

Governor Edmund G. Brown Jr.
State of California

Alexis Podesta, Acting Secretary
Business, Consumer Services
and Housing Agency

Awet Kidane, Director
Department of Consumer Affairs



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

Thomas Wagner, BS, RRT, FAARC
Vice-President

Mary Ellen Early
Member

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
Website: www.rcb.ca.gov

Respiratory Care Board of California

3750 Rosin Court, Suite 100, Sacramento, CA 95834

Board Meeting Agenda

June 24, 2016

10:00 AM

TELEPHONE CONFERENCE LOCATIONS

Respiratory Care Board
3750 Rosin Court, Suite 100
Sacramento, CA 95834

South San Francisco Main Library
840 West Orange Avenue
South San Francisco, CA 94080

Assemblyman Chad Mayes
Rancho Mirage District Office
41608 Indian Trail, Suite 1
Rancho Mirage, CA 92270

Ohlone College
Health Science & Env. Studies Dept.
39399 Cherry Street, Room NC 2200
Newark, CA 94560

Evanston Public Library
1703 Orrington Avenue
Evanston, IL 60201

10:00 a.m. **Call to Order and Establishment of Quorum**

1. Public Comment

Public comment will be accepted after each agenda item and toward the end of the agenda for public comment not related to any particular agenda item. The President may set a time limit for public comment as needed.

2. Approval of March 11, 2016 Minutes [Action Item]

3. Status Updates [Information and discussion only]

- a. Legislation: AB 923 and SB 1334
- b. Little Hoover Commission Review: Occupational Licensing

4. Workforce Study: Update and Request for Extension [Action Item]

5. Consideration to Support “Position Statement Pertaining to Concurrent Therapy” by the California Society for Respiratory Care [Action Item]

6. Consideration of California Society for Respiratory Care’s (CSRC’s) Request to Update the Law and Professional Ethics Continuing Education Course [Action Item]

7. Public Comment on Items Not on the Agenda

8. Future Agenda Items (Next meeting: October 7th, Sacramento)

• **Closed Session** •

[Not Open to the Public]

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 **

Adjournment

NOTICE

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.

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 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.



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PUBLIC SESSION MINUTES

Friday, March 11, 2016

**Hilton San Diego Mission Valley
901 Camino Del Rio South
San Diego, CA 92108**

Members Present: Alan Roth, MS MBA RRT-NPS FAARC, President
Thomas Wagner, BS, RRT, FAARC, Vice President
Mary Ellen Early
Mark Goldstein
Michael Hardeman
Ronald Lewis, M.D.

Staff Present: Kelsey Pruden, Legal Counsel
Stephanie Nunez, Executive Officer
Christine Molina, Staff Services Manager

CALL TO ORDER

The Public Session was called to order at 8:00 a.m. by President Roth. A quorum was established.

Roll Call (present: Early, Goldstein, Hardeman, Lewis, Roth, Wagner)

PUBLIC COMMENT

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

APPROVAL OF NOVEMBER 6, 2015 MINUTES

Dr. Lewis moved to approve the November 6, 2015 Public Session minutes as written.

M/Lewis /S/Wagner

In favor: Early, Hardeman, Lewis Roth, Wagner

Abstain: Goldstein

MOTION PASSED

EXECUTIVE OFFICER'S REPORT

(Nunez)

a. Sunset Review:

Ms. Nunez stated the written report for Sunset Review will be due sometime at the end of the year adding she is not yet sure what it will consist of but expects a change in format. She further explained that the Board's sunset hearing will likely be scheduled for this time next year.

b. Staffing Ratios

Ms. Nunez reminded the Board of the discussion on staffing ratios from the last meeting. During that meeting Ms. Early stated developing staffing ratios seemed to be beyond the Board's purview, and Mr. Wagner requested staff talk to CSRC about possibly developing a ratio proposal. After discussing it with CSRC, Ms. Nunez determined that CSRC had already been working on staffing ratios and is looking forward to the outcome of their study which will be shared once it is available.

President Roth stated the Board has been successful in completing the majority of the Strategic Plan items relative to the last Sunset Review

Request for Public Comment:

Michael Madison, CSRC President, confirmed CSRC is actively working on requests to come up with a safe staffing practices statement. He stated they have sifted through an abundance of data and will be using a two-step process focusing first on the requirements for safe staffing then the ratio will come in later. He added, UCSD has done some great work in the past which the North Carolina Board later adopted. He hopes to submit something to the Board on or before July 1, 2016.

