

2012–2013
Sunset Oversight Review





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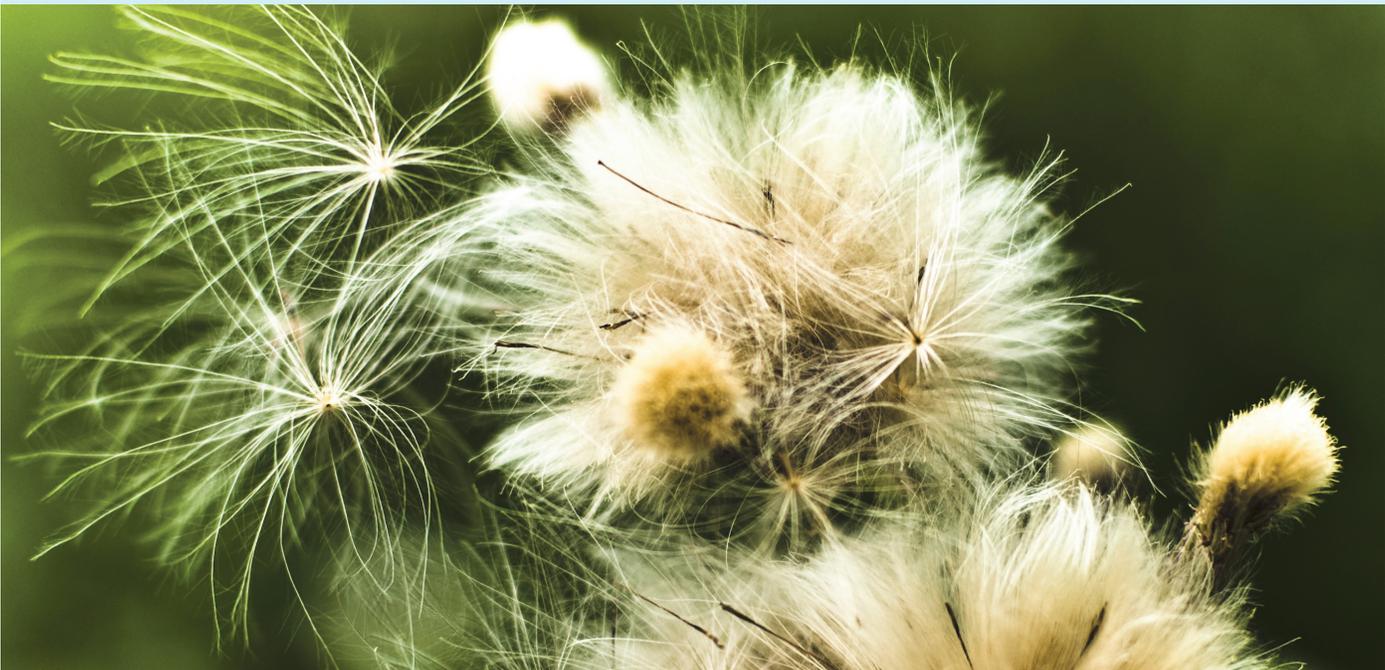


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Acronyms and Abbreviations

AARC	American Association for Respiratory Care
ADA	Americans with Disabilities Act
ALJ	Administrative Law Judge
APA	Administrative Procedure Act
BCP	Budget Change Proposal
Board	Respiratory Care Board of California
B&P	Business and Professions Code
CCR	California Code of Regulations
CDPH	California Department of Public Health (formerly DHS)
CE	Continuing Education
C&F	Cite and Fine
CoARC	Committee on Accreditation for Respiratory Care
CPEI	Consumer Protection Enforcement Initiative
CRT	Certified Respiratory Therapist
CSRC	California Society for Respiratory Care
DAG	Deputy Attorney General
DCA	Department of Consumer Affairs
DHS	Department of Health Services (renamed CDPH)
DOJ	Department of Justice
DMV	Department of Motor Vehicles
EDD	Employment Development Department
EMSA	Emergency Medical Services Authority
ISO	Interim Suspension Order
MBC	Medical Board of California
NBRC	National Board for Respiratory Care
OAG	Office of the Attorney General
OAH	Office of Administrative Hearings
PC 23	Penal Code §23 (Suspension)
RCP	Respiratory Care Practitioner
RCPA	Respiratory Care Practice Act
RRT	Registered Respiratory Therapist
SACC	Substance Abuse Coordination Committee
SOI	Statement of Issues

Section 1:

Background and Description of the Respiratory Care Board and Respiratory Care Practitioners

BACKGROUND AND DESCRIPTION OF THE RESPIRATORY CARE BOARD

The enabling statute to license Respiratory Care Practitioners (RCPs) was signed into law 30 years ago in 1982, thus establishing the Respiratory Care Examining Committee. In 1994, the name was changed to the Respiratory Care Board of California (Board).

The Board was the eighth “allied health” profession created “within” the jurisdiction of the Medical Board of California (MBC). Although created within the jurisdiction of the MBC, the Board had sole responsibility for the enforcement and administration of the Respiratory Care Practice Act (RCPA) **[Attachment 1]**. At the time the Board was established, the MBC had a Division of Allied Health Profession (DAHP) designated to oversee several allied health committees. It was believed that this additional layer of oversight (in addition to the Department of Consumer Affairs (DCA)) was unnecessary and ineffective. Therefore, the DAHP subsequently dissolved on July 1, 1994.

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. This current framework helps prevent quorum issues and provides a balanced representation needed to effectuate 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 (B&P, § 3701).

The Board is further mandated to ensure that protection of the public shall be the highest priority in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount (B&P, § 3710.1).

The Board's mission is to protect the public from the unauthorized and unqualified practice of respiratory care by enforcing the RCPA, expanding the delivery and availability of services, increasing public awareness of respiratory care as a profession, and supporting the development and education of all RCPs.

The Board's vision is for all California consumers to be aware of the respiratory care profession and its licensing board, its mission and mandate, and that every person treated by an RCP in California receives the most competent and qualified care available in the world.

In carrying out its mandate, the Board:

- Screens each application for licensure to ensure minimum education and competency standards are met and conducts a thorough criminal background check on each applicant.
- Investigates complaints against licensees primarily as a result of updated criminal history reports (subsequent rap sheets) and mandatory reporting (licensees and employers are required to report violations).
- Aggressively monitors RCPs placed on probation.
- Exercises its authority to penalize or discipline applicants and licensees which may include: 1) issuing a citation and fine; 2) issuing a public reprimand; 3) placing the license on probation (which may include suspension); 4) denying an application for licensure, or 5) revoking a license.
- Addresses current issues related to the unlicensed and/or unqualified practice of respiratory care.
- Promotes public awareness of its mandate and function, as well as current issues affecting patient 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 strives to increase the quality or availability of services, as well as regularly provide courteous and competent service to its stakeholders.

The Board regulates and issues licenses solely for RCPs. The RCPA is comprised of Business and Professions Code Section 3700, et. seq. and California Code of Regulations, Title 16, Division 13.6, Article 1, et. seq..

BACKGROUND AND DESCRIPTION OF RESPIRATORY CARE PRACTITIONERS

RCPs are one of three licensed healthcare professionals who work at patients' bedsides, with the other two being physicians and nurses. RCPs work under the direction of a medical director and specialize in providing evaluation of, and treatment to, patients with breathing difficulties, as a result of heart, lung, and other disorders, as well as providing diagnostic, educational, and rehabilitation services. RCPs are needed in virtually all healthcare settings.

On a daily basis, RCPs provide services to patients ranging from premature infants to the elderly. RCPs provide treatments for patients who have breathing difficulties and

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care for those who are dependent upon life support and cannot breathe on their own. RCPs treat patients with acute and chronic diseases, including Chronic Obstructive Pulmonary Disease (COPD), trauma victims, and surgery patients. Most familiar are patients or victims of the following conditions or traumas:

Asthma	Bronchitis
Stroke	Cystic Fibrosis
Emphysema	Near Drowning
Heart Attack	Lung Cancer
Premature Infants	Infants with Birth Defects

RCPs are the key healthcare professionals that will provide the needed treatments and services to these types of patients, as well as patients suffering from other ailments. RCPs are educated and trained in this very specialized area of medicine.

RCPs perform a number of diagnostic, treatment, and life support procedures, including, but not limited to:

- Employing life support mechanical ventilation for patients who cannot breathe adequately on their own.
- Administering medications to help alleviate breathing problems and to help prevent respiratory infections.
- Monitoring equipment and assessing patient responses to therapy.
- Operating and maintaining various types of highly sophisticated equipment to administer oxygen or to assist with breathing.
- Obtaining blood specimens and analyzing them to determine levels of oxygen, carbon dioxide, and other gases.
- Maintaining a patient's artificial airway (i.e. tracheostomy or endotracheal tube).
- Performing diagnostic testing to determine disease state of a patient's lungs and heart.



- Obtaining and analyzing sputum specimens and chest X-rays.
- Interpreting data obtained from tests.
- Assessing vital signs and other indicators of respiratory dysfunction.
- Performing stress tests and other studies of the cardiopulmonary system.
- Studying disorders of people with disruptive sleep patterns.
- Conducting rehabilitation activities.
- Conducting asthma education and smoking cessation programs.

Hospitals employ the majority of RCPs. However, there is a growing number of RCPs being employed in alternative facilities and locations. RCPs may be employed in any of the following settings:

- Hospitals.
- Emergency care departments.
- Adult, pediatric, and neonatal intensive care units.
- Critical care units.
- Neonatal (Infant) units.
- Pediatric units.
- Home care.
- Skilled nursing facilities.
- Fixed wing and helicopter critical care transport.
- Critical ground transportation.
- Physicians' offices.
- Hyperbaric oxygen therapy facilities.
- Pulmonary function, rehabilitation, cardiopulmonary, blood gas and sleep laboratories.



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The U.S. Bureau of Labor Statistics reports that, "Employment is expected to grow by 28 percent from 2010 to 2020, faster than the average for all occupations. Growth in the middle-aged and elderly population will lead to greater demand for respiratory therapy services and treatments... "

Older Americans suffer most from respiratory ailments and cardiopulmonary diseases such as pneumonia, chronic bronchitis, emphysema, and heart disease. As the numbers of older Americans increase, the need for respiratory therapists will increase, as well. In addition, advances in treating victims of heart attacks, accident victims, and premature infants (many of whom are dependent on a ventilator during part of their treatment) will increase the demand for advanced respiratory care services.

The California Employment Development Department (EDD) reported in 2012 that, "Job opportunities should be good due to the expanding role of Respiratory Therapists in case management, disease prevention, emergency care, and the early detection of pulmonary disorders." The EDD also reported that the median wage in California in 2011 for an RCP was \$68,421. Currently, a minimum of an Associate Degree is required for licensure, but over one-third of California's active licensees hold bachelor's, master's, and doctoral degrees.

RESPIRATORY CARE BOARD COMMITTEES

The Board has established committees to enhance the efficacy, efficiency and prompt dispatch of duties upon the Board. They are as follows:

Executive Committee

Members of the Executive Committee include the Board's president and vice-president. As elected officers, this Committee makes interim (between Board meetings) decisions as necessary. This Committee is responsible for making recommendations to the Board with respect to legislation impacting the Board's mandate. This Committee also provides guidance to administrative staff for the budgeting and organizational components of the Board and is responsible for directing the fulfillment of recommendations made by legislative oversight committees.

President: Murray Olson, RCP, RRT-NPS, RPFT

Vice-President: Charles B. Spearman, MEd, RCP

Enforcement Committee

Members of the Enforcement Committee are responsible for the development and review of Board-adopted policies, positions and disciplinary guidelines. Although members of the Enforcement Committee do not typically review individual enforcement cases (if they do they recuse themselves from any further proceedings), they are responsible for policy development of the enforcement program, pursuant to the provisions of the Administrative Procedure Act (APA).

Chair: Lupe Aguilera

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

Outreach Committee

Members of the Outreach Committee are responsible for the development of consumer outreach projects, including the Board's newsletter, website, e-government initiatives and outside organization presentations. These members act as goodwill ambassadors and represent the Board at the invitation of outside organizations and programs.

