF CALIFORNIA.....	1
RECENT ACCOMPLISHMENTS .....	2
MISSION, VISION AND VALUES .....	5
GOALS AND OBJECTIVES.....	6

# **ABOUT THE RESPIRATORY CARE BOARD OF CALIFORNIA**

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

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

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

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

## RECENT ACCOMPLISHMENTS

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

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

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

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

## OUR MISSION

To 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.

## OUR VISION

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

## OUR VALUES

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

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

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

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

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

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

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

# GOAL 1: ENFORCEMENT

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

- ✓ **1.1** Pursue legislation to allow the release of criminal records without authorization for individuals seeking licensure with the Board. (Essential)  
**SB 305 (statutes of 2013) carried the Board's proposed legislation authorizing all boards to receive information without individual authorization (Section 144.5 of the B&P)**
- ✓ **1.2** Partner with other healing arts boards to pursue legislation that will allow for the immediate suspension of a license for an egregious act. (Essential)  
**The initial legislative proposal for immediate suspension was rejected (concerns for due process). The Board had sponsored legislation, AB 923, to make such arrests public information and grant the Board authorization to notify employers of arrests. This language proved to be too controversial as well. Currently, Assembly B&P is proposing the issue become a "cross-cutting" issue for DCA during the Sunset Review process, to determine its viability and impact across all boards.**
- ✓ **1.3** Establish a maximum time period to post on the internet, citations, fines and disciplinary matters. (Essential)  
**On April 4, 2014, the Board adopted a policy where it now considers the removal of public reprimands and citations and fines after a period of five years has elapsed.**
- ✓ **1.4** Reengineer the Board's enforcement processes for formal disciplinary actions by securing authority to draft routine accusations, statements of issue, and possibly stipulated agreements. (Important)  
**The Department of Consumer of Affairs is of the opinion that our board currently has this authority. However, the Office of the Attorney General does not support this process. As a result, no staffing resources exist to implement this process. Discussed further in Goal 4.2.**
- ✓ **1.5** Further define the process for addressing practice-related violations using the Board's authority to issue reprimands. (Important)  
**This process has evolved since the Board expanded the use of the "in-house public reprimand" for practice-related violations in 2014. Consideration to issue public reprimands is done on a case by case basis. In general, cases that fit at least three of the following criteria are considered:**
  - 1) The error was acknowledged by the licensee and corrective action was taken immediately, if applicable.**
  - 2) No patient harm.**
  - 3) No history of practice-related violations.**
  - 4) The benefit of placing a licensee on probation for the error is insignificant.****Ultimately, the Board has the final determination on whether a public reprimand is appropriate or if further disciplinary action is warranted.**

## GOAL 2: PRACTICE STANDARDS

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

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

**AB 1972 (Jones, Statutes of 2014) changed the competency examination required for licensure as a respiratory care practitioner, from the CRT exam to the RRT written and clinical exams. The RRT credential issued by the National Board for Respiratory Care is the nationally recognized as the highest level credential specific to respiratory care.**

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

**The Workforce Study currently underway by the University of California, San Francisco will be providing more information for the Board to act upon as it relates to Goal 2.2. Specifically, the following questions are key issues the UCSF will be exploring:**

- How is the 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?**

**The Workforce Study is expected to be complete by 1/1/17.**

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

**SB 305 (Lieu, Statutes of 2013/Sunset extension bill) exempted specific personnel employed by Los Angeles County hospitals from respiratory care practitioner licensure in order to perform pulmonary function testing.**

**At the Board's May 2013 it was decided to not allow for any additional exemptions and to begin enforcing existing law. The Medical Board of California disagreed with this interpretation as it relates to medical assistants performing pulmonary function testing. In December 2013, the Board, along with the Medical Board of California, jointly requested a legal opinion on the performance of pulmonary function testing by unlicensed personnel.**

**UPDATE: On October 22, 2015, the Attorney General issued an opinion concluding, " A medical assistant may lawfully perform spirometric pulmonary function testing if the test is a usual and customary part of the medical practice where the medical assistant is employed, and the requirements for training, competency, authorization, and supervision are satisfied."**

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

**It was determined that the intent of this goal is outside the Board's purview and would be better addressed by the CMS or a facility's legal counsel. The Board currently has regulations, California Code of Regulations, Section 1399.360, that provide for the care that RCPs should provide as it relates respiratory durable medical equipment in the home.**

- WS** **2.5** Evaluate the effectiveness and impact of the Professional Ethics and Law courses to determine whether or not the courses should be mandated. (Important)

**The Workforce Study currently underway by the University of California, San Francisco will be providing more information for the Board to act upon as it relates to Goal 2.5. Specifically, the following questions are key issues the UCSF will be exploring:**

- 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 Workforce Study is expected to be complete by 1/1/17.**

WS

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

The number of continuing education (CE) hours required for license renewal was increased from 15 to 30 hours effective 7/1/15 (renewals with expiration dates on or after 7/31/17 will be required to meet this new requirement). [The regulatory package was approved 4/9/15]

#### Regulatory Change

§ 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. ...

On 8/27/2015, the California Society for Respiratory Care submitted a request for the Board to consider mandating that half of the continuing education required for renewal, be obtained through an in-person live format. The Board will consider this request at its 11/6/15 meeting.

The Workforce Study currently underway by the University of California, San Francisco will be providing more information for the Board to act upon as it relates to Goal 2.6. Specifically, the following questions are key issues the UCSF will be exploring:

- Should the number of CE hours be increased [further]? If so, by how much? Why do CE hours need to be increased?
- Should there be restriction on the extent to which CE courses can be delivered online rather than in person?
- Should there be core CE courses taken by all RCPOs? If so, why?

The Workforce Study is expected to be complete by 1/1/17.

WS

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

The Workforce Study currently underway by the University of California, San Francisco will be providing more information for the Board to act upon as it relates to Goal 2.7. Specifically, the following questions are key issues the UCSF will be exploring:

- What is the feasibility and what would be the impact of establishing the requirement that respiratory therapists have a baccalaureate degree in California?
- 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-the-job] training programs?
- 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?

The Workforce Study is expected to be complete by 1/1/17.

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

SB 525 (Nielsen, Statutes of 2015) was signed by the Governor on 9/2/15. SB 525 included the following provision as part of the respiratory care scope of practice, providing clarity that licensure as a respiratory care practitioner is required for educators:

**Business and Professions Code**

**Section 3702.7.**

The respiratory care practice is further defined and includes, but is not limited to, the following:

.....

(d) Educating students, health care professionals, or consumers about respiratory care, 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. ...

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

**UPDATED**

Initially, this item was included in the scope of work in the Board's Workforce Study. Specifically, the plan was to conduct a review of curricula to compare and contrast respiratory therapy education programs with registered nursing, physician assistant, and nurse practitioner education programs. The objective was to understand how the RT curriculum supports granting RCPs the authority to prescribe therapy and medication per protocol, using the other health professions as benchmarks.

However, after conducting interviews with respiratory care directors, the perception was that medical directors would resist this idea. The interviews also revealed that RCPs (at some facilities) already have some degree of practice under protocol that would involve the types of competencies that we were going to assess in the curriculum review.

Thus, it was agreed that this curricular analysis, be replaced in the scope of work with conducting key informant interviews with medical directors on this subject.

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

SB 525 (Nielsen, Statutes of 2015) was signed by the Governor on 9/2/15. SB 525 included the following provision as part of the respiratory care scope of practice:

Business and Professions Code

Section 3702.

(a) 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:

...

(b) As used in this section, the following apply:

(1) “Associated aspects of cardiopulmonary and other systems functions” includes patients with deficiencies and abnormalities affecting the heart and cardiovascular system.

...

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

SB 525 (Nielsen, Statutes of 2015) was signed by the Governor on 9/2/15. SB 525 included the following provision as part of the respiratory care scope of practice:

Business and Professions Code

Section 3701.

...

(c) For purposes of this section, it is the intent of the Legislature that “overlapping functions” includes, but is not limited to, providing therapy, management, rehabilitation, diagnostic evaluation, and care for nonrespiratory-related diagnoses or conditions provided (1) a health care 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, as needed.

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

**Continuing education (CE) requirements were updated via regulation as follows. The regulatory package was approved 4/9/15 and the provisions contained in the package have an effective date of 7/1/15.**

**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;**

...

**(5) Sleep Disorders Testing and Therapeutic Intervention Respiratory Care Specialist (SDS) - 15 hours**

...

**(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.**

...

## GOAL 3: OUTREACH

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

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

**Board staff generated email blasts as well as direct communications with program directors at all education programs in California. Additional communications will be made once the "Apply On-Line" feature is turned on.**

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

**Board staff implemented the "e-blast" notice system in May 2013. Applicants and licensees were notified via hard copy newsletters to submit their e-mail addresses to receive future news. The Board published a final hard copy newsletter to share recent and significant news and event as well as, encourage licensees to sign up for the e-blast communications. In addition, the on-line application feature in BreEZe will begin collecting email addresses that may be used for an alternate form of sharing information.**

## GOAL 4: ORGANIZATIONAL EFFECTIVENESS

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

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

**UPDATED:** Board staff are actively working on a full redesign of the Board's website to be launched by 12/31/16.

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

Board staff submitted a budget change proposal (BCP) requesting two additional positions in 2013. One position was requested for practice-related investigations and one to pursue Goal #1.4 to generate draft legal pleadings in-house. The budget change proposal (BCP) was approved by the Department of Consumer Affairs and the Business, Consumer Services, and Housing Agency. The Department of Finance was also very encouraged by the efficiencies sought. Unfortunately, the Office of the Attorney General took issue with the proposal. Ultimately, only the position designated for investigations was approved and received 7/1/14.

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

**UPDATED:** The initial BreZE rollout took place in October 2013. At that time, Board staff chose to hold off on turning on the "Apply On-Line" feature to provide sufficient time and familiarization with the system to ensure a smooth transition. Staff managers developed intricate business plans to accommodate the numerous process changes that accompanied BreZE. Overall, the initial rollout went smoothly. Staff managers developed alternate methods to work around minor glitches. Since that time all of the "glitches" have been addressed. The only outstanding item is the "Apply On-Line" feature for new applicants. It is in the queue; however DCA has given it a low priority in connection with all roll outs.

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

Necessary clarification for military exemptions was made via regulation as follows. The regulatory package was approved 4/9/15 and the provisions contained in the package have an effective date of 7/1/15.

**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.**

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

An exemption process for out-of-state practitioners for sponsored events was established via regulation. The regulations are extensive and are covered in California Code of Regulations, Title 16, Division 13.6, Article 4, Sections 1399.343-1399.346. The regulatory package was approved 4/9/15 and the provisions contained in the package have an effective date of 7/1/15. The regulations were promulgated to comply with AB 2699. However, the Board does not expect any significant number, if any, of such requests.

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

Necessary clarification for driving history records was made via regulation as follows. The regulatory package was approved 4/9/15 and the provisions contained in the package have an effective date of 7/1/15.

**1399.326. Driving Record**

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

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

**The Board adopted its first ever Record Retention Policy for electronic and paper records in February 2011. In 2013, staff had completed destroying records in accordance with the policy back to 1985 (the first year of licensure).**

**All electronic records will be maintained for a minimum of 60 years. No electronic files were destroyed.**

**All hard copies of abandoned applications for licensure (without enforcement history), are scheduled to be destroyed after two years. Board staff have destroyed 367 records, to date.**

**All records for cancelled, deceased or retired licensees (without enforcement history) are scheduled to be destroyed after ten years. Board staff have destroyed over 6,800 hard copy records (6,749 cancelled; 76 deceased; 23 retired), to date.**

**Records with an enforcement history are scheduled to be destroyed after 60 years. No such records have been destroyed, to date.**

**Destruction of records now occurs on regular basis, at least quarterly.**

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

**UPDATE: At this time, the Board receives monthly reports that identify records where “no longer interested” notices should be sent and those records are current. Board staff look forward to this process being automated through a Breeze interface.**

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



## CALIFORNIA EXAM STATISTICS

*Effective January 1, 2015, the Board established the Registered Respiratory Therapist (RRT) as the minimum exam requirement for licensure. The RRT is comprised of the Therapist Multiple Choice (TMC) and the Clinical Simulation Exam (CSE). Prior to January 1, 2015, applicants were only required to take and pass a single Certified Respiratory Therapist (CRT) written examination.*

### 2014 CALENDAR YEAR

Certified Respiratory Therapist Exam		
	Attempts	Percentage
Pass Count	1291	62.3%
Fail Count	780	37.7%
<b>Total No. of Attempts</b>	2071	
<b>2014 New Licenses Issued: 1403</b>		

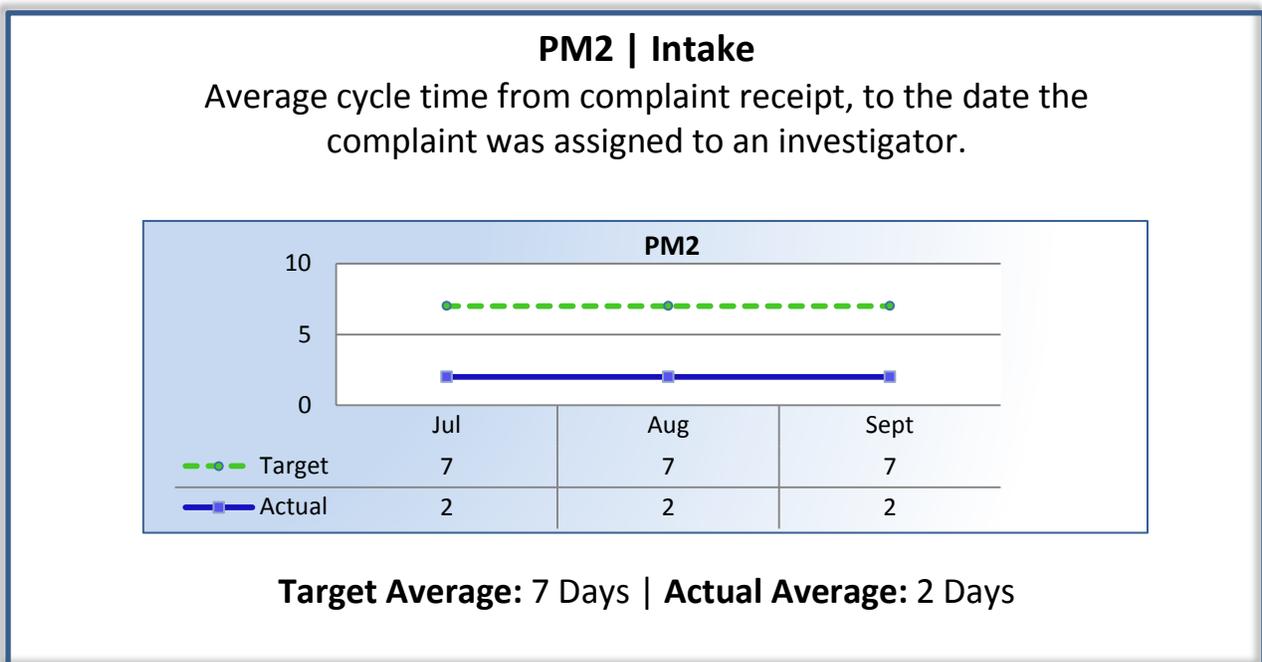
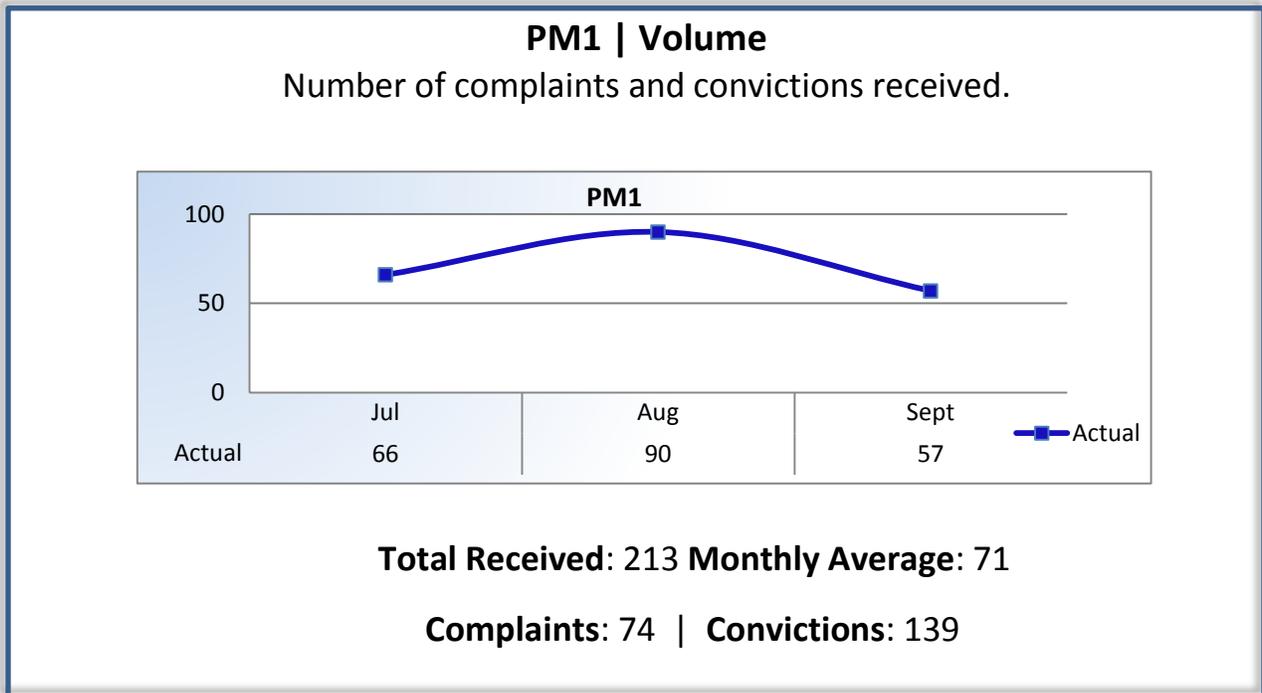
### 2015 CALENDAR YEAR

Therapist Multiple Choice Exam		
	Attempts	Percentage
Low Cut (CRT) Pass Count	311	13.2%
High Cut (RRT) Pass Count	1323	56.0%
Fail Count	726	30.8%
<b>Total No. of Attempts</b>	2360	
Clinical Simulation Exam		
	Attempts	Percentage
Pass Count	1084	49.7%
Fail Count	1096	50.3%
<b>Total No. of Attempts</b>	2180	
<b>2015 New Licenses Issued: 1103</b>		

## Performance Measures

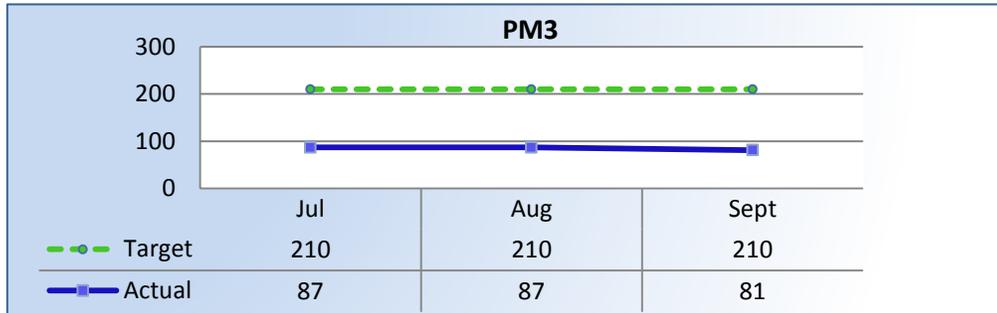
### Q1 Report (July - September 2015)

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



### PM3 | Intake & Investigation

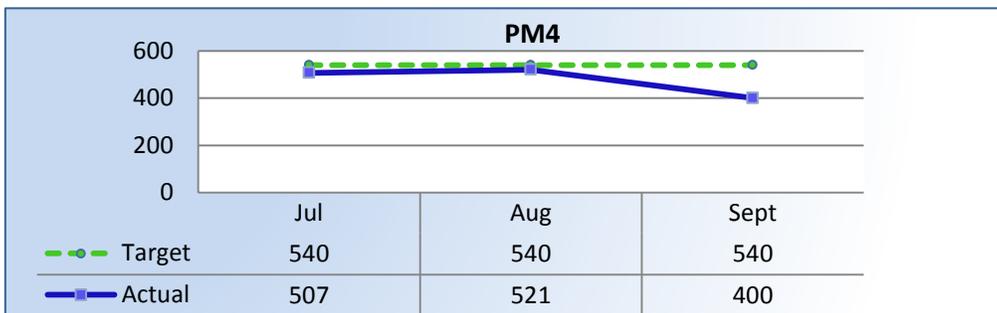
Average number of days to complete the entire enforcement process for cases not transmitted to the AG. (Includes intake and investigation)



**Target Average: 210 Days | Actual Average: 86 Days**

### PM4 | Formal Discipline

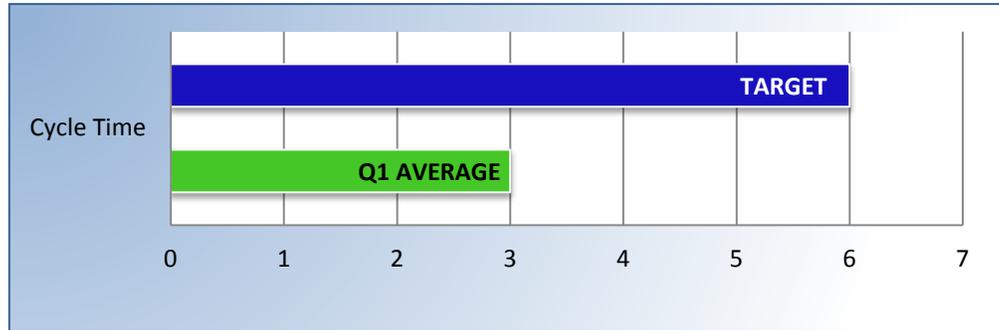
Average number of days to complete the entire enforcement process for cases transmitted to the AG for formal discipline. (Includes intake, investigation, and transmittal outcome)



**Target Average: 540 Days | Actual Average: 475 Days**

### PM7 | Probation Intake

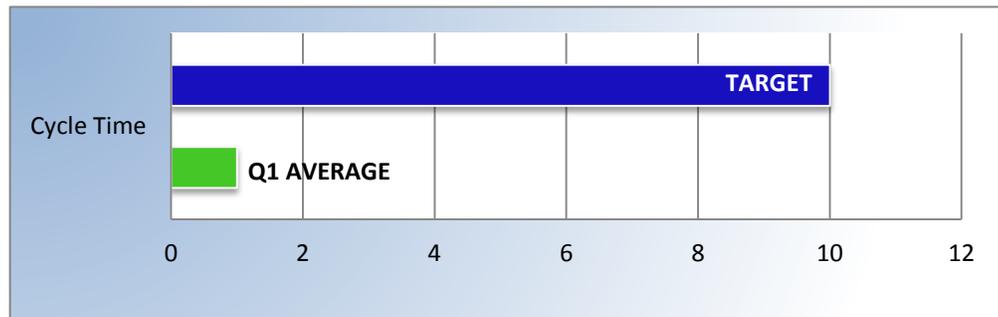
Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.