President Roth inquired how the CSRC's staffing ratio study is relevant to the AARC and national standards.

Mr. Madison stated, the AARC Uniform Reporting Manual is one of the CSRC's reference documents as well as Title 22. They are also referencing the nursing section of Title 22. He added they also sent out network requests, through the AARC, to all state affiliate presidents and all members of the AARC's House of Delegates to get feedback from them in terms of policies, procedures and "rules of thumbs" that they use for following safe standards.

Dr. Lewis inquired whether the staffing ratio is based on the acuteness of the patient or the type of equipment that is being utilized by that particular patient and if there will be built-in safety measures to accommodate for a change in patient status.

Mr. Madison stated that most hospitals have some sort of rule of thumb for such occurrences. He used an example of oxygen and PAP therapy as a threshold with anything above that in acuity level or

1 difficulty having some type of respiratory assessment action. He added staffing ratios can essentially
2 be built off of that point.

3
4 President Roth inquired whether the study was also looking at data concerning outpatient facilities
5 and outpatient care.

6
7 Mr. Madison replied that they have looked at data from several sources such as pulmonary
8 rehabilitation, COPD rehabilitation, and cystic fibrosis support management.

10 **4. 2013-2016 STRATEGIC PLAN REVIEW**

11 *(Roth)*

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13
14 President Roth reviewed the status and progress of some of the Strategic Plan items as follows:

- 15
16 Item 2.4 Define limits of RCP's responsibility on home delivery of equipment and patient care.
17 Item 2.9 Pursue legislative or regulatory amendments to gain or clarify authorization that would
18 allow RCPs who meet certain requirements to write orders including medications under
19 protocol.
20 Item 4.2 Pursue budget change proposals to secure additional staffing to meet strategic
21 objectives.

22
23 Dr. Lewis inquired about item 4.3, where it mentioned that the BreEZe online feature was not yet
24 available to new applicants and asked if this was still an outstanding item or if BreEZe is now
25 available to all users (licensees and applicants). He also inquired if a licensee's status is also
26 available to the public on Breeze.

27
28 Ms. Nunez replied that currently initial applicants cannot apply online, however, once an individual has
29 been licensed they can renew through BreEZe. She added this is a priority for DCA but has been
30 delayed until after the Breeze Release 2. Ms. Nunez added that the public can view an RCP's license
31 status online through BreEZe.

32 **Request for Public Comment:**

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34
35 Jeffrey Davis, Director of Respiratory Care Services at UCLA, stated he approves of the new BreEZe
36 system and commented on the ease of use as a practitioner. He added, the managers use it regularly
37 and are able to check the status of every employee through the system.

38 **5. CALIFORNIA EXAM STATISTICS**

39 *(Roth)*

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41
42
43 President Roth reviewed the exam data from the NBRC for the new RRT exam. He stated the pass
44 rate for the Therapist Multiple Choice exam (high cut) dropped initially then rose significantly by the 4th
45 quarter, averaging at about 56% for the entire year. The new Clinical Simulation Exam has doubled
46 the number of clinical simulations and as a result the pass rate has dropped for 2015. He added
47 repeat examinations continue to be low. President Roth stated the exam has changed significantly
48 from a recall type to more of an applicable exam, better testing the ability to make decisions. He
49 added programs should be aware of these statistics when preparing their students. Many respiratory
50 directors do not feel that students are well prepared for the rigors of an acute care scenario in all
51 areas. President Roth mentioned a couple of the specialty areas lacking in knowledge are diagnostic
52 and pulmonary rehabilitation.

1 Dr. Lewis inquired how these numbers compare among different states as this is national data being
2 presented.

3
4 Ms. Nunez responded that the data was not separated by states. She stated there was some
5 expectation that the pass percentages would initially drop, however, it actually did not drop as much
6 as expected. She added that, as predicted, the Board did experience a drop in new licensees of
7 about 300/year due to the increase to the new RRT exam.

8
9 Dr. Lewis inquired if there is an additional exam respiratory therapists take years after becoming
10 licensed and how competency is accessed in the more seasoned respiratory care practitioners if not
11 through written exam (for example testing every 10 years).

12
13 President Roth stated most hospitals and institutions have annual competency days where therapists
14 review high risk procedures and problem prone areas and are tested both written and hands on.