Chair: Sandra Magaña Cuellar

Member: Mark Goldstein, RCP

Professional Qualifications Committee

Members of the Professional Qualifications Committee are responsible for the review and development of regulations regarding educational and professional ethics course requirements for initial licensure and continuing education (CE) programs. Essentially, they monitor various education criteria and requirements for licensure, taking into consideration new developments in technology, managed care, and current activity in the healthcare industry.

Chair: Mark Goldstein, RCP

Member: Charles B. Spearman, MEd, RCP

Disaster Preparedness Committee

The Disaster Preparedness Committee is a one-person committee responsible for keeping the Board abreast of issues regarding disaster preparedness and facilitating communication between the Board, respiratory therapists, and public and private agencies regarding related matters.

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

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**RESPIRATORY CARE BOARD COMMITTEES’
RELATIONSHIP TO BOARD**



**RESPIRATORY CARE BOARD MEETINGS AND MEMBER
ATTENDANCE**

The Board generally meets three times per year and as mandated by B&P, §101.7 (Eff. January 1, 2008), holds at least one meeting per calendar year in each Northern and Southern California. In the past four years, the Board has not had to cancel or delay any meetings as a result of quorum issues. However, the Board did cancel its October 2010 meeting scheduled to take place in Southern California, as a result of a budget stalemate, that lasted 100 days, the longest stalemate in history. Fortunately, there were no pressing cases or other business that required immediate attention.

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INTERNAL STRUCTURE AND OTHER SIGNIFICANT EVENTS/ CHANGES

Staffing

The Board's office leadership, consisting of Stephanie Nunez, Executive Officer; Christine Molina, Staff Services Manager, and Liane Freels, Staff Services Manager has remain unchanged since the last Sunset Review in FY 2001-02. Support staff for the Board has also remained relatively unchanged. Of the Board's 18 employees, 14 were employed at the time of the Board's last Sunset Review in 2001.

Relocation

The Board's office was previously located at 444 North 3rd Street in Sacramento from April 2001 through May 2012. The Board's lease could not be renewed at this location, as a result of the owner being unable to meet new Americans with Disabilities Act (ADA) requirements, and finally, as a result of the building going into foreclosure. In May 2012, the Board moved to 3750 Rosin Court, Suite 100 in Sacramento approximately one mile from the DCA's headquarters. With the help of the Department of General Services, the Board was able to secure a square footage rate near what it was previously paying.

Strategic Planning

The Board has conducted extensive strategic planning efforts in 2002, 2006, and 2008 (available on the Board's website). The 2002 plan concentrated on developing new programs and re-engineering its processes. The 2006 plan focused on increasing awareness of existing laws and regulations, addressing unlicensed practice, and acquiring a workforce study to evaluate shortages and existing education components. The Board's 2008 plan was aimed at launching a full blown outreach campaign and participating in the then trending emergency response activities. The Board's next plan will be developed following the conclusion of this Legislative Review.

Board Member Administrative Manual

In 2009, the Board revamped its Board member administrative manual to assist new members in familiarizing themselves with the Board, its mandate, and its overall processes and operations. The manual was most recently updated in 2012 (**Attachment 1**).

Hospital Tours

In 2006, Board staff began coordinating hospital tours for Board staff and Office of the Attorney General (OAG) staff to enhance familiarization with the respiratory care practice, patients and providers, by offering an in-depth perspective of the day-to-day activities and responsibilities of licensed RCPs. Staff continue to coordinate tours for new public members and other interested parties involved in Board matters.

Emergency/Disaster Response Efforts

In July 2006, Board staff began meeting with the Office of Emergency Services and the then Department of Health Services (DHS) to assist in the development of the State's response plan. The Board arranged a meeting with seven licensed RCPs and the DHS to assist the DHS in identifying a ventilator for mass purchase in the event of an epidemic.

In July 2007, Board staff began meeting with the Emergency Medical Services Authority (EMSA) and providing assistance in getting the word out for various projects aimed at seeking medical volunteers. The Board also established its own Disaster Response web page with information about medical volunteer recruitment opportunities, and links to the EMSA and training materials for the stockpiled LTV 1200 ventilators that were selected and purchased by the State for use in the event of a pandemic or disaster.

In 2008, the Board sponsored legislation to include RCPs in an existing law to provide protection from liability for services rendered during a state of war, state of emergency, or local emergency, that was subsequently enacted in 2009. This provision was extremely important given the need for respiratory therapists to sustain life in emergency situations and the Board's efforts toward emergency planning.

Furthermore, the Board is extremely cognizant of the need to expeditiously respond to applications for licensure or licensure verifications, for either displaced therapists or volunteers, as a result of any catastrophe. In 2005, after the destruction of Hurricane Katrina, Board staff responded expeditiously to those affected. Additional efforts were made to assist displaced victims in becoming eligible to work (on a work permit) immediately, and ensure license verifications were issued immediately, following up with calls to verify that information was received.

Outreach/Military RCPs Recognition

In November 2003, the Board held a special ceremony to recognize and honor eleven of its licensees who served in the armed forces during Operation Iraqi Freedom. As part of the ceremony, each honoree was presented with a certificate of appreciation from the Board. The ceremony was also attended by Senator Mike Machado who presented honorees from his district with a certificate of recognition on behalf of himself and Assemblywoman Lois Wolk. Several other members of the Legislature, including Assemblyman Dave Cox and Tim Leslie and Senators Deborah Ortiz and Rico Oller also provided certificates of recognition to their constituents.

Board Recognition

In 2010, the Board was honored by the Administration and the DCA, for its significant role in the previous administration's Consumer Protection Enforcement Initiative (CPEI), aimed at overhauling the enforcement and disciplinary processes of all healing arts boards. The overarching goal of this initiative was to reduce the average enforcement completion timeline for our healing arts boards from 36 months to between 12 and 18 months.

In 2011, the Board was recognized by the DCA for its role in developing Uniform Standards, specifically for chairing the subcommittee concerning drug testing frequency for substance-abusing licensees, and for being the driving force in achieving middle ground within the affected groups.

Subacute Facilities/Unqualified Practice by Licensed Vocational Nurses

Since 1997, administrators and licensed vocational nurses (LVNs), most predominantly those in subacute facilities, have pursued utilizing the services of LVNs to perform advanced respiratory care. The Board has met with the Board of Vocational Nursing and Psychiatric Technicians (BVNPT) on several occasions, over the years, adamantly expressing why it is opposed to allowing LVNs to manage ventilator patients, in any manner. In recent years, the Board has received a few complaints of this nature. In 2009, the Board cited a facility \$75,000 for the use of 10-plus LVNs to perform respiratory care. The citation and fine was appealed and upheld. However, the facility filed a "writ of mandate" and the decision was overturned for reasons unrelated to the facts of the case. Since this time, the Board has found that the BVNPT is no longer advising its licensees that they are authorized to perform ventilator management.

Polysomnography/Oversight by Registered Nurses

Following legislation requiring polysomnography (sleep) technicians to be registered with the Medical Board (discussed further in Section 10), the California Department of Health (CDPH) issued a directive requiring registered nurses (RNs) to oversee these personnel, which created a major shift in the current practice.

In April 2010, the CDPH issued an “All Facilities Letter (AFL)” that, in brief, provided that an RN must provide patient assessments and be responsible for the nursing service in outpatient facilities. This directive only applied to those sleep centers associated with a licensed acute care hospital as the CDPH has no oversight of free-standing facilities (where greater concerns exist).

The Board (and members of the respiratory care community) met with CDPH representatives on several occasions, to educate them on the existing practice in sleep labs, the respiratory care practice (many RCPs work in sleep labs), and the unnecessary costs that were being assumed by these hospitals. In 2011, with newly appointed CDPH staff (including RNs), the AFL was modified to correctly provide guidance for necessary oversight and eliminated unnecessary RN staffing and those associated costs.

LEGISLATIVE CHANGES AFFECTING THE BOARD SINCE 2002

(All sections are from the Business and Professions Code unless otherwise noted.)

SB 1955 (*Statutes of 2002*)

- §3710 and §3716 were amended to extend the Board's sunset date.
- §3717 was amended to allow designated staff to also "copy" inspected records and added subdivision (b) which provides an employer's failure to provide documents is punishable by a fine not to exceed \$10,000.
- §3740 was amended to clarify education requirements, require an Associate Degree (in line with forthcoming accreditation standards), recognize educational accreditation body successors, and add new subdivisions to provide criteria for waiving existing education requirements based on work experience and licensure in another state (to remove reciprocity roadblocks that may occur with the new degree requirement).
- §3750.5 was amended and redefined the grounds for disciplinary action as it relates to alcohol use. A provision was added to include applying for employment or working in any healthcare profession or environment while under the influence of alcohol as grounds for discipline.
- §3751.1 was added to allow licensees on probation (as a result of less serious violations) to petition for early termination of probation from January 1, 2003 through December 31, 2003. During the Board's last Sunset Review process, the Joint Committee made recommendations for the Board to conduct a comprehensive review of its disciplinary policies to ensure that its disciplinary actions are relevant to consumer protection and appropriate to the violations. This section was added to provide equity among licensees as a result of revisions made to the Board's disciplinary guidelines and the establishment of the Board's "In-House Penalty Determination Guidelines." This section has since been repealed.
- §3753.1 was amended to provide that the Board shall not renew or reinstate a license of any person who has outstanding cost recovery or probation monitoring costs.
- §3758.6 was amended to grant the Board the authority to cite and fine an employer up to \$10,000, for failing to adhere to the existing mandatory reporting requirements of terminated or suspended employees.
- §3761 was amended to repeal the maximum fine amount of \$1,000 for unlicensed practice, thereby establishing a new maximum of \$2,500 as provided for in §125.9 (the \$2,500 was subsequently increased to \$5,000 through amendments to §125.9).

- §3766, §3767 and §3768 were added to establish authority for the Board to develop a more comprehensive citation and fine program.
- §3770 was amended to accept an “address of record” in lieu of a residence address for purposes of public disclosure.
- §3774 was amended to give the Board the authority to not renew a license for failure to identify current employer(s) or to indicate whether or not the licensee has been convicted of a crime since the last renewal.
- §3775.1 was repealed as a result of the education accreditation issue being resolved and because there was no longer a need to charge a transcript review fee.
- §3712.5, §3718, §3735.3, §3750.6, and §3777 were repealed or amended as part of clean-up efforts to eliminate unnecessary and duplicative sections, provide clarity and/or maintain continuity among sections.

AB 269 (*Statutes of 2002*)

- §3710.1 was added to mandate that protection of the public shall be the highest priority of the Board.

SB 363 (*Statutes of 2003*)

- §3740 was amended to clarify education requirements, provide a pathway for foreign-educated applicants, and an additional pathway for Canadian-trained applicants.

AB 1777 (*Statutes of 2003*)

- §3714, §3721, §3733, §3736.5, §3737, §3750.6, and §3751.1 were repealed or amended as part of clean-up efforts to eliminate unnecessary and duplicative sections, provide clarity and/or maintain continuity among sections.
- §3732 was amended to clarify that an applicant may be denied licensure for any causes that would be grounds for suspension or revocation of a license.
- §3750 was amended to include the Board may “deny” a license for existing grounds to suspend or revoke a license.
- §3760 and §3761 were amended to strengthen grounds to take action against any person practicing respiratory care unlicensed.
- §3775 and 3775.2 were amended to make established fees for a duplicate license, endorsement, or for CE providers, a maximum ceiling rather than an established amount (the amounts were not increased).
- §3775.6 was added to establish a “retired” status, thereby allowing licensees who no longer choose to practice to “retire” rather than “cancel” their license. The Board also includes “retired” licensees on its newsletter mailing list.
- §3777 was amended to allow the Board to not renew or reinstate a license if it is later discovered that CE, employer reporting or any other requirements are not met (in addition

to the existing authority on grounds if required fees were discovered to have not been paid).

- §3778 was added to grant the Board the authority to contract with a collections service and disclose personal information (including Social Security numbers) to collect any and all outstanding fees.

SB 1913 (*Statutes of 2004*)

- §3702.7 was added to clarify “mechanical or physiological ventilatory support” as used in §3702 (Scope of Practice) to accommodate technological advancements and methods in providing ventilatory support.
- §3750.5 was amended to make non-substantive edits.
- §3719.5 was added, giving the Board authority to require the successful completion of specific professional course(s) prior to the issuance, renewal, or reinstatement of a license.