**Target Average: 6 Days | Actual Average: 3 Days**

### PM8 | Probation Violation Response

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

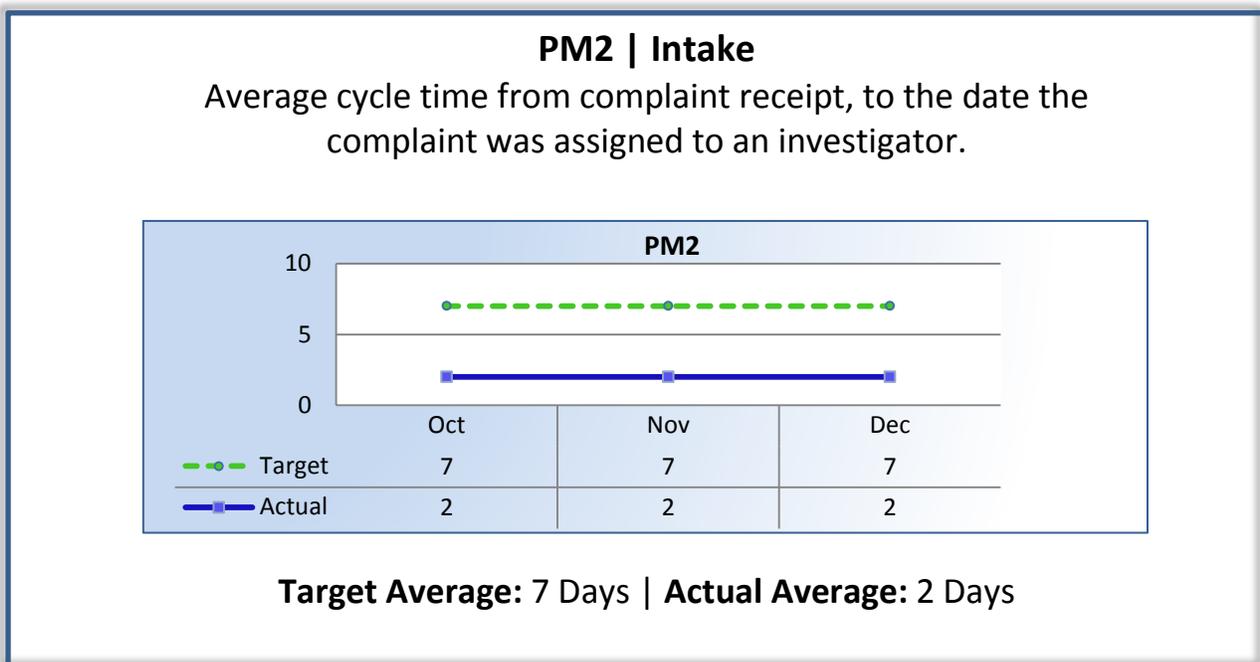
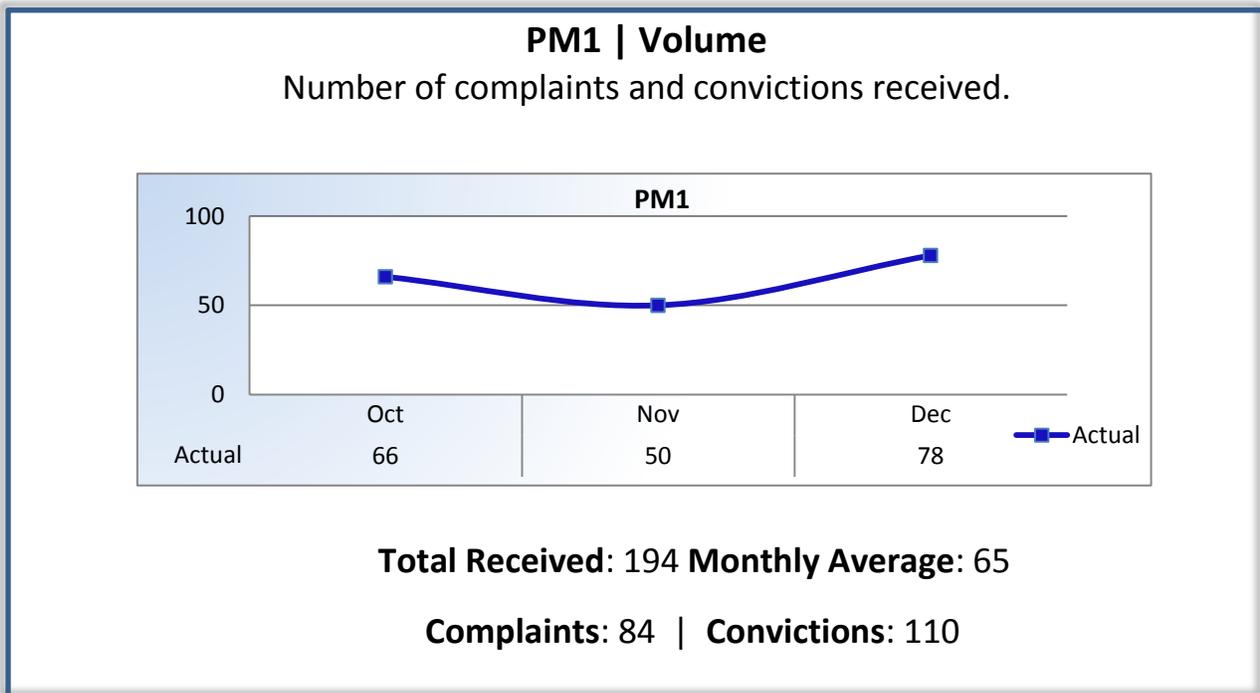


**Target Average: 10 Days | Actual Average: 1 Day**

## Performance Measures

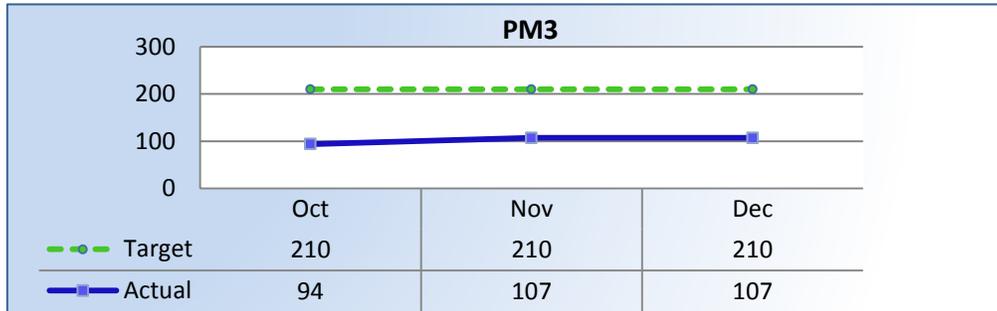
### Q2 Report (October - December 2015)

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



### PM3 | Intake & Investigation

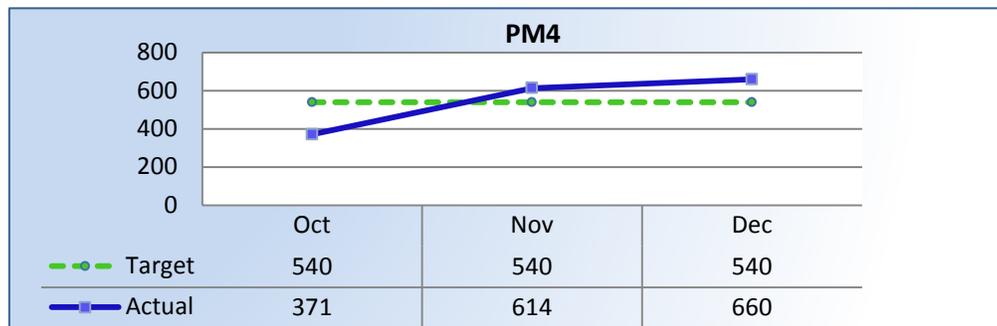
Average number of days to complete the entire enforcement process for cases not transmitted to the AG. (Includes intake and investigation)



**Target Average: 210 Days | Actual Average: 102 Days**

### PM4 | Formal Discipline

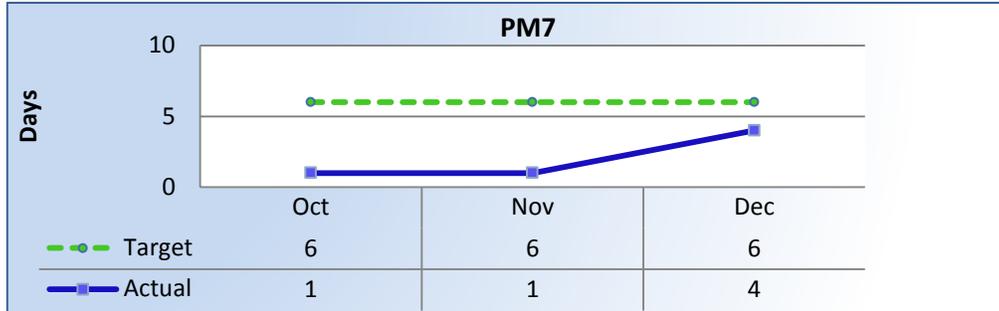
Average number of days to complete the entire enforcement process for cases transmitted to the AG for formal discipline. (Includes intake, investigation, and transmittal outcome)



**Target Average: 540 Days | Actual Average: 597 Days**

### PM7 | Probation Intake

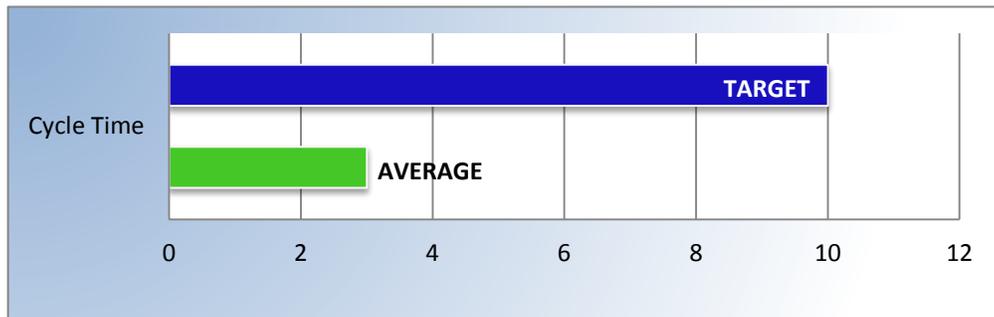
Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.



**Target Average: 6 Days | Actual Average: 1 Day**

### PM8 | Probation Violation Response

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



**Target Average: 10 Days | Actual Average: 3 Days**



University of California  
San Francisco

Attachment: 8  
Meeting Date: 3/11/16

Phillip R. Lee  
Institute for  
Health Policy Studies  
3333 California Street  
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S Francisco, CA 94118  
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fax: 415/476-0705  
<http://healthpolicy.ucsf.edu>

March 1, 2016

Narrative Progress Report

### **California Respiratory Care Workforce Study**

Period covered: March 1, 2015 – August 31, 2016

Goals of study:

Comprehensive analysis of key issues facing the state's respiratory care workforce, as identified by the California Board of Respiratory Care. These include: establishing the baccalaureate degree as the entry-level credential for respiratory therapists; allowing respiratory care practitioners to prescribe therapies (including medication) per protocol; how facilities supervise students during their clinical education; the impact of required professional ethics and law courses; the structure of continuing education requirements.

Proposed study activities:

- Conduct a literature review of scholarly work addressing the impact of respiratory care education on patient care
- Conduct and summarize ten key informant interviews with directors of respiratory care
- Develop, field, and analyze a survey of directors of respiratory care
- **Conduct an analysis of the curriculum used in respiratory care education programs to identify content that supports respiratory care practitioners exercising prescriptive authority per protocol**
- Conduct and summarize five focus groups with currently employed respiratory therapists
- Conduct and summarize ten key informant interviews with directors of respiratory therapy education programs.

### ***Project accomplishments since last update***

- Findings from key informant interviews with ten directors of respiratory care were summarized and a draft of the analysis was submitted to the advisory group for feedback. This feedback was incorporated and a final summary report was provided to the Board.
- A database with contact information for approximately 350 directors of respiratory care across multiple settings was developed. These settings include DME oxygen providers, outpatient clinics, respiratory care staffing agencies, home health agencies, long term sub-acute care facilities, and general acute care hospitals. This database is the survey frame for the survey of directors of care.
- The survey of directors of care which will be used to validate findings from the key informant interviews was developed and is being field-tested. Survey is expected to be launched during the second week of March, 2016.
- Study team solicited bids from companies that specialize in the recruitment of health care professionals for focus groups.
- Study team has begun process of securing space to conduct focus group sessions in five cities across California: San Francisco, Sacramento, Los Angeles, San Diego, and Fresno.

### ***Proposed activities still to be completed***

- Field the survey of directors of respiratory care. Collect and summarize data from respondents.
- Develop, field and summarize findings for a survey of respiratory care directors.
- Analysis of respiratory care education curricula to identify content that supports prescriptive authority for respiratory therapists.
- Scheduling, conducting, and summarizing findings from focus groups with currently employed respiratory therapists.
- Scheduling, conducting, summarizing findings from key informant interviews with directors of respiratory therapy education programs

### ***Proposed revision to scope of work***

The original proposal included a curricular review, in which we would compare/contrast respiratory therapy education programs with that of registered nurses and physician assistants to understand how the respiratory therapy curriculum supports granting RCPs the authority to prescribe therapy and medication per protocol. As a result of findings that emerged from the

key informant interviews with directors of respiratory care, we are proposing that the issue of prescriptive authority per protocol be tabled and the scope of work be revised.

**In place of the originally proposed curricular review we are proposing one of the following two project components as alternatives, both of which would be budget-neutral:**

- 1) Survey of program directors at RT education programs – This would be in addition to the key informant interviews with education program directors that we will be conducting. The purpose of the survey would be to validate the findings of the interviews.

OR

- 2) Comparative analysis of associate degree vs. bachelor's degree curricula – Some of the key findings that emerged from the interviews with directors of respiratory care were related new graduates' not being exposed to certain topics in their education programs. For example, chronic care models, rehabilitative care, population health, patient education, case management, and generally the development skills that would be considered non-clinical.

Rather than frame this analysis around the topic of prescriptive authority, we would analyze the curricula of AD and BS programs in respiratory therapy for differences in course content related to the kinds of topics directors indicated new graduates are not adequately exposed to in their education. Using this same analytical framework, we would also examine the curricula of other professions that have multiple educational pathways to licensure, e.g. registered nursing. (In other words, we would identify how the content of a bachelor's in nursing program differs from that of an associate's degree program, in the context of the kinds of skills and knowledge RC directors identified as missing from RT education programs.)



University of California  
San Francisco

**PRIOR STATUS UPDATE  
FROM 11/6/15 MEETING**

Phillip R. Lee  
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tel: 415/476-4921  
fax: 415/476-0705  
<http://healthpolicy.ucsf.edu>

November 4, 2015

## Narrative Progress Report

### **California Respiratory Care Workforce Study**

Period covered: March 1, 2015 – August 31, 2016

#### Goals of study:

Comprehensive analysis of key issues facing the state's respiratory care workforce, as identified by the California Board of Respiratory Care. These include: establishing the baccalaureate degree as the entry-level credential for respiratory therapists; allowing respiratory care practitioners to prescribe therapies (including medication) per protocol; how facilities supervise students during their clinical education; the impact of required professional ethics and law courses; the structure of continuing education requirements.

#### Proposed study activities:

- Conduct a literature review of scholarly work addressing the impact of respiratory care education on patient care
- Conduct and summarize ten key informant interviews with directors of respiratory care
- Develop, field, and analyze a survey of directors of respiratory care
- Conduct an analysis of the curriculum used in respiratory care education programs to identify content that supports respiratory care practitioners exercising prescriptive authority per protocol
- Conduct and summarize five focus groups with currently employed respiratory therapists
- Conduct and summarize ten key informant interviews with directors of respiratory therapy education programs.

### ***Project accomplishments to date***

- Established the core advisory group for the project, which includes all six individuals recommended by the Board. Members of the advisory group have proven to be generous with their time and in their willingness to review materials and provide guidance.
- Conducted a literature review of scholarly work that addresses the relationship between the type of degree earned by respiratory therapists and patient outcomes. The findings of the review were summarized and provided to the advisory group for feedback. A final version was submitted to the Board.
- Developed an interview guide for key informant interviews with directors of respiratory care. The interview guide was submitted to the advisory group for feedback. A final version of the guide was provided to the Board.
- Worked with the advisory group to identify potential directors of respiratory care for key informant interviews. Directors were selected in order to represent different care settings (home care, outpatient care, and inpatient care) and different geographic regions of the state.
- Scheduled and conducted ten key informant interviews with directors of respiratory care. The findings from these interviews are currently being summarized in a thematic analysis. A draft of this analysis will be provided to the advisory group and the Board for feedback. Any needed revisions will then be made and a final version will be submitted to the Board.
- Significant development of a database containing contact information for directors of respiratory care across multiple settings: DME oxygen providers, outpatient clinics, respiratory care staffing agencies, home health agencies, long term sub-acute care facilities, and general acute care hospitals. This database of contact information will be used to field the survey of directors of respiratory care.

### ***Proposed activities still to be completed***

- We are in the process of summarizing the findings from the key informant interviews with directors of respiratory care into a thematic analysis. Our expectation is that this analysis will be completed and submitted to members of the advisory group for feedback by Friday, November 6.
- Develop, field and summarize findings for a survey of respiratory care directors.
- Analysis of respiratory care education curricula to identify content that supports prescriptive authority for respiratory therapists.

- Scheduling, conducting, and summarizing findings from focus groups with currently employed respiratory therapists.
- Scheduling, conducting, summarizing findings from key informant interviews with directors of respiratory therapy education programs

### ***Proposed revision to project timeline***

We would propose the following revision the project timeline: Postpone fielding the survey of directors of respiratory care until early January.

Scheduling and conducting the key informant interviews with directors of respiratory care took longer than anticipated. Because the findings from these interviews forms the basis for the survey instrument, the questionnaire is not ready. Based on our professional experience, fielding a survey during the months of November and December will almost certainly yield poor results, due to the impact of the Thanksgiving, Christmas and New Year holidays. We think it makes more sense to delay putting the survey in the field until January, and in the meantime focus on those study activities that will not be impacted by the holiday season.

We have attached a revised project timeline.

### ***Additional projection information***

We anticipate that our summary of findings from the key informant interviews with directors of respiratory care will be complete by Friday, November 6, 2015. We will submit our analysis to the advisory group for feedback, and any needed revisions will then be made and a final document will be provided to the Board.

For all outstanding study components, we will follow the same process of soliciting guidance from members of the advisory group prior to conducting the work, summarizing each component's key findings, submitting these findings to the advisory group for feedback, and then making any necessary revisions before providing a final product to the Board.



**American Association for Respiratory Care**  
9425 N. MacArthur Blvd., Suite 100, Irving, TX 75063

## **Position Statement**

# **Respiratory Therapist Education**

Respiratory therapists provide direct patient care, patient education, and care coordination. They practice in acute care facilities, long-term acute care facilities, skilled nursing facilities, assisted-living centers, subacute care units, rehabilitation centers, diagnostics units, and in the home. Their clinical decisions are increasingly data-driven by scientifically supported algorithms (protocols) to deliver respiratory care. They are involved in research and need to be adept at understanding the practical ramifications of published research. Respiratory therapists use sophisticated medical equipment and perform complex therapeutic procedures and diagnostic studies. They also provide education to patients and other members of the public. Respiratory therapists must possess an in-depth understanding of human physiology and apply that knowledge in the clinical setting.

The continually expanding knowledge base of today's respiratory care field requires a more highly educated professional than ever before. Factors such as increased emphasis on evidence-based medicine, focus on respiratory disease management, demands for advanced patient assessment, and growing complexities of American healthcare overall, clearly mandate that respiratory therapists achieve formal academic preparation commensurate with an advanced practice role.

The primary purpose of a formal respiratory care educational program is to prepare competent respiratory therapists for practice across multiple health care venues. Respiratory care educational programs are offered at technical and community colleges, four-year colleges, and universities. Training and education for entry-to-practice as a respiratory therapist should be provided within programs awarding a bachelor's or master's degree in respiratory care (or equivalent degree titles) and all newly accredited respiratory care educational programs must award, as a minimum, the bachelor's degree in respiratory care (or equivalent degree title). Associate degree respiratory care programs which are currently accredited by the Commission on Accreditation for Respiratory Care (CoARC) should be allowed to continue in good standing as long as they remain in compliance with all other CoARC policies and standards. The AARC supports existing and future articulation agreements between associate and baccalaureate respiratory therapy programs. Respiratory therapists seeking to practice in advanced clinical settings, leadership roles, research, and in professional educator roles should seek higher education at the masters or doctoral levels.

Effective 1998  
Revised 03/2009  
Revised 04/2012  
Revised 07/2015  
Revised 11/2015



## CoARC Communication to our Communities of Interest:

### Response to AARC Position Statement on Respiratory Therapist Education

January 28, 2016

The mission of the Commission on Accreditation for Respiratory Care (CoARC) is to ensure that high quality educational programs prepare competent respiratory therapists for practice, education, research and service. To achieve its mission, the CoARC holds programs accountable to their communities of interest - the profession, patients, employers, students and their families, practitioners - and to one another, by ensuring that program graduates are competent to fulfill their expected roles. The CoARC uses the *Accreditation Standards for Entry into Respiratory Care Professional Practice* to ensure that all accredited programs can prepare students to successfully complete the National Board for Respiratory Care (NBRC) credentialing examinations. These examinations objectively assess the extent to which program graduates have achieved the essential knowledge, skills, and abilities required of a Registered Respiratory Therapist (RRT).

On January 5<sup>th</sup>, 2016, the American Association for Respiratory Care (AARC) revised its [position statement](#) on Respiratory Therapist Education. The AARC's new position is that all programs applying for accreditation be able to award a minimum of a baccalaureate degree upon student completion of programmatic and degree requirements. The position statement emphasizes that the AARC supports continuing the accreditation of existing associate degree programs that meet the CoARC Standards.

The CoARC acknowledges that respiratory therapists with baccalaureate and graduate education are needed in larger numbers to serve as educators, researchers, managers, clinical specialists, and other roles throughout the healthcare delivery system. Likewise the CoARC recognizes the prominent role played by associate degree respiratory therapy programs. To support the increasing extent and complexity of the skills required of graduates of Respiratory Care programs and the associated movement of the profession toward baccalaureate and graduate degrees, the CoARC Board of Commissioners, in collaboration with the AARC, is proposing the following change to Standard 1.01 in the *Accreditation Standards for Entry into Respiratory Care Professional Practice*, to be effective January 1, 2018:

*~~An Except as provided in the following sentence, an~~ educational sponsor must be a post-secondary academic institution accredited by a regional or national accrediting agency that is recognized by the U.S. Department of Education (USDE) and ~~must be~~ authorized under applicable law or other acceptable authority to award graduates of the program a ~~an associate or higher~~ baccalaureate or graduate degree upon ~~at the~~ completion of the program. For programs that were accredited prior to January 1, 2018, an educational sponsor must be a post-secondary academic institution accredited by a regional or national accrediting agency that is recognized by the USDE and that is authorized under applicable law or other acceptable authority to award graduates of the program an associate or equivalent degree upon completion of the program.*

The intended effect of this change is that if the sponsor of a proposed Respiratory Care educational program is capable of granting only an Associate degree (or equivalent) upon completion of the program, the sponsor must receive approval for the program at, or prior to, the November 2017 meeting of the CoARC Board.

To facilitate a consensus, information will be provided to, and input solicited from, all the CoARC's communities of interest during the formal revision process outlined below. Before finalizing any changes to the Standards CoARC will provide advance public notice of the proposed revisions. The CoARC has also developed an FAQ (see last page of this announcement) in an effort to address concerns and questions from sponsoring institutions, programs, and students.



## COMMISSION ON ACCREDITATION FOR RESPIRATORY CARE

### CoARC STANDARD 1.01 REVISION PROPOSED TIMELINE

#### January 2016:

1. Blast email all accredited programs and place an announcement on the CoARC and AARC web sites announcing the first draft of the revised Standard 1.01. Disseminate a call for comment (with an **April 1, 2016** deadline) to all communities of interest\* and outline the procedure for those wishing to provide input to the CoARC.

*\*Communities of interest include all the bodies within the CoARC organizational structure; related bodies or organizations (the American Association for Respiratory Care, the American College of Chest Physicians, the American Society of Anesthesiologists, the American Thoracic Society, the Association of Schools of Allied Health Professions, the National Network of Two-Year Community Colleges, and the National Board for Respiratory Care; RT educational program representatives (CEOs, deans, program directors, medical directors, site visitors, and advisory committee members); respiratory therapy educators; practitioners; consumers; employers; regulators (licensure boards, state higher education commissions); recognition bodies (Council for Higher Education Accreditation); accreditors (regional, national, and specialized accreditors); Association of Specialized and Professional Accreditors; students; and the public at large.*

2. Use the CoARC web site and Survey Monkey to collect data and feedback from CoARC's communities of interest.
3. CoARC Accreditation Policies/Standards/Bylaws Committee (April– May 2016):
  - Review the data collected from the survey, and from any correspondence, e-mails, or telephone calls regarding the proposed change in the Standards.
  - Propose revisions to the first draft for review by the Full Board at June meeting.
4. At June 2016 CoARC Board meeting:
  - Hold a Standards Open Hearing (time TBD);
  - Review, discuss, and approve any proposed changes to the first draft of Standard 1.01.

#### Following June 2016 CoARC Board meeting:

5. Blast email all accredited programs and place an announcement on the CoARC and AARC\_web sites announcing the final draft of revised Standard 1.01. Disseminate a call for comment (with an **October 1, 2016** deadline) to all communities of interest\* and outline the procedure for those wishing to provide input to the CoARC.
6. Use the CoARC web site and Survey Monkey to collect data and feedback from the communities of interest.
7. At 2016 AARC International Congress (October 15-18, San Antonio, TX):
  - Hold a Standards Open Hearing (time and location TBD).
8. CoARC Accreditation Policies/Standards/Bylaws Committee (September– October 2016):
  - Review the data collected from the survey, and from any correspondence, e-mails, or telephone calls regarding the proposed change to the Standards.
  - Recommend revisions to the final draft for review by Full Board at June meeting.
9. At November 2016 CoARC Board meeting:
  - Review, discuss, and approve any proposed changes to the final draft of Standard 1.01.