15
16 **Request for Public Comment:**

17
18 Wayne Walls, Educator from Lakewood California, stated programs were not geared up for the
19 change in the requirements. The contributing factors to those statistics are changing the exam format
20 by the NBRC and the new RRT requirement in California. Historically, the RRT exam was not a
21 minimum entry level program. As such, most programs did not prepare students to take the RRT
22 exam anticipating the practitioners would go on and get practical application after getting licensed
23 then return to take the RRT exam. He added, in his opinion, there are not enough hours in an
24 Associate Degree program to meet all of the needs across the entire spectrum of services to include
25 rehab, home care, alternate care site as well as acute care settings. He believes the Board should
26 consider looking at a baccalaureate degree as a minimum requirement to prepare those entering the
27 profession as well as to promote the growth of the profession.

28
29 Jeffrey Davis, UCLA, stated as a manager of a large teaching hospital, he has seen in the past 30
30 years, a change in that so much more is being required coming out of school. While he believes there
31 is still a place for the Associate Degree program (as there are hospitals that do not perform advance
32 procedures), there is definitely a need for advanced degree training. He added it is important to make
33 sure it is not just a baccalaureate degree but a degree in respiratory care.

34
35
36 **6. ENFORCEMENT PERFORMANCE MEASURES AND STATISTICS**

37
38 President Roth reviewed the Performance Measures and commended staff for their excellent work
39 and ability to expedite all licensing issues as they pertain to the Performance Measure results.

40
41 Ms. Early questioned how and by whom the targets for the Performance Measures were set.

42
43 Ms. Nunez responded that several years ago, the Department asked each board to set their own
44 targets. Many Boards selected the same targets which have resulted in similarities across the Boards.

45
46 Ms. Early then questioned that in the interest of total quality improvement, would it make sense to
47 raise the benchmarks by lowering some of the targets since the Board seemed to be performing so
48 well.

49
50 Ms. Nunez stated that although she understood the logic behind the question, the problem lies in
51 when the Board goes before the Legislature for the Sunset Review or a Budget Proposal, if the Board
52 is not meeting their target, it can be held against them. So lowering the targets could harm the Board.

53

1 Dr. Lewis stated, he believes these targets are serving the public well and to change could possibly
2 work against the Board.

3
4 President Roth added the Strategic Plan should be used as a tool for improving quality as opposed to
5 changing the performance measures.

6
7 Ms. Early praised the staff for doing a marvelous job on these Performance Measures.
8

9
10 **7. PRESENTATION AND DISCUSSION ON THE NORTH CAROLINA STATE BOARD OF DENTAL**
11 **EXAMINERS VS. FEDERAL TRADE COMMISSION DECISION AND ATTORNEY GENERAL**
12 **OPINION**
13 *(Pruden)*
14

15 Ms. Pruden gave an overview of the case of the North Carolina State Board of Dental Examiners vs.
16 the Federal Trade Commission:
17

18 In February of last year, the Supreme Court issued a decision which addressed whether a personal
19 licensing board with licensing members can be held liable for violations of the Anti-Trust Law. The
20 following September, the Attorney General issued an opinion addressing the case. In October of
21 2015, the Federal Trade Commission staff also issued guidance on this topic. Ms. Pruden stated that
22 the Board should note that Anti-Trust Laws seek to prohibit anti-competitive economic practices. In
23 theory, regulation of being anti-competitive as it restricts competition by certain controls in the market
24 place. State agencies may displace competition for public policy purposes. State agencies cannot be
25 held liable for violating anti-trust laws if the action is taken pursuant to the clearly articulated and
26 permanently expressed state policies to displace competition. Until the North Carolina case, it was
27 widely believed that the same standard applied to state licensing boards such as the RCB and other
28 boards within DCA. The decision of the United States Supreme Court held that a state board with a
29 controlling number of decision makers, who are active participants in the occupation that the board
30 regulates, must meet an active supervision requirement to receive Anti-Trust State Action Immunity.
31

32 In the North Carolina Case, the N.C. Board of Dental Examiners was made up of six dentists, one
33 dental hygienist and one consumer member. The Board received complaints of non-dentists providing
34 teeth whitening services to which the Board opened an investigation and eventually issued multiple
35 "Cease and Desist" letters. North Carolina statutes and regulations did not specifically address
36 whether teeth whitening was held within the scope of practices of dentistry. The Board ultimately did
37 not have the authority to issue "Cease and Desist" letters.
38

39 The Federal Trade Commission brought an action against the anti-trust laws. The case was
40 eventually heard by the United States Supreme Court. The Attorney General identified broad areas of
41 operation for Board members to act with reasonable conference. These areas include but are:
42