SB 232 (*Statutes of 2005*)

- §3710 and §3716 were amended to extend the Board’s sunset date.

AB 139 (*Statutes of 2005*)

- §3771 was amended to eliminate the Board's continuous appropriation of funds.

SB 229 (*Statutes of 2005*)

- §3751 was amended to modify the petition for reinstatement process to include licenses that have been surrendered (in addition to revoked), ensure all past costs are paid, meet current education requirements, and to permit written arguments to be voted upon by the Board by mail.

SB 1111 (*Statutes of 2005*)

- §3735, §3735.3, §3736, and §3739 were repealed or amended as part of clean-up efforts to align the application process with the then, new daily computerized examination testing.
- §3775.2 was repealed to eliminate the Board's authority to approve CE providers (program was never established; regulations citing approved programs were updated).
- §3775.3 was repealed and eliminated the need for the Board to report to the Legislature fee increases.
- §3779 was added to codify that for purposes of license verification, a person may rely upon a printout from the Board's website.

SB 1476 (*Statutes of 2006*)

- §3710 and §3716 were amended to extend the Board’s sunset date.
- §3765 was amended to clarify that paramedical personnel may practice

respiratory care in “an emergency situation” and that home medical device retail facility or home health agency personnel may practice limited and basic respiratory care services that are authorized by the Board.

SB 1498 (*Statutes of 2008*)

- §3702 was amended to make non-substantive edits.

SB 819 (*Statutes of 2009*)

- §8659 of the Government Code was amended to exempt RCPs from liability for the provision of specified services rendered during a state of war, state of emergency, or local emergency.

AB 1071 (*Statutes of 2009*)

- §3710 and §3716 were amended to extend the Board’s sunset date.

SB 821 (*Statutes of 2009*)

- §3740 was amended to correctly reflect the accrediting oversight body of education programs.
- §3750.5 was amended to clarify that the illegal use of a controlled substance was grounds for discipline.
- §3773 was amended to give the Board authority to make a license inactive after 30 days if a license holder fails to report or provide documentation 30 days after a request.

SB 819 (*Statutes of 2009*)

- §3753.5 was amended to modify the grounds in which to collect cost recovery to include any person found to have violated a term and condition of probation.

SB 294 (*Statutes of 2010*)

- §3710 and §3716 were amended to extend the Board’s sunset date.

AB 1023 (*Statutes of 2011*)

- §3769.3 was amended to make one small non-substantive change (“Procedures” to “Procedure”).

SB 1575 (*2012 Legislation*)

- §3742 was amended to prevent any probationer or otherwise disciplined licensee from providing supervision to students.
- §3750 was amended to include negligence in the practice as a respiratory care practitioner or in any capacity as a healthcare worker, consultant, supervisor, manager or health facility owner, or as a party responsible for the care of another, as grounds for disciplinary action.
- §3750.5 was amended to include illegal possession of drug-associated paraphernalia as grounds for discipline.

REGULATORY CHANGES AFFECTING THE BOARD SINCE 2002

DISCIPLINARY GUIDELINES/CITATION AND FINE

(Effective May 21, 2003)

§1399.302 Definitions. Definition for “Employer” and “Regulations” were established.

§1399.370 Substantial Relationship Criteria. Non-substantive change.

§1399.374 Disciplinary Guidelines. March 2002 revision of Disciplinary Guidelines was incorporated by reference, replacing the previous August 1997 version.

§1399.375. Citation Review. (Repealed)

§1399.376 Citation Review. (Amended)

§1399.380 Citations. (Added)

§1399.381 Fines. (Added)

§1399.382 Citation Appeals. (Added)

§1399.383 Failure to Comply/Citation. (Added)

These sections were repealed, amended, or added as part of the Board's effort to expand its citation and fine program. Section 1399.375 was repealed and previously permitted the Board to fine for a single violation of unlicensed practice in the amount of \$1,000. It was primarily used against licensees who renewed late and continued to work on an expired license. The amended and new sections made changes to 1) allow the executive officer to hear citation reviews/appeals; 2) provide a basis for determining fine amounts and identify the process for issuing citations against licensed RCPs; 3) identify numerous violations and fine ranges where a citation and fine could be issued with a maximum fine amount of \$2,500; 4) identify the process for appealing a citation; and 5) identify the consequences against a licensee for failing to comply with a citation including the non renewal of a license, referral to a collection agency, or the pursuit of further legal action by the Board.

§1399.384 Licensee Reporting. This section was added to require licensed RCPs to disclose information to the Board within ten days. This section is primarily used in connection with mandatory reporting by RCPs and employers.

§1399.385 Employer Reporting. This section was added to require any employer of an RCP to disclose information to the Board within ten days. This section is used in connection with mandatory reporting requirements by employers.

§1399.387 Citations - Employer. (Added)

§1399.388 Fines- Employer. (Added)

§1399.389 Appeals - Employer. (Added)

§1399.390 Failure to Comply/Employer Citation. (Added)

These sections were added to establish a citation and fine process for employers who are not licensed RCPs. Similar to the provisions above for citing and fining licensed RCPs, these provisions established 1) a basis for determining fine amounts and identifying the process for issuing citations against employers; 2) potential violations and fine ranges where a citation and fine could be issued against an employer (one fine maximum was \$10,000); 3) the process for appealing a citation issued against an employer; and 4) the consequences for an employer for failing to comply with a citation including pursuit of further action by the Board to collect the fine.

§1399.395 Fee Schedule. This section was renumbered. No fees changes were made.

TECHNICAL AMENDMENTS AND EDUCATION (Effective May 22, 2004)

§1399.301 Location of Office. This section was amended to update the Board's address from Howe Avenue to 444 North 3rd Street (the actual move took place in April 2001).

§1399.321 Abandonment of Applications. This section was amended to provide clarification on when an application is considered abandoned (one year).

§1399.330 Respiratory Care Curriculum Requirements.

§1399.331 License Applicants - Education Requirements.

§1399.333 Educational Grade Requirements.

These sections were repealed. They were previously established in January 1998 and provided specific education requirements in anticipation of the loss of an educational accreditation oversight body on January 1, 1998. A new oversight body was in place on January 1, 1998, however, standards and positioning were not clearly established at that time.

§1399.330 Education Waiver Criteria. This section was added to provide criteria for waiving existing education requirements based on experience and licensure in another state. This criteria was primarily established to prevent roadblocks for reciprocity, as a result of the new Associate Degree requirement that went into effect January 2003.

§1399.349 Continuing Education Defined.

§1399.350 Continuing Education Required.

§1399.351 Approved Continuing Education Programs.

§1399.352 Criteria for Acceptability of Courses.

§1399.352.5 Continuing Education Hours.

§1399.353 Audit and Sanctions for Noncompliance.

These sections were added or amended as part of the Board's goals to strengthen its CE program, including identifying approved courses.

§1399.356 License Status (active/inactive). This section was amended to require all outstanding renewal fees be paid prior to changing the status of a license.

§1399.395 Fee Schedule. This section was amended to make some technical edits and fee changes. Actual fee changes or fiscal impacts made, include: 1) Changing the initial license fee of \$200 to be "prorated" based on the number of months an initial license is issued rather than a flat amount, regardless of the months the initial license was issued; 2) Recognizing the increase in a renewal fee from \$200 to \$230 that was actually in effect on January 1, 2002; 3) Reducing the duplicate license fee from \$75 to \$25; 4) Increasing the endorsement fee from \$50 to \$75; and 5) Eliminating the transcript review fee that had no longer been charged as of January 1, 2003. [SB 1980, Statutes of 1998 increased the renewal fee to \$230 effective January 1, 1999, however, the Board delayed implementation of this fee increase for three years].

LAW AND PROFESSIONAL ETHICS COURSE REQUIREMENTS

(Effective August 17, 2005)

§1399.327 Satisfactory Completion of Law and Professional Ethics Course Prerequisite to License.

§1399.350.5 Law and Professional Ethics Course.

§1399.352.7 Law and Professional Ethics Course Criteria.

§1399.372.5 Satisfactory Completion of a Law and Professional Ethics Course Prerequisite to Reinstatement.

These sections were added, establishing the Board's first approved Law and Professional Ethics Course offered by only the California Society for Respiratory Care (CSRC) and the American Association for Respiratory Care (AARC). The course is required to be completed by applicants prior to licensure, by licensees as part of CE for every other renewal, and persons applying for reinstatement of their license. The course is three hours in length, with one hour including education on laws and regulations governing RCPs. [The course was available January 1, 2006 and is updated every four years]

CITATION AND FINE/UNLICENSED PERSONNEL

(Effective October 7, 2006)

§1399.391 Cite and Fine - Unlicensed Personnel. This section was added to fill in gaps from other regulations to cite and fine unlicensed personnel and employers.

HOME RESPIRATORY CARE (Effective March 16, 2007)

§1399.302 Definitions.

§1399.360 Unlicensed Personnel Services; Home Care.

These sections were amended or adopted to clearly delineate services that may and may not be provided by unlicensed personnel as it relates to respiratory care in the home, in an effort to curb unlicensed practice. This is discussed further in Section 11, in connection to issues that were raised under the prior Sunset Review.

DISCIPLINARY GUIDELINES, CITATION AND FINE, FEES, AND VARIOUS REGULATORY REVISIONS (Effective June 24, 2012)

§1399.301 Location of Office.

§1399.340 Failure on Examinations.

§1399.353 Audit and Sanctions for Noncompliance (of CE).

§1399.378 Licensee Reporting.

§1399.379 Employer Reporting.

These sections were repealed or amended as part of clean-up efforts to eliminate unnecessary and duplicative sections, provide clarity and/or maintain continuity among sections.

§1399.302 Definitions. This section was amended to include a “registry” or “staffing agent or agency” under the definition of employer. Other changes made were for clarity purposes.

§1399.303 Delegation of Authority. This section was amended to provide clarity and to give the Executive Officer the authority to adopt stipulated settlements where an action to revoke the license has been filed, and the respondent agrees to surrender his or her license.

§1399.320 Applications. This section was amended to allow 90 days (rather than 30 days) for an applicant to submit required documentation prior to their application for licensure being received.

§1399.330 Education Waiver Criteria. This section was amended to recognize military education and experience as criteria to waive education requirements. Other amendments made were to clarify reasons the Board may deny a waiver and that the application fee paid will not be refunded, if the waiver is denied.

§1399.352.7 Law and Professional Ethics Course Criteria. This section was amended to provide specific criteria for course providers to develop and maintain a Board-approved course. Both the national and state associations had been adhering to this criteria, however, legal counsel advised that the criteria be established in regulation to prevent future disputes.

§1399.360 - Unlicensed Personnel Services; Home Care. This section was amended with a few minor changes to address the most questioned task of “mask fitting” and to further clarify criteria. In addition, it was added that “at least annually” education and competency testing is performed for unlicensed personnel.

§1399.364 Orders. This section was added to coincide with the Joint Commission and the Centers for Medicare and Medicaid Services (CMS) amended regulations which allow RCPs to take orders from non-physician practitioners, at licensed health facilities, provided medical staff policies specify such and state law permits such.

§1399.370 Substantial Relationship Criteria. This section was amended to add acts involving human trafficking, gross negligence in the care of an animal or any form of animal cruelty, failure to comply with a court order, and an act involving verbally abusive conduct or unlawful possession of a firearm or weapon, as substantially related to the practice of respiratory care for purposes of establishing grounds to take disciplinary action. It was also modified to recognize the “commission of an act” rather than only a conviction.

§1399.374 Disciplinary Guidelines. This section was amended to reflect the 2011 revisions of the Board's disciplinary guidelines, with several revisions resulting from the Uniform Standards developed by the Substance Abuse Coordination Committee (SACC) (established pursuant to SB 1441). Most notable is the establishment of major and minor violations that can result in a cease practice notice being issued by the Board.

§1399.375 Cease Practice-Probation. This section was added based on SB 1172 (statutes of 2010) wherein section 315.4 is added to the B&P and provides that a board may adopt regulations authorizing it to order a licensee on probation to cease practice for major violations. This provision is not governed by the APA. [Probationers were notified of the new guidelines and cease practice provision on June 6, 2012]

§1399.377 Records from Employer. This section was added and provides that records requested by the Board, pursuant to B&P §3717 shall be provided within ten days.

§1399.380 Citations.

§1399.381 Fines.