**Following November 2016 CoARC Board meeting:**

10. Send the final version of the Standards to the CoARC's collaborating organizations (AARC, ATS, ASA, and ACCP) for endorsement as per CoARC Bylaw 2.05.01.
11. The endorsed Standards' revision will be posted on the CoARC web site and will go into effect following endorsement. An e-mail announcement will be distributed to all communities of interest.

## **FREQUENTLY ASKED QUESTIONS**

### **(PROPOSED CHANGES TO STANDARD 1.01)**

**What effect would the change have on existing accredited associate degree programs?**

Existing associate degree programs will be able to participate in the accreditation process provided that they continue to comply with CoARC Standards and Policies.

**My sponsoring institution has submitted a Letter of Intent application for an associate degree program. How will this change impact us?**

There will be no impact on your application as long as Provisional Accreditation is granted prior to January 1, 2018 (see below). The process for seeking an Approval of Intent remains the same.

**How many applications for new associate degree programs have there been in recent years?**

In 2012, there were two Letter of Intent applications submitted by sponsoring institutions limited to granting an Associate degree. Since 2012, there have been no applications submitted by such institutions; two applications for associate degree programs were submitted by sponsoring institutions able to grant a baccalaureate or higher degree.

**What if my program has a Letter of Intent or Approval of Intent as of January 1, 2018? Will we still receive accreditation?**

No. All sponsoring institutions seeking accreditation of an associate degree program must receive Provisional Accreditation prior to or at the November 2017 CoARC Board meeting. As of that date, for programs having only the Letter of Intent or Approval of Intent status, the process will be terminated.

**What happens if my associate degree program withdraws after January 1, 2018 and we subsequently seek reaccreditation?**

In the reaccreditation process, applicant programs are considered to be new programs and must therefore comply with current, applicable Standards. Accordingly, after January 1, 2018, for such an application to be considered, this means that the program sponsor would need to be capable of awarding a baccalaureate or graduate degree upon program completion.

**Will this proposed change have any impact on CoARC's plans to establish a threshold for the higher cut score on the NBRC TMC exam?**

No. Compliance with this new threshold will be required starting with the annual reports due on July 1, 2018.

For questions regarding this communication, please contact Tom Smalling, Executive Director, at 817-283-2835 ext. 101 or by email at [tom@coarc.com](mailto:tom@coarc.com).

[Commission Reports](#)

**Study**

[Study Schedule](#)

**Agendas**

[February 4, 2016](#)

**Subject Area**

[General Government](#)

## Occupational Licensing

### Study Schedule

DATE & TIME	EVENT	WRITTEN MATERIAL
<a href="#">Thursday, February 4, 2016</a> 9:30 a.m., State Capitol, Room 437	Public Hearing	<a href="#">Agenda</a>

### Description of Study

The Little Hoover Commission is beginning a review of occupational licensing in California.

The number of individuals who must meet government-established criteria to practice a given occupation has grown rapidly in the last half century. In the 1950s, fewer than five percent of workers nationwide were required to hold licenses to practice their professions; by 2008, that number had increased to 29 percent of workers nationwide, according to economists Morris Kleiner and Alan Krueger. Approximately 21 percent of California's 19 million member workforce is licensed. Proponents of occupational licensing advocate that these regulations are necessary to protect the health and safety of consumers. Critics contend that these regulations at times go beyond consumer protection and unjustifiably restrict competition.

The focus of the Commission's review is on the impact of occupational licensing on upward mobility and opportunities for entrepreneurship and innovation for Californians, particularly those of modest means. The Commission also will examine the result of occupational licensing on the cost and availability of services provided by licensed practitioners to consumers. The Commission also will assess the connection between occupational licensing regulations and the underground economy. The Commission will explore the balance between protecting consumers and enabling Californians to enter the occupation of their choice.

If you would like more information regarding this study, please contact project manager Krystal Beckham at [krystal.beckham@lhc.ca.gov](mailto:krystal.beckham@lhc.ca.gov) or at 916-445-2125. To be notified electronically of meetings, events, or even when the report is complete, please send a request to [littlehoover@lhc.ca.gov](mailto:littlehoover@lhc.ca.gov).

Reports

Research in Progress

Meetings

Legislation

Reorganization

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[Commission Reports](#)

**Study**

[Study Schedule](#)

**Agendas**

[February 4, 2016](#)

## AGENDA

Public Hearing on Occupational Licensing  
Thursday, February 4, 2016  
State Capitol, Room 437  
Sacramento

Click [here](#) to view archived CalChannel video coverage of the hearing.

*Written testimony is linked below.*

### **Public Hearing: 9:30 a.m.**

#### *Opening Remarks*

*The Economic Links Between Occupational Licensing, Employment, Wages, Prices, and the Quality and Availability of Services*

- [Morris Kleiner, Ph.D.](#), Professor, Humphrey School of Public Affairs, University of Minnesota

*The Impact of Occupational Licensing on Innovation, Entrepreneurship and Upward Mobility*

- [Dick Carpenter II, Ph.D.](#), Director of Strategic Research, Institute for Justice
- [Jason Wiens\\*](#), Policy Director in Research and Policy, Ewing Marion Kauffman Foundation

\*Mr. Wiens was unable to attend the hearing in person

#### *Protecting the Public Interest*

- [Robert Fellmeth](#), Executive Director, Center for Public Interest Law, University of San Diego

#### *Legislative Sunrise and Sunset Review*

- [Le Ondra Clark Harvey, Ph.D.](#), Chief Consultant, Assembly Committee on Business and Professions
- [Sarah Mason](#), Consultant, Senate Committee on Business, Professions and Economic Development

#### *Public Comment*



Testimony of Jason Wiens  
Policy Director  
Ewing Marion Kauffman Foundation

Before the  
Milton Marks "Little Hoover" Commission on California State Government  
Organization and Economy

*Occupational Licensing: A Looming Barrier to Entrepreneurship and Upward  
Mobility*  
February 4, 2016

Chairman Nava, Vice Chairman Kaye, and members of the Commission, thank you for the opportunity to testify about the importance of entrepreneurship and the barriers to new business formation caused by occupational licensing.

The Ewing Marion Kauffman Foundation is the world's largest private foundation dedicated to the study and promotion of entrepreneurship. Founded by the late entrepreneur and philanthropist Ewing Kauffman, the Kauffman Foundation is a nonpartisan foundation based in Kansas City, Missouri that aims to foster economic independence by advancing educational achievement and entrepreneurial success. At the Kauffman Foundation, we believe in the power of entrepreneurship to change individual lives and create economic opportunities for many others in society.

Entrepreneurship is an invaluable catalyst for economic growth, creating vibrant communities where opportunity abounds. There are a number of economic indicators pointing to the importance of entrepreneurship. Foremost is the role of new and young businesses in job creation. Nearly all net new jobs are created by new and young companies<sup>1</sup>. In 2013, new businesses created 2.29 million jobs in the United States<sup>2</sup>. In California, 53,731 new employer firms created more than 317,000 jobs that same year<sup>3</sup>.

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<sup>1</sup> John Haltiwanger, Ron S. Jarmin and Javier Miranda, "Who Creates Jobs? Small vs. Large vs. Young," *Review of Economics and Statistics*, 2013, at [http://www.mitpressjournals.org/doi/pdf/10.1162/REST\\_a\\_00288](http://www.mitpressjournals.org/doi/pdf/10.1162/REST_a_00288)

<sup>2</sup> Business Dynamics Statistics, United States Census Bureau, at [http://www.census.gov/ces/dataproducts/bds/data\\_firm.html](http://www.census.gov/ces/dataproducts/bds/data_firm.html)

<sup>3</sup> Ibid

Startups are also responsible for a disproportionate share of innovative activity, which raises living standards for all and pushes the boundaries of science, technology, and human knowledge<sup>4</sup>.

This is the good news of entrepreneurship. The bad news is that entrepreneurship, even high-growth entrepreneurship, has been in decline<sup>5</sup>, as epitomized by a slowdown in the usually high-powered technology industry.<sup>6</sup> Firm entry rates were lower, for example, between 2009 and 2011 than they were between 1978 and 1980 in every state<sup>7</sup>.

The Kauffman Index: Startup Activity is a measure of entrepreneurship that allows states to compare their entrepreneurial performance to others. The Index accounts for three factors: the annual rate of new entrepreneurs; the opportunity share of new entrepreneurs, which are those who were employed before starting their new ventures; and startup density, or the number of new employer businesses by total population in a given area. According to this measure, California ranked 14th out of 50 states in 2015. While this is better than most, California had been ranked nine spots higher in 2014<sup>8</sup>.

If one thing is clear from the data, it is that entrepreneurship cannot be taken for granted. The policy environment matters. Decisions by government officials at the federal, state, and local levels interact to create conditions that are either favorable to new business creation and growth or not. One public policy with particular effects on entrepreneurship is occupational licensing, which

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<sup>4</sup> Natarajan Balasubramanian and Jeongsik Lee, "Firm age and innovation," *Industrial and Corporate Change*, 2008, at [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1314522](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1314522); Jesper B. Sørensen and Toby E. Stuart, "Aging, obsolescence, and organizational innovation." *Administrative Science Quarterly*, 2000, at <http://www.jstor.org/stable/2666980>

<sup>5</sup> Ryan Decker, John Haltiwanger, Ron Jarmin and Javier Miranda, "The Secular Decline in Business Dynamism in the U.S.," Working Paper, 2014, at [http://econweb.umd.edu/~haltiwan/DHJM\\_6\\_2\\_2014.pdf](http://econweb.umd.edu/~haltiwan/DHJM_6_2_2014.pdf)

<sup>6</sup> John Haltiwanger, Ian Hathaway and Javier Miranda, "Declining Business Dynamism in the U.S. High-Technology Sector," The Kauffman Foundation, 2014, at: [http://www.kauffman.org/~media/kauffman\\_org/research%20reports%20and%20covers/2014/02/declining\\_business\\_dynamism\\_in\\_us\\_high\\_tech\\_sector.pdf](http://www.kauffman.org/~media/kauffman_org/research%20reports%20and%20covers/2014/02/declining_business_dynamism_in_us_high_tech_sector.pdf)

<sup>7</sup> Ian Hathaway and Bob Litan, "Declining Business Dynamism in the United States," Economic Studies at Brookings 2014, at [http://www.brookings.edu/~media/research/files/papers/2014/05/declining%20business%20dynamism%20litan/declining\\_business\\_dynamism\\_hathaway\\_litan.pdf](http://www.brookings.edu/~media/research/files/papers/2014/05/declining%20business%20dynamism%20litan/declining_business_dynamism_hathaway_litan.pdf)

<sup>8</sup> Arnobio Morelix, Robert Fairlie, Joshua Russell, and E.J. Reedy, "The 2015 Kauffman Index: Startup Activity, State Trends," The Kauffman Foundation, 2015, at [http://www.kauffman.org/~media/kauffman\\_org/research%20reports%20and%20covers/2015/05/kauffman\\_index\\_startup\\_activity\\_state\\_trends\\_2015.pdf](http://www.kauffman.org/~media/kauffman_org/research%20reports%20and%20covers/2015/05/kauffman_index_startup_activity_state_trends_2015.pdf)

creates barriers for would-be entrepreneurs and strengthens incumbent businesses.

The Kauffman Foundation was not the first to recognize the harmful effects licensing has on entrepreneurs, but we have worked to advance understanding of occupational licensing, build awareness about its effects, and educate policymakers about alternative strategies of occupational regulation that facilitate entrepreneurial entry and competition.

In 2012, we published “A License to Grow,” which details several state and federal barriers that can prevent innovative activity in industries like medicine and legal services. That same year, our “Startup Act for the States” report highlighted occupational licensing reform as one of several key issues for state governments to consider. In 2014, we funded a study by the Goldwater Institute that examined the effects of occupational licensing on low-income entrepreneurship. We are currently supporting research lead by Dr. Morris Kleiner at the University of Minnesota to develop a comprehensive database of state licenses and their requirements. We also are working with the Institute for Justice, which is planning several forums to discuss opportunities and options for state-level reform. Through these projects and others, we have refined our understanding of how occupational licensing restricts entrepreneurship.

### *Undesirable Effects of Licensing*

Put simply, occupational licensing fences out entrepreneurs. When states regulate the practice of an occupation through the imposition of a license, the license creates a barrier to entry into the occupation or business. This “fence” is not impermeable, but scaling it can be difficult. To enter a licensed profession, an applicant will commonly have to prove a minimum number of years of education or experience; pay initial licensing fees, which can exceed \$500; pass one or more exams; and be of good moral character and in good legal standing. Many licenses also require licensed professionals to engage in continuing education and pay renewal fees to maintain the license.

Once these requirements are met, the licensed enjoy the protection the “fence” provides them—mainly in terms of higher pay<sup>9</sup>. For this reason, licensing is most often sought by those in the occupation—not by the public or consumer interest groups concerned about ensuring public health and safety. Protected by

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<sup>9</sup> Morris Kleiner, “Occupational Licensing,” *Journal of Economic Perspectives*, 2000, at <http://pubs.aeaweb.org/doi/pdfplus/10.1257/jep.14.4.189>

the “fence,” the licensed can then control the supply of providers of the service and box out competition<sup>10</sup>.

In addition to limiting the number of individuals who can practice that occupation, occupational licensing also restricts how the occupation is practiced, and this limits business innovation.

Entrepreneurs are most successful when they create a new way of doing something or delivering a new product consumers want. This type of “out-of-the-box” thinking is precisely what occupational licensing discourages by mandating specific ways in which the work of an occupation is done. Low cost legal clinics and African hair-braiding are among the new types of services that have been hindered or disallowed because the licensing regulations dictate specific education and training to practice. In the case of an African hair-braider in Utah, she was prohibited from practicing without a valid cosmetology license, even though the cosmetology courses included little to no training for African hair-braiding<sup>11</sup>.

When entrepreneurs envision new ways to deliver a good or service but are restricted from doing so by license regulations, the economy as a whole suffers. For example, innovations in law and legal services have opened up new markets and providers for services like wills and trusts, but this expansion has not reached broader legal services due to licensing restrictions<sup>12</sup>.

As one scholar wrote, “in many fields, advances have resulted from the very ‘crackpots,’ ‘quacks,’ and ‘outsiders’ who have no standing in the profession and whom licensing seeks to eliminate.” According to this scholar, Thomas Edison could not be a licensed engineer under today’s guidelines and architectural greats like Mies van der Rohe and Frank Lloyd Wright would not qualify to sit for the architects’ examination<sup>13</sup>. One wonders what innovations society has missed because occupational licensing prohibited entrepreneurs from pursuing new ideas.

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<sup>10</sup> Morris Kleiner and Alan B Krueger, “Analyzing the Extent and Influence of Occupational Licensing on the Labor Market,” *Journal of Labor Economics*, 2013, at

<http://archive.hhh.umn.edu/people/mkleiner/pdf/Final.occ.licensing.JOLE.pdf>

<sup>11</sup> Jacob Goldstein, “So You Think You Can Be a Hair-Braider?,” *The New York Times*, 2012, at

<http://www.nytimes.com/2012/06/17/magazine/so-you-think-you-can-be-a-hair-braider.html>

<sup>12</sup> The White House “Occupational Licensing: A Framework for Policymakers,” 2015, at

[https://www.whitehouse.gov/sites/default/files/docs/licensing\\_report\\_final\\_nonembargo.pdf](https://www.whitehouse.gov/sites/default/files/docs/licensing_report_final_nonembargo.pdf)

<sup>13</sup> S. David Young, “Occupational Licensing,” *The Library of Economics and Liberty*, 2002, at

<http://www.econlib.org/library/Enc1/OccupationalLicensing.html>

The effects of occupational licensing do not end there. Licensing also can restrict upward economic mobility.

Entrepreneurship can function as a ladder, allowing individuals to climb upward to achieve greater economic security. Yet, for those of lesser means and education, licensing fees, the cost to obtain requisite training or coursework, and the time it takes to complete these requirements, may put a licensed job and greater financial security out of reach. Furthermore, character and legal standing requirements may block one avenue of upward mobility for those with a criminal record.

In a study of low-income entrepreneurship, research showed entrepreneurship dropped by 11 percent in states that licensed a high percentage (50 percent or more) of traditionally low-income occupations<sup>14</sup>.

Finally, because occupational licensing limits competition (i.e., by restricting the number of people who can perform the occupation), licensing increases consumer costs. Higher prices might be justified if they paid for higher quality, but studies have found little evidence that licensing enhances quality.

For example, an analysis of licensed interior designers in one state and certified interior designers in another state found no difference in the number of consumer complaints registered<sup>15</sup>. Another study documented higher rates of electrocution in states with the most restrictive licensing laws for electricians. In this instance, the licensing laws actually failed to have the intended effect and did not increase safety<sup>16</sup>.

### *Growth of Occupational Licensing*

These effects are amplified across the economy as more occupations are subject to licensure. Research shows an increase in the percentage of the

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<sup>14</sup> Steve Slivinski, "Bootstraps Tangled in Red Tape: How State Occupational Licensing Hinders Low-Income Entrepreneurship," Goldwater Institute, 2014, at <http://www.goldwaterinstitute.org/en/work/topics/free-enterprise/entrepreneurship/bootstraps-tangled-in-red-tape/>

<sup>15</sup> Dick Carpenter, "Regulation Through Titling Laws; A Case Study of Occupational Regulation," *Regulation and Governance Vol 2, Issue 3*, 2008, at <http://onlinelibrary.wiley.com/doi/10.1111/j.1748-5991.2008.00041.x/full>

<sup>16</sup> Morris Kleiner, "Stages of Occupational Regulation: Analysis of Case Studies," Upjohn Institute Kalamzoo, Michigan, 2013.

population that requires a license to practice, from 5 percent in the early 1950s to 29 percent of all American workers in 2009<sup>17</sup>.

The growth in licensing has two main sources—one benign, the other more harmful. Economic and demographic changes have contributed to the growth of some occupations that have long been subject to licensure. The number of registered nurses, for example, grew 24.1 percent from 2000 to 2010<sup>18</sup>. This natural growth in expanding sectors of the economy like health care and services contrasts with the other source of licensing growth: newly created state licenses.

The number of occupations subject to public occupational licensing is growing in absolute terms. Though no comprehensive dataset on licensing yet exists, anecdotal evidence confirms the push to subject occupations to licensure. Last year in the State of Missouri (where the Kauffman Foundation is located), at least three pieces of legislation were introduced in the General Assembly to create new occupational licenses<sup>19</sup>.

Government at all levels (federal, state, and local) is guilty, but most occupations are licensed by the states. Yet, there is little uniformity in what occupations are licensed and the requirements to obtain a license. Security alarm installers, for example, are licensed in 34 states, including California. The State of California requires these workers to pay a fee, pass an exam, and complete more than 900 days of education or training. Neighboring Nevada, however, has no education or training requirement for security alarm installers<sup>20</sup>. California licenses a number of occupations that are licensed in few states, including tree trimmers (seven other states), landscape workers (ten states), and dental assistants (seven states)<sup>21</sup>.

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<sup>17</sup> Morris Kleiner and Alan B Krueger, "Analyzing the Extent and Influence of Occupational Licensing on the Labor Market," *Journal of Labor Economics*, 2013, at [http://archive.hhh.umn.edu/people/mkleiner/pdf/Final\\_occ.licensing.JOLE.pdf](http://archive.hhh.umn.edu/people/mkleiner/pdf/Final_occ.licensing.JOLE.pdf)

<sup>18</sup> Health Resources and Management Association, "The U.S. Nursing Workforce; Trends in Supply and Education," 2013, at <http://bhpr.hrsa.gov/healthworkforce/reports/nursingworkforce/nursingworkforcefullreport.pdf>

<sup>19</sup> H. 109 to license advanced radiology practitioners or radiologic technologists:

<http://www.house.mo.gov/billsummary.aspx?bill=HB109&year=2015&code=R>;

S. 154 to license those practicing music therapy:

[http://www.senate.mo.gov/15info/BTS\\_Web/Bill.aspx?SessionType=R&BillID=216703](http://www.senate.mo.gov/15info/BTS_Web/Bill.aspx?SessionType=R&BillID=216703); and

S. 250 to license electrical contractors:

[http://www.senate.mo.gov/15info/BTS\\_Web/Bill.aspx?SessionType=R&BillID=1225934](http://www.senate.mo.gov/15info/BTS_Web/Bill.aspx?SessionType=R&BillID=1225934).

<sup>20</sup> Dick Carpenter, "License to Work: A National Study of Burdens from Occupational Licensing," 2012, at <http://licensetowork.ij.org/ca>.

<sup>21</sup> Ibid

### *Alternatives to Licensure*

Advocates for new occupational licensure frequently argue that licensure is needed to ensure quality and protect the public from unscrupulous, negligent, or dangerous providers. While this may be sufficient and legitimate reason to license some occupations, the case is harder to justify for others.

Policymakers are not faced with a binary choice—to license or not. Licensure is just one option among several forms of occupational regulation. Other forms of regulation can blunt the negative effects licensing has on entrepreneurship and economic mobility while still addressing concerns about public health and safety.

A less-restrictive form of regulation is certification, which allows any individual to perform the service but recognizes those who have achieved a certain level of competency with a certificate. Such a certificate can be issued by the state or a private organization. With certification, consumers have a choice as to whether they want to give their business to a provider with a certificate or not. In this way, certification increases competition, while at the same time opening the door to potential innovation in the practice of an occupation.

An even less restrictive form of regulation is registration, which requires professionals only to record their qualifications with the state. With a list of registered professionals, the state can exercise oversight of the occupation.

In some cases, no regulation may be justified and existing licenses, certificates, or registration requirements eliminated.

### *Evaluating New Requests for Licensure*

The question, then, for policymakers is how to evaluate both existing occupational regulation and new requests for licensure.

To begin, policymakers should assess whether public safety is or has been put at risk by unregulated practice of the occupation. Here, the experience of other states can be useful. While some occupations are licensed by all states, others are licensed only by a few. For example, California licenses travel agents while Texas does not. Has the public been harmed in Texas by unlicensed travel agents? The answer may shed light on the necessity of California's license.

For occupations licensed by multiple states, the requirements can be quite different. As mentioned previously, California is one of more than 30 states that license security alarm installers. To obtain that license in California, an individual

must complete more than 900 days of education or training. Yet, in Texas, only 733 days of education or training are required. And in Nevada, no education or training are required at all<sup>22</sup>. Do outcomes differ in these states with less rigorous education and training requirements?

If regulation of an occupation is deemed necessary, policymakers next have to decide on the appropriate level of regulation. Protecting public health and safety may be possible with a lesser form of regulation than licensing. The principle to abide by is to apply the appropriate protection at minimal burden. The lower and fewer barriers to entry, the better for entrepreneurship and economy of California.

Finally, states should consider whether there are other more valuable signals of quality than licensing, including online reviews from websites like Yelp and Angie's List. These are free to the state, popular with consumers, and can serve as a guide to assess quality.

#### *Making the System Better for Entrepreneurs*

To the extent policymakers value new business creation, innovation, economic mobility, and competition, they should reexamine the necessity of many licensing laws. We recommend the following:

1. Policymakers should eliminate onerous licensing requirements and replace them with less burdensome regulations, if regulation is necessary.
2. If elimination of licenses is politically unfeasible, policymakers should reduce the burdens imposed by licensure by lowering fees and scaling back education requirements to let more entrepreneurs in to facilitate competition and upward economic mobility.
3. Policymakers should resist calls from special interests and operate according to the maxim of "let entrepreneurs compete," recognizing the many benefits of entrepreneurship.
4. Policymakers should consider reforming licensing boards to give greater representation to non-licensed practitioners to protect against regulatory capture.

Thankfully, there is growing interest by conservatives and liberals in reforming occupational licensing laws. Those on the right may be drawn to the issue by their concern for economic liberty and a preference for competition.

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<sup>22</sup> Dick Carpenter, "License to Work: A National Study of Burdens from Occupational Licensing," 2012, at <http://licensetowork.ij.org/>

Those on the left may be motivated by concerns over wage inequality (which occupational licensing worsens), the burden higher prices place on low-income consumers, and opportunities for upward economic mobility. Whatever the motivation, opportunity exists for bipartisan consensus and action that can positively impact a range of constituents.

State governments in Idaho, Michigan, and Wisconsin have all realized the need to ease the burden licensing places on workers and entrepreneurs. Idaho's governor vetoed a bill last year that would have licensed sign-language interpreters. Michigan Governor Rick Snyder wrote a letter urging legislators to reconsider the licensing regime in the state. And Wisconsin lawmakers passed a bill last year that prevents local governments from establishing new licenses<sup>23</sup>.