- 43 1.) Provocation of ordinary regulations carried out under applicable rules as the process
44 includes public notice, re-justification, and review by The Office of Administrated Law.
- 45 2.) Individual disciplinary decisions carried out under applicable rules because of due process
46 procedures. Participation of State actors such as the Executive Officer, the Investigators,
47 the Attorney General's Office, House Counsel and Administrative Law Judges.
- 48 3.) Carrying out acts required by a statutory law as the Legislature has provided that
49 supervision.
- 50 4.) Actions with competitive facts such as the adoption of safety standards based on objective,
51 expert judgments for measures making information available for consumer's relating,
52 competing products.
53

1 The Attorney General also suggested that state boards should be taught to recognize actual anti-trust
2 issues.
3

4 Along with the Attorney General's Office, the Department of Consumer Affairs has also recently
5 provided some options. The Attorney General and the Federal Trade Commission opinions both
6 indicate that the controlling number of active market participants implicates the need for active seat
7 supervision not simply a majority of the Board Members. DCA has recognized important lessons from
8 these resources and has been working to assist the Boards in understanding anti-trust issues and
9 identifying market sensitive decisions. The Legal Affairs Department will continue to provide guidance
10 as this area of law continues to develop. Ms. Pruden will be working proactively with the Board
11 pointing out issues as they arise.
12

13 Dr. Lewis stated that the RCB was likely not in the sights of the public as much as other boards are.
14

15 Ms. Pruden responded that although this issue was not on our radar before, it should not be
16 downplayed just because this particular board does not seem to be as much in the public eye as
17 others. Legal Affairs will definitely be proactive about issues.
18

19 **Public Comment:**

20 No public comment was received.
21
22

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24 **8. RCP WORKFORCE STUDY UPDATE/SCOPE OF WORK**

25 *(Roth)*
26

27 President Roth stated the UCSF has done a wonderful job on the Workforce Study in interviewing
28 directors and educators regarding critical respiratory care workforce issues. Some of the key findings
29 that emerged from the interviews included that the majority of directors felt that the new graduates
30 were not fully prepared for work upon graduation and supported establishing the baccalaureate
31 degree as a requirement to enter into respiratory therapy practice. A small number of directors,
32 however, expressed some concerns about the requirement of a baccalaureate degree citing a lack of
33 evidence that the bachelor's degree has an impact on patient outcomes.
34

35 President Roth stated not all respiratory care jobs require a bachelor's degree, such as those in the
36 lower acuity areas of the field. He added the gatekeeper of a particular job is the director of the
37 hospital and the scope of work that hospital does relative to respiratory care.
38

39 Dr. Lewis commented that the Board, ultimately, needs to make sure patients are protected and
40 served appropriately whether that is with a 2 year degree or a 4 year degree.
41

42 Mr. Wagner stated the emphasis is on the educational program. A standard has to be set on the
43 educational institutions where respiratory therapists come out of school and are able to perform at a
44 certain level.
45

46 Dr. Lewis stated the goal should be to train the trainers and get those preceptors trained.
47

48 President Roth stated he does not believe we have authority over the schools and this is something
49 the Board may need to look at relative to the strategic plan. He also stated that the curriculum is
50 different among the different programs and there is no clinical component in those additional two
51 years of the baccalaureate program. He added, CoARC does not specify the number of clinical hours
52 required for graduation anymore.
53

1 Mr. Goldstein stated this brings into question the efficacy of CoARC and whether going forward, it is in
2 itself, an adequate agency to meet the needs of protecting the patients. CoBGRTE is competing with
3 CoARC and advocating a much higher standard.
4

5 Mr. Goldstein made a motion that the workforce study proceed with the proposed study option #2
6 which offers: "Comparative analysis of associate degree vs. bachelor's degree curricula ... in
7 respiratory therapy for differences in course content related to the kinds of topics directors indicated
8 new graduates are not adequately exposed to in their education. Use the same analytical framework
9 to examine the curricula of other professions that have multiple educational pathways to licensure"

10 M/Goldstein /S/Lewis

11 In favor: Early, Goldstein, Hardeman, Lewis Roth, Wagner

12 Unanimous

13 MOTION PASSED
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16

17 **9. LITTLE HOOVER COMMISSION REVIEW: OCCUPATIONAL LICENSING**

18 *(Roth)*
19

20 President Roth reviewed the meeting held February 4, 2016 with the DCA boards' executive officers,
21 board presidents and the Little Hoover Commission who is reviewing occupational licensing in
22 California. He added there was no decision, at that time, about how the Commission will be moving
23 forward or what the scope of that will look like but he mentioned it is something the Board will need to
24 continue to pay attention to and remain a participant. The next meeting will be March 30, 2016 in
25 Culver City, California.
26
27