§1399.382 Citation Review.

§1399.383 Citation Appeals.

§1399.384 Failure to Respond or Appear.

§1399.385 Failure to Comply with Citation.

§1399.387 Citations-Employer. (Repealed)

§1399.388 Fines-Employer. (Repealed)

§1399.389 Appeals-Employer. (Repealed)

§1399.390 Failure to Comply with Citation-Employer. (Repealed)

§1399.391 Citation and Fine-Unlicensed Personnel. (Repealed)

These sections were repealed, adopted or amended to streamline the regulations for the citation and fine process to provide one area for all types of citations issued against licensed RCPs, unlicensed personnel and/or employers. These regulations reduced the maximum time to pay a fine from 365 to 120 days; thereby, also reducing overall enforcement processing times in accordance with the CPEI; added methodology in how fine amounts are applied (e.g. per incident or violation), partly based on SB 1111 to provide consistency and clarity; the majority of maximum fine amounts were increased based on previous amendments to section 125.9 of the B&P, raising the ceiling from \$2,500 to \$5,000; and the time for the executive officer to hold a citation review was reduced from 240 to 60 calendar days.

§1399.395 Fee Schedule. This section was amended in support of the Administration's Job Creation Initiative and simplifies the Board's fee schedule. The Board increased its application fee from \$200 to \$300 and also eliminated its Initial Licensing Fee, which has reduced the time to issue a license by 28 to 60 days (by eliminating the need to request and wait for an additional fee and wait for the fee to be processed by the DCA). The Board also eliminated an alternative application fee that was used for foreign graduate applicants, so that now all applicants have one fee. [Implemented July 1, 2012, however applicants ready to be licensed in June were given the option to wait until July 1 for licensure at a lower cost]

MAJOR STUDIES

California Respiratory Care Practitioner Workforce Study (June 2007) (Attachment 2)

In 2006, the Board contracted with the Institute for Social Research at the California State University, Sacramento to conduct a study to determine the current dynamics of the respiratory care profession. The study documented current workforce trends, future workforce needs and demographic and economic data. Please see Section 8, Workforce Development and Job Creation, for more information.

NATIONAL ASSOCIATION PARTICIPATION

Currently, the Board is a member of the American Association for Respiratory Care (AARC), the Council on Licensure, Enforcement, and Regulation (CLEAR), and the Federation of Associations of Regulatory Boards (FARB). The Board's membership in each of these associations does not include voting privileges. However, they all provide valuable resources in connection with enforcement, licensure, exams, or issues specific to respiratory care.

In addition, most RCP Board members are also members of the AARC. Several members have participated on their own in AARC's Annual Conferences or Summer Forums and our prior physician member continues to be part of AARC's Board of Medical Advisors (with voting rights), a group that meets regularly.

In 2007, the AARC established a task force to identify likely new roles and responsibilities of respiratory therapists in the year 2015 and beyond. A series of three professional conferences was held between 2008 and 2010 to address the following:

- What will the future healthcare system look like?
- What will the roles and responsibilities of respiratory therapists be in the future system?
- What competencies will be required for respiratory therapists to succeed in the future?
- How do we transition the profession from where it is today to where we need to be in the future?

The Board has been actively participating in this project with one member attending the three conferences. The Board has provided collective input and has had the AARC, the National Board for Respiratory Care (NBRC), and the Committee on Accreditation for Respiratory Care (CoARC) attend several Board meetings to discuss the prospective changes.

The series of “2015 and Beyond” conferences resulted in recommendations for the following major policy changes:

- Change CoARC accreditation standards to require new programs after 2012 to offer a baccalaureate degree in Respiratory Therapy.
- Change CoARC accreditation standards to require all accredited programs after 2020 to offer a baccalaureate degree in Respiratory Therapy.
- Retire the NBRC’s Certified Respiratory Therapist Examination after 2014.

Recommendations also included attributes that the “2015 and Beyond” transition plan must meet. The following recommendations have been adopted by the AARC’s Board of Directors:

- Maintain an adequate number of respiratory therapists throughout the transition.
- Address unintended consequences such as respiratory therapist shortages.
- Require multiple options and flexibility in educating both students and the existing workforce (e.g. Affiliation agreements, internships, special skills workshops, CE, etc).
- Require competency documentation options for new graduates.
- Support a process of competency documentation for the existing workforce.
- Assure that credentialing and licensure recommendations evolve with changes in practice.
- Address implications of changes in licensing and credentialing.
- Establish practical timelines for recommended actions.

The AARC is currently conducting additional research in line with the adopted attributes to assess feasibility prior to establishing a road map for the recommendations resulting from the “2015 and Beyond” conferences.

NATIONAL EXAM PARTICIPATION

The Board continues to use the National Board for Respiratory Care’s (NBRC’s) “Certified Respiratory Therapist” examination for licensure, which is developed, scored, analyzed and administered by the NBRC and its subsidiary, Applied Measurement Professionals, Inc. (AMP). Annually, the Board verifies that the NBRC meets the requirements set forth in §139 of the B&P, for occupational analyses and ongoing item analyses.

Section 2: Performance Measures and Customer Satisfaction Surveys

NEW FEATURES AND CORE PHILOSOPHIES

Since the Board was last reviewed, it has added new features and maintained core philosophies in its effort to continually improve service to all of its stakeholders:

- **Toll-Free Number:** In April 2002, the Board acquired a toll free number for statewide use. The Board continues to actively publicize and promote the use of the toll free number (866-375-0386).
- **E-mail Address:** In 2002, the Board also established an e-mail address (rcbinfo@dca.ca.gov) for consumers and applicants to contact the Board with any questions. The Board makes it a point to respond to each e-mail within 24 to 72 hours.
- **Human Contact:** Since the inception of the Board, it has rejected automated systems that pick up calls (from the main telephone number) with a recorded phone tree. The Board believes immediate human contact is the optimal choice in providing outstanding customer service.
- **Online Satisfaction Survey:** In 2002, a "Satisfaction Survey" was added to its website for consumers, licensees and applicants to complete online.
- **Enforcement Performance Measures:** In 2010, the Board, in concert with the DCA, began compiling and reporting "average days" to complete various aspects of the enforcement process.
- **Consumer Satisfaction Survey:** In 2012, the Board revised its survey sent to complainants and updated its "letter-style" format to the following, postage-paid postcard (actual size larger than shown below).



CONSUMER SATISFACTION SURVEY (COMPLAINT HANDLING/RESOLUTION)

As part of the Board's procedures to close enforcement cases, staff provide Consumer Satisfaction Surveys to each complainant (primarily those complaints received from patients, family members, and employers). Complaints initiated by rap sheets or similar entities are excluded.

The Board had an unusually high satisfaction rate in all categories. Question 5 concerning the time it took from start to finish a case, and question 6 concerning outcomes, received the lowest ratings.

Table 2a. Consumer Satisfaction (Complaint Handling/Resolution) Survey Results	FY 01/02	FY 02/03	FY 03/04	FY 04/05	FY 05/06	FY 06/07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12
NUMBER OF SURVEYS RETURNED	2	25	28	37	18	12	16	5	7	16	12
1. Were you satisfied with knowing where to file a complaint and whom to contact?	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Average Rating (Scale 1-5)	4.00	4.64	4.59	4.62	4.89	4.83	4.69	4.80	4.86	4.63	4.67
2. When you initially contacted the Board, were you satisfied with the way you were treated and how your complaint was handled?	100%	100%	93%	100%	100%	100%	100%	100%	100%	100%	100%
Average Rating (Scale 1-5)	3.50	4.48	4.36	4.76	4.72	4.83	4.75	5.00	4.86	4.50	4.50
3. Were you satisfied with the information and advice you received on the handling of your complaint and any further action the Board would take?	100%	92%	93%	100%	94%	100%	100%	100%	100%	94%	100%
Average Rating (Scale 1-5)	4.00	4.24	4.29	4.56	4.22	4.75	4.38	4.40	4.71	4.13	4.33
4. Were you satisfied with the way the Board kept you informed about the status of your complaint?	100%	80%	82%	89%	94%	100%	94%	100%	86%	94%	92%
Average Rating (Scale 1-5)	4.00	3.88	3.82	4.16	4.22	4.42	4.06	4.60	4.43	4.06	4.00
5. Were you satisfied with the time it took to process your complaint and to investigate, settle, or prosecute your case?	100%	80%	71%	86%	82%	100%	100%	100%	100%	81%	83%
Average Rating (Scale 1-5)	4.00	3.56	3.50	3.97	4.00	4.42	3.94	4.00	4.57	3.38	3.92
6. Were you satisfied with the final outcome of your case?	100%	88%	93%	89%	78%	100%	88%	80%	86%	88%	92%
Average Rating (Scale 1-5)	4.50	4.12	4.22	4.03	3.89	4.67	4.00	4.20	4.43	3.75	4.33
7. Were you satisfied with the overall service provided by the Board?	100%	92%	93%	100%	100%	100%	100%	100%	100%	100%	100%
Average Rating (Scale 1-5)	4.00	4.20	4.21	4.35	4.39	4.67	4.31	4.80	4.57	4.13	4.50

Scale is from 1-5, with 1 representing very dissatisfied and 5 representing very satisfied.

ONLINE SATISFACTION SURVEY

In 2002, the Board developed and added an online survey to gauge satisfaction among applicants, consumers and licensees. The Board includes a link to the survey or directions to the link in application correspondence, inquiries received through our general e-mail address: rcbinfo@dca.ca.gov, and in most Board newsletters.

Overall satisfaction for each year and category ranged from:

Applicants: 50% to 100%

Consumers: 75% to 100%

Licensees: 80% to 97%

Table 2b. Online Survey Summaries	FY 02/03	FY 03/04	FY 04/05	FY 05/06	FY 06/07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12
APPLICANTS										
Number of Responses	3	6	5	8	19	9	9	12	6	8
Courtesy	100%	100%	80%	63%	89%	88%	78%	75%	100%	75%
Responsiveness	67%	83%	100%	38%	53%	56%	56%	80%	100%	63%
Knowledgeable	100%	83%	100%	75%	79%	78%	67%	90%	100%	75%
Accessibility	100%	83%	100%	63%	68%	50%	67%	80%	100%	75%
Overall Satisfaction	100%	83%	100%	50%	67%	56%	78%	80%	100%	75%
CONSUMERS										
Number of Responses	0	3	2	3	0	0	0	1	4	4
Courtesy	-	100%	100%	100%	-	-	-	0%	100%	100%
Responsiveness	-	100%	100%	67%	-	-	-	0%	75%	75%
Knowledgeable	-	100%	100%	100%	-	-	-	-	100%	100%
Accessibility	-	100%	100%	100%	-	-	-	0%	100%	100%
Overall Satisfaction	-	100%	100%	100%	-	-	-	0%	75%	75%
LICENSEES										
Number of Responses	51	52	53	32	62	47	41	27	20	30
Courtesy	98%	96%	96%	91%	92%	96%	90%	100%	100%	100%
Responsiveness	96%	90%	98%	94%	90%	93%	88%	93%	100%	97%
Knowledgeable	94%	96%	94%	94%	90%	91%	90%	96%	100%	100%
Accessibility	94%	96%	94%	91%	90%	93%	85%	96%	95%	97%
Overall Satisfaction	96%	92%	96%	91%	87%	85%	80%	85%	95%	97%

UNANNOUNCED TELEPHONE CUSTOMER SERVICE IMPROVEMENT SURVEY BY DCA

From approximately November 2005 through March 2006, the DCA conducted a survey, unbeknownst to the boards, to rate accessibility and customer service at each board. A DCA representative contacted or attempted to contact boards via public telephone numbers on at least three different occasions. After DCA completed its survey, it revealed to boards that it conducted the survey and the findings.

The Board was contacted on three separate occasions and was given the highest rating for “helpfulness” and “politeness” with each contact.

UNANNOUNCED DCA SURVEY STANDARDS

Questions

1. I was wondering how I can pick up an application for a license? (Or ask a “non-jurisdictional” question if entity does not have a licensing function for individuals/sole proprietors).
2. What are your office hours?
3. If I want to come into your office during lunchtime, around 12:15, will you be open?