Interest in reform has also come from the White House. Last year, the President's Council of Economic Advisors published a report laying out the different labor effects of occupational licensing and encouraging states to adjust their licensing policies to better accommodate growth.<sup>24</sup>

Even the U.S. Supreme Court has weighed in on the anti-competitive effects of occupational licensing. In *North Carolina Board of Dental Examiners v. Federal Trade Commission* the court found that the Board of Dental Examiners was not immune from antitrust laws because the state exercised insufficient oversight of the board, which was controlled by market participants.<sup>25</sup>

These are encouraging trends. But after decades of unchecked growth in occupational licensure, much work remains to be done. While potentially challenging, if done right, the list of benefits can be substantial, including greater opportunity for entrepreneurs to form businesses, create jobs, and innovate. As entrepreneurs achieve their dreams they advance up the economic ladder, enhance standards and quality of living, and provide new opportunities for those around them.

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<sup>23</sup> Eric Morath, "Anti-Licensing Movement Scores a Victory," *The Wall Street Journal*, 2015, at <http://www.wsj.com/articles/anti-licencing-movement-scores-a-victory-1447433906>

<sup>24</sup> The White House, "Occupational Licensing: A Framework for Policymakers" 2015, at [https://www.whitehouse.gov/sites/default/files/docs/licensing\\_report\\_final\\_nonembargo.pdf](https://www.whitehouse.gov/sites/default/files/docs/licensing_report_final_nonembargo.pdf)

<sup>25</sup> Brent Kendall "Supreme Court Affirms FTC Antitrust Authority Over Licensing Boards," *The Wall Street Journal*, 2015 at <http://www.wsj.com/articles/supreme-court-affirms-ftc-antitrust-authority-over-licensing-boards-1424881999>

# California's Bipartisan Push Against Occupational Licensing

## **Removing barriers to entrepreneurship for the poor.**

Steven Greenhut | Feb. 22, 2016 12:00 pm

In an election year, it's hard to imagine any substantive issue transcending the din of partisan bickering and resulting in meaningful proposals embraced by members of both parties. Yet such an issue is emerging in California. Many Democrats and Republicans are recognizing the role that overly restrictive "occupational-licensing laws" play in limiting opportunities for the poor, ex-convicts and veterans.

Licensing laws require barbers, contractors, interior designers and people in myriad lines of work to complete training and pass a test before legally plying their trade. It sounds reasonable at first given that everyone wants service providers to be competent in their chosen fields. Advocates argue the public's health and safety is at risk without such rules and regulations.

But the dirty secret of occupational licensing is these laws often are backed by lobbyists representing established businesses. Licensing requirements often have less to do with ensuring competence and more to do with imposing costly and time-consuming barriers that limit the competition. Costly licenses and education requirements push some professions out of reach for low-income people. Because licensing rules vary by state, it becomes tough for the spouses of veterans to gain licenses when they move to another base.

One highly publicized national example involves African hair braiders, who in some locales must spend hundreds of hours in a cosmetology program to be allowed to practice their trade—even though they may learn little that has anything to do with their particular skill. In those places, the government turns entrepreneurs who don't go through the long training into scofflaws.

California's Little Hoover Commission, an independent oversight agency, recently held a hearing in Sacramento to evaluate the situation. It eventually will make some recommendations to the Legislature. Panelists pointed to the myriad inconsistencies and counterproductive elements in California's array of occupational-licensing laws.

"In California, barbers and cosmetologists devote about one year to education or experience, and EMTs (emergency medical technicians) only one month," explained (in prepared testimony) panelist Dick Carpenter, of the libertarian Institute for Justice. "Comparisons like these lead one to question the public safety rationale underlying licensure of many occupations in our sample." California has some of the tightest restrictions in the country.

California legislators regularly propose bills that give state enforcement officials more power to fine and arrest people who are operating without a license. But this Little Hoover Commission effort recognizes that a big part of the problem is a regulatory regime that criminalizes people who are working and selling their services to willing buyers.

In his testimony, Professor Robert Fellmeth, of the University of San Diego School of Law, explained "there are some clearly necessary regulatory systems," but "a substantial portion" of California's occupational-related rules impose "unnecessary barriers to entry" and "limit entry but thereafter fail to provide an assurance of competence."

He pointed to a key problem: "Most trades have sophisticated lobbies at the state Capitol. ... These are the proponents of most of the regulatory boards within the (Department of Consumer Affairs) in particular; they have actively lobbied for licensing by boards whose membership and licensing fees... they control."

Advocates for such systems ask, "How else can the state assure that these practitioners know what they are doing?" Panelists brought up several alternative ways to police these industries. For instance, voluntary certifications are a successful means to assure that people comply with industry standards. The state wouldn't stop someone from operating—but the certification tells consumers of a certain level of training.

Market competition provides checks and balances, Carpenter added. He pointed to the information available today through Yelp, Angie's List and other websites. That's more useful than simply learning whether the company has a license. After I purchased a home, the insurer sent out an inspector who flagged a potential roof problem. I would lose my coverage by a certain date if I didn't fix it. This is a perfect example of private regulation. In a private system, though, I'm free to fix the problem or find an insurance company with different standards.

Additionally, as Carpenter added, the tort system exists to address "consumer harm." There are laws against fraud and deceptive trade practices. Some laws simply require inspections (such as building inspections) or people to carry insurance or be bonded. Legislators could also streamline and eliminate some of the current rules. Some other states have embraced

such reform.

California has the highest poverty rate in the nation, adjusted for the high cost of living. Instead of focusing solely on new welfare programs, the Legislature ought to eliminate barriers that poor people face as they seek jobs or try to start businesses. Reformers will face resistance from established interests, but maybe the Little Hoover effort will give them the courage they need to tackle this issue.

*This column originally appeared at the San Diego Union-Tribune*



**2015 CSRC Position Statement pertaining to Concurrent Therapy**  
**Approved by the CSRC Board of Directors on August 27th, 2015**

On any given day, literally millions of doses of bronchodilator drugs are administered to patients with reactive airways disease (RAD) in the United States. In the vast majority of cases, these doses are administered by laymen, and not licensed caregivers. The population of laymen to which we refer here is patients themselves. And, in the vast majority of those cases, the device used to mobilize the particulate bronchodilator to the airways is the metered-dose inhaler (“MDI”). This method of delivery is consummately appropriate, insofar as the bronchodilator agents delivered are administered to/by patients whose RAD is stable.

Similarly, bronchodilator agents are commonly administered to hospitalized patients whose RAD is stable. The stability of their RAD is traceable to the fact that: 1) the presumptive diagnosis to which the hospitalization is attributable is a co-morbid condition other than RAD itself (congestive heart failure, sepsis, diabetes, cardiac dysrhythmias, trauma, etc); or 2) the acute exacerbation of RAD initially responsible for the patient’s admission has been successfully managed to the point that the now-stable patient is being prepared for discharge. In the context of the patients described above, the incidence of serious side effects in the wake of MDI use is virtually zero. Consequently, outpatients receive MDI treatments without being monitored by a caregiver, while their inpatient counterparts will either self-administer the drugs without being monitored, or will receive the MDI dose while being observed by a “med nurse”. If and when the MDI is employed by an inpatient in the presence of a nurse, no charge will be incurred by the patient or third-party payor, because nursing care is considered an integral component of inpatient care.

In the balance of this Position Statement, however, we will direct our attention to the delivery of aerosolized adrenergic beta<sub>2</sub>-agonist and/or aerosolized cholinergic agents to patients with RAD whose condition is not stable. Physicians typically wish to deliver higher doses of adrenergic and/or cholinergic agents to patients with exacerbated RAD than is practical by means of an MDI, such that a small-volume nebulizer (SVN) is usually employed, under the watchful eye of a respiratory care practitioner (RCP). It is prudent to employ an SVN in lieu of an MDI here, inasmuch as the former device is capable of delivering a far higher dose of pharmacologic agent(s) than is the latter. Consequently, bronchodilators delivered by SVN are far more likely to elicit: 1) symptom relief; and 2) side effects. This renders the presence of an RCP during the delivery of the drug(s) highly advisable, in order to assess the efficacy of the agent(s) and to be alert to the possible emergence of adverse side effects. In the event that the inpatient in question is a beneficiary of Medicare or Medicaid, the Centers for Medicare and Medicaid Services (CMS) does authorize the institutional care provider to submit a charge for the RCP’s services.



Concurrent Therapy, also termed “stacking”, is a practice whereby an RCP initiates an aerosol treatment for a patient and immediately proceeds to initiate one or more subsequent treatments to additional patients in succession before the initial treatment is complete. The practice of stacking, therefore, robs the individual patient of the scrutiny that would be afforded that patient had the RCP remained at the bedside for the entire duration of the treatment. This is problematic for two reasons. First and foremost, the absence of the RCP ensures that any adverse side effect(s) which might emerge will go unnoticed, with potentially dire consequences. Secondly, CMS recognizes that the aerosol treatment “...is not being delivered according to Medicare coverage guidelines: that is, the therapy is not being provided individually.”<sup>1</sup> If the recipient of the treatment is a Medicare/Medicaid beneficiary, submission of a charge for the treatment could be considered to constitute Medicare fraud.

In a previous Position Statement, the California Society for Respiratory Care (CSRC), in the wake of comprehensive research into the issue of Concurrent Therapy, concluded that “....aside from declared disaster, there is no compelling medical, ethical, or safety rationale for the continuation of this practice” and “....takes the position that [it] should be abandoned....in the interests of patient safety, interventional efficacy, and the ethical practice of Respiratory Therapy.”<sup>1</sup>

California’s Respiratory Care Board (RCB) also inveighed against the practice of stacking in a strongly-worded statement in 2003 that reads, in part, “....we would strongly discourage any organization from adopting a policy which leaves patients unattended for administration of medication” because it “....would be contradictory to safe practice”.<sup>2</sup>

It is understood and acknowledged that the dose response curves of bronchodilator aerosols typically require that two to five minutes elapse between the initial inhalation of that aerosol and the actual onset of salutary (as well as adverse) effects. Certain technological advances have emerged since the CSRC’s Position Statement was issued in 2007, most notably the development of the breath-actuated nebulizer (BAN), the waste-reducing nebulizer (WRN), and the vibrating mesh nebulizer (VMN). The BAN and the WRN incur far less wastage of aerosol than is observed with a conventional (“Tee-type”) nebulizer, and also deliver a higher dose of drug than their Tee-type counterparts within a shorter timeframe.<sup>3</sup> The VMN is another new category of aerosol device that elaborates an entire (three-milliliter) dose of aqueous solution within a six-minute time window.<sup>4</sup> Hence, the duration of therapy with a BAN, a WRN, or a VMN, although far shorter than the fifteen-to-twenty-minute duration of therapy



*-Position Statement on Concurrent Therapy-*

*page 3 of 4*

required when using conventional SVN's, is still sufficiently long to enable the RCP to detect adverse side effects while s/he is still at the patient's bedside.

Finally, it is recognized that the RCP's ability to deliver a quantitatively enhanced dose of aerosolized bronchodilator within an abbreviated time window through the use of any technologically advanced nebulizer has largely removed the fundamental motive that led some respiratory care departments to resort to stacking in the past. Stated another way, departments that have invested in these newer technologies enable their therapists to deliver more treatments, and more effective (higher-dose) treatments, during a given shift than was possible in the past. The convergence of these events will, it is hoped, result in the abandonment of stacking once and for all. This view is echoed in a clear and unambiguous Position Statement recently published by the Oklahoma Board of Medical Licensure and Supervision.<sup>5</sup>

It should also be noted that the development of the Uniform Reporting Manual by the American Association for Respiratory Care (AARC) has provided managers with a tool for implementation of a time-based standard for workload determination. Use of unweighted metrics of workloads may lead to inaccurate staffing assessments and result in underestimating the number of staff needed. In addition, the use of appropriate evidence-based assessment-driven protocols helps to reduce the incidence of misallocation of therapies, which can adversely impact workloads and render the use of concurrent therapy more probable.

It must also be recognized that the AARC enunciated their strong opposition to Concurrent Therapy in a White Paper<sup>6</sup>, the full text of which can be accessed from the CSRC website: [www.csrc.org/page-1211546](http://www.csrc.org/page-1211546)

Finally, the Centers for Medicare and Medicaid Services (CMS) have suggested that, because stacking robs the RCP of the ability to focus her/his full attention on the patient, "...it is unlikely that the services being delivered are at the complex skill level required for coverage by Medicare."<sup>7</sup> This unambiguous and unequivocal language renders it highly likely that a care provider that submitted a claim for a Medicare/Medicaid client who received a "stacked" treatment would be subject to the full range of penalties provided in connection with Medicare fraud.



In summary, then, it is the position of the California Society for Respiratory Care to advocate for safe practice and quality care, and to denounce the practice of concurrent therapy as unethical, unsafe, and unconscionable.

## References

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7. Federal Register, HCFA Proposed Rules. 23983-24036 [01-11560], May 10, 2001, Vol.. 66, No. 91, [http://www.access.gpo.gov/su\\_docs/fedreg/a010510c.html](http://www.access.gpo.gov/su_docs/fedreg/a010510c.html)

## 2016 LEGISLATION OF INTEREST

### SENATE BILL 66 (LEYVA - D & MCGUIRE - D)

Title: Career Technical Education  
Introduced: January 17, 2015 / Last Amended: January 14, 2016  
Status: January 27, 2016 - In Assembly, pending referral

Existing law establishes various career technical education programs, including regional occupational centers and programs, specialized secondary programs, partnership academies, and agricultural career technical education programs. Existing law provides for numerous boards, bureaus, commissions, or programs within the Department of Consumer Affairs that administer the licensing and regulation of various businesses and professions.

This bill would require the department to make available, only to the extent specified, to the Office of the Chancellor of the California Community Colleges, any licensure information that the department has in electronic format for its boards, bureaus, commissions, or programs for the sole purpose of enabling the office of the chancellor to measure employment outcomes of students who participate in career technical education programs offered by the California Community Colleges and recommend how these programs may be improved.

Existing law requires the Chancellor of the California Community Colleges to implement performance accountability outcome measures for the California Community Colleges Economic and Workforce Development Program.

This bill would urge the chancellor to align these measures with the performance accountability measures of the federal Workforce Innovation and Opportunity Act.

Staff Recommended Position: **WATCH**

### SENATE BILL 547 (LIU - D)

Title: Aging and long term care services, supports, and program coordination  
Introduced: February 26, 2015 / Last Amended: January 26, 2016  
Status: January 27, 2016 - In Assembly, pending referral

Existing law establishes the California Health and Human Services Agency consisting of the Departments of Aging, Child Support services, Community Services and Development, Developmental Services, Health Care Services, Managed Health Care, Public Health, Rehabilitation, Social Services, and State Hospitals. Existing law sets forth legislative findings and declarations regarding long-term care services, including that consumers of those services experience great differences in service levels, eligibility criteria, and service availability that often result in inappropriate and expensive care that is not responsive to individual needs. Those findings and declarations also state that the laws governing long-term care facilities have established an uncoordinated array of long-term care services that are funded and administered by a state structure that lacks necessary integration and focus.

This bill, among other things, would create the Statewide Aging and Long-Term Care Services Coordinating Council, chaired by the Secretary of California Health and Human Services, and would consist of the heads, or their designated representative, of specified departments and offices. The secretary would have specified responsibilities, including, but not limited to, leading the council in the development and implementation of a state aging and long-term care services strategic plan to address how the state will meet the needs of the aging population in the years 2020, 2025, and 2030. The bill would require the strategic plan to be submitted to the Secretary of the Senate, the Chief Clerk of the Assembly, and the chairs of specified policy and fiscal committees of the Legislature by July 1, 2018.

Staff Recommended Position: **WATCH**

## SENATE BILL 1155 (Morrell - R)

Title: Professions and vocation: licenses: military service  
Introduced: February 18, 2016  
Status: February 19, 2016 - May be acted upon on or after March 20, 2016

Existing law authorizes any DCA licensee whose license expired while he or she was on active duty as a member of the California National Guard or the United States Armed Forces to reinstate his or her license without examination or penalty if certain requirements are met. Existing law also requires the boards to waive the renewal fees, continuing education requirements, and other renewal requirements, if applicable, of any licensee called to active duty, if certain requirements are met. Existing law requires each board to inquire in every application if the individual applying for licensure is serving in, or has previously served in, the military. Existing law, on and after July 1, 2016, requires a board within DCA to expedite, and authorizes a board to assist, the initial licensure process for an applicant who has served as an active duty member and was honorably discharged.

This bill would require the DCA, in consultation with the Department of Veterans Affairs and the Military Department, to establish and maintain a program that grants a fee waiver for the application for and the issuance of an initial license to an individual who is an honorably discharged veteran, as specified.

Staff Recommended Position: **SUPPORT**

## SENATE BILL 1334 (Stone - R)

Title: Crime reporting: healthcare practitioners: human trafficking  
Introduced: February 19, 2016  
Status: February 22, 2016 - May be acted upon on or after March 23

Existing law requires a health practitioner, as specified, who, in his or her professional capacity or within the scope of his or her employment, provides medical services to a patient who he or she knows, or reasonably suspects, has suffered from a wound or other physical injury where the injury is by means of a firearm or is the result of assaultive or abusive conduct, to make a report to a law enforcement agency, as specified. Existing law defines "assaultive or abusive conduct" for these purposes as a violation of specified crimes. Under existing law, a violation of this provision is a crime.

This bill would add the crime of human trafficking to the list of crimes that constitute assaultive or abusive conduct for purposes of the above reporting requirements. By increasing the scope of an existing crime, this bill would impose a state-mandated local program.

Staff Recommended Position: **WATCH**

## SENATE BILL 1348 (Cannella - R)

Title: Licensure applications: military experience  
Introduced: February 19, 2016  
Status: February 22, 2016 - May be acted upon on or after March 23

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs. Existing law requires each board to inquire in every application for licensure if the individual applying for licensure is serving in, or has previously served in, the military.

This bill would require each board, with a governing law authorizing veterans to apply military experience and training towards licensure requirements, to modify their application for licensure to advise veteran applicants about their ability to apply that experience and training towards licensure requirements.

Staff Recommended Position: **WATCH**

## ASSEMBLY BILL 1939 (Patterson - R)

Title: Licensing Requirements  
Introduced: February 12, 2016  
Status: February 25, 2016 - Referred to Assembly Business & Professions Committee

Under existing law, the Department of Consumer Affairs is comprised of various boards, bureaus, commissions, committees, and similarly constituted agencies that license and regulate the practice of various professions and vocations for the purpose of protecting the people of California. Existing law requires each of these entities to submit annually to the director of the department its methods for ensuring that every licensing examination it administers is subject to periodic evaluation.

This bill would required the director of the Department of Consumer Affairs to conduct a study and submit to the Legislature by July 1, 1017, a report identifying, exploring, and addressing occupational licensing requirements that create unnecessary barriers to labor market entry or mobility.

Staff Recommended Position: **WATCH**

## ASSEMBLY BILL 2079 (Calderon - D)

Title: Skilled nursing facilities: staffing.  
Introduced: February 17, 2016  
Status: February 19, 2016 - May be heard in committee after March 19

(1) Existing law provides for the licensure and regulation by the State Department of Public Health of health facilities, including skilled nursing facilities. Existing law requires the department to develop regulations that become effective August 1, 2003, that establish staff-to-patient ratios for direct caregivers working in a skilled nursing facility. Existing law requires that these ratios include separate licensed nurse staff-to-patient ratios in addition to the ratios established for other direct caregivers. Existing law also requires every skilled nursing facility to post information about staffing levels in the manner specified by federal requirements. Existing law makes it a misdemeanor for any person to willfully or repeatedly violate these provisions. This bill would require the department to develop regulations that become effective July 1, 2017, and include a minimum overall staff-to-patient ratio that includes specific staff-to-patient ratios for certified nurse assistants and for licensed nurses that comply with specified requirements. The bill would require the posted information to include a resident census and an accurate report of the number of staff working each shift and to be posted in specified locations, including an area used for employee breaks. The bill would require a skilled nursing facility to make staffing data available, upon oral or written request and at a reasonable cost, within 15 days of receiving a request.

(2) Existing law generally requires that skilled nursing facilities have a minimum number of nursing hours per patient day of 3.2 hours. This bill would substitute the term “direct care service hours” for the term “nursing hours” and, commencing July 1, 2017, except as specified, increase the minimum number of direct care service hours per patient day to 4.1 hours.

(3) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law, the Medi-Cal Long-Term Care Reimbursement Act, operative until August 1, 2020, requires the department to make a supplemental payment to skilled nursing facilities based on specified criteria and according to performance measure benchmarks. Existing law requires the department to establish and publish quality and accountability measures, which are used to determine supplemental payments. Existing law requires, beginning in the 2011–12 fiscal year, the measures to include, among others, compliance with specified nursing hours per patient per day requirements. This bill would also require, beginning in the 2017–18 fiscal year, the measures to include compliance with specified direct care service hour requirements for skilled nursing facilities.

Staff Recommended Position: **SUPPORT IF AMENDED**

## ASSEMBLY BILL 2606 (Grove - R)

Title: Crimes against children, elders, dependent adults, and persons with disabilities.  
Introduced: February 19, 2016  
Status: February 21, 2016 - May be heard in committee March 22

The Child Abuse and Neglect Reporting Act requires a law enforcement agency that receives a report of child abuse to report to an appropriate licensing agency every known or suspected instance of child abuse or neglect that occurs while the child is being cared for in a child day care facility or community care facility or that involves a licensed staff person of the facility. Existing law proscribes the commission of certain crimes against elders and dependent adults, including, but not limited to, inflicting upon an elder or dependent adult unjustifiable physical pain or mental suffering, as specified. Existing law proscribes the commission of a hate crime, as defined, against certain categories of persons, including disabled persons. Existing law provides for the licensure of various healing arts professionals, and specifies that the commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action against the licensee. Existing law also establishes that the crime of sexual exploitation by a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor has occurred when the licensee engages in specified sexual acts with a patient, client, or former patient or client.

This bill would require, if a law enforcement agency receives a report, or if a law enforcement officer makes a report, that a person who holds a state professional or occupational credential, license, or permit that allows the person to provide services to children, elders, dependent adults, or persons with disabilities is alleged to have committed one or more of specified crimes, the law enforcement agency to promptly send a copy of the report to the state licensing agency that issued the credential, license, or permit.

Staff Recommended Position: **SUPPORT**

## ASSEMBLY BILL 2701 (Jones - R)

Title: Department of Consumer Affairs: boards: training requirements  
Introduced: February 19, 2016  
Status: February 21, 2016 - May be heard in committee March 22

Existing law provides for the licensure and regulation of various professions and vocations by various boards, as defined, within the Department of Consumer Affairs, and provides for the membership of those various boards. Existing law requires newly appointed board members, within one year of assuming office, to complete a training and orientation offered by the department regarding, among other things, the obligations of the board member. Existing law requires the department to adopt regulations necessary to establish the training and orientation program and its contents. The Bagley-Keene Open Meeting Act (Bagley-Keene Act) generally requires, with specified exceptions for authorized closed sessions, that the meetings of state bodies be open and public and that all persons be permitted to attend. The Administrative Procedure Act governs the procedure for the adoption, amendment, or repeal of regulations by state agencies, and for the review of those regulatory actions by the Office of Administrative Law. Existing law requires every agency to adopt and promulgate a Conflict of Interest Code that contains, among other requirements, the circumstances under which designated employees or categories of designated employees must disqualify themselves from making, participating in the making, or using their official position to influence the making of, any decision.

This bill would additionally require the training of new board members to include, but not be limited to, information regarding the requirements of the Bagley-Keene Act, the Administrative Procedure Act, the Office of Administrative Law, and the department's Conflict of Interest Code.

Staff Recommended Position: **WATCH**

AMENDED IN SENATE JANUARY 14, 2016

AMENDED IN SENATE JANUARY 4, 2016

**SENATE BILL**

**No. 66**

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**Introduced by ~~Senator~~ *Senators Leyva and McGuire***

January 7, 2015

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An act to add Section 463 to the Business and Professions Code, and to amend ~~Sections 69439 and~~ *Section* 88650 of the Education Code, relating to career technical education.

LEGISLATIVE COUNSEL'S DIGEST

SB 66, as amended, Leyva. Career technical education.

(1) Existing law establishes various career technical education programs, including regional occupational centers and programs, specialized secondary programs, partnership academies, and agricultural career technical education programs. Existing law provides for numerous boards, bureaus, commissions, or programs within the Department of Consumer Affairs that administer the licensing and regulation of various businesses and professions.

This bill would require the department to make ~~available~~ *available, only to the extent specified*, to the Office of the Chancellor of the California Community ~~Colleges~~ *Colleges*, any licensure information that the department has in electronic format for its boards, bureaus, commissions, or programs ~~to enable~~ *for the sole purpose of enabling* the office of the chancellor to measure employment outcomes of students who participate in career technical education programs offered by the California Community Colleges and recommend how these programs may be improved.