28 **10. DISCUSSION OF 2015 CALIFORNIA SOCIETY FOR RESPIRATORY CARE (CSRC) POSITION 29 STATEMENT PERTAINING TO CONCURRENT THERAPY**

30 *(Roth)*
31

32 President Roth stated he appreciates the attention to detail on the CSRC's Position Statement
33 pertaining to concurrent therapy He added it is a thoughtful and well put together paper about how
34 this effects the profession relative to care, assessment, patient advocacy and safety. He asked the
35 Board members if anyone had an objection to including this statement in the Board's newsletter. All
36 members supported the inclusion of the CSRC's statement pertaining to concurrent therapy in the
37 next newsletter.
38

39 **Public Comment:**

40
41 Mike Madison, CSRC President gave some history about the position statement stating a paper was
42 already in place and part of the references for that paper had become no longer applicable. As such,
43 CSRC went back and refreshed their references. He added the CSRC is looking for an endorsement
44 from the Respiratory Care Board for this position statement as it adds weight to the principles they
45 abide by concerning patient safety and care.
46

47 Vice President Wagner asked Ms. Pruden, Legal Counsel, to look into whether the Board is able to
48 offer a letter of support for this position and what restrictions the Board might have. This item will be
49 placed on a future agenda for further discussion and review.

11. LEGISLATIVE ACTION
(Molina/Nunez)

a. 2016 Legislation of Interest:

Ms. Molina reviewed and provided updates regarding the 2016 Legislation of Interest. The staff recommended positions are as follows:

- SB 66: Career Technical Education
Staff Recommended Position: Watch
- SB 547: Aging and long term care services, supports, and program coordination
Staff Recommended Position: Watch
- SB 1155: Profession and vocation: licenses: military services
Staff Recommended Position: Support
- SB 1334: Crime reporting: healthcare practitioners: human trafficking
Staff recommended Position: Watch
- SB 1348: Licensure applications: military experience
Staff Recommended Position: Watch
- AB 1939: Licensing Requirements
Staff Recommended Position: Watch
- AB 2079: Skilled nursing facilities: staffing
Staff Recommended Position: Support if amended
- AB 2606: Crimes against children, elders, dependent adults, and persons with disabilities
Staff Recommended Position: Support
- AB 2701: Department of Consumer Affairs: boards: training requirements
Staff Recommended Position: Watch

Ms. Molina explained this is the second year of a two year legislative cycle. Some bills have died and are no longer being reported upon while there are some new bills which have been identified as legislation of interest.

SB1155: Requires DCA to work with the Department of Veteran's Affairs to grant a fee waiver for the application and issuance of an initial license to an individual who is an honorable discharged veteran. Staff recommended a position of "Support" as this is in line with what has been done in the past by the Board, as far as expediting the processing of military applications.

AB 2079: The recommended staff position is "Support if Amended" and will depend upon what is presented by the CSRC regarding staffing ratios. This bill may provide the Board with an opportunity for proposed legislation since it is the same subject matter. However, at this point, it is specific to nurses and certified nursing assistants. It may give the Board an opportunity to work with the author if at some point the Board decides to move forward with the ratios.

AB 2606: The recommended position for this bill is "Support" because it is directly in line with the Board's consumer protection mandate. It would require law enforcement agencies to notify the Board immediately if a report of specific crimes (such as: child abuse, corporal injury against the elderly or dependent and hate crimes against the disabled) is made against a person who holds a license.

Dr. Lewis moved to approve the staff recommended positions as presented.

1 M/Lewis /S/Goldstein
2 In favor: Early, Goldstein, Hardeman, Lewis, Roth, Wagner
3 Unanimous
4 MOTION PASSED
5

6 **b. 2015/16 Board Sponsored Legislation: AB 923**
7

8 Ms. Nunez advised the Board that she has continued to work with legislative staff on AB 923 which
9 she expects to be successful this year.
10

11
12 =====
13 **CLOSED SESSION**
14

15 The Board convened into Closed Session, as authorized by Government Code Section 11126c,
16 subdivision (3) at 10:15 a.m. and reconvened into Public Session at 11:34 a.m.
17 =====