Rating Scales for Survey

Politeness Rating (Pleasant, even paced, clear, understandable)

1 = Very Impolite 2 = Somewhat Impolite 3 = Neutral 4 = Somewhat Polite 5 = Very Polite

Helpfulness Rating

(Perceived as enthusiastic, perceived as willing to help, asks if you need anything else, perceived as interested in helping the customer)

1 = Not Clearly Evident [questions not answered satisfactorily]

2 = Neutral [some questions answered/some not answered]

3 = Clearly Evident [questions answered satisfactorily]

Notes = If necessary, add a few brief notes to support your ratings.

Table 2c. Unannounced Telephone Customer Service Improvement Survey Results

Date and Time Contacted	Seconds to Human Contact	No. of Rings	Politeness Scale 1-5	Helpfulness Scale 1-3	Notes
11/30/05 10:47 am	10	1	5	3	None
2/21/06 9:50 am	2	1	5	3	Person gave extensive directions to office; complete info on required supplementary documentation
3/8/06 4:36 pm	15	2	5	3	Pleasant voice, very professional and helpful; hrs 8-5 and lunch (someone always there); gave clear directions to office

ENFORCEMENT PERFORMANCE MEASURES

As part of the CPEI, the DCA spearheaded a movement to collect and report the average number of days to complete various components of the enforcement process, to offer a method of evaluating performance. Following are those figures reported quarterly and annually, though they are condensed into simplified charts for easy reference and comparison.

Table 2d. Enforcement Performance Measures

	Volume	Intake	Intake and Investigation	Formal Discipline	Probation Intake	Probation Violation Response
TARGETS (in days)	-	7	210	540	6	10
FY 10/11						
July 2010	67	2	104	778	-	-
August 2010	62	3	117	608	-	-
September 2010	62	2	124	690	-	-
Q1 Averages	64	2	113	692	-	-
October 2010	70	2	135	574	n/a	6
November 2010	78	3	120	668	1	3
December 2010	60	2	101	491	2	1
Q2 Averages	69	2	119	582	2	3
January 2011	60	3	155	662	1	1
February 2011	70	3	121	580	1	1
March 2011	70	2	111	658	1	1
Q3 Averages	67	3	131	640	1	1
April 2011	70	3	116	470	2	1
May 2011	91	3	107	272	1	1
June 2011	75	3	97	416	1	1
Q4 Averages	79	3	105	428	1	1

Table 2d. Enforcement Performance Measures (Continued)

	Volume	Intake	Intake and Investigation	Formal Discipline	Probation Intake	Probation Violation Response
TARGETS (in days)	-	7	210	540	6	10
FY 11/12						
July 2011	77	3	113	447	2	n/a
August 2011	82	3	81	504	2	7
September 2011	58	3	89	688	2	8
Q1 Averages	72	3	92	502	2	7
October 2011	66	2	114	694	2	9
November 2011	60	2	78	732	2	n/a
December 2011	56	2	94	459	1	4
Q2 Averages	61	2	94	640	2	6
January 2012	90	2	83	n/a	n/a	2
February 2012	86	2	72	553	2	2
March 2012	65	2	84	597	2	2
Q3 Averages	80	2	79	581	2	2
April 2012	86	2	93	696	1	1
May 2012	57	3	69	382	1	2
June 2012	92	3	105	857	1	4
Q4 Averages	78	3	92	692	1	2

NOTE: Quarterly Averages are based on total days divided by total cases closed, rather than monthly averages.

COLUMN EXPLANATIONS

Volume: Number of complaints and conviction received.

Intake: Average cycle time (in days) from complaint receipt, to the date the complaint was assigned to an investigator.

Intake and Investigation: Average cycle time (in days) from complaint receipt to closure of the investigation process. Does not include cases sent to the OAG or other forms of formal discipline.

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

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

Probation Violation Response: Average number of days from date violation is reported to date the assigned monitor initiates appropriate action.

Section 3: Fiscal Issues and Staffing

FUND CONDITION

The Board's fund condition (Table 3a) shows that at the end of FY 2011-12 the Board had a balance of \$2,363,124 or nine months in reserve. However, future years show a decline in the months in reserve based on projected annual authorized expenditures. The Board has not made any loans to the general fund, in the last ten years. Loans made prior to that date were repaid in FY 2000-01.

SB 1980 (statutes of 1998) increased the ceiling of the Board's renewal fee and established a statutory reserve level as follows:

§ 3775. Amount of fees

The amount of fees provided in connection with licenses or approvals for the practice of respiratory care shall be as follows:

(d) For any license term beginning on or after January 1, 1999, the renewal fee shall be established at two hundred thirty dollars (\$230). The board may increase the renewal fee, by regulation, to an amount not to exceed three hundred thirty dollars (\$330). **The board shall fix the renewal fee so that, together with the estimated amount from revenue, the reserve balance in the board's contingent fund shall be equal to approximately six months of annual authorized expenditures. If the estimated reserve balance in the board's contingent fund will be greater than six months, the board shall reduce the renewal fee.** In no case shall the fee in any year be more than 10 percent greater than the amount of the fee in the preceding year...

While this amendment would have increased the renewal fee on January 1, 1999, from \$200 to \$230, the Board opted to delay this increase until January 2002, when expenditures (including reimbursements) continued to exceed revenues and reserves were steadily declining.

The Board continued to work toward striking a balance between its expenditures and revenues and for the first time in over a decade, revenues slightly exceeded expenditures (including reimbursements) in FY 2006-07. Soon thereafter, there were severe cuts in salaries driven by the State's ongoing fiscal crisis, which resulted in significant actual expenditure reductions from FY 2008-09 through FY 2010-11. In FY 2011-12, actual expenditures moved upward and further increases are expected over the next two years. The Board will see an increase in actual expenditures attributed to BreEZe, increased rent for office space, and the fees paid to accept credit cards for payment. Also, in 2013, PLP is scheduled to be discontinued with full salaries issued. Furthermore, history shows that expenditures for items outside the Board's control (e.g. pro rata, Attorney General, etc..) will continue to increase.

Since 2002, there have been no fee changes that have made a significant impact on revenues. The renewal fee has not been increased since 2002 and remains at \$230. The Board's endorsement fee (a fee charged to prepare an official verification of licensure) was raised from \$50 to \$75 in 2004 and subsequently reduced to \$25 in June 2012. The fee changes made in June 2012 made an increase to the application fee but eliminated the licensing fee, which ultimately resulted in the changes having little impact on revenue. Rather, revenue increases are attributed to increases in new applications received, a

greater number of licensees maintaining their license (renewal), and the expansion of the Board's citation and fine program.

Toward the end of FY 2007-08, the Board observed that its estimated reserve balance was near exceeding the six month reserve level. However, it also recognized that its actual expenditures (including reimbursements) and revenues were fairly balanced. In March 2008, at the Board's strategic planning session, there was discussion on reducing the renewal fee. In light of the fact any reduction to the renewal fee would be a one-time reduction, and would have amounted to no more than \$20 per licensee, and the fact that the Board was also planning a large outreach movement which was tied to significant expenditures, it opted to not reduce its renewal fee. When the Board's marketing plan was interrupted by executive orders to halt all outreach and resources were redirected as a result of the CPEI, these one-time expenditures were not realized. In 2010 and 2011, the Board also attempted to secure additional positions through the Budget Change Proposal process which would have increased expenditures.

As it stands, Table 3a reflects the Board's fund condition will have a reserve balance of seven months in FY 2012-13 and five months in FY 2013-14. The Board is currently analyzing its fund condition to determine if a fee reduction is warranted based on unscheduled reimbursements and salary reductions that are not reflected in these projections.

Table 3a. Fund Condition						
(DOLLARS IN THOUSANDS)	FY 08/09 ACTUAL	FY 09/10 ACTUAL	FY 10/11 ACTUAL	FY 11/12 ACTUAL	FY 12/13 PROJECTED	FY 13/14 PROJECTED
Beginning Balance	\$1,487,080	\$1,789,093	\$2,017,407	\$2,176,982	\$2,363,124	\$1,899,834
Adjusted Beginning Balance	\$150,258	\$58,000	(\$48,593)	-	-	-
Revenues and Transfers	\$2,309,310	\$2,471,777	\$2,534,107	\$2,658,814	\$2,689,710	\$2,716,055
Total Revenue	\$3,946,648	\$4,318,870	\$4,502,921	\$4,835,796	\$5,052,834	\$4,615,889
Budget Authority	\$2,924,844	\$2,849,279	\$3,040,196	\$3,108,981	\$3,153,000	\$3,216,000
Expenditures	\$2,315,867	\$2,481,992	\$2,507,500	\$2,680,172	\$3,153,000	\$3,216,000
Disbursements ¹	\$2,000	\$9,000	\$7,000	\$12,000	-	-
Reimbursements	(\$160,312)	(\$189,529)	(\$188,561)	(\$219,500)	-	-
Fund Balance	\$1,789,093	\$2,017,407	\$2,176,982	\$2,363,124	\$1,899,834	\$1,399,889
Months in Reserve	7.53	7.96	8.40	8.99	7.09	5.22

¹ Represents FSCU (State Operations) and FISC (State Controller Operations) disbursements.

EXPENDITURES BY PROGRAM COMPONENT

Examining expenditures by program you will find that the majority of expenditures are attributed to the Board's Enforcement Program followed by its Licensing/Examination program and finally Administration. Enforcement expenditures comprise 61 percent of FY 2008-09, 68 percent of FY 2009-10, 68 percent of FY 2010-11 and 67 percent of FY 2011-12 of the Board's expenditures. Expenditures for the Licensing/Examination Program consisted of 19 percent for FY 2008-09 and 16 percent of the total expenditures for the following years. Followed by Administration Program expenditures consisting of

seven percent for FY 2008-09 and four to five percent of the total expenditures for the following years. (DCA Pro Rata reflected nearly 12 percent of the total expenditures in each year.)

While there was fluctuation in actual expenditures in each program area, the percentages of the overall expenditures for each year were relatively the same with the exception of FY 2008-09. The dramatic shift from FY 2008-09 to the following year is primarily attributed to the redirection of staff to the Enforcement Unit previously dedicated to Outreach efforts (Administration Program) as a result of the CPEI.

Table 3b. Expenditures by Program Component

Program Area	FY 08/09		FY 09/10		FY 10/11		FY 11/12		AVG %
	Personnel Services	OE&E							
Enforcement	\$718,021	\$703,367	\$776,427	\$902,201	\$829,174	\$866,631	\$882,687	\$924,170	66.0%
Licensing/ Exam	\$324,584	\$115,401	\$283,939	\$113,659	\$306,256	\$98,783	\$307,524	\$123,840	16.8%
Administration	\$138,966	\$34,193	\$81,439	\$36,371	\$83,944	\$27,659	\$91,137	\$36,121	5.4%
DCA Pro Rata	-	\$281,335	-	\$287,956	-	\$295,053	-	\$314,693	11.8%
TOTALS	\$1,181,571	\$1,134,296	\$1,141,805	\$1,340,187	\$1,219,374	\$1,288,126	\$1,281,348	\$1,398,824	

HISTORY OF FEE CHANGES

The authority for the Board's fees is found in §3775 of the B&P and provides either a ceiling for the fee amount or an actual amount. This section also provides the Board some flexibility by authorizing it to reduce the amount of any fee at its discretion. All fees were recently updated in the Board's regulations (effective June 2012), specifically, in §1399.395 (CCR, Title 16, Division 13.6).

As previously discussed and as shown in Table 3c, the Board's fees have remained fairly steady. In May 2004, the Board's regulations were amended to reflect the following changes:

- Initial License Fee of \$200 was modified to be "prorated" based on the number of months an initial license was issued rather than a flat amount.
- Renewal Fee Increase from \$200 to \$230 (implemented by statutory authority on January 1, 2002).
- Duplicate License Fee from \$75 to \$25.
- Endorsement Fee from \$50 to \$75.
- Transcript Review Fee of \$100 was eliminated (implemented January 1, 2003).

In June 2012, the Board's fee schedule was amended again, primarily to improve application processing times. The overall impact on revenue was insignificant. Following are those changes:

- Initial License Fee was eliminated.
- Application Fee was increased from \$200 to \$300 and established a sole fee for applications.
- Application Fee of \$250 for O-O-S/Foreign applicants was eliminated.
- Endorsement Fee reduced from \$75 to \$25.