~~(2) The Cal Grant Program establishes Cal Grant C awards, which may be used only for occupational or technical training in a course of~~

~~not less than 4 months, under the administration of the Student Aid Commission. Existing law requires the maximum award amount and the total amount of funding for Cal Grant C awards to be determined each year in the annual Budget Act.~~

~~Unless adjusted in the annual Budget Act, this bill would set the maximum Cal Grant C award amount for tuition and fees at \$2,462 and for access costs at \$3,000.~~

(3)

(2) Existing law requires the Chancellor of the California Community Colleges to implement performance accountability outcome measures for the California Community Colleges Economic and Workforce Development Program.

This bill would urge the chancellor to align these measures with the performance accountability measures of the federal Workforce Innovation and Opportunity Act.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: no.

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

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

3 (a) The economic competitiveness of California is fueled by the  
4 strength of regional economies and their skilled workers. Upward  
5 social and economic mobility and increased opportunities keep  
6 the state's economy diversified and vibrant.

7 (b) The pathway out of poverty for millions of California  
8 residents is the attainment of industry-valued "middle skill  
9 credentials," which is defined as a job requiring a certificate,  
10 associate's degree, or third-party credential that is less advanced  
11 than a bachelor's degree, but more advanced than a high school  
12 diploma.

13 (c) Middle skill credentials serve as the gateway for a large  
14 number of careers in the state's prioritized and emergent industry  
15 sectors.

16 (d) The California Community Colleges Board of Governor's  
17 Task Force on Workforce, Job Creation, and a Strong Economy,  
18 also referred to as the Strong Workforce Task Force, identified 25  
19 policy and strategy recommendations to help close the gap on these  
20 middle skill credentials.

1 (e) The recommendations built upon the foundation established  
2 by the California Community Colleges Economic and Workforce  
3 Development Program in Part 52.5 (commencing with Section  
4 88600) of Division 7 of Title 3 of the Education Code, the Office  
5 of the Chancellor of the California Community Colleges Doing  
6 What MATTERS for Jobs and the Economy framework, and the  
7 federal Workforce Innovation and Opportunities Act (Public Law  
8 113-128).

9 (f) With the enactment of the federal Workforce Innovation and  
10 Opportunity Act (Public Law 113-128), California agencies  
11 receiving workforce-related funds have adopted the following  
12 common program strategies articulated by the California Workforce  
13 Investment Board:

14 (1) Partnering in sector strategies to ensure training programs  
15 are relevant to the economy.

16 (2) Building career pathways to increase access, flexibility, and  
17 facilitated navigation of training and education programs.

18 (3) Utilizing “earn and learn” to increase simultaneous access  
19 to income and training for those who cannot afford full-time  
20 education.

21 (4) Organizing regionally to benefit from economies of scale,  
22 recognizing gains when labor markets and industry are organized  
23 regionally.

24 (5) Providing supportive services to remove barriers to program  
25 completion and employment.

26 (6) Creating cross-system data capacity to ensure effective use  
27 of resources.

28 (7) Integrating service delivery and braiding of resources to  
29 optimize limited resources and make use of program specializations  
30 to better serve individuals.

31 SEC. 2. Section 463 is added to the Business and Professions  
32 Code, to read:

33 463. (a) The department shall make available to the Office of  
34 the Chancellor of the California Community Colleges any licensure  
35 information that the department has in electronic format for its  
36 boards, bureaus, commissions, or programs to enable the office of  
37 the chancellor to measure employment outcomes of students who  
38 participate in career technical education programs offered by the  
39 California Community Colleges and recommend how these  
40 programs may be improved. *Licensure information made available*

1 *by the department pursuant to this section shall not be used for*  
2 *any other purpose.*

3 (b) ~~The department may make available confidential information~~  
4 ~~pursuant to subdivision (a) only to the extent that making the~~  
5 ~~information available is in compliance~~ *complies* with state and  
6 federal privacy laws.

7 (c) *The department may, by agreement, condition or limit the*  
8 *availability of licensure information pursuant to subdivision (a)*  
9 *in order to ensure the security of the information and to protect*  
10 *the privacy rights of the individuals to whom the information*  
11 *pertains.*

12 (d) *All of the following apply to the licensure information made*  
13 *available pursuant to subdivision (a):*

14 (1) *It shall be limited to only the information necessary to*  
15 *accomplish the purpose authorized in subdivision (a).*

16 (2) *It shall not be used in a manner that permits third parties*  
17 *to personally identify the individual or individuals to whom the*  
18 *information pertains.*

19 (3) *Except as provided in subdivision (e), it shall not be shared*  
20 *with or transmitted to any other party or entity without the consent*  
21 *of the individual or individuals to whom the information pertains.*

22 (4) *It shall be protected by reasonable security procedures and*  
23 *practices appropriate to the nature of the information to protect*  
24 *that information from unauthorized access, destruction, use,*  
25 *modification, or disclosure.*

26 (5) *It shall be immediately and securely destroyed when no*  
27 *longer needed for the purpose authorized in subdivision (a).*

28 (e) *The department or the Office of the Chancellor of the*  
29 *California Community Colleges may share licensure information*  
30 *with a third party who contracts to perform the function authorized*  
31 *in subdivision (a), if the third party is required by contract to*  
32 *follow the requirements of this section.*

33 ~~SEC. 3. Section 69439 of the Education Code is amended to~~  
34 ~~read:~~

35 ~~69439. (a) For the purposes of this section, the following terms~~  
36 ~~have the following meanings:~~

37 (1) ~~“Career pathway” has the same meaning as set forth in~~  
38 ~~Section 88620.~~

39 (2) ~~“Economic security” has the same meaning as set forth in~~  
40 ~~Section 14005 of the Unemployment Insurance Code.~~

1 (3) “Industry cluster” has the same meaning as set forth in  
2 Section 88620.

3 (4) “Long-term unemployed” means, with respect to an award  
4 applicant, a person who has been unemployed for more than 26  
5 weeks at the time of submission to the commission of his or her  
6 application.

7 (5) “Occupational or technical training” means that phase of  
8 education coming after the completion of a secondary school  
9 program and leading toward recognized occupational goals  
10 approved by the commission.

11 (b) A Cal Grant C award shall be utilized only for occupational  
12 or technical training in a course of not less than four months. There  
13 shall be the same number of Cal Grant C awards each year as were  
14 made in the 2000–01 fiscal year. The total amount of funding shall  
15 be determined each year in the annual Budget Act and the  
16 maximum award amount shall be in accordance with the following:

17 (1) The maximum amount of an annual Cal Grant C award for  
18 tuition and fees shall not exceed two thousand four hundred  
19 sixty-two dollars (\$2,462).

20 (2) The maximum amount of an annual Cal Grant C award for  
21 access costs shall not exceed three thousand dollars (\$3,000).

22 (3) The maximum amount of a Cal Grant C award pursuant to  
23 paragraphs (1) and (2) may be adjusted in the annual Budget Act.

24 (e) The commission may use criteria it deems appropriate in  
25 selecting students to receive grants for occupational or technical  
26 training and shall give special consideration to the social and  
27 economic situations of the students applying for these grants, giving  
28 additional weight to disadvantaged applicants, applicants who face  
29 economic hardship, and applicants who face particular barriers to  
30 employment. Criteria to be considered for these purposes shall  
31 include, but are not limited to, all of the following:

32 (1) Family income and household size.

33 (2) Student’s or the students’ parent’s household status,  
34 including whether the student is a single parent or child of a single  
35 parent.

36 (3) The employment status of the applicant and whether the  
37 applicant is unemployed, giving greater weight to the long-term  
38 unemployed.

39 (d) The Cal Grant C award recipients shall be eligible for  
40 renewal of their grants until they have completed their occupational

1 or technical training in conformance with terms prescribed by the  
2 commission. A determination by the commission for a subsequent  
3 award year that the program under which a Cal Grant C award was  
4 initially awarded is no longer deemed to receive priority shall not  
5 affect an award recipient's renewal. In no case shall the grants  
6 exceed two calendar years.

7 (e) Cal Grant C awards may be used for access costs, as defined  
8 in subdivision (b) of Section 69432.7, and training-related costs,  
9 such as special clothing, required tools and equipment, and  
10 institutional charges. In determining the individual award amounts,  
11 the commission shall take into account the financial means  
12 available to the student to fund his or her course of study and costs  
13 of attendance as well as other state and federal programs available  
14 to the applicant.

15 (f) (1) To ensure alignment with the state's dynamic economic  
16 needs, the commission, in consultation with appropriate state and  
17 federal agencies, including the Economic and Workforce  
18 Development Division of the Office of the Chancellor of the  
19 California Community Colleges and the California Workforce  
20 Investment Board, shall identify areas of occupational and technical  
21 training for which students may utilize Cal Grant C awards. The  
22 commission, to the extent feasible, shall also consult with  
23 representatives of the state's leading competitive and emerging  
24 industry clusters, workforce professionals, and career technical  
25 educators, to determine which occupational training programs and  
26 industry clusters should be prioritized.

27 (2) (A) Except as provided in subparagraph (B), the areas of  
28 occupational and technical training developed pursuant to  
29 paragraph (1) shall be regularly reviewed and updated at least  
30 every five years, beginning in 2012.

31 (B) By January 1, 2016, the commission shall update the priority  
32 areas of occupational and technical training.

33 (3) (A) The commission shall give priority in granting Cal  
34 Grant C awards to students pursuing occupational or technical  
35 training in areas that meet two of the following criteria pertaining  
36 to job quality:

37 (i) High employer need or demand for the specific skills offered  
38 in the program.

39 (ii) High employment growth in the occupational field or  
40 industry cluster for which the student is being trained.

1 (iii) High employment salary and wage projections for workers  
2 employed in the occupations for which they are being trained.

3 (iv) The occupation or training program is part of a  
4 well-articulated career pathway to a job providing economic  
5 security.

6 (B) To receive priority pursuant to subparagraph (A), at least  
7 one of the criteria met shall be specified in clause (iii) or (iv) of  
8 that subparagraph.

9 (g) The commission shall determine areas of occupational or  
10 technical training that meet the criteria described in paragraph (3)  
11 of subdivision (f) in consultation with the Employment  
12 Development Department, the Economic and Workforce  
13 Development Division of the Office of the Chancellor of the  
14 California Community Colleges, and the California Workforce  
15 Investment Board using projections available through the Labor  
16 Market Information Data Library. The commission may supplement  
17 the analyses of the Employment Development Department's Labor  
18 Market Information Data Library with the labor market analyses  
19 developed by the Economic and Workforce Development Division  
20 of the Office of the Chancellor of the California Community  
21 Colleges and the California Workforce Investment Board, as well  
22 as the projections of occupational shortages and skills gap  
23 developed by industry leaders. The commission shall publish, and  
24 retain, on its Internet Web site a current list of the areas of  
25 occupational or technical training that meet the criteria described  
26 in paragraph (3) of subdivision (f), and update this list as necessary.

27 (h) Using the best available data, the commission shall examine  
28 the graduation rates and job placement data, or salary data, of  
29 eligible programs. Commencing with the 2014-15 academic year,  
30 the commission shall give priority to Cal Grant C award applicants  
31 seeking to enroll in programs that rate high in graduation rates and  
32 job placement data, or salary data.

33 (i) (1) The commission shall consult with the Employment  
34 Development Department, the Office of the Chancellor of the  
35 California Community Colleges, the California Workforce  
36 Investment Board, and the local workforce investment boards to  
37 develop a plan to publicize the existence of the grant award  
38 program to California's long-term unemployed to be used by those  
39 consulting agencies when they come in contact with members of  
40 the population who are likely to be experiencing long-term

1 unemployment. The outreach plan shall use existing administrative  
2 and service delivery processes making use of existing points of  
3 contact with the long-term unemployed. The local workforce  
4 investment boards are required to participate only to the extent  
5 that the outreach efforts are a part of their existing responsibilities  
6 under the federal Workforce Investment Act of 1998 (Public Law  
7 105-220).

8 (2) The commission shall consult with the Workforce Services  
9 Branch of the Employment Development Department, the Office  
10 of the Chancellor of the California Community Colleges, the  
11 California Workforce Investment Board, and the local workforce  
12 investment boards to develop a plan to make students receiving  
13 awards aware of job search and placement services available  
14 through the Employment Development Department and the local  
15 workforce investment boards. Outreach shall use existing  
16 administrative and service delivery processes making use of  
17 existing points of contact with the students. The local workforce  
18 investment boards are required to participate only to the extent  
19 that the outreach efforts are a part of their existing responsibilities  
20 under the federal Workforce Investment Act of 1998 (Public Law  
21 105-220).

22 (j) (1) Notwithstanding Section 10231.5 of the Government  
23 Code, the Legislative Analyst's Office shall submit a report to the  
24 Legislature on the outcomes of the Cal Grant C program on or  
25 before April 1, 2015, and on or before April 1 of each  
26 odd-numbered year thereafter. This report shall include, but not  
27 necessarily be limited to, information on all of the following:

28 (A) The age, gender, and segment of attendance for recipients  
29 in two prior award years.

30 (B) The occupational and technical training program categories  
31 prioritized.

32 (C) The number and percentage of students who received  
33 selection priority as defined in paragraph (3) of subdivision (f).

34 (D) The extent to which recipients in these award years were  
35 successfully placed in jobs that meet local, regional, or state  
36 workforce needs.

37 (2) For the report due on or before April 1, 2015, the Legislative  
38 Analyst's Office shall include data for two additional prior award  
39 years and shall compare the mix of occupational and technical  
40 training programs and institutions in which Cal Grant C award

1 recipients enrolled before and after implementation of subdivision  
2 (f):

3 ~~(3) A report to be submitted pursuant to this subdivision shall~~  
4 ~~be submitted in compliance with Section 9795 of the Government~~  
5 ~~Code.~~

6 ~~SEC. 4.~~

7 *SEC. 3.* Section 88650 of the Education Code is amended to  
8 read:

9 88650. (a) The chancellor shall implement performance  
10 accountability outcome measures for the economic and workplace  
11 development program that provide the Governor, Legislature, and  
12 general public with information that quantifies employer and  
13 student outcomes for those participating in the program. These  
14 performance accountability measures should, to the extent possible,  
15 align with the performance accountability measures of the federal  
16 Workforce Innovation and Opportunity Act (Public Law 113-128).

17 (b) The chancellor shall submit a report to the Governor and  
18 Legislature on or about March 1 of each year. This report shall  
19 include, but not necessarily be limited to, both of the following:

20 (1) Sufficient information to ensure the understanding of the  
21 magnitude of expenditures, by type of expenditure, including those  
22 specified in Section 88625, disaggregated by industry sector or  
23 cluster, region, and type of grant.

24 (2) Data summarizing outcome accountability performance  
25 measures required by this section.

AMENDED IN SENATE JANUARY 26, 2016

AMENDED IN SENATE JANUARY 4, 2016

**SENATE BILL**

**No. 547**

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**Introduced by Senator Liu**  
(Principal coauthor: Assembly Member Brown)

February 26, 2015

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An act to add Division 121 (commencing with Section 152000) to the Health and Safety Code, relating to aging.

LEGISLATIVE COUNSEL'S DIGEST

SB 547, as amended, Liu. Aging and long-term care services, supports, and program coordination.

Existing law establishes the California Health and Human Services Agency consisting of the Departments of Aging, Child Support services, Community Services and Development, Developmental Services, Health Care Services, Managed Health Care, Public Health, Rehabilitation, Social Services, and State Hospitals.

Existing law sets forth legislative findings and declarations regarding long-term care services, including that consumers of those services experience great differences in service levels, eligibility criteria, and service availability that often result in inappropriate and expensive care that is not responsive to individual needs. Those findings and declarations also state that the laws governing long-term care facilities have established an uncoordinated array of long-term care services that are funded and administered by a state structure that lacks necessary integration and focus.

This bill, among other things, would create the Statewide Aging and Long-Term Care Services Coordinating Council, chaired by the Secretary of California Health and Human Services, and would consist

of the heads, or their designated representative, of specified departments and offices. The secretary would have specified responsibilities, including, but not limited to, leading the council in the development and implementation of a state aging and long-term care services strategic plan to address how the state will meet the needs of the aging population in the years 2020, 2025, and 2030. ~~The bill would also require the secretary to enter into a contract with the Regents of the University of California so that the council may either partner with the University of California, San Francisco, to operate, revise, and manage the CalQualityCare.org Internet Web site or acquire the rights to operate the CalQualityCare.org Internet Web site to function as a consumer-oriented portal that provides specified aging and long-term care information on a statewide basis. The bill would require the strategic plan to be submitted to the Secretary of the Senate, the Chief Clerk of the Assembly, and the chairs of specified policy and fiscal committees of the Legislature by July 1, 2018.~~

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: no.

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

- 1     SECTION 1. *The Legislature finds and declares all of the*  
 2 *following:*
- 3     (a) *The California Health and Human Services Agency consists*  
 4 *of the following departments: the California Department of Aging,*  
 5 *the Department of Community Services and Development, the State*  
 6 *Department of Developmental Services, the State Department of*  
 7 *Health Care Services, the Department of Managed Health Care,*  
 8 *the State Department of Public Health, the Department of*  
 9 *Rehabilitation, the State Department of Social Services, and the*  
 10 *State Department of State Hospitals.*
- 11     (b) *The agency also includes the Emergency Medical Services*  
 12 *Authority, the Office of Health Information Integrity, the Office of*  
 13 *Patient Advocate, the Office of Statewide Health Planning and*  
 14 *Development, the Office of Systems Integration, the Office of Law*  
 15 *Enforcement Support, and the State Council on Developmental*  
 16 *Disabilities.*
- 17     (c) *California baby boomers are turning 65 years of age at the*  
 18 *highest rate in the nation, and over 20 percent of California's*  
 19 *population will be 65 years of age or older by 2030.*

1 (d) Among persons 65 years of age and older, an estimated 70  
2 percent will use long-term services and supports (LTSS).

3 (e) Persons who are 85 years of age or older are the fastest  
4 growing segment of the United States population, and they are  
5 four times more likely to need LTSS than persons who are 65 years  
6 of age or older, but younger than 85 years of age.

7 (f) People are living longer, and the aging population is  
8 increasingly diverse.

9 (g) A report by the Senate Select Committee on Aging and Long  
10 Term Care on January 2015, called, "A Shattered System:  
11 Reforming Long-Term Care in California. Envisioning and  
12 Implementing an IDEAL Long-Term Care System in California,"  
13 found that the state's system of 112 aging long-term care programs  
14 administered by 20 agencies and departments is almost impossible  
15 for consumers to navigate.

16 (h) Other deficiencies of the system include the lack of  
17 person-centered care, poor transitions from hospital to home or  
18 to other institutions, limited access to a range of services that  
19 enable aging in place, deficiency of services and supports in rural  
20 areas, limited cultural competency, skilled workforce shortages  
21 across a range of disciplines, the lack of uniform data, the lack of  
22 a universal assessment tool, and limited caregiver supports.

23 **SECTION 1.**

24 **SEC. 2.** Division 121 (commencing with Section 152000) is  
25 added to the Health and Safety Code, to read:

26  
27 **DIVISION 121. AGING AND LONG-TERM CARE**  
28 **SERVICES, SUPPORTS, AND PROGRAM COORDINATION**

29  
30 ~~152000. The Legislature finds and declares all of the following:~~

31 ~~(a) The California Health and Human Services Agency consists~~  
32 ~~of the following departments: the California Department of Aging,~~  
33 ~~the Department of Community Services and Development, the~~  
34 ~~State Department of Developmental Services, the State Department~~  
35 ~~of Health Care Services, the Department of Managed Health Care,~~  
36 ~~the State Department of Public Health, the Department of~~  
37 ~~Rehabilitation, the State Department of Social Services, and the~~  
38 ~~State Department of State Hospitals.~~

39 ~~(b) The agency also includes the Emergency Medical Services~~  
40 ~~Authority, the Office of Health Information Integrity, the Office~~

1 of Patient Advocate, the Office of Statewide Health Planning and  
2 Development, the Office of Systems Integration, the Office of Law  
3 Enforcement Support, and the State Council on Developmental  
4 Disabilities.

5 (c) California baby boomers are turning 65 years of age at the  
6 highest rate in the nation, and over 20 percent of California's  
7 population will be 65 years of age or older by 2030.

8 (d) Among persons 65 years of age and older, an estimated 70  
9 percent will use long-term services and supports (LTSS).

10 (e) Persons 85 years of age and older are the fastest growing  
11 segment of the United States population, and they are four times  
12 more likely to need LTSS than persons between 65 and 84 years  
13 of age.

14 (f) People are living longer, and the aging population is  
15 increasingly diverse.

16 (g) A report by the Senate Select Committee on Aging and Long  
17 Term Care on January 2015, called, "A Shattered System:  
18 Reforming Long-Term Care in California. Envisioning and  
19 Implementing an IDEAL Long-Term Care System in California,"  
20 found that the state's system of 112 aging long-term care programs  
21 administered by 20 agencies and departments is almost impossible  
22 for consumers to navigate.

23 (h) Other deficiencies of the system include no person-centered  
24 care, poor transitions from hospital to home or to other institutions,  
25 limited access to a range of services that enable aging in place,  
26 deficiency of services and supports in rural areas, limited cultural  
27 competency, skilled workforce shortages across a range of  
28 disciplines, no uniform data, no universal assessment tool, and  
29 limited caregiver supports.

30 (i) Also, the End of Life Option Act authorizes an adult, who  
31 meets certain qualifications and who has been determined by his  
32 or her attending physician to be suffering from a terminal disease,  
33 to make a request for a drug for the purpose of ending his or her  
34 life. Paragraph (5) of subdivision (i) of Section 443.1 states that  
35 an individual choosing the end-of-life option is required to be  
36 informed of "feasible alternatives or additional treatment  
37 opportunities, including, but not limited to, comfort care, hospice  
38 care, palliative care, and pain control." Better systemwide  
39 coordination of aging and long-term care services and supports is  
40 needed to ensure access to services and information, so individuals

1 ~~can plan for, access, and make informed decisions on end-of-life~~  
2 ~~options.~~

3 ~~152001.~~

4 *152000.* The Secretary of California Health and Human  
5 Services shall be responsible for all of the following:

6 (a) Inter- and intra-agency coordination of state aging and  
7 long-term care services, supports, and programs.

8 (b) Ensuring efficient and effective use of state funds.

9 (c) Maximizing the drawdown, and the efficient and effective  
10 use of federal funds.

11 ~~152002.~~

12 *152001.* There is hereby created a Statewide Aging and  
13 Long-Term Care Services Coordinating Council, chaired by the  
14 Secretary of California Health and Human Services, and consisting  
15 of the heads, or their designated representative, of all of the  
16 following:

17 (a) The California Department of Aging.

18 (b) The Department of Community Services and Development.

19 (c) The Department of Consumer Affairs.

20 (d) The Department of Food and Agriculture.

21 (e) The Department of Human Resources.

22 (f) The Department of Insurance.

23 (g) The Department of Justice.

24 (h) The Department of Motor Vehicles.

25 (i) The Department of Rehabilitation.

26 (j) The Department of Transportation.

27 (k) The Department of Veterans Affairs.

28 (l) The Emergency Medical Services Authority.

29 (m) The Employment Development Department.

30 (n) The Office of Health Information Integrity.

31 (o) The Office of Law Enforcement Support.

32 (p) The Office of Patient Advocate.

33 (q) The Office of Statewide Health Planning and Development.

34 (r) The Office of Systems Integration.

35 (s) The State Department of Developmental Services.

36 (t) The State Department of Health Care Services.

37 (u) The State Department of Public Health.

38 (v) The State Department of Social Services.

1 ~~152003.~~

2 152002. (a) The secretary shall lead the council in the  
3 development ~~and implementation~~ of a state aging and long-term  
4 care services strategic plan to address how the state will meet the  
5 needs of the aging population in the years 2020, 2025, and 2030.  
6 The strategic plan shall incorporate clear benchmarks and timelines  
7 for achieving the goals set forth in the strategic plan ~~and be updated~~  
8 ~~every five years.~~ *and a cost and benefit analysis for each goal or*  
9 *recommendation included in the plan.* In developing the strategic  
10 plan, the council shall consult with all of the following:

11 (1) Experts, researchers, practitioners, service providers, and  
12 facility operators in the field of aging and long-term care.

13 (2) Consumer advocates and stakeholders, including the  
14 Olmstead Advisory Committee, the California Commission on  
15 Aging, ~~the area agency~~ *area agencies* on aging, the State Council  
16 on Developmental Disabilities, the California Foundation for  
17 Independent Living Centers, and the Milton Marks “Little Hoover”  
18 Commission on California State Government Organization and  
19 Economy.