18
19
20 **13. PUBLIC COMMENT ON ITEMS NOT ON THE AGENDA**
21

22 No public comment was provided at this time.
23

24
25 **14. FUTURE AGENDA ITEMS**
26

27 Future agenda items include the discussion of the CSRC's request for endorsement of their position
28 statement pertaining to concurrent therapy.
29

30
31 **ADJOURNMENT**
32

33 The Public Session Meeting was adjourned by President Roth at 11:45 a.m.
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41 _____
42 ALAN ROTH
President

40
41 _____
42 STEPHANIE A. NUNEZ
Executive Officer

LEGISLATION UPDATE

ASSEMBLY BILL 923 (Steinorth - R)

Title: Respiratory care practitioners
Introduced: February 26, 2015
Last Amended: May 31, 2016
Status: June 6, 2016 - Referred to Senate Appropriations Committee

This bill is co-sponsored by the Respiratory Care Board and the California Society for Respiratory Care.

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 employment of an unlicensed person who presents herself or himself as a licensed respiratory care practitioner when the employer should have known the person was not licensed. The bill would also include among those causes for discipline the 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 when the individual knew or should have known the statements or information was false.

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 and any act of administering unsafe respiratory care procedures, protocols, therapeutic regimens, or diagnostic testing or monitoring techniques. Because this bill would change the definition of a crime, it 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.

Position: **SUPPORT**

SENATE BILL 1334 (Stone - R)

Senate Bill 1334 was identified as potential legislation of interest following the March Board Meeting. In accordance with Board policy, the Executive Committee was made aware of the bill and approved a support position on April 19, 2016. However, SB 1334 did not meet the legislative deadline to be passed out of its house of origin, so it is no longer an active bill.

Title: Crime Reporting: Health Practitioners: Reports
Introduced: February 19, 2016 / Last Amended: April 19, 2016
Status: May 27, 2106 - Held in Senate Appropriations: **Bill has died.**

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 require a health care practitioner who provides medical services to a patient who discloses that he or she is seeking treatment due to being the victim of assaultive or abusive conduct, to additionally make a report to a law enforcement agency. By increasing the scope of an existing crime, this bill would impose a state-mandated local program.

Position: **SUPPORT**

AMENDED IN SENATE MAY 31, 2016

AMENDED IN SENATE MAY 17, 2016

AMENDED IN ASSEMBLY JANUARY 4, 2016

AMENDED IN ASSEMBLY APRIL 6, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL**No. 923****Introduced by Assembly Member Steinorth**

February 26, 2015

An act to amend Sections 3750 and 3755 of, and to add 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 employment of an unlicensed person who presents herself or himself as a licensed respiratory care practitioner when the employer should have known the person was not licensed. ~~The bill would also 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.~~ The bill

would also include among those causes for discipline the 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 when the individual knew or should have known the statements or information was false.

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 act of abuse towards a patient and any act of administering unsafe respiratory care procedures, protocols, therapeutic regimens, or diagnostic testing or monitoring techniques. Because this bill would change the definition of a crime, it would impose a state-mandated local program.

(3) 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:

1 3750. The board may order the denial, suspension, or revocation
2 of, or the imposition of probationary conditions upon, a license
3 issued under this chapter, for any of the following causes:

4 (a) Advertising in violation of Section 651 or Section 17500.

5 (b) Fraud in the procurement of any license under this chapter.

6 (c) Employing an unlicensed person who presents herself or
7 himself as a licensed respiratory care practitioner when the
8 employer knew or should have known the person was not licensed.

9 (d) Conviction of a crime that substantially relates to the
10 qualifications, functions, or duties of a respiratory care practitioner.
11 The record of conviction or a certified copy thereof shall be
12 conclusive evidence of the conviction.

13 (e) Impersonating or acting as a proxy for an applicant in any
14 examination given under this chapter.

15 (f) Negligence in his or her practice as a respiratory care
16 practitioner.

17 (g) Conviction of a violation of this chapter or of Division 2
18 (commencing with Section 500), or violating, or attempting to
19 violate, directly or indirectly, or assisting in or abetting the
20 violation of, or conspiring to violate this chapter or Division 2
21 (commencing with Section 500).

22 (h) The aiding or abetting of any person to violate this chapter
23 or any regulations duly adopted under this chapter.

24 (i) The aiding or abetting of any person to engage in the unlawful
25 practice of respiratory care.

26 (j) The commission of any fraudulent, dishonest, or corrupt act
27 that is substantially related to the qualifications, functions, or duties
28 of a respiratory care practitioner.