Since the inception of the Board, its renewal cycle has always been scheduled on a biennial basis, based upon the licensee's birth month. The renewal fee has remained \$230 since January 2002.

FEE	Current Fee Amount	Statutory Limit	FY 08/09 Revenue	%	FY 09/10 Revenue	%	FY 10/11 Revenue	%	FY 11/12 Revenue	%
Duplicate License	\$25	\$75	\$2,500	0.1%	\$2,475	0.1%	\$2,400	0.1%	\$2,075	0.1%
Endorsement Fee ¹	\$75/(\$25)	\$100	\$26,390	1.1%	\$23,100	0.9%	\$24,975	1.0%	\$24,470	0.9%
Initial License Fee ²	varies/(\$0)	\$300	\$117,009	5.1%	\$119,328	4.8%	\$127,488	5.0%	\$115,068	4.3%
Examination Fee	\$190	actual cost	\$190	0.0%	\$0	0.0%	\$0	0.0%	\$760	0.0%
Re-Examination Fee	\$150	actual cost	\$0	0.0%	\$0	0.0%	\$0	0.0%	\$0	0.0%
Application Fee ³	\$200/(\$300)	\$300	\$233,800	10.1%	\$256,600	10.4%	\$241,800	9.5%	\$284,900	10.7%
Application Fee (OOS)	\$200/(\$300)	\$300	\$37,800	1.6%	\$31,800	1.3%	\$29,400	1.2%	\$33,800	1.3%
Application Fee (Foreign)	\$250/(\$300)	\$350	\$400	0.0%	\$200	0.0%	\$200	0.0%	\$0	0.0%
Biennial Renewal Fee	\$230	\$330	\$1,797,985	77.9%	\$1,915,310	77.5%	\$1,987,767	78.4%	\$2,095,565	78.8%
Delinquent Fee (<2 yrs)	\$230	\$330	\$35,881	1.6%	\$34,500	1.4%	\$30,590	1.2%	\$37,030	1.4%
Delinquent Fee (>2 yrs)	\$460	\$660	\$5,060	0.2%	\$8,980	0.4%	\$9,660	0.4%	\$6,900	0.3%
Citation and Fine	varies	\$15,000	\$30,121	1.3%	\$41,863	1.7%	\$41,378	1.6%	\$28,646	1.1%
Enf. Review Fee	varies	actual cost	\$20,193	0.9%	\$21,420	0.9%	\$22,093	0.9%	\$20,291	0.8%
Reinstatement Fee	\$200	\$300	\$800	0.0%	\$400	0.0%	\$400	0.0%	\$800	0.0%
Miscellaneous*	N/A	N/A	\$1,181	0.1%	\$15,801	0.6%	\$15,956	0.6%	\$8,509	0.3%
TOTAL REVENUE			\$2,309,310		\$2,471,777		\$2,534,107		\$2,658,814	

*Miscellaneous includes: income from surplus money investments, cancelled warrants, dishonored check fees, and services to the public.

REGULATIONS EFFECTIVE 6/24/12 RESULTED IN THE FOLLOWING CHANGES TO THE BOARD'S FEE SCHEDULE:

¹ Endorsement fee reduced to \$25. ² Initial licensing fee eliminated. ³ Single application fee established and fee increased to \$300.

BUDGET CHANGE PROPOSALS

In 2002, the Board submitted a negative BCP (FY 2003-04) to reduce authorized expenditures associated with the Office of Attorney General (OAG), which was subsequently approved. The BCP was prompted as a direct result of the Board establishing a fully expanded citation and fine program.

In 2010 and 2011, the Board submitted BCPs (FY 2011-12 and FY 2012-13) to augment its enforcement staff by three PYs (approximately \$283,000). Both BCPs were ultimately denied. The BCPs were in support of the CPEI and aimed at developing processes to assume many of the responsibilities of the OAG for routine pleadings and stipulated decisions.

Table 3d. Budget Change Proposals (BCPs)

BCP ID #	Fiscal Year	Description of Purpose of BCP	Personnel Services				OE&E	
			Staff Requested	Staff Approved	**Funds Requested	**Funds Approved	**Funds Requested	**Funds Approved
1455-01	03/04	The Board requested a reduction to its OAG line item due to projected reductions in its OAG caseload.	N/A	N/A	N/A	N/A	(-132)	(-132)
1110-14	11/12	Enforcement Workload: The Board requested a permanent ongoing staff increase of 3.0 positions to address significant growth in enforcement workload, meet the challenges of the CPEI, and provide focused staff resources to the Board's enforcement program.	<u>3.0 PYs</u> 3 AGPAs	0	\$245	\$0	\$23	\$0
1110-07	12/13	Enforcement Workload: The Board requested a permanent ongoing staff increase of 3.0 positions to address significant growth in enforcement workload, meet the challenges of the CPEI, and provide focused staff resources to the Board's enforcement program.	<u>3.0 PYs</u> 3 AGPAs	0	\$241	\$0	\$42	\$0

*AGPA - Associate Governmental Program Analyst

** Numbers are in thousands.

STAFFING ISSUES

The Board has been fortunate in retaining a highly skilled and experienced workforce over the last ten years. Turnover is extremely rare, with only a handful of employees leaving to pursue other promotional opportunities. Fourteen of the Board's current 18 staff were employed at the Board during its last Sunset Review in 2001. Organizational charts for the last four fiscal years are attached (**Attachment 3**).

Over the last four fiscal years, the Board has spent an estimated \$6,000 on training and education. Most costs are associated with private and college courses related to investigative techniques, drug testing procedures, computer software training and college courses taken as part of the State's Career Development program. However, staff have also participated in numerous courses, free of (direct) charge, offered through the DCA, including, but not limited to, Investigative Report Writing; How to Monitor Probation; How to Become a Better Communicator; Customer Service Excellence, and Unlocking the Mysteries of Analytical Thinking.

The Board's greatest staffing challenges have occurred over the last two years. Not only has its efforts to increase staffing to pursue greater enforcement efficiencies been denied, but the most recent cuts to staffing have also placed the Board in a vulnerable position. In June 2012, the Board learned it would need to reduce staffing by 1.6 personnel years, pursuant to Budget Letter 12-03. This resulted in the loss of one of the two special investigator positions the Board recently assumed, a part time position dedicated to an expert (that was never established and was previously partially taken under another drill), and reducing an existing staff person's office assistant position to less than full-time. While the special investigator position was vacant, it was being kept in the event the Board ever lost its highly experienced retired annuitant. Now, should the retired annuitant leave, the Board will be severely understaffed, until a BCP is approved. Further, the Board was advised that should the person working full-time in the Office Assistant position (that was reduced) ever leave, the Board would need to fill it in a part-time capacity. These most recent reductions could cripple the Board's operations should these key personnel vacate their positions. Considering it takes 18 months to acquire new personnel and an additional three to nine months to fill a position, the Board's enforcement and licensing programs would be negatively affected.

Section 4: Licensing Program

LICENSEE POPULATION

Since the Board's inception in 1985, it has issued over 33,000 licenses. As of June 30, 2012, the Board had 18,869 active and current licensees and an additional 1,521 delinquent licensees. The Board does not track the number of licensees currently residing "out-of-state" or "out-of-country." However, while writing this report, the Board requested these figures to provide a general baseline. As of August 8, 2012, the number of ACTIVE licensees with an address of record "Out-of-State" and "Out-of-Country" were 875 and 21, respectively.

Table 4a. Licensee Population					
		FY 08/09	FY 09/10	FY 10/11	FY 11/12
Respiratory Care Practitioner	Active	16,608	17,274	18,177	18,869
	Out-of-State	Not Tracked	Not Tracked	Not Tracked	Not Tracked
	Out-of-Country	Not Tracked	Not Tracked	Not Tracked	Not Tracked
	Delinquent	1,469	1,529	1,481	1,521



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APPLICATION PROCESSING TIMES

The Board strives to process applications for licensure as quickly as possible. The average cycle time to process a complete application from date of receipt to date of licensure is 67 days as of June 30, 2012. A complete application includes all required materials, with the exception of official transcripts and verification of successful completion of the licensing exam. Because the Board allows applicants to apply 90 days in advance of graduation, this 67 days cycle time, includes a waiting period for the majority of applicants to graduate and have their official transcripts submitted, as well as submit proof of exam passage. In most instances, applications and required documentation are reviewed and action is taken by the Board (where applicable) within one to two days of receipt.

In 2010, the Board examined its application process to determine if it could be re-engineered to speed the process any further. It found that by imposing a prorated licensing fee, the process was being delayed by an average of three to eight weeks. Previously, once an applicant was approved for licensure, the Board would send notification to the applicant requesting the licensing fee. Significant delays were associated with the waiting periods to receive the licensing fee and for DCA to cashier the monies before the license could be issued. The Board amended its fees through regulation, by eliminating the initial licensing fee all together. As of July 2012, once an applicant is approved for licensure, the license is issued immediately. The Board expects its average application processing time (from date of receipt to date of licensure) to be reduced significantly beginning with FY 2012-13.

Tables 4b and 4c demonstrate that the number of pending applications at the end of each fiscal year is significant in comparison to the total number of applications received (i.e., 687 pending compared to 1,593 received in FY 2011-12). This is a direct correlation with the graduation cycles of respiratory care programs. The largest graduating classes begin submitting applications mid-May through June. Therefore, a count of “pending applications” anywhere from May-August will be significantly higher than at any other time of the year.

Further, it should be noted that in FY 2002-03, the Board only received an average of 700 applications a year. This number has steadily increased over the last nine years to 1,593 applications received in FY 2011-12. The Board has managed the majority of this additional workload through re-engineering its processes, while continuing to improve processing times.

INITIAL LICENSURE AND RENEWALS

The Board currently issues approximately 1,300 new and renews approximately 9,000 licenses each year. While the following tables demonstrate a significant increase in the last three fiscal years, there have been even more significant increases since the Board was last reviewed. In FY 2002-03 approximately 620 licenses were issued and 7,200 licenses were renewed each year. These figures have grown fairly steadily over the last nine years, with the most noticeable jump beginning in FY 2006-07.

Table 4b. Licensing Data by Type

	Application Type	Received	Approved	Closed (Withdrawn Abandoned or Denied)	Issued (Initial and Renewed Licenses Issued)	Pending Applications at Close of FY	Cycle Times (in days)	
							Complete Apps	Incomplete Apps
FY 09/10	License/Exam	1,443	1,272	107	1,272	602	82	155
	Renewal	8,327	8,327	N/A	8,327	-	9	19
FY 10/11	License/Exam	1,357	1,391	101	1,391	560	65	101
	Renewal	8,642	8,642	N/A	8,642	-	5	13
FY 11/12	License/Exam	1,593	1,313	88	1,313	687	67	106
	Renewal	9,111	9,111	N/A	9,111	-	9	15

Table 4c. Total Licensing Data

	FY 09/10	FY 10/11	FY 11/12
Initial Licensing Data			
Initial License/Initial Exam Applications Received	1,443	1,357	1,593
Initial License/Initial Exam Applications Approved	1,272	1,391	1,313
Initial License/Initial Exam Applications Closed	107	101	88
License Issued	1,272	1,391	1,313
Initial License/Initial Exam Pending Application Date			
Pending Applications (total at close of FY)	602	560	687
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE)			
Average Days to License Issued (All - Complete/Incomplete)	119	83	87
Average Days to License Issued (Incomplete applications)	155	101	106
Average Days to License Issued (Complete applications)	82	65	67
License Renewal Data			
License Renewed	8,327	8,642	9,111

APPLICATION BACKGROUND VERIFICATION/FINGERPRINTS

As part of the application for licensure process, the Board requires the following documentation (as applicable):

- 10-year California DMV History Report (or similar report from out-of-state applicants).
- Department of Investigation Background Check.
- Federal Bureau of Investigation Background Check.
- Official Education Transcript(s).
- Licensing Examination Verification (of successful completion).
- Board-approved Law and Professional Ethics Course Verification (of successful completion).
- Out-of-State Licensure History (as applicable).
- National Practitioner Databank History for applicants where residence or education may be outside of California.

With the exception of motor vehicle history reports, all of the above documentation must come directly from the source. Documentation submitted by the applicant will not be accepted.

Since the inception of the Board, all applicants have been fingerprinted to ascertain any criminal history. The Board continues to receive follow-up reports on all licensees, until such time the Board notifies the Department of Justice (DOJ) that it is no longer interested in receiving this follow-up information.