20 (3) Rural and urban ~~communities~~ *communities*, in order to  
21 identify infrastructure capacity issues, the need for uniform access  
22 standards for home and community-based services, and  
23 mechanisms for supporting coordination of regional and local  
24 service access and delivery.

25 (4) The California Task Force on Family Caregiving, the  
26 findings and recommendations of which shall be incorporated into  
27 the strategic plan.

28 (b) Technical support for the development of the strategic plan  
29 shall be provided by the Office of Health Equity in the State  
30 Department of Public Health and by the California Department of  
31 Aging.

32 (c) The strategic plan shall address all of the following:

33 (1) Integration and coordination of services that support  
34 independent living, aging in place, social and civic engagement,  
35 and preventative care.

36 (2) Long-term care financing.

37 (3) Managed care expansion and continuum of care.

38 (4) Advanced planning for end-of-life care.

39 (5) Elder justice.

1 (6) Care guidelines for Alzheimer’s disease, dementia,  
2 Amyotrophic Lateral Sclerosis (ALS), and other debilitating  
3 diseases.

4 (7) Caregiver support.

5 (8) Data collection, consolidation, uniformity, analysis, and  
6 access.

7 (9) Affordable housing.

8 (10) Mobility.

9 (11) Workforce.

10 (12) The alignment of state programs with the federal  
11 Administration for Community Living.

12 (13) The potential for integration and coordination of aging and  
13 long-term care services with services and supports for people with  
14 disabilities.

15 (d) In developing the strategic plan, the council shall examine  
16 model programs in various cities, counties, and states. The strategic  
17 plan shall consider how to scale up local, regional, and state-level  
18 best practices and innovations designed to overcome the challenges  
19 related to long-term care services delivery.

20 (e) Notwithstanding Section 10231.5 of the Government Code,  
21 the strategic plan shall be submitted to the Secretary of the Senate  
22 and the Chief Clerk of the Assembly, to the appropriate chairs of  
23 the policy committees of the Legislature with jurisdiction over any  
24 aging and long-term care related issues, and to the chairs of the  
25 fiscal committees of the Legislature by July 1, 2018, with updates  
26 submitted by July 1, 2023, and by July 1, 2028. 2018.

27 ~~(f) Notwithstanding Section 10231.5 of the Government Code,  
28 beginning on July 1, 2017, the secretary shall report on an annual  
29 basis to the appropriate policy committees of the Legislature with  
30 jurisdiction over any aging and long-term care related issues and  
31 to the fiscal committees of the Legislature regarding the current  
32 status of long-term care in the state, the level of state spending on  
33 long-term care programs, federal funding received, progress in  
34 developing and implementing the strategic plan as provided in this  
35 section, and the statewide Internet Web site portal as provided in  
36 Section 152004.~~

37 ~~152004. Notwithstanding Chapter 2 (commencing with Section  
38 10290) and Chapter 3 (commencing with Section 12100) of Part  
39 2 of Division 2 of the Public Contract Code, the secretary shall  
40 enter into a contract with the Regents of the University of~~

1 California so that the council may either partner with the University  
2 of California, San Francisco, to operate, revise, and manage the  
3 CalQualityCare.org Internet Web site or acquire the rights to  
4 operate the CalQualityCare.org Internet Web site to function as a  
5 consumer oriented portal that provides all of the following  
6 information on a statewide basis:

7 (a) Comprehensive, free, unbiased information on long-term  
8 care services and supports, including licensed skilled nursing  
9 facilities (freestanding and hospital-based), congregate living health  
10 facilities, hospice, home health, assisted living, continuing care  
11 retirement communities, adult day care, adult day health care, and  
12 intermediate care for the developmentally disabled (ICF/DD).

13 (b) Depending on the availability and reliability of the data,  
14 information within all of the following domains shall be provided:

15 (1) Provider characteristics, such as location, size, and  
16 ownership.

17 (2) Ratings of skilled nursing facilities, home health, hospice,  
18 and ICF/DD.

19 (3) Staffing, such as number and type.

20 (4) Quality of the facility, such as deficiencies and complaints.

21 (5) Quality of care, such as incidence of pressure ulcers and  
22 infections.

23 (6) Cost and finances.

24 (e) The CalQualityCare.org Internet Web site shall include  
25 information that assists the consumer to learn about options and  
26 how to make decisions on long-term care services and supports,  
27 advanced planning, and end-of-life options.

28 (d) By July 1, 2018, the secretary shall expand the  
29 CalQualityCare.org Internet Web site to provide all of the  
30 following:

31 (1) Information about long-term services and supports eligibility  
32 and how to access long-term care services and supports.

33 (2) Internet links to reputable local resource portals, such as  
34 county long-term care services and supports Internet Web sites.

35 (3) Internet links to reputable caregiver resources.

36 (4) Information on additional licensed providers, such as  
37 nonmedical home care aides.

**Introduced by Senator Morrell**February 18, 2016

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An act to add Section 114.6 to the Business and Professions Code, relating to professions and vocations.

## LEGISLATIVE COUNSEL'S DIGEST

SB 1155, as introduced, Morrell. Professions and vocations: licenses: military service.

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs. Existing law authorizes any licensee whose license expired while he or she was on active duty as a member of the California National Guard or the United States Armed Forces to reinstate his or her license without examination or penalty if certain requirements are met. Existing law also requires the boards to waive the renewal fees, continuing education requirements, and other renewal requirements, if applicable, of any licensee or registrant called to active duty as a member of the United States Armed Forces or the California National Guard, if certain requirements are met. Existing law requires each board to inquire in every application if the individual applying for licensure is serving in, or has previously served in, the military. Existing law, on and after July 1, 2016, requires a board within the Department of Consumer Affairs to expedite, and authorizes a board to assist, the initial licensure process for an applicant who has served as an active duty member of the Armed Forces of the United States and was honorably discharged.

This bill would require the Department of Consumer Affairs, in consultation with the Department of Veterans Affairs and the Military Department, to establish and maintain a program that grants a fee waiver

for the application for and the issuance of an initial license to an individual who is an honorably discharged veteran, as specified.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

1 SECTION 1. Section 114.6 is added to the Business and  
2 Professions Code, to read:

3 114.6. The Department of Consumer Affairs, in consultation  
4 with the Department of Veterans Affairs and the Military  
5 Department, shall establish and maintain a program that grants a  
6 fee waiver for the application for and issuance of a license to an  
7 individual who is an honorably discharged veteran who served as  
8 an active duty member of the California National Guard or the  
9 United States Armed Forces. Under this program, all of the  
10 following apply:

11 (a) The Department of Consumer Affairs shall grant only one  
12 fee waiver to a veteran.

13 (b) The fee waiver shall apply only to an application of and a  
14 license issued to an individual veteran and not to an application  
15 of or a license issued to a business or other entity.

16 (c) A waiver shall not be issued for a renewal of a license or for  
17 the application for and issuance of a license other than one initial  
18 license.

**Introduced by Senator Stone**February 19, 2016

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An act to amend Section 11160 of the Penal Code, relating to crime reporting.

## LEGISLATIVE COUNSEL'S DIGEST

SB 1334, as introduced, Stone. Crime reporting: health practitioners: human trafficking.

Existing law requires a health practitioner, as specified, who, in his or her professional capacity or within the scope of his or her employment, provides medical services to a patient who he or she knows, or reasonably suspects, has suffered from a wound or other physical injury where the injury is by means of a firearm or is the result of assaultive or abusive conduct, to make a report to a law enforcement agency, as specified. Existing law defines "assaultive or abusive conduct" for these purposes as a violation of specified crimes. Under existing law, a violation of this provision is a crime.

This bill would add the crime of human trafficking to the list of crimes that constitute assaultive or abusive conduct for purposes of the above reporting requirements. By increasing the scope of an existing crime, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

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

1 SECTION 1. Section 11160 of the Penal Code is amended to  
2 read:

3 11160. (a) ~~Any~~A health practitioner employed in a health  
4 facility, clinic, physician's office, local or state public health  
5 department, or a clinic or other type of facility operated by a local  
6 or state public health department who, in his or her professional  
7 capacity or within the scope of his or her employment, provides  
8 medical services for a physical condition to a patient ~~whom~~ *who*  
9 he or she ~~knows~~ *knows*, or reasonably ~~suspects~~ *suspects*, is a person  
10 described as follows, shall immediately make a report in  
11 accordance with subdivision (b):

12 (1) ~~Any~~A person suffering from ~~any~~ a wound or other physical  
13 injury inflicted by his or her own act or inflicted by another where  
14 the injury is by means of a firearm.

15 (2) ~~Any~~A person suffering from ~~any~~ a wound or other physical  
16 injury inflicted upon the person where the injury is the result of  
17 assaultive or abusive conduct.

18 (b) ~~Any~~A health practitioner employed in a health facility,  
19 clinic, physician's office, local or state public health department,  
20 or a clinic or other type of facility operated by a local or state  
21 public health department shall make a report regarding persons  
22 described in subdivision (a) to a local law enforcement agency as  
23 follows:

24 (1) A report by telephone shall be made immediately or as soon  
25 as practically possible.

26 (2) A written report shall be prepared on the standard form  
27 developed in compliance with paragraph (4) of this subdivision,  
28 and Section 11160.2, and adopted by the Office of Emergency  
29 Services, or on a form developed and adopted by another state  
30 agency that otherwise fulfills the requirements of the standard  
31 form. The completed form shall be sent to a local law enforcement  
32 agency within two working days of receiving the information  
33 regarding the person.

34 (3) A local law enforcement agency shall be notified and a  
35 written report shall be prepared and sent pursuant to paragraphs  
36 (1) and (2) even if the person who suffered the wound, other injury,  
37 or assaultive or abusive conduct has expired, regardless of whether  
38 or not the wound, other injury, or assaultive or abusive conduct

1 was a factor contributing to the death, and even if the evidence of  
2 the conduct of the perpetrator of the wound, other injury, or  
3 assaultive or abusive conduct was discovered during an autopsy.

4 (4) The report shall include, but shall not be limited to, the  
5 following:

6 (A) The name of the injured person, if known.

7 (B) The injured person's whereabouts.

8 (C) The character and extent of the person's injuries.

9 (D) The identity of ~~any~~ a person the injured person alleges  
10 inflicted the wound, other injury, or assaultive or abusive conduct  
11 upon the injured person.

12 (c) For the purposes of this section, "injury" shall not include  
13 any psychological or physical condition brought about solely  
14 through the voluntary administration of a narcotic or restricted  
15 dangerous drug.

16 (d) For the purposes of this section, "assaultive or abusive  
17 conduct" shall include any of the following offenses:

18 (1) Murder, in violation of Section 187.

19 (2) Manslaughter, in violation of Section 192 or 192.5.

20 (3) Mayhem, in violation of Section 203.

21 (4) Aggravated mayhem, in violation of Section 205.

22 (5) Torture, in violation of Section 206.

23 (6) Assault with intent to commit mayhem, rape, sodomy, or  
24 oral copulation, in violation of Section 220.

25 (7) Administering controlled substances or anesthetic to aid in  
26 commission of a felony, in violation of Section 222.

27 (8) *Human trafficking, in violation of Section 236.1.*

28 ~~(8)~~

29 (9) Battery, in violation of Section 242.

30 ~~(9)~~

31 (10) Sexual battery, in violation of Section 243.4.

32 ~~(10)~~

33 (11) Incest, in violation of Section 285.

34 ~~(11)~~

35 (12) Throwing any vitriol, corrosive acid, or caustic chemical  
36 with intent to injure or disfigure, in violation of Section 244.

37 ~~(12)~~

38 (13) Assault with a stun gun or taser, in violation of Section  
39 244.5.

40 ~~(13)~~

- 1 (14) Assault with a deadly weapon, firearm, assault weapon, or  
2 machinegun, or by means likely to produce great bodily injury, in  
3 violation of Section 245.  
4 ~~(14)~~
- 5 (15) Rape, in violation of Section 261.  
6 ~~(15)~~
- 7 (16) Spousal rape, in violation of Section 262.  
8 ~~(16)~~
- 9 (17) Procuring ~~any~~ a female to have sex with another man, in  
10 violation of Section 266, 266a, 266b, or 266c.  
11 ~~(17)~~
- 12 (18) Child abuse or endangerment, in violation of Section 273a  
13 or 273d.  
14 ~~(18)~~
- 15 (19) Abuse of spouse or cohabitant, in violation of Section  
16 273.5.  
17 ~~(19)~~
- 18 (20) Sodomy, in violation of Section 286.  
19 ~~(20)~~
- 20 (21) Lewd and lascivious acts with a child, in violation of  
21 Section 288.  
22 ~~(21)~~
- 23 (22) Oral copulation, in violation of Section 288a.  
24 ~~(22)~~
- 25 (23) Sexual penetration, in violation of Section 289.  
26 ~~(23)~~
- 27 (24) Elder abuse, in violation of Section 368.  
28 ~~(24)~~
- 29 (25) An attempt to commit any crime specified in paragraphs  
30 (1) to ~~(23)~~, (24), inclusive.
- 31 (e) ~~When~~ If two or more persons who are required to report are  
32 present and jointly have knowledge of a known or suspected  
33 instance of violence that is required to be reported pursuant to this  
34 section, and ~~when~~ if there is an agreement among these persons to  
35 report as a team, the team may select by mutual agreement a  
36 member of the team to make a report by telephone and a single  
37 written report, as required by subdivision (b). The written report  
38 shall be signed by the selected member of the reporting team. ~~Any~~  
39 A member who has knowledge that the member designated to  
40 report has failed to do so shall thereafter make the report.

1 (f) The reporting duties under this section are individual, except  
2 as provided in subdivision (e).

3 (g) ~~No~~A supervisor or administrator shall *not* impede or inhibit  
4 the reporting duties required under this section and ~~no~~ a person  
5 making a report pursuant to this section shall *not* be subject to ~~any~~  
6 sanction for making the report. However, internal procedures to  
7 facilitate reporting and apprise supervisors and administrators of  
8 reports may be established, except that these procedures shall not  
9 be inconsistent with this article. The internal procedures shall not  
10 require ~~any~~ an employee required to make a report under this article  
11 to disclose his or her identity to the employer.

12 (h) For the purposes of this section, it is the Legislature's intent  
13 to avoid duplication of information.

14 SEC. 2. No reimbursement is required by this act pursuant to  
15 Section 6 of Article XIII B of the California Constitution because  
16 the only costs that may be incurred by a local agency or school  
17 district will be incurred because this act creates a new crime or  
18 infraction, eliminates a crime or infraction, or changes the penalty  
19 for a crime or infraction, within the meaning of Section 17556 of  
20 the Government Code, or changes the definition of a crime within  
21 the meaning of Section 6 of Article XIII B of the California  
22 Constitution.

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**Introduced by Senator Cannella**February 19, 2016

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

## LEGISLATIVE COUNSEL'S DIGEST

SB 1348, as introduced, Cannella. Licensure applications: military experience.

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs. Existing law requires each board to inquire in every application for licensure if the individual applying for licensure is serving in, or has previously served in, the military.

This bill would require each board, with a governing law authorizing veterans to apply military experience and training towards licensure requirements, to modify their application for licensure to advise veteran applicants about their ability to apply that experience and training towards licensure requirements.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

1 SECTION 1. Section 114.5 of the Business and Professions  
2 Code is amended to read:  
3 114.5. ~~Commencing January 1, 2015, each~~ (a) Each board  
4 shall inquire in every application for licensure if the individual  
5 applying for licensure is serving in, or has previously served in,  
6 the military.

1     ***(b) If a board's governing law authorizes veterans to apply***  
2     ***military experience and training towards licensure requirements,***  
3     ***that board shall modify their application for licensure to advise***  
4     ***veteran applicants about their ability to apply military experience***  
5     ***and training towards licensure requirements.***

**ASSEMBLY BILL**

**No. 1939**

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**Introduced by Assembly Member Patterson**

February 12, 2016

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An act to add Section 312.3 to the Business and Professions Code, relating to professions.

LEGISLATIVE COUNSEL'S DIGEST

AB 1939, as introduced, Patterson. Licensing Requirements.

Under existing law, the Department of Consumer Affairs is comprised of various boards, bureaus, commissions, committees, and similarly constituted agencies that license and regulate the practice of various professions and vocations for the purpose of protecting the people of California. Existing law requires each of these entities to submit annually to the director of the department its methods for ensuring that every licensing examination it administers is subject to periodic evaluation.

This bill would require the director of the department to conduct a study and submit to the Legislature by July 1, 2017, a report identifying, exploring, and addressing occupational licensing requirements that create unnecessary barriers to labor market entry or mobility.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

- 1 SECTION 1. Section 312.3 is added to the Business and  
2 Professions Code, to read:  
3 312.3. (a) The director shall conduct a study and submit to the  
4 Legislature by July 1, 2017, a report identifying, exploring, and

1 addressing areas where occupational licensing requirements create  
2 an unnecessary barrier to labor market entry or labor mobility,  
3 particularly for dislocated workers, transitioning service members,  
4 and military spouses.

5 (b) The report to be submitted pursuant to subdivision (a) shall  
6 be submitted in compliance with Section 9795 of the Government  
7 Code.

**ASSEMBLY BILL****No. 2079****Introduced by Assembly Member Calderon**

February 17, 2016

An act to amend Sections 1276.5 and 1276.65 of the Health and Safety Code, and to amend Section 14126.022 of, and to repeal and add Section 14110.7 of, the Welfare and Institutions Code, relating to health facilities.

## LEGISLATIVE COUNSEL'S DIGEST

AB 2079, as introduced, Calderon. Skilled nursing facilities: staffing.

(1) Existing law provides for the licensure and regulation by the State Department of Public Health of health facilities, including skilled nursing facilities. Existing law requires the department to develop regulations that become effective August 1, 2003, that establish staff-to-patient ratios for direct caregivers working in a skilled nursing facility. Existing law requires that these ratios include separate licensed nurse staff-to-patient ratios in addition to the ratios established for other direct caregivers. Existing law also requires every skilled nursing facility to post information about staffing levels in the manner specified by federal requirements. Existing law makes it a misdemeanor for any person to willfully or repeatedly violate these provisions.

This bill would require the department to develop regulations that become effective July 1, 2017, and include a minimum overall staff-to-patient ratio that includes specific staff-to-patient ratios for certified nurse assistants and for licensed nurses that comply with specified requirements. The bill would require the posted information to include a resident census and an accurate report of the number of staff working each shift and to be posted in specified locations, including

an area used for employee breaks. The bill would require a skilled nursing facility to make staffing data available, upon oral or written request and at a reasonable cost, within 15 days of receiving a request. By expanding the scope of a crime, this bill would impose a state-mandated local program.

(2) Existing law generally requires that skilled nursing facilities have a minimum number of nursing hours per patient day of 3.2 hours.

This bill would substitute the term “direct care service hours” for the term “nursing hours” and, commencing July 1, 2017, except as specified, increase the minimum number of direct care service hours per patient day to 4.1 hours.

(3) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

Existing law, the Medi-Cal Long-Term Care Reimbursement Act, operative until August 1, 2020, requires the department to make a supplemental payment to skilled nursing facilities based on specified criteria and according to performance measure benchmarks. Existing law requires the department to establish and publish quality and accountability measures, which are used to determine supplemental payments. Existing law requires, beginning in the 2011–12 fiscal year, the measures to include, among others, compliance with specified nursing hours per patient per day requirements.

This bill would also require, beginning in the 2017–18 fiscal year, the measures to include compliance with specified direct care service hour requirements for skilled nursing facilities.

(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: yes.

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

1 SECTION 1. Section 1276.5 of the Health and Safety Code is  
2 amended to read:

1 1276.5. (a) (1) The department shall adopt regulations setting  
2 forth the minimum number of equivalent ~~nursing direct care~~  
3 ~~service~~ hours per patient required in ~~skilled nursing and~~  
4 intermediate care facilities, subject to the specific requirements of  
5 Section 14110.7 of the Welfare and Institutions Code. ~~However,~~  
6 ~~notwithstanding Section 14110.7 or any other law, commencing~~  
7 ~~January 1, 2000, the minimum number of actual nursing hours per~~  
8 ~~patient required in a skilled nursing facility shall be 3.2 hours,~~  
9 ~~except as provided in Section 1276.9.~~

10 (b) (1) ~~For~~

11 (2) ~~For the purposes of this section, “nursing subdivision,~~  
12 ~~“direct care service hours” means the number of hours of work~~  
13 ~~performed per patient day by aides, nursing assistants, or orderlies~~  
14 ~~plus two times the number of hours worked per patient day by~~  
15 ~~registered nurses and licensed vocational nurses (except directors~~  
16 ~~of nursing in facilities of 60 or larger capacity) and, in the distinct~~  
17 ~~part of facilities and freestanding facilities providing care for~~  
18 ~~persons with developmental disabilities or mental health disorders~~  
19 ~~by licensed psychiatric technicians who perform direct nursing~~  
20 ~~services for patients in skilled nursing and intermediate care~~  
21 ~~facilities, except when the skilled nursing and intermediate care~~  
22 ~~facility is licensed as a part of a state hospital, and except that~~  
23 ~~nursing hours for skilled nursing facilities means the actual hours~~  
24 ~~of work, without doubling the hours performed per patient day by~~  
25 ~~registered nurses and licensed vocational nurses: hospital.~~

26 (2) ~~Concurrent with implementation of the first year of rates~~  
27 ~~established under the Medi-Cal Long Term Care Reimbursement~~  
28 ~~Act of 1990 (Article 3.8 (commencing with Section 14126) of~~  
29 ~~Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions~~  
30 ~~Code), for the purposes of this section, “nursing hours” means the~~  
31 ~~number of hours of work performed per patient day by aides,~~  
32 ~~nursing assistants, registered nurses, and licensed vocational nurses~~  
33 ~~(except directors of nursing in facilities of 60 or larger capacity)~~  
34 ~~and, in the distinct part of facilities and freestanding facilities~~  
35 ~~providing care for persons with developmental disabilities or~~  
36 ~~mental health disorders, by licensed psychiatric technicians who~~  
37 ~~performed direct nursing services for patients in skilled nursing~~  
38 ~~and intermediate care facilities, except when the skilled nursing~~  
39 ~~and intermediate care facility is licensed as a part of a state hospital.~~

1     **(b) (1)** *The department shall adopt regulations setting forth the*  
2 *minimum number of equivalent direct care service hours per*  
3 *patient required in skilled nursing facilities, subject to the specific*  
4 *requirements of Section 14110.7 of the Welfare and Institutions*  
5 *Code. However, notwithstanding Section 14110.7 of the Welfare*  
6 *and Institutions Code or any other law, the minimum number of*  
7 *direct care service hours per patient required in a skilled nursing*  
8 *facility shall be 3.2 hours, and, commencing July 1, 2017, shall*  
9 *be 4.1 hours, except as provided in paragraph (2) or Section*  
10 *1276.9.*

11     **(2)** *Notwithstanding Section 14110.7 or any other law, the*  
12 *minimum number of direct care service hours per patient required*  
13 *in a skilled nursing facility that is a distinct part of a facility*  
14 *licensed as a general acute care hospital shall be 3.2 hours, except*  
15 *as provided in Section 1276.9.*

16     **(3)** *For the purposes of this subdivision “direct care service*  
17 *hours” means the numbers of hours of work performed per patient*  
18 *day by a direct caregiver, as defined in Section 1276.65.*

19     **(c)** Notwithstanding Section 1276, the department shall require  
20 the utilization of a registered nurse at all times if the department  
21 determines that the services of a skilled nursing and intermediate  
22 care facility require the utilization of a registered nurse.

23     **(d) (1)** Except as otherwise provided by law, the administrator  
24 of an intermediate care facility/developmentally disabled,  
25 intermediate care facility/developmentally disabled habilitative,  
26 or an intermediate care facility/developmentally disabled—nursing  
27 shall be either a licensed nursing home administrator or a qualified  
28 intellectual disability professional as defined in Section 483.430  
29 of Title 42 of the Code of Federal Regulations.

30     **(2)** To qualify as an administrator for an intermediate care  
31 facility for the developmentally disabled, a qualified intellectual  
32 disability professional shall complete at least six months of  
33 administrative training or demonstrate six months of experience  
34 in an administrative capacity in a licensed health facility, as defined  
35 in Section 1250, excluding those facilities specified in subdivisions  
36 (e), (h), and (i).