29 (k) Falsifying, or making grossly incorrect, grossly inconsistent,
30 or unintelligible entries in any patient, hospital, or other record.

31 (l) Changing the prescription of a physician and surgeon, or
32 falsifying verbal or written orders for treatment or a diagnostic
33 regime received, whether or not that action resulted in actual patient
34 harm.

35 (m) Denial, suspension, or revocation of any license to practice
36 by another agency, state, or territory of the United States for any
37 act or omission that would constitute grounds for the denial,
38 suspension, or revocation of a license in this state.

39 (n) (1) Except for good cause, the knowing failure to protect
40 patients by failing to follow infection control guidelines of the

1 board, thereby risking transmission of bloodborne infectious
2 diseases from licensee to patient, from patient to patient, and from
3 patient to licensee. In administering this subdivision, the board
4 shall consider referencing the standards, regulations, and guidelines
5 of the State Department of Health *Care Services* developed
6 pursuant to Section 1250.11 of the Health and Safety Code and
7 the standards, regulations, and guidelines pursuant to the California
8 Occupational Safety and Health Act of 1973 (Part 1 (commencing
9 with Section 6300) of Division 5 of the Labor Code) for preventing
10 the transmission of HIV, hepatitis B, and other bloodborne
11 pathogens in health care settings. As necessary, the board shall
12 consult with the California Medical Board, the Board of Podiatric
13 Medicine, the Dental Board of California, the Board of Registered
14 Nursing, and the Board of Vocational Nursing and Psychiatric
15 Technicians, to encourage appropriate consistency in the
16 implementation of this subdivision.

17 (2) The board shall seek to ensure that licensees are informed
18 of the responsibility of licensees and others to follow infection
19 control guidelines, and of the most recent scientifically recognized
20 safeguards for minimizing the risk of transmission of bloodborne
21 infectious diseases.

22 (o) Incompetence in his or her practice as a respiratory care
23 practitioner.

24 (p) A pattern of substandard care or negligence in his or her
25 practice as a respiratory care practitioner, or in any capacity as a
26 health care worker, consultant, supervisor, manager or health
27 facility owner, or as a party responsible for the care of another.

28 ~~(q) If the licensee is a mandated reporter or is required to report~~
29 ~~under Article 2 (commencing with Section 11160) or Article 2.5~~
30 ~~(commencing with Section 11164) of Title 1 of Part 4 of the Penal~~
31 ~~Code. The commission of an act of neglect, endangerment, or~~
32 ~~abuse involving a person under 18 years of age, a person 65 years~~
33 ~~of age or older, or a dependent adult as described in Section 368~~
34 ~~of the Penal Code, without regard to whether the person is a patient.~~

35 (r)

36 (q) Providing false statements or information on any form
37 provided by the board or to any person representing the board
38 during an investigation, probation monitoring compliance check,
39 or any other enforcement-related action when the individual knew
40 or should have known the statements or information was false.

1 SEC. 2. Section 3754.8 is added to the Business and Professions
2 Code, to read:

3 3754.8. The expiration, cancellation, forfeiture, or suspension
4 of a license, practice privilege, or other authority to practice
5 respiratory care by operation of law or by order or decision of the
6 board or a court of law, the placement of a license on a retired
7 status, or the voluntary surrender of the license by a licensee shall
8 not deprive the board of jurisdiction to commence or proceed with
9 any investigation of, or action or disciplinary proceeding against,
10 the licensee, or to render a decision to suspend or revoke the
11 license.

12 SEC. 3. Section 3755 of the Business and Professions Code is
13 amended to read:

14 3755. (a) The board may take action against a respiratory care
15 practitioner who is charged with unprofessional conduct in
16 administering, or attempting to administer, direct or indirect
17 respiratory care in any care setting. Unprofessional conduct
18 includes, but is not limited to, the following:

19 (1) Repeated acts of clearly administering directly or indirectly
20 inappropriate respiratory care procedures, protocols, therapeutic
21 regimens, or diagnostic testing or monitoring techniques.

22 (2) Any act of administering unsafe respiratory care procedures,
23 protocols, therapeutic regimens, or diagnostic testing or monitoring
24 techniques.

25 (3) Any act of abuse towards a patient.

26 (4) A violation of any provision of Section 3750.

27 (b) The board may determine unprofessional conduct involving
28 any and all aspects of respiratory care performed by anyone
29 licensed as a respiratory care practitioner.