Effective July 1, 2005, the Board began issuing “No Longer Interested” notifications for all denied applicants and all licenses that are no longer active (i.e. cancelled, retired, deceased, revoked). The Board currently has approximately 8,000 records, that were cancelled prior to July 1, 2005, that still need to have the “No Longer Interested” notification sent to DOJ. The Board plans to make a concentrated effort to complete this project once the existing freeze to hire students is lifted and staff resources are available to oversee the project. With proper resources the project can be completed by Summer 2014.

The Board's application also includes very specific background questions for the rare occasion, an event is not captured by other means. The Board takes a tough stance against any type of perjury, discouraging applicants from concealing any historical criminal/disciplinary information. An incident that may result in a strong warning letter if revealed will nearly always result in the denial of a license if perjury is committed.

Section 4: Licensing Program

In addition to fingerprinting, the Board will also run a check with the National Practitioner Databank if it appears that the applicant may have resided or obtained his or her education outside of California (this check is not performed on existing licensees). The Board also requires applicants who reveal they have been licensed out-of-state, to have those states where licensure was held, submit a license verification indicating if there has ever been any disciplinary action taken against that license, directly to the Board's office.

EXAMINATION

An applicant must successfully pass the NBRC's "Certified Respiratory Therapist (CRT)" examination to qualify for licensure as an RCP. The Entry-Level CRT examination is designed to objectively measure essential knowledge, skills, and abilities required of entry-level respiratory therapists. The examination consists of 160 multiple-choice questions (140 scored items and 20 pretest items) distributed among three major content areas: clinical data, equipment, and therapeutic procedures.

The NBRC also offers a voluntary credential upon passage of this exam, which is required to qualify to sit for the advanced and more esteemed "Registered Respiratory Therapist (RRT)" examination. While passage of the RRT examination is not required for licensure, it is required for various reimbursements and is recognized by the medical community to be of a higher standard.

The NBRC administers up to six different, but equivalent versions of the CRT examination on a daily basis and ensures that no candidate is permitted to consecutively repeat an examination form previously taken. Applicants may apply to take the examination online or via paper application. Upon verification of education requirements, applicants may schedule themselves to sit for the examination at one of 16 locations throughout California. Applicants are given three hours to complete the entry-level examination via computer-based testing (exceptions are made in accordance with the ADA). Once applicants have completed the examination, they will be notified immediately of the results. Those results are then shared with the Board on a weekly basis.

Over the last four years, the pass rates for first time takers of the CRT examination has hovered around 80 percent and is between 24 percent to 32 percent for repeat takers.

Table 4d. Examination Data		
NATIONAL EXAMINATION		
	<i>License Type</i>	Respiratory Care Practitioner
	<i>Exam Title</i>	Certified Respiratory Therapist Exam
FY 08/09	Number of First Time Candidates	1,231
	Pass %	80.50%
	Number of Repeat Candidates	793
	Pass %	26.73%
FY 09/10	Number of First Time Candidates	1,182
	Pass %	80.37%
	Number of Repeat Candidates	701
	Pass %	24.68%
FY 10/11	Number of First Time Candidates	1,254
	Pass %	80.14%
	Number of Repeat Candidates	609
	Pass %	32.02%
FY 11/12	Number of First Time Candidates	1,443
	Pass %	79.83%
	Number of Repeat Candidates	638
	Pass %	31.19%
	<i>Date of Last Occupational Analysis</i>	2007¹
	<i>Name of Occupational Analysis Developer</i>	National Board for Respiratory Care
	<i>Target Occupational Analysis Date</i>	2012

¹ New test specifications as a result of the 2007 occupational analysis were introduced in July 2009.

Section 4: Licensing Program

The NBRC is sponsored by the American College of Chest Physicians, the AARC, the American Society of Anesthesiologists, and the American Thoracic Society and is a voluntary health certifying board which was created in 1960 to evaluate the professional competence of respiratory therapists. Its executive office has been located in the metropolitan Kansas City area since 1974. The NBRC is a member of the Institute for Credentialing Excellence (ICE), and both the CRT and RRT examinations (as well as several others) are accredited by the National Commission for Certifying Agencies (NCCA). Accreditation by the NCCA signifies unconditional compliance with stringent testing and measurement standards among national health testing organizations.

SCHOOL APPROVALS

There are 36 respiratory care programs in California that are approved by the Board by virtue of their accreditation status. Pursuant to §3740, the Board requires two components of education:

- 1) Completion of an education program for respiratory care that is accredited by the Committee on Accreditation for Respiratory Care (CoARC) AND
- 2) Possession of a minimum of an associate degree from an institution or university accredited by a regional accreditation agency or association recognized by the United States Department of Education (USDOE).

Most often, these components are one in the same, but in some instances, they may be distinct. A degree will be issued by a different institution usually when the respiratory care program was completed prior to 2001 (when education requirements were changed) or if the respiratory care education was received outside of California.

Board staff verify the status of each respiratory care program one to two times annually, to ensure that the programs and schools continue to hold valid accreditation. In addition, the Board also confers with the Bureau for Private Postsecondary Education (BPPE) to ensure private institutions continue to hold their approval. All 36 programs are accredited by CoARC, 24 are accredited by the Western Association of Schools and Colleges (WASC) and the remaining 12 are accredited by an agency recognized by the USDOE and are approved by the Bureau for Private Postsecondary Education. Other respiratory care programs' and schools' accreditation statuses are verified as they are presented.

CoARC accredits degree-granting programs in respiratory care that have undergone a rigorous process of voluntary peer review and have met or exceeded the minimum accreditation standards as set by the professional association in cooperation with

CoARC. The CoARC reviews schools annually and performs full-level reviews and site visits once every ten years. The Board regularly communicates with the CoARC and provides input into their review process. In 2007 and 2008, a member of the Board's Education Committee participated as an observer in six of these school site visits/reviews.

Over the years, the Board has performed detailed audits of all education programs' transcripts and catalogs and has received a handful of complaints from students. The overwhelming majority of the concerns raised, were in connection with programs that were not WASC accredited. The BPPE plays a pivotal role in overseeing these private institutions. It has been a hardship for the Board, as well as students, with the rise and fall of the postsecondary oversight agency.

In recent years, during the sunset of the previous Bureau for Private Postsecondary and Vocational Education, the Board was forced to review a school's transcripts in detail to find a resolution to significant and ongoing issues with courses reported as complete that did not match various catalogs. Several applicants had their licensure delayed until the "official" transcripts correctly reflected the courses they completed. After nearly two years of close review, the issues appeared to be resolved. However, the Board was not equipped nor authorized to investigate the school further, to determine if greater deficiencies existed. The Board did forward its findings to the CoARC who ascertained they would take the findings into consideration during the school's next complete review. However, given the BPPE's vested interest in California schools and its mandates aimed at protecting students and preventing fraud, the BPPE would have been the appropriate source to investigate the issues further.

The Board does not have any legal requirements regarding approval of international schools. With the exception of Canadian students, all other foreign-educated students can obtain "advanced standing" at most of the respiratory care programs in California, where their education and experience is evaluated and they are placed in the program accordingly. Canadian students, who provide evidence of a degree equivalent to that required for all other students and completion of a respiratory care program approved by the Canadian Board of Respiratory Care, qualify for licensure (reference §3740).

Aside from approving schools, in 2009, the Board added respiratory programs' CRT exam pass/fail rates to its website for prospective students. This success rate can be an important factor when a student is selecting a program from among various programs offered within the same geographical area.

Section 4: Licensing Program

CONTINUING EDUCATION

Every two years, an active RCP must complete 15 hours of approved CE. Ten of those 15 hours must be directly related to clinical practice. In addition, during every other renewal cycle, each active RCP must also complete a Board-approved Law and Professional Ethics Course which may be claimed as three hours of non-clinical CE credit (reference CCR §1399.350).

Since the Board was last reviewed, the regulations surrounding CE have been amended to identify approved providers, identify advanced credentialing examinations that qualify for credit, clarify definitions, and strengthen audit and sanctions for noncompliance. The Board held several workshops in 2002 and 2003, to gather input from interested parties to determine if the Board should move forward with approving its own courses or providers, prior to beginning the regulation process. Ultimately, the Board found that there were a significant number of qualified entities already approving courses and chose to recognize those agencies, rather than add an additional layer of approval for providers. Each course must be provided or approved by one of the following entities:

- (1) Any postsecondary institution accredited by a regional accreditation agency or association recognized by the United States Department of Education.
- (2) A hospital or healthcare facility licensed by the California Department of Health Services.
- (3) The American Association for Respiratory Care (AARC).
- (4) The California Society for Respiratory Care (CSRC) (and all other state societies directly affiliated with the AARC).
- (5) The American Medical Association.
- (6) The California Medical Association.
- (7) The California Thoracic Society.
- (8) The American College of Surgeons.
- (9) The American College of Chest Physicians.
- (10) Any entity approved or accredited by the California Board of Registered Nursing or the Accreditation Council for Continuing Medical Education.

In 2005, the Board also moved forward with amending its regulations to require each licensee to successfully complete a Board-approved Law and Professional Ethics Course. The course is currently offered by the AARC and the CSRC and is aimed at informing RCPs of the expectations placed upon them as professional practitioners in the State of California. Two-thirds of the course is comprised of scenarios based

on workplace ethics and one-third is specific to acts that jeopardize licensure based on the laws and regulations that govern their licenses (reference §1399.350.5 and §1399.352.7).

All CE course content must be relevant to the scope of practice of respiratory care. As previously mentioned, a minimum of ten hours must be directly related to clinical practice. Licensees may also count up to five hours of CE in courses not directly related to clinical practice if the content of the course or program relates to any of the following:

- (1) Those activities relevant to specialized aspects of respiratory care, which activities include education, supervision, and management.
- (2) Healthcare cost containment or cost management.
- (3) Preventative health services and health promotion.
- (4) Required abuse reporting.
- (5) Other subject matter which is directed by legislation to be included in CE for licensed healing arts practitioners.
- (6) Re-certification for ACLS, NRP, PALS, and ATLS.
- (7) Review and/or preparation courses for credentialing examinations provided by the NBRC, excluding those courses for entry-level respiratory therapy certification.
- (8) The Law and Professional Ethics Course required every other renewal cycle.

The Board also accepts the passage of any of the following credentialing exams as credit towards CE:

- (1) Registered Respiratory Therapist (RRT).
- (2) Certified Pulmonary Function Technologist (CPFT).
- (3) Registered Pulmonary Function Technologist (RPFT).
- (4) Neonatal/Pediatric Respiratory Care Specialist (NPS).
- (5) Advanced Cardiac Life Support (ACLS).
- (6) Neonatal Resuscitation Program (NRP).
- (7) Pediatrics Advanced Life Support (PALS).
- (8) Advanced Trauma Life Support (ATLS).

Upon renewing an RCP license, active RCPs must attest, under penalty of perjury, that they have completed 15 hours of the required CE. In 2004, the Board targeted five to eight percent of its renewals to audit. However, in 2009, the Board temporarily halted

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its CE audit program in order to redirect resources needed to respond to numerous drills presented by the Administration at that time, as well as the CPEI. In 2011, the Board resumed performing CE audits and is on track to audit five percent of its licensees in FY 2012-13.

Table 4e. CE Audits Performed/Failed

	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12
Renewals Audited	598	315	0	0	213
Failed	54	18	0	0	7

Records submitted by the licensee are reviewed to determine if all the required information is present. The Board's auditor will also verify many of the records received with the actual provider to verify authenticity.

Licensees who fail a CE audit are initially subject to their license being placed in an inactive status. These matters are then referred to enforcement where cases are investigated to determine if unlicensed practice has also taken place. Once a matter is investigated, if the licensee has still not produced records verifying completion of required CE (also verified by Board staff), a citation and fine will be issued. The citation and fine may be based upon the CE violation itself or may also include other violations, primarily, unlicensed practice. Below are the guidelines Board staff rely upon in issuing fine amounts for licensees with no discipline history:

Table 4f. CE Violations/Citation and Fine Guidelines

Scenario	Fine Amount
Non-Compliance/No Response to 30 day and 10 day initial requests (and subsequently cleared)	\$250
Each CE unit lacking	\$25
Perjury on renewal form	\$300
Unlicensed practice (per day worked) up to 30 days	\$50
Unlicensed practice (per day worked) > 30 days	\$100

Cases where certificates of completion are believed to be forged are referred to the Enforcement Unit for investigation. If evidence of forgery is found, the case will be referred for formal disciplinary action.