37     **SEC. 2.** Section 1276.65 of the Health and Safety Code is  
38 amended to read:

39     1276.65. **(a)** For purposes of this section, the following  
40 definitions shall apply:

1 (1) (A) “Direct caregiver” means a registered nurse, as referred  
2 to in Section 2732 of the Business and Professions Code, a licensed  
3 vocational nurse, as referred to in Section 2864 of the Business  
4 and Professions Code, a psychiatric technician, as referred to in  
5 Section 4516 of the Business and Professions Code, ~~and a certified~~  
6 ~~nurse assistant, as defined in Section 1337. 1337 of this code, or~~  
7 ~~a nurse assistant in an approved training program, as defined in~~  
8 ~~Section 1337, while the nurse assistant in an approved training~~  
9 ~~program is performing nursing services as described in Sections~~  
10 ~~72309, 72311, and 72315 of Title 22 of the California Code of~~  
11 ~~Regulations.~~

12 (B) “Direct caregiver” also includes (i) a licensed nurse serving  
13 as a minimum data set coordinator and (ii) a person serving as  
14 the director of nursing services in a facility with 60 or more  
15 licensed beds and a person serving as the director of staff  
16 development when that person is providing nursing services in the  
17 hours beyond those required to carry out the duties of these  
18 positions, as long as these direct care service hours are separately  
19 documented.

20 (2) “Licensed nurse” means a registered nurse, as referred to  
21 in Section 2732 of the Business and Professions Code, a licensed  
22 vocational nurse, as referred to in Section 2864 of the Business  
23 and Professions Code, and a psychiatric technician, as referred  
24 to in Section 4516 of the Business and Professions Code.

25 (2)

26 (3) “Skilled nursing facility” means a skilled nursing facility as  
27 defined in subdivision (c) of Section 1250.

28 (b) A person employed to provide services such as food  
29 preparation, housekeeping, laundry, or maintenance services shall  
30 not provide nursing care to residents and shall not be counted in  
31 determining ratios under this section.

32 (c) (1) (A) Notwithstanding any other ~~provision of law, the~~  
33 ~~State Department of Public Health—Services shall develop~~  
34 ~~regulations that become effective August 1, 2003, July 1, 2017,~~  
35 ~~that establish a minimum staff-to-patient-ratios ratio for direct~~  
36 ~~caregivers working in a skilled nursing facility. These ratios shall~~  
37 ~~include separate licensed nurse staff-to-patient ratios in addition~~  
38 ~~to the ratios established for other direct caregivers. The ratio shall~~  
39 ~~include as a part of the overall staff-to-patient ratio, specific~~

1 *staff-to-patient ratios for licensed nurses and certified nurse*  
2 *assistants.*

3 (B) (i) *For a skilled nursing facility that is not a distinct part*  
4 *of a general acute care hospital, the certified nurse assistant*  
5 *staff-to-patient ratios developed pursuant to subparagraph (A)*  
6 *shall be no less than the following:*

7 (I) *During the day shift, a minimum of one certified nurse*  
8 *assistant for every six patients, or fraction thereof.*

9 (II) *During the evening shift, a minimum of one certified nurse*  
10 *assistant for every eight patients, or fraction thereof.*

11 (III) *During the night shift, a minimum of one certified nurse*  
12 *assistant for every 17 patients, or fraction thereof.*

13 (ii) *For the purposes of this subparagraph, the following terms*  
14 *have the following meanings:*

15 (I) *“Day shift” means the 8-hour period during which the*  
16 *facility’s patients require the greatest amount of care.*

17 (II) *“Evening shift” means the 8-hour period when the facility’s*  
18 *patients require a moderate amount of care.*

19 (III) *“Night shift” means the 8-hour period during which a*  
20 *facility’s patients require the least amount of care.*

21 (2) ~~The department, in developing staff-to-patient ratios for~~  
22 ~~direct caregivers~~ *an overall staff-to-patient ratio for direct*  
23 *caregivers, and in developing specific staff-to-patient ratios for*  
24 *certified nurse assistants and licensed nurses as required by this*  
25 *section, shall convert the existing requirement under Section 1276.5*  
26 *of this code and Section 14110.7 of the Welfare and Institutions*  
27 *Code for 3.2 nursing direct care hours per patient day of care day,*  
28 *and commencing July 1, 2017, except as specified in paragraph*  
29 *(2) of subdivision (b) of Section 1276.5, for 4.1 direct care service*  
30 *hours per patient day, including a minimum of 2.8 direct care*  
31 *service hours per patient day for certified nurse assistants, and a*  
32 *minimum of 1.3 direct care service hours per patient day for*  
33 *licensed nurses, and shall ensure that no less care is given than is*  
34 *required pursuant to Section 1276.5 of this code and Section*  
35 *14110.7 of the Welfare and Institutions Code. Further, the*  
36 *department shall develop the ratios in a manner that minimizes*  
37 *additional state costs, maximizes resident access to care, and takes*  
38 *into account the length of the shift worked. In developing the*  
39 *regulations, the department shall develop a procedure for facilities*  
40 *to apply for a waiver that addresses individual patient needs except*

1 that in no instance shall the minimum staff-to-patient ratios be less  
2 than the 3.2 ~~nursing~~ *direct care service hours per patient day*,  
3 *and, commencing July 1, 2017, except as specified in paragraph*  
4 *(2) of subdivision (b) of Section 1276.5, be less than the 4.1 direct*  
5 *care service hours per patient day*, required under Section 1276.5  
6 of this code and Section 14110.7 of the Welfare and Institutions  
7 Code.

8 (d) The staffing ratios to be developed pursuant to this section  
9 shall be minimum standards ~~only~~. *only and shall be satisfied daily.*  
10 Skilled nursing facilities shall employ and schedule additional staff  
11 as needed to ensure quality resident care based on the needs of  
12 individual residents and to ensure compliance with all relevant  
13 state and federal staffing requirements.

14 (e) No later than January 1, ~~2006~~, 2019, and every five years  
15 thereafter, the department shall consult with consumers, consumer  
16 advocates, recognized collective bargaining agents, and providers  
17 to determine the sufficiency of the staffing standards provided in  
18 this section and may adopt regulations to increase the minimum  
19 staffing ratios to adequate levels.

20 (f) (1) In a manner pursuant to federal requirements, effective  
21 January 1, 2003, every skilled nursing facility shall post  
22 information about *resident census and staffing levels* that includes  
23 the current number of licensed and unlicensed nursing staff directly  
24 responsible for resident care in the facility. This posting shall  
25 include staffing requirements developed pursuant to this ~~section~~.  
26 *section and an accurate report of the number of direct care staff*  
27 *working during the current shift, including a report of the number*  
28 *of registered nurses, licensed vocational nurses, psychiatric*  
29 *technicians, and certified nurse assistants. The information shall*  
30 *be posted on paper that is at least 8.5 inches by 14 inches and*  
31 *shall be printed in a type of at least 16 point.*

32 (2) *The information described in paragraph (1) shall be posted*  
33 *daily, at a minimum, in the following locations:*

34 (A) *An area readily accessible to members of the public.*

35 (B) *An area used for employee breaks.*

36 (C) *An area used by residents for communal functions,*  
37 *including, but not limited to, dining, resident council meetings, or*  
38 *activities.*

39 (3) (A) *Upon oral or written request, every skilled nursing*  
40 *facility shall make direct caregiver staffing data available to the*

1 public for review at a reasonable cost. A skilled nursing facility  
2 shall provide the data to the requestor within 15 days after  
3 receiving a request.

4 (B) For the purpose of this paragraph, “reasonable cost”  
5 includes, but is not limited to, a ten-cent (\$.10) per page fee for  
6 standard reproduction of documents that are 8.5 inches by 14  
7 inches or smaller or a retrieval or processing fee not exceeding  
8 sixty dollars (\$60) if the requested data is provided on a digital  
9 or other electronic medium and the requestor requests delivery of  
10 the data in a digital or other electronic medium, including  
11 electronic mail.

12 (g) (1) Notwithstanding any other ~~provision~~ of law, the  
13 department shall inspect for compliance with this section during  
14 state and federal periodic inspections, including, but not limited  
15 to, those inspections required under Section 1422. This inspection  
16 requirement shall not limit the department’s authority in other  
17 circumstances to cite for violations of this section or to inspect for  
18 compliance with this section.

19 (2) A violation of the regulations developed pursuant to this  
20 section may constitute a class “B,” “A,” or “AA” violation pursuant  
21 to the standards set forth in Section 1424.

22 (h) The requirements of this section are in addition to any  
23 requirement set forth in Section 1276.5 of this code and Section  
24 14110.7 of the Welfare and Institutions Code.

25 ~~(i) Initial implementation of the staffing ratio developed~~  
26 ~~pursuant to requirements set forth in this section shall be contingent~~  
27 ~~on an appropriation in the annual Budget Act or another statute.~~

28 ~~(j)~~

29 (i) In implementing this section, the department may contract  
30 as necessary, on a bid or nonbid basis, for professional consulting  
31 services from nationally recognized higher education and research  
32 institutions, or other qualified individuals and entities not  
33 associated with a skilled nursing facility, with demonstrated  
34 expertise in long-term care. This subdivision establishes an  
35 accelerated process for issuing contracts pursuant to this section  
36 and contracts entered into pursuant to this section shall be exempt  
37 from the requirements of Chapter 1 (commencing with Section  
38 10100) and Chapter 2 (commencing with Section 10290) of Part  
39 2 of Division 2 of the Public Contract Code.

40 ~~(k)~~

1 (j) This section shall not apply to facilities defined in Section  
2 1276.9.

3 SEC. 3. Section 14110.7 of the Welfare and Institutions Code  
4 is repealed.

5 ~~14110.7.—(a) The director shall adopt regulations increasing~~  
6 ~~the minimum number of equivalent nursing hours per patient~~  
7 ~~required in skilled nursing facilities to 3.2, in skilled nursing~~  
8 ~~facilities with special treatment programs to 2.3, in intermediate~~  
9 ~~care facilities to 1.1, and in intermediate care~~  
10 ~~facilities/developmentally disabled to 2.7.~~

11 ~~(b) (1) The director shall adopt regulations that shall establish~~  
12 ~~the minimum number of equivalent nursing hours per patient~~  
13 ~~required in the following, for the first year of implementation of~~  
14 ~~the first year of rates established pursuant to this article:~~

15 ~~(A) 2.6 hours for skilled nursing facilities.~~

16 ~~(B) 1.9 hours for skilled nursing facilities with special treatment~~  
17 ~~programs.~~

18 ~~(C) 0.9 hours for intermediate care facilities.~~

19 ~~(D) 2.2 hours for intermediate care facilities/developmentally~~  
20 ~~disabled.~~

21 ~~(2) The staffing standards established by paragraph (1) shall~~  
22 ~~become effective concurrently with the establishment of the first~~  
23 ~~reimbursement rates under this article.~~

24 ~~(3) The director shall adopt regulations that establish the~~  
25 ~~minimum number of equivalent nursing hours per patient required~~  
26 ~~in skilled nursing facilities at 2.7 for the second year of~~  
27 ~~implementation of rates established pursuant to this article.~~

28 ~~(e) (1) The Legislature finds and declares all of the following:~~

29 ~~(A) The one-year transition phase from 2.6 to 2.7 equivalent~~  
30 ~~nursing hours allows ample time to restructure staffing.~~

31 ~~(B) The 4 percent augmentation to reimburse for direct patient~~  
32 ~~care, as defined in paragraph (2) of subdivision (b) of Section~~  
33 ~~14126.60, provides funds to cover additional expenses, if any,~~  
34 ~~incurred by facilities to implement this staffing standard.~~

35 ~~(2) Subject to the appropriation of sufficient funds, the~~  
36 ~~department may adopt regulations to increase the minimum number~~  
37 ~~of equivalent nursing hours required of facilities subject to this~~  
38 ~~section per patient beyond 2.7 nursing hours per patient day.~~

39 ~~(d) (1) The department shall identify those skilled nursing~~  
40 ~~facilities that are in compliance with the 3.0 minimum double~~

1 nursing hour standards, as defined in subdivision (a) of Section  
2 1276.5 of the Health and Safety Code, but have actual staffing  
3 ratios below 2.5, as of July 1, 1990, and shall not enforce the 2.7  
4 equivalent nursing hours with respect to those facilities until the  
5 third year of implementation of the rates established under this  
6 article.

7 (2) The department shall periodically review facilities that have  
8 actual staffing ratios described in paragraph (1) to ensure that they  
9 are making sufficient progress toward 2.7 hours.

10 (e) Notwithstanding paragraph (1) of subdivision (d),  
11 commencing January 1, 2000, the minimum number of nursing  
12 hours per patient day required in skilled nursing facilities shall be  
13 3.2, without regard to the doubling of nursing hours as described  
14 in paragraph (1) of subdivision (b) of Section 1276.5 of the Health  
15 and Safety Code, and except as set forth in Section 1276.9 of the  
16 Health and Safety Code.

17 SEC. 4. Section 14110.7 is added to the Welfare and  
18 Institutions Code, to read:

19 14110.7. (a) In skilled nursing facilities, the minimum number  
20 of equivalent direct care service hours shall be 3.2, except as set  
21 forth in Section 1276.9 of the Health and Safety Code.

22 (b) Commencing July 1, 2017, in skilled nursing facilities,  
23 except those skilled nursing facilities that are a distinct part of a  
24 general acute care facility, the minimum number of equivalent  
25 direct care service hours shall be 4.1, except as set forth in Section  
26 1276.9 of the Health and Safety Code.

27 (c) In skilled nursing facilities with special treatment programs,  
28 the minimum number of equivalent direct care service hours shall  
29 be 2.3.

30 (d) In intermediate care facilities, the minimum number of  
31 equivalent direct care service hours shall be 1.1.

32 (e) In intermediate care facilities/developmentally disabled, the  
33 minimum number of equivalent direct care service hours shall be  
34 2.7.

35 SEC. 5. Section 14126.022 of the Welfare and Institutions  
36 Code is amended to read:

37 14126.022. (a) (1) By August 1, 2011, the department shall  
38 develop the Skilled Nursing Facility Quality and Accountability  
39 Supplemental Payment System, subject to approval by the federal

1 Centers for Medicare and Medicaid Services, and the availability  
2 of federal, state, or other funds.

3 (2) (A) The system shall be utilized to provide supplemental  
4 payments to skilled nursing facilities that improve the quality and  
5 accountability of care rendered to residents in skilled nursing  
6 facilities, as defined in subdivision (c) of Section 1250 of the  
7 Health and Safety Code, and to penalize those facilities that do  
8 not meet measurable standards.

9 (B) A freestanding pediatric subacute care facility, as defined  
10 in Section 51215.8 of Title 22 of the California Code of  
11 Regulations, shall be exempt from the Skilled Nursing Facility  
12 Quality and Accountability Supplemental Payment System.

13 (3) The system shall be phased in, beginning with the 2010–11  
14 rate year.

15 (4) The department may utilize the system to do all of the  
16 following:

17 (A) Assess overall facility quality of care and quality of care  
18 improvement, and assign quality and accountability payments to  
19 skilled nursing facilities pursuant to performance measures  
20 described in subdivision (i).

21 (B) Assign quality and accountability payments or penalties  
22 relating to quality of care, or direct care staffing levels, wages, and  
23 benefits, or both.

24 (C) Limit the reimbursement of legal fees incurred by skilled  
25 nursing facilities engaged in the defense of governmental legal  
26 actions filed against the facilities.

27 (D) Publish each facility's quality assessment and quality and  
28 accountability payments in a manner and form determined by the  
29 director, or his or her designee.

30 (E) Beginning with the 2011–12 fiscal year, establish a base  
31 year to collect performance measures described in subdivision (i).

32 (F) Beginning with the 2011–12 fiscal year, in coordination  
33 with the State Department of Public Health, publish the direct care  
34 staffing level data and the performance measures required pursuant  
35 to subdivision (i).

36 (5) The department, in coordination with the State Department  
37 of Public Health, shall report to the relevant Assembly and Senate  
38 budget subcommittees by May 1, 2016, information regarding the  
39 quality and accountability supplemental payments, including, but

1 not limited to, its assessment of whether the payments are adequate  
2 to incentivize quality care and to sustain the program.

3 (b) (1) There is hereby created in the State Treasury, the Skilled  
4 Nursing Facility Quality and Accountability Special Fund. The  
5 fund shall contain moneys deposited pursuant to subdivisions (g)  
6 and (j) to (m), inclusive. Notwithstanding Section 16305.7 of the  
7 Government Code, the fund shall contain all interest and dividends  
8 earned on moneys in the fund.

9 (2) Notwithstanding Section 13340 of the Government Code,  
10 the fund shall be continuously appropriated without regard to fiscal  
11 year to the department for making quality and accountability  
12 payments, in accordance with subdivision (n), to facilities that  
13 meet or exceed predefined measures as established by this section.

14 (3) Upon appropriation by the Legislature, moneys in the fund  
15 may also be used for any of the following purposes:

16 (A) To cover the administrative costs incurred by the State  
17 Department of Public Health for positions and contract funding  
18 required to implement this section.

19 (B) To cover the administrative costs incurred by the State  
20 Department of Health Care Services for positions and contract  
21 funding required to implement this section.

22 (C) To provide funding assistance for the Long-Term Care  
23 Ombudsman Program activities pursuant to Chapter 11  
24 (commencing with Section 9700) of Division 8.5.

25 (c) No appropriation associated with this bill is intended to  
26 implement the provisions of Section 1276.65 of the Health and  
27 Safety Code.

28 (d) (1) There is hereby appropriated for the 2010–11 fiscal year,  
29 one million nine hundred thousand dollars (\$1,900,000) from the  
30 Skilled Nursing Facility Quality and Accountability Special Fund  
31 to the California Department of Aging for the Long-Term Care  
32 Ombudsman Program activities pursuant to Chapter 11  
33 (commencing with Section 9700) of Division 8.5. It is the intent  
34 of the Legislature for the one million nine hundred thousand dollars  
35 (\$1,900,000) from the fund to be in addition to the four million  
36 one hundred sixty-eight thousand dollars (\$4,168,000) proposed  
37 in the Governor’s May Revision for the 2010–11 Budget. It is  
38 further the intent of the Legislature to increase this level of  
39 appropriation in subsequent years to provide support sufficient to

1 carry out the mandates and activities pursuant to Chapter 11  
2 (commencing with Section 9700) of Division 8.5.

3 (2) The department, in partnership with the California  
4 Department of Aging, shall seek approval from the federal Centers  
5 for Medicare and Medicaid Services to obtain federal Medicaid  
6 reimbursement for activities conducted by the Long-Term Care  
7 Ombudsman Program. The department shall report to the fiscal  
8 committees of the Legislature during budget hearings on progress  
9 being made and any unresolved issues during the 2011–12 budget  
10 deliberations.

11 (e) There is hereby created in the Special Deposit Fund  
12 established pursuant to Section 16370 of the Government Code,  
13 the Skilled Nursing Facility Minimum Staffing Penalty Account.  
14 The account shall contain all moneys deposited pursuant to  
15 subdivision (f).

16 (f) (1) Beginning with the 2010–11 fiscal year, the State  
17 Department of Public Health shall use the direct care staffing level  
18 data it collects to determine whether a skilled nursing facility has  
19 met the ~~nursing~~ *direct care services* hours per patient per day  
20 requirements pursuant to Section 1276.5 of the Health and Safety  
21 Code.

22 (2) (A) Beginning with the 2010–11 fiscal year, the State  
23 Department of Public Health shall assess a skilled nursing facility,  
24 licensed pursuant to subdivision (c) of Section 1250 of the Health  
25 and Safety Code, an administrative penalty if the State Department  
26 of Public Health determines that the skilled nursing facility fails  
27 to meet the ~~nursing~~ *direct care service* hours per patient per day  
28 requirements pursuant to Section 1276.5 of the Health and Safety  
29 Code as follows:

30 (i) Fifteen thousand dollars (\$15,000) if the facility fails to meet  
31 the requirements for 5 percent or more of the audited days up to  
32 49 percent.

33 (ii) Thirty thousand dollars (\$30,000) if the facility fails to meet  
34 the requirements for over 49 percent or more of the audited days.

35 (B) (i) If the skilled nursing facility does not dispute the  
36 determination or assessment, the penalties shall be paid in full by  
37 the licensee to the State Department of Public Health within 30  
38 days of the facility's receipt of the notice of penalty and deposited  
39 into the Skilled Nursing Facility Minimum Staffing Penalty  
40 Account.

1 (ii) The State Department of Public Health may, upon written  
2 notification to the licensee, request that the department offset any  
3 moneys owed to the licensee by the Medi-Cal program or any other  
4 payment program administered by the department to recoup the  
5 penalty provided for in this section.

6 (C) (i) If a facility disputes the determination or assessment  
7 made pursuant to this paragraph, the facility shall, within 15 days  
8 of the facility's receipt of the determination and assessment,  
9 simultaneously submit a request for appeal to both the department  
10 and the State Department of Public Health. The request shall  
11 include a detailed statement describing the reason for appeal and  
12 include all supporting documents the facility will present at the  
13 hearing.

14 (ii) Within 10 days of the State Department of Public Health's  
15 receipt of the facility's request for appeal, the State Department  
16 of Public Health shall submit, to both the facility and the  
17 department, all supporting documents that will be presented at the  
18 hearing.

19 (D) The department shall hear a timely appeal and issue a  
20 decision as follows:

21 (i) The hearing shall commence within 60 days from the date  
22 of receipt by the department of the facility's timely request for  
23 appeal.

24 (ii) The department shall issue a decision within 120 days from  
25 the date of receipt by the department of the facility's timely request  
26 for appeal.

27 (iii) The decision of the department's hearing officer, when  
28 issued, shall be the final decision of the State Department of Public  
29 Health.

30 (E) The appeals process set forth in this paragraph shall be  
31 exempt from Chapter 4.5 (commencing with Section 11400) and  
32 Chapter 5 (commencing with Section 11500), of Part 1 of Division  
33 3 of Title 2 of the Government Code. The provisions of ~~Section~~  
34 *Sections* 100171 and 131071 of the Health and Safety Code shall  
35 not apply to appeals under this paragraph.

36 (F) If a hearing decision issued pursuant to subparagraph (D)  
37 is in favor of the State Department of Public Health, the skilled  
38 nursing facility shall pay the penalties to the State Department of  
39 Public Health within 30 days of the facility's receipt of the

1 decision. The penalties collected shall be deposited into the Skilled  
2 Nursing Facility Minimum Staffing Penalty Account.

3 (G) The assessment of a penalty under this subdivision does not  
4 supplant the State Department of Public Health's investigation  
5 process or issuance of deficiencies or citations under Chapter 2.4  
6 (commencing with Section 1417) of Division 2 of the Health and  
7 Safety Code.

8 (g) The State Department of Public Health shall transfer, on a  
9 monthly basis, all penalty payments collected pursuant to  
10 subdivision (f) into the Skilled Nursing Facility Quality and  
11 Accountability Special Fund.

12 (h) Nothing in this section shall impact the effectiveness or  
13 utilization of Section 1278.5 or 1432 of the Health and Safety Code  
14 relating to whistleblower protections, or Section 1420 of the Health  
15 and Safety Code relating to complaints.

16 (i) (1) Beginning in the 2010–11 fiscal year, the department,  
17 in consultation with representatives from the long-term care  
18 industry, organized labor, and consumers, shall establish and  
19 publish quality and accountability measures, benchmarks, and data  
20 submission deadlines by November 30, 2010.

21 (2) The methodology developed pursuant to this section shall  
22 include, but not be limited to, the following requirements and  
23 performance measures:

24 (A) Beginning in the 2011–12 fiscal year:

25 (i) Immunization rates.

26 (ii) Facility acquired pressure ulcer incidence.

27 (iii) The use of physical restraints.

28 (iv) Compliance with the ~~nursing~~ *direct care service* hours per  
29 patient per day requirements pursuant to Section 1276.5 of the  
30 Health and Safety Code.

31 (v) Resident and family satisfaction.

32 (vi) Direct care staff retention, if sufficient data is available.

33 (B) *Beginning in the 2017–18 fiscal year, compliance with the*  
34 *direct care service hour requirements for skilled nursing facilities*  
35 *established pursuant to Section 1276.65 of the Health and Safety*  
36 *Code and Section 14110.7 of this code.*

37 ~~(B)~~

38 (C) If this act is extended beyond the dates on which it becomes  
39 inoperative and is repealed, in accordance with Section 14126.033,  
40 the department, in consultation with representatives from the

1 long-term care industry, organized labor, and consumers, beginning  
2 in the 2013–14 rate year, shall incorporate additional measures  
3 into the system, including, but not limited to, quality and  
4 accountability measures required by federal health care reform  
5 that are identified by the federal Centers for Medicare and Medicaid  
6 Services.

7 ~~(C)~~

8 (D) The department, in consultation with representatives from  
9 the long-term care industry, organized labor, and consumers, may  
10 incorporate additional performance measures, including, but not  
11 limited to, the following:

12 (i) Compliance with state policy associated with the United  
13 States Supreme Court decision in *Olmstead v. L.C. ex rel. Zimring*  
14 (1999) 527 U.S. 581.

15 (ii) Direct care staff retention, if not addressed in the 2012–13  
16 rate year.

17 (iii) The use of chemical restraints.

18 ~~(D)~~

19 (E) Beginning with the 2015–16 fiscal year, the department, in  
20 consultation with representatives from the long-term care industry,  
21 organized labor, and consumers, shall incorporate direct care staff  
22 retention as a performance measure in the methodology developed  
23 pursuant to this section.