30 (c) Any person who engages in repeated acts of unprofessional
31 conduct shall be guilty of a misdemeanor and shall be punished
32 by a fine of not more than one thousand dollars (\$1,000), or by
33 imprisonment for a term not to exceed six months, or by both that
34 fine and imprisonment.

35 SEC. 4. No reimbursement is required by this act pursuant to
36 Section 6 of Article XIII B of the California Constitution because
37 the only costs that may be incurred by a local agency or school
38 district will be incurred because this act creates a new crime or
39 infraction, eliminates a crime or infraction, or changes the penalty
40 for a crime or infraction, within the meaning of Section 17556 of

1 the Government Code, or changes the definition of a crime within
2 the meaning of Section 6 of Article XIII B of the California
3 Constitution.



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June 9, 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 a comparative analysis of respiratory therapy education curricula and standards of program accreditation that is focused on identifying content related to under-emphasized topics and underdeveloped skills in new graduate therapists, as reported by respiratory care directors and managers.
- 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

- The survey of respiratory care directors was launched. In an effort to boost participation, all potential respondents have received a follow-up phone call as well as follow-up emails. The survey has also been publicized by the California Society for Respiratory Care through several emails to its membership. We will continue to call and email directors who have not completed a survey, but we are also going to extend the survey completion deadline to June 24, 2016 in order to generate as many respondents as possible.
- The study team has begun the comparative analysis focused on identifying content in respiratory therapy education related to topical areas that respiratory care directors indicated should receive greater coverage, as well as the types of non-clinical skills that respiratory care directors reported were underdeveloped in new graduate therapists. We are comparing the curricula of bachelor's and associate degree programs in respiratory therapy. In addition, we will be comparing standards of program accreditation in respiratory therapy with other health professions education programs including physician assistant, physical therapy, registered nursing and nurse practitioner.

Proposed activities still to be completed

- Complete data collection and summary for the survey of directors and managers of respiratory care. Deadline for survey has been extended to June 24, 2016 in an effort to maximize the number of survey respondents.
- Complete the comparative analysis of respiratory care education curricula and education standards of accreditation, and summarize findings.
- Schedule, conduct, and summarize findings from key informant interviews with directors of respiratory therapy education programs
- Schedule, conduct, and summarize findings from focus groups with currently employed respiratory therapists.

Proposed revision to timeline of work

We would like to request a no-cost extension for the Respiratory Care Workforce Study. The current project end date is August 31, 2016 and we would like to extend that until December 31, 2016.

Since work commenced on the study, we have had several analysts leave our team for other opportunities. Recruiting and hiring new staff members proved to be challenging and as a result, work on the project has proceeded more slowly than anticipated. Fortunately, we

recently hired two exceptional analysts who are providing support for the study, which means that all of the resources are in place to meet the stated objectives. The request for an extension will ensure that we are able to deliver the high quality work product you are expecting, and spend the existing funds within UCSF guidelines.

If the Board is amenable to this request, we would propose a shift in the timing of the remaining project components. We feel that conducting key informant interviews with education program directors should take place during the summer months. From our experience with other projects, the summer break between academic sessions is when program directors are most likely to have the time to participate in a research study. We would then schedule the focus group sessions to commence in September. (This would have the added benefit of having all of the information collected in the other project components inform the focus group session with practicing therapists.)

A short letter granting the no-cost extension—sent via email—is all that we would need to process the request with UCSF.



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**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 beta₂-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.



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-Position Statement on Concurrent Therapy-

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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.”¹ 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.”¹

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”.²

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.³ 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.⁴ 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



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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.⁵

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 Paper⁶, the full text of which can be accessed from the CSRC website: 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."⁷ 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.



-Position Statement on Concurrent Therapy-

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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

Law and Professional Ethics for RCPS

California Society for Respiratory Care
Proposed Changes (in red)

Section I: Introduction to Ethics and Professionalism

- Introduction
- Language of Ethics/Ethical Principles
- Professional Organizations
- AARC 2015 and Beyond taskforce recommendations, CoARC regulations, and minimum education requirements
- Practitioner Responsibility

Section II: Critical Thinking

Section III: Concurrent Therapy and Workloads

Section IV: Laws and Regulations Governing Respiratory Care

- Introduction
- Changes to Respiratory Care Act
 - Minimum Credential
 - Licensure requirement and CEU requirement
- License Renewal and Continuing Education Requirements
- Grounds for Denial, Suspension or Revocation of License
- Offenses Relating to Professional Misconduct
- Mandatory Reporting Requirements
- Professional Title Requirements and Practice Related Issues