24 (j) (1) Beginning with the 2010–11 rate year, and pursuant to  
25 subparagraph (B) of paragraph (5) of subdivision (a) of Section  
26 14126.023, the department shall set aside savings achieved from  
27 setting the professional liability insurance cost category, including  
28 any insurance deductible costs paid by the facility, at the 75th  
29 percentile. From this amount, the department shall transfer the  
30 General Fund portion into the Skilled Nursing Facility Quality and  
31 Accountability Special Fund. A skilled nursing facility shall  
32 provide supplemental data on insurance deductible costs to  
33 facilitate this adjustment, in the format and by the deadlines  
34 determined by the department. If this data is not provided, a  
35 facility's insurance deductible costs will remain in the  
36 administrative costs category.

37 (2) Notwithstanding paragraph (1), for the 2012–13 rate year  
38 only, savings from capping the professional liability insurance cost  
39 category pursuant to paragraph (1) shall remain in the General

1 Fund and shall not be transferred to the Skilled Nursing Facility  
2 Quality and Accountability Special Fund.

3 (k) For the 2013–14 rate year, if there is a rate increase in the  
4 weighted average Medi-Cal reimbursement rate, the department  
5 shall set aside the first 1 percent of the weighted average Medi-Cal  
6 reimbursement rate increase for the Skilled Nursing Facility Quality  
7 and Accountability Special Fund.

8 (l) If this act is extended beyond the dates on which it becomes  
9 inoperative and is repealed, for the 2014–15 rate year, in addition  
10 to the amount set aside pursuant to subdivision (k), if there is a  
11 rate increase in the weighted average Medi-Cal reimbursement  
12 rate, the department shall set aside at least one-third of the weighted  
13 average Medi-Cal reimbursement rate increase, up to a maximum  
14 of 1 percent, from which the department shall transfer the General  
15 Fund portion of this amount into the Skilled Nursing Facility  
16 Quality and Accountability Special Fund.

17 (m) Beginning with the 2015–16 rate year, and each subsequent  
18 rate year thereafter for which this article is operative, an amount  
19 equal to the amount deposited in the fund pursuant to subdivisions  
20 (k) and (l) for the 2014–15 rate year shall be deposited into the  
21 Skilled Nursing Facility Quality and Accountability Special Fund,  
22 for the purposes specified in this section.

23 (n) (1) (A) Beginning with the 2013–14 rate year, the  
24 department shall pay a supplemental payment, by April 30, 2014,  
25 to skilled nursing facilities based on all of the criteria in subdivision  
26 (i), as published by the department, and according to performance  
27 measure benchmarks determined by the department in consultation  
28 with stakeholders.

29 (B) (i) The department may convene a diverse stakeholder  
30 group, including, but not limited to, representatives from consumer  
31 groups and organizations, labor, nursing home providers, advocacy  
32 organizations involved with the aging community, staff from the  
33 Legislature, and other interested parties, to discuss and analyze  
34 alternative mechanisms to implement the quality and accountability  
35 payments provided to nursing homes for reimbursement.

36 (ii) The department shall articulate in a report to the fiscal and  
37 appropriate policy committees of the Legislature the  
38 implementation of an alternative mechanism as described in clause  
39 (i) at least 90 days prior to any policy or budgetary changes, and  
40 seek subsequent legislation in order to enact the proposed changes.

1 (2) Skilled nursing facilities that do not submit required  
2 performance data by the department's specified data submission  
3 deadlines pursuant to subdivision (i) shall not be eligible to receive  
4 supplemental payments.

5 (3) Notwithstanding paragraph (1), if a facility appeals the  
6 performance measure of compliance with the ~~nursing direct care~~  
7 *service* hours per patient per day requirements, pursuant to Section  
8 1276.5 of the Health and Safety Code, to the State Department of  
9 Public Health, and it is unresolved by the department's published  
10 due date, the department shall not use that performance measure  
11 when determining the facility's supplemental payment.

12 (4) Notwithstanding paragraph (1), if the department is unable  
13 to pay the supplemental payments by April 30, 2014, then on May  
14 1, 2014, the department shall use the funds available in the Skilled  
15 Nursing Facility Quality and Accountability Special Fund as a  
16 result of savings identified in subdivisions (k) and (l), less the  
17 administrative costs required to implement subparagraphs (A) and  
18 (B) of paragraph (3) of subdivision (b), in addition to any Medicaid  
19 funds that are available as of December 31, 2013, to increase  
20 provider rates retroactively to August 1, 2013.

21 (o) The department shall seek necessary approvals from the  
22 federal Centers for Medicare and Medicaid Services to implement  
23 this section. The department shall implement this section only in  
24 a manner that is consistent with federal Medicaid law and  
25 regulations, and only to the extent that approval is obtained from  
26 the federal Centers for Medicare and Medicaid Services and federal  
27 financial participation is available.

28 (p) In implementing this section, the department and the State  
29 Department of Public Health may contract as necessary, with  
30 California's Medicare Quality Improvement Organization, or other  
31 entities deemed qualified by the department or the State  
32 Department of Public Health, not associated with a skilled nursing  
33 facility, to assist with development, collection, analysis, and  
34 reporting of the performance data pursuant to subdivision (i), and  
35 with demonstrated expertise in long-term care quality, data  
36 collection or analysis, and accountability performance measurement  
37 models pursuant to subdivision (i). This subdivision establishes  
38 an accelerated process for issuing any contract pursuant to this  
39 section. Any contract entered into pursuant to this subdivision shall

1 be exempt from the requirements of the Public Contract Code,  
2 through December 31, 2020.

3 (q) Notwithstanding Chapter 3.5 (commencing with Section  
4 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
5 the following shall apply:

6 (1) The director shall implement this section, in whole or in  
7 part, by means of provider bulletins, or other similar instructions  
8 without taking regulatory action.

9 (2) The State Public Health Officer may implement this section  
10 by means of ~~all facility~~ *all-facility* letters, or other similar  
11 instructions without taking regulatory action.

12 (r) Notwithstanding paragraph (1) of subdivision (n), if a final  
13 judicial determination is made by any state or federal court that is  
14 not appealed, in any action by any party, or a final determination  
15 is made by the administrator of the federal Centers for Medicare  
16 and Medicaid Services, that any payments pursuant to subdivisions  
17 (a) and (n), are invalid, unlawful, or contrary to any provision of  
18 federal law or regulations, or of state law, these subdivisions shall  
19 become inoperative, and for the 2011–12 rate year, the rate increase  
20 provided under subparagraph (A) of paragraph (4) of subdivision  
21 (c) of Section 14126.033 shall be reduced by the amounts described  
22 in subdivision (j). For the 2013–14 and 2014–15 rate years, any  
23 rate increase shall be reduced by the amounts described in  
24 subdivisions (j) to (l), inclusive.

25 SEC. 6. No reimbursement is required by this act pursuant to  
26 Section 6 of Article XIII B of the California Constitution because  
27 the only costs that may be incurred by a local agency or school  
28 district will be incurred because this act creates a new crime or  
29 infraction, eliminates a crime or infraction, or changes the penalty  
30 for a crime or infraction, within the meaning of Section 17556 of  
31 the Government Code, or changes the definition of a crime within  
32 the meaning of Section 6 of Article XIII B of the California  
33 Constitution.

**ASSEMBLY BILL**

**No. 2606**

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**Introduced by Assembly Member Grove**

February 19, 2016

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An act to add Chapter 14 (commencing with Section 368.7) to Title 9 of Part 1 of the Penal Code, relating to crimes.

LEGISLATIVE COUNSEL'S DIGEST

AB 2606, as introduced, Grove. Crimes against children, elders, dependent adults, and persons with disabilities.

The Child Abuse and Neglect Reporting Act requires a law enforcement agency that receives a report of child abuse to report to an appropriate licensing agency every known or suspected instance of child abuse or neglect that occurs while the child is being cared for in a child day care facility or community care facility or that involves a licensed staff person of the facility.

Existing law proscribes the commission of certain crimes against elders and dependent adults, including, but not limited to, inflicting upon an elder or dependent adult unjustifiable physical pain or mental suffering, as specified. Existing law proscribes the commission of a hate crime, as defined, against certain categories of persons, including disabled persons.

Existing law provides for the licensure of various healing arts professionals, and specifies that the commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action against the licensee. Existing law also establishes that the crime of sexual exploitation by a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor has occurred when the licensee

engages in specified sexual acts with a patient, client, or former patient or client.

This bill would require, if a law enforcement agency receives a report, or if a law enforcement officer makes a report, that a person who holds a state professional or occupational credential, license, or permit that allows the person to provide services to children, elders, dependent adults, or persons with disabilities is alleged to have committed one or more of specified crimes, the law enforcement agency to promptly send a copy of the report to the state licensing agency that issued the credential, license, or permit. By imposing additional duties on law enforcement agencies, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: yes.

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

1 SECTION 1. Chapter 14 (commencing with Section 368.7) is  
2 added to Title 9 of Part 1 of the Penal Code, to read:

3

4 CHAPTER 14. REPORTING CRIMES AGAINST CHILDREN, ELDERS,  
5 DEPENDENT ADULTS, AND PERSONS WITH DISABILITIES

6

7 368.7. If a law enforcement agency receives a report, or if a  
8 law enforcement officer makes a report, that a person who holds  
9 a state professional or occupational credential, license, or permit  
10 that allows the person to provide services to children, elders,  
11 dependent adults, or persons with disabilities is alleged to have  
12 committed one or more of the crimes described in subdivisions (a)  
13 to (f), inclusive, the law enforcement agency shall promptly send  
14 a copy of the report to the state agency that issued the credential,  
15 license, or permit.

1 (a) Sexual exploitation by a physician and surgeon,  
2 psychotherapist, or drug or alcohol abuse counselor, as described  
3 in Section 729 of the Business and Professions Code.

4 (b) Rape or other crimes described in Chapter 1 (commencing  
5 with Section 261).

6 (c) Elder or dependent adult abuse, failure to report elder or  
7 dependent adult abuse, interfering with a report of elder or  
8 dependent adult abuse or other crimes, as described in Chapter 13.

9 (d) A hate crime motivated by antidisability bias, as described  
10 in Chapter 1 (commencing with Section 422.55) of Title 11.6.

11 (e) Sexual abuse, as defined in Section 11165.1.

12 (f) Child abuse, failure to report child abuse, or interfering with  
13 a report of child abuse.

14 SEC. 2. If the Commission on State Mandates determines that  
15 this act contains costs mandated by the state, reimbursement to  
16 local agencies and school districts for those costs shall be made  
17 pursuant to Part 7 (commencing with Section 17500) of Division  
18 4 of Title 2 of the Government Code.

**ASSEMBLY BILL**

**No. 2701**

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**Introduced by Assembly Member Jones**

February 19, 2016

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An act to amend Section 453 of the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

AB 2701, as introduced, Jones. Department of Consumer Affairs: boards: training requirements.

Existing law provides for the licensure and regulation of various professions and vocations by various boards, as defined, within the Department of Consumer Affairs, and provides for the membership of those various boards. Existing law requires newly appointed board members, within one year of assuming office, to complete a training and orientation offered by the department regarding, among other things, the obligations of the board member. Existing law requires the department to adopt regulations necessary to establish the training and orientation program and its contents.

The Bagley-Keene Open Meeting Act (Bagley-Keene Act) generally requires, with specified exceptions for authorized closed sessions, that the meetings of state bodies be open and public and that all persons be permitted to attend. The Administrative Procedure Act governs the procedure for the adoption, amendment, or repeal of regulations by state agencies, and for the review of those regulatory actions by the Office of Administrative Law. Existing law requires every agency to adopt and promulgate a Conflict of Interest Code that contains, among other requirements, the circumstances under which designated employees or categories of designated employees must disqualify

themselves from making, participating in the making, or using their official position to influence the making of, any decision.

This bill would additionally require the training of new board members to include, but not be limited to, information regarding the requirements of the Bagley-Keene Act, the Administrative Procedure Act, the Office of Administrative Law, and the department's Conflict of Interest Code.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: no.

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

1 SECTION 1. Section 453 of the Business and Professions Code  
2 is amended to read:  
3 453. Every newly appointed board member shall, within one  
4 year of assuming office, complete a training and orientation  
5 program offered by the department regarding, among other things,  
6 his or her functions, responsibilities, and obligations as a member  
7 of a board. *This training shall include, but is not limited to,*  
8 *information about the Bagley-Keene Open Meeting Act (Article 9*  
9 *(commencing with Section 11120) of Chapter 1 of Part 1 of*  
10 *Division 3 of Title 2 of the Government Code), the Administrative*  
11 *Procedure Act (Chapter 3.5 (commencing with Section 11340) of*  
12 *Part 1 of Division 3 of Title 2 of the Government Code), the Office*  
13 *of Administrative Law, and the department's Conflict of Interest*  
14 *Code, as required pursuant to Section 87300 of the Government*  
15 *Code.* The department shall adopt regulations necessary to establish  
16 this training and orientation program and its content.

## 2015 - 2016 BOARD CO-SPONSORED LEGISLATION

### ASSEMBLY BILL 923 (Steinorth - R)

Title: Respiratory care practitioners  
Introduced: February 26, 2015  
Last Amended: January 4, 2016  
Status: February 4, 2016 - Referred to Senate Business, Professions & Economic Development Committee

Under the Respiratory Care Practice Act, the Respiratory Care Board of California licenses and regulates the practice of respiratory care and therapy. The act authorizes the board to order the denial, suspension, or revocation of, or the imposition of probationary conditions upon, a license issued under the act, for any of specified causes. A violation of the act is a crime.

This bill would include among those causes for discipline the commission by specified licensees of an act of neglect, endangerment, or abuse involving a person under 18 years of age, a person 65 years of age or older, or a dependent adult, as described, without regard to whether the person is a patient, and the knowing provision of false statements or information on any form provided by the board or to any person representing the board during an investigation, probation monitoring compliance check, or any other enforcement-related action.

The bill would provide that the expiration, cancellation, forfeiture, or suspension of a license, practice privilege, or other authority to practice respiratory care, the placement of a license on a retired status, or the voluntary surrender of a license by a licensee, does 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 to suspend or revoke the license.

Under the act the board may take action against a respiratory care practitioner who is charged with unprofessional conduct which includes, but is not limited to, repeated acts of clearly administering directly or indirectly inappropriate or unsafe respiratory care procedures, protocols, therapeutic regimens, or diagnostic testing or monitoring techniques, and violation of any provision for which the board may order the denial, suspension, or revocation of, or the imposition of probationary conditions upon, a license. The act provides that engaging in repeated acts of unprofessional conduct is a crime.

This bill would expand the definition of unprofessional conduct to include any act of abuse towards a patient.

Position: **SUPPORT**

AMENDED IN ASSEMBLY JANUARY 4, 2016

AMENDED IN ASSEMBLY APRIL 6, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

**ASSEMBLY BILL**

**No. 923**

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**Introduced by Assembly Member Steinorth**

February 26, 2015

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An act to amend Sections 3750 and 3755 of, and to add ~~Sections 3754.8 and 3769.7~~ Section 3754.8 to, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 923, as amended, Steinorth. 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 authorizes the board to order the denial, suspension, or revocation of, or the imposition of probationary conditions upon, a license issued under the act, for any of specified causes. A violation of the act is a crime.

This bill would include among those causes for discipline the commission *by specified licensees* of an act of neglect, endangerment, or abuse involving a person under 18 years of age, a person 65 years of age or older, or a dependent adult, as described, *without regard to whether the person is a patient*, and the *knowing* provision of false statements or information on any form provided by the board or to any person representing the board during an investigation, probation monitoring compliance check, or any other enforcement-related action.

The bill would provide that the expiration, cancellation, forfeiture, or suspension of a license, practice privilege, or other authority to

practice respiratory care, the placement of a license on a retired status, or the voluntary surrender of a license by a licensee, does 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 to suspend or revoke the license.

(2) Under the act the board may take action against a respiratory care practitioner who is charged with unprofessional conduct which includes, but is not limited to, repeated acts of clearly administering directly or indirectly inappropriate or unsafe respiratory care procedures, protocols, therapeutic regimens, or diagnostic testing or monitoring techniques, and violation of any provision for which the board may order the denial, suspension, or revocation of, or the imposition of probationary conditions upon, a license. The act provides that engaging in repeated acts of unprofessional conduct is a crime.

This bill would expand the definition of unprofessional conduct to include ~~any single act described above or any single act of abusive behavior, including, but not limited to, humiliation, intimidation, ridicule, coercion, threat, or any other conduct that threatens the health, welfare, or safety of a person, whether or not the victim is a patient, a friend or family member of the patient, or an employee. any act of abuse towards a patient.~~ Because this bill would change the definition of a crime, it would impose a state-mandated local program.

~~(3) The act authorizes the board to deny, suspend, or take other actions against a license for, among other things, conviction of a sex offense or any crime involving bodily injury or sexual misconduct.~~

~~This bill would authorize the board to provide notice of an applicant's or licensee's arrest for those crimes on the board's Internet Web site, to employers, or both, and would require the board to remove the notice 60 days after the criminal matter is adjudicated or when all appeal rights have been exhausted, whichever is later.~~

(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: yes.

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

1 SECTION 1. Section 3750 of the Business and Professions  
2 Code is amended to read:

3 3750. The board may order the denial, suspension, or revocation  
4 of, or the imposition of probationary conditions upon, a license  
5 issued under this chapter, for any of the following causes:

6 (a) Advertising in violation of Section 651 or Section 17500.

7 (b) Fraud in the procurement of any license under this chapter.

8 (c) Knowingly employing unlicensed persons who present  
9 themselves as licensed respiratory care practitioners.

10 (d) Conviction of a crime that substantially relates to the  
11 qualifications, functions, or duties of a respiratory care practitioner.  
12 The record of conviction or a certified copy thereof shall be  
13 conclusive evidence of the conviction.

14 (e) Impersonating or acting as a proxy for an applicant in any  
15 examination given under this chapter.

16 (f) Negligence in his or her practice as a respiratory care  
17 practitioner.

18 (g) Conviction of a violation of this chapter or of Division 2  
19 (commencing with Section 500), or violating, or attempting to  
20 violate, directly or indirectly, or assisting in or abetting the  
21 violation of, or conspiring to violate this chapter or Division 2  
22 (commencing with Section 500).

23 (h) The aiding or abetting of any person to violate this chapter  
24 or any regulations duly adopted under this chapter.

25 (i) The aiding or abetting of any person to engage in the unlawful  
26 practice of respiratory care.

27 (j) The commission of any fraudulent, dishonest, or corrupt act  
28 that is substantially related to the qualifications, functions, or duties  
29 of a respiratory care practitioner.

30 (k) Falsifying, or making grossly incorrect, grossly inconsistent,  
31 or unintelligible entries in any patient, hospital, or other record.

32 (l) Changing the prescription of a physician and surgeon, or  
33 falsifying verbal or written orders for treatment or a diagnostic  
34 regime received, whether or not that action resulted in actual patient  
35 harm.

36 (m) Denial, suspension, or revocation of any license to practice  
37 by another agency, state, or territory of the United States for any

1 act or omission that would constitute grounds for the denial,  
2 suspension, or revocation of a license in this state.

3 (n) (1) Except for good cause, the knowing failure to protect  
4 patients by failing to follow infection control guidelines of the  
5 board, thereby risking transmission of bloodborne infectious  
6 diseases from licensee to patient, from patient to patient, and from  
7 patient to licensee. In administering this subdivision, the board  
8 shall consider referencing the standards, regulations, and guidelines  
9 of the State Department of Health Services developed pursuant to  
10 Section 1250.11 of the Health and Safety Code and the standards,  
11 regulations, and guidelines pursuant to the California Occupational  
12 Safety and Health Act of 1973 (Part 1 (commencing with Section  
13 6300) of Division 5 of the Labor Code) for preventing the  
14 transmission of HIV, hepatitis B, and other bloodborne pathogens  
15 in health care settings. As necessary, the board shall consult with  
16 the California Medical Board, the Board of Podiatric Medicine,  
17 the Dental Board of California, the Board of Registered Nursing,  
18 and the Board of Vocational Nursing and Psychiatric Technicians,  
19 to encourage appropriate consistency in the implementation of this  
20 subdivision.

21 The

22 (2) *The* board shall seek to ensure that licensees are informed  
23 of the responsibility of licensees and others to follow infection  
24 control guidelines, and of the most recent scientifically recognized  
25 safeguards for minimizing the risk of transmission of bloodborne  
26 infectious diseases.

27 (o) Incompetence in his or her practice as a respiratory care  
28 practitioner.

29 (p) A pattern of substandard care or negligence in his or her  
30 practice as a respiratory care practitioner, or in any capacity as a  
31 health care worker, consultant, supervisor, manager or health  
32 facility owner, or as a party responsible for the care of another.

33 (q) ~~Commission~~ *If the licensee is a mandated reporter or is*  
34 *required to report under Article 2 (commencing with Section*  
35 *11160) or Article 2.5 (commencing with Section 11164) of Title 1*  
36 *of Part 4 of the Penal Code. The commission of an act of neglect,*  
37 *endangerment, or abuse involving a person under 18 years of age,*  
38 *a person 65 years of age or older, or a dependent adult as described*  
39 *in Section 368 of the Penal Code, without regard to whether the*  
40 *person was is a patient.*

1 (r) ~~Providing~~—*Knowingly providing* false statements or  
2 information on any form provided by the board or to any person  
3 representing the board during an investigation, probation  
4 monitoring compliance check, or any other enforcement-related  
5 action.

6 SEC. 2. Section 3754.8 is added to the Business and Professions  
7 Code, to read:

8 3754.8. The expiration, cancellation, forfeiture, or suspension  
9 of a license, practice privilege, or other authority to practice  
10 respiratory care by operation of law or by order or decision of the  
11 board or a court of law, the placement of a license on a retired  
12 status, or the voluntary surrender of the license by a licensee shall  
13 not deprive the board of jurisdiction to commence or proceed with  
14 any investigation of, or action or disciplinary proceeding against,  
15 the licensee, or to render a decision to suspend or revoke the  
16 license.

17 SEC. 3. Section 3755 of the Business and Professions Code is  
18 amended to read:

19 3755. The board may take action against ~~any a~~ respiratory care  
20 practitioner who is charged with unprofessional conduct in  
21 administering, or attempting to administer, direct or indirect  
22 respiratory care in any care setting. Unprofessional conduct  
23 includes, but is not limited to, ~~any act repeated acts~~ of clearly  
24 administering directly or indirectly inappropriate or unsafe  
25 respiratory care procedures, protocols, therapeutic regimens, or  
26 diagnostic testing or monitoring techniques, ~~abusive behavior,~~  
27 ~~including, but not limited to, humiliation, intimidation, ridicule,~~  
28 ~~coercion, threat, or any other conduct that threatens the health,~~  
29 ~~welfare, or safety of a person, whether or not the victim is a patient,~~  
30 ~~a friend or family member of the patient, or an employee, any act~~  
31 ~~of abuse towards a patient, or a violation of any provision of~~  
32 Section 3750. The board may determine unprofessional conduct  
33 involving any and all aspects of respiratory care performed by  
34 anyone licensed as a respiratory care practitioner. Any person who  
35 engages in repeated acts of unprofessional conduct shall be guilty  
36 of a misdemeanor and shall be punished by a fine of not more than  
37 one thousand dollars (\$1,000), or by imprisonment for a term not  
38 to exceed six months, or by both that fine and imprisonment.

39 SEC. 4. ~~Section 3769.7 is added to the Business and Professions~~  
40 ~~Code, to read:~~

1       ~~3769.7. (a) If a licensee or applicant is arrested for any crime~~  
2 ~~described in Section 3752.5, 3752.6, or 3752.7, upon receipt of~~  
3 ~~certified copies of arrest documents, the board may provide notice~~  
4 ~~of the licensee's or applicant's arrest on the board's Internet Web~~  
5 ~~site, to employers, or both.~~

6       ~~(b) If the board provides notice of a licensee's or applicant's~~  
7 ~~arrest pursuant to this section, the board shall remove the notice~~  
8 ~~60 days after the criminal matter is adjudicated or when all appeal~~  
9 ~~rights have been exhausted, whichever is later.~~

10       ~~SEC. 5.~~

11       ~~SEC. 4.~~ No reimbursement is required by this act pursuant to  
12 Section 6 of Article XIII B of the California Constitution because  
13 the only costs that may be incurred by a local agency or school  
14 district will be incurred because this act creates a new crime or  
15 infraction, eliminates a crime or infraction, or changes the penalty  
16 for a crime or infraction, within the meaning of Section 17556 of  
17 the Government Code, or changes the definition of a crime within  
18 the meaning of Section 6 of Article XIII B of the California  
19 Constitution.