Section 5: Enforcement Program

OVERVIEW

The Board's enforcement program is charged with investigating complaints; issuing penalties and warnings, and overseeing the administrative prosecution against licensed RCPs and unlicensed personnel for violations of the RCPA. The enforcement program is key to the Board's success in meeting its mandate and highest priority of consumer protection.

Since the Board was last reviewed, it has re-engineered many processes and developed new programs which have significantly contributed to the Board's ability to meet its mandate while containing overall enforcement costs. In 2001, the Board had 24 PYs compared to 18 PYs at the end of FY 2011-12. Reductions of six positions (3.5 of which were designated to Enforcement) were made over a two year period between 2002 and 2004. The Board also requested and received a budget reduction in its Office of Attorney General (OAG) line item of \$132k in FY 2003-04. Many of the contributing factors to these reductions were the result of:

- 1) The Board assuming more investigative responsibilities (previously performed by an outside investigative agency) after gaining additional authority to obtain records.
- 2) Establishing a comprehensive citation and fine program.
- 3) Establishing the Board's "In-House Review Penalty Determinations" guidelines to provide for consistency in handling the most common types of violations.
- 4) Continual review and re-engineering of workflow processes.
- 5) Training and retaining highly qualified staff.
- 6) Developing a database to track and invoice all outstanding costs, fines, and monthly probation monitoring fees.
- 7) Establishing authority that allowed the Board to contract with a collection agency to collect outstanding costs.
- 8) Establishing a contract with a company to drug test probationers rather than having monitors conduct routine testing.

Over the years, the Board has gained control of many aspects of enforcement as a matter of efficacy. Prior to the Board's last Sunset Review, it had just begun obtaining criminal records for cases rather than referring cases out to investigation.

Since the Board's last Sunset Review it has taken on more of these investigative responsibilities. As staff became more familiar with the investigative process and completed investigative training, the Board expanded its in-house investigations to include any and all paper cases in 2002. The only exceptions were those cases where employers refused to produce records. In those instances, cases would be referred for investigation by an outside agency. The Board found that it took anywhere from three to eight months for the records to be requested by the outside agency, and began to pursue obtaining its own subpoena authority. With the onset of the CPEI, Brian Stiger, the newly appointed Director of DCA, at that time, created a process whereby boards could obtain authority from DCA to issue their own subpoenas. In January 2010, the Board officially received this authorization. Since that time, the Board has had very few problems in obtaining records as part of an official investigation.

The CPEI also brought forth problems all health boards had when relying upon an outside source to conduct investigations; most notably, significant time lapses and inconsistent quality of investigations. In addition, the Board began receiving a notable increase in practice-related complaints in or about 2003, where quality and processing times suffered even more. It was acknowledged that part of the problem was that the outside investigative agency was understaffed and responsible for investigating numerous matters, many *outside* the healthcare arena. It was especially difficult for investigators to maintain any familiarity with the terms, technology, standards and regulations specific to respiratory care, given the few cases the Board referred for investigation.

The DCA, in concert with the State Personnel Board, was instrumental again, in finding a means within the current structure that would allow boards to hire their own "non-sworn" investigators. In 2010, the Board reclassified two of its Associate Governmental Program Analyst positions to the new non-sworn Special Investigator class and began to recruit. The positions were filled mid 2010 and in 2011 (one filled with a very seasoned retired annuitant). As a result, the number of investigations referred outside the Board to sworn investigators was reduced significantly with none being referred in FY 2011-12. These in-house investigators now handle all practice-related and other complex investigations (e.g. unlicensed practice) in consult with Board experts. Table 5c demonstrates the dramatic decline in time to close investigations over the last three years: 42 percent (368 cases) were closed in less than 90 days in FY 2009-10 compared to 68 percent (558 cases) in FY 2011-12.

Section 5: Enforcement Program

PERFORMANCE MEASURES

In 2010, the Board established performance targets for measures developed by the DCA, as a result of the CPEI. The DCA also developed the criteria and program to calculate these days, according to their measures. The Board's overall goal is for all cases to be completed, from the date the complaint is received to final adjudication, within 18 months (or approximately 540 days). Below you will see that the Board's averages are all well below the Board's maximum targets with the exception of "Formal Discipline."

Table 5a. Enforcement Program Performance Targets	TARGET	Actual FY 10/11 Average	Actual FY 11/12 Average
Intake: Average cycle time (in days) from complaint receipt, to the date the complaint was assigned to an investigator.	7 days	3 days	3 days
Intake and Investigation: Average cycle time (in days) from complaint receipt to closure of the investigation process. Does not include cases sent to the OAG or other forms of formal discipline.	210 days	116 days	89 days
Formal Discipline: Average number of days to complete the entire enforcement process for cases resulting in formal discipline. Includes intake and investigation by the Board, and dispensation by the OAG.	540 days	593 days	625 days
Probation Intake: Average number of days from monitor assignment to the date the monitor makes first contact with the probationer.	6 days	1 day	2 days
Probation Violation Response: Average number of days from date violation is reported to date the assigned monitor initiates appropriate action.	10 days	2 days	5 days

While the Board continues to strive to reach an average well under 540 days for "Formal Discipline," it should be noted that this figure is dependent upon processing times by the OAG and often the Office of Administrative Hearings (OAH).

Two-thirds of the Board's formal disciplinary cases result in a stipulated decision. Board staff roughly estimate the time for most of these cases from intake to ordering the final decision, is between one and one and one-half years to complete. The remaining cases that go to hearing and result in an Administrative Law Judge (ALJ) or Board decision generally take anywhere from two to four-plus years to complete. There are a significant amount of cases (24 or nearly one-third of the cases closed in FY 2011-12) that took two or more years to adjudicate.

Table 5b. Enforcement Statistics

	FY 09/10	FY 10/11	FY 11/12
COMPLAINT			
Intake			
Received	237	205	227
Closed	7	11	11
Referred to Investigation	230	194	216
Average Time to Close	3	3	3
Pending (close of FY)	0	0	0
Source of Complaint			
Public	30	25	28
Licensee/Professional Groups	42	46	44
Governmental Agencies	5	1	4
Other	160	133	151
Conviction/Arrest			
Conviction Received	665	630	648
Conviction Closed*	39	35	45
Referred to Investigation	626	595	603
Average Time to Close	3	3	2
Conviction Pending (close of FY)	0	0	0
LICENSE DENIAL			
License Applications Denied**	6	5	4
Statement of Issues Filed	29	20	13
Statement of Issues Withdrawn	0	0	0
Statement of Issues Dismissed	0	0	0
Statement of Issues Declined	0	0	1
Average Days to File SOI	89	88	72
Pending (close of FY)	24	15	10
ACCUSATION			
Accusations Filed	42	58	51
Accusations Withdrawn	0	3	1
Accusations Dismissed	0	0	0
Accusations Declined	2	2	3
Average Days to File Accusation	102	85	118
Pending (close of FY)	37	57	48

* Conviction Closed stats represents arrest/convictions that are closed non-jurisdictional (cancelled licensees, unrelated crimes, etc.) and are not referred to investigation

** License Applications Denied includes only those denied by way of order. It does not include initial denials made pursuant to B&P §485(b), where the applicant opted to not appeal the denial.

Table 5b. Enforcement Statistics (continued)			
	FY 09/10	FY 10/11	FY 11/12
DISCIPLINE			
Disciplinary Actions			
Proposed/Default Decisions	23	21	35
Stipulations	51	43	40
Average Number of Days to Complete	608	593	625
AG Cases Initiated	69	80	69
AG Cases Pending (close of FY)	61	72	58
Disciplinary Outcomes			
Revocation	15	12	25
Voluntary Surrender	9	5	8
Suspension	0	0	0
Probation with Suspension	3	3	1
Probation	36	25	35
Public Reprimand	4	10	4
Other	1	4	2
PROBATION			
Please see Table 5b. Enforcement Statistics/Extended Probation Data (Page 58)			
PETITIONS			
Petitions to Modify Probation			
Granted	0	0	0
Denied	0	0	0
Petitions to Terminate Probation			
Granted	3	1	9
Denied	1	0	1
Petitions for Reinstatement of License			
Granted	1	1	4
Denied	3	1	0

Table 5b. Enforcement Statistics (continued)

	FY 09/10	FY 10/11	FY 11/12
INVESTIGATION			
All Investigations			
First Assigned	856	789	819
Closed	878	856	818
Average days to close	170	128	102
Pending (close of FY)	323	240	242
Desk Investigations			
Closed	864	819	746
Average days to close	161	118	88
Pending (close of FY)	321	197	204
Non-Sworn Investigation			
Closed	0	30	70
Average days to close	0	329	242
Pending (close of FY)	0	42	38
Sworn Investigation			
Closed	14	7	2
Average days to close	597	445	314
Pending (close of FY)	2	1	0
COMPLIANCE ACTION			
ISO and TRO Issued	4	4	0
PC 23 Orders Issued	1	1	1
Cease and Desist/Warning	307	289	269
Referred for Diversion	n/a	n/a	n/a
Compel Examination	0	2	0
CITATION AND FINE			
Citations Issued	75	96	69
Average Days to Complete	245	201	153
Amount of Fines Assessed	\$123,975	\$51,450	\$25,925
Reduced, Withdrawn, Dismissed	\$400	\$3,500	\$75,525
Amount Collected	\$39,873	\$47,166	\$30,933
CRIMINAL ACTION			
Referred for Criminal Prosecution	0	1	0

Table 5b. Enforcement Statistics / Extended Probation Data

	FY 09/10	FY 10/11	FY 11/12
New Probationers	41	30	39
Probations Successfully Completed	30	23	22
Probationers (close of FY)	105	92	98
Petitions to Revoke Probation	21	9	10
Probations Revoked	15	7	6
Probations Surrendered in Lieu of Disc Action	6	6	1
Probations Voluntary Surrendered	0	2	4
Probations Extended	1	1	2
Probationers Subject to Drug Testing (entire FY)	115	97	96
OVERALL DRUG TESTS ORDERED/POSITIVE TESTS			
Drug Tests Ordered	1,153	1,325	2,368
Positive Drug Tests	115	101	216
Number of Probationers Testing Positive	30	26	30
POSITIVE DRUG TESTS FOR BANNED SUBSTANCES			
Positive Drug Tests	5	5	4
Number of Probationers w/Positive Drug Tests	5	3	4

Table 5c. Enforcement Aging

	FY 09/10	FY 10/11	FY 11/12	Cases Closed	Average %
Attorney General Cases (Average %)					
CLOSED WITHIN:					
0-1 Year	9	11	23	43	20%
1-2 Years	50	35	28	113	53%
2-3 Years	11	16	18	45	21%
3-4 Years	3	2	4	9	4%
Over 4 Years	1	0	2	3	1%
Total Cases Closed	74	64	75	213	100%
Investigations (Average %)					
CLOSED WITHIN:					
90 Days	368	521	558	1,447	57%
180 Days	242	162	135	539	21%
1 Year	163	95	78	336	13%
2 Years	92	75	41	208	8%
3 Years	11	2	6	19	1%
Over 3 Years	2	1	0	3	0%
Total Cases Closed	878	856	818	2,552	100%

SIGNIFICANT CHANGES IN STATISTICAL DATA

Since the Board's last review, the overall statistics have remained relatively steady with the exception of:

- 1) "Accusations Filed" which hovered around 95 per year until FY 2004-05 when the average fell to approximately 50 per year. This was a direct result of the implementation of the Board's citation and fine program.
- 2) Probation Statistics as shown in Table 5b (Extended Probation Data), specific to drug testing, reflect the implementation of the Uniform Standards and provide one early snapshot to evaluate the effectiveness of more frequent random testing (discussed later).
- 3) Attorney General Case Aging (Table 5c) which shows mixed results, but does show a marked increase in the number of cases closed in less than a year from only nine cases in FY 2009-10 to 23 in FY 2011-12. It should be noted that in FY 2009-10, the Board witnessed a significant reduction in time for Accusations to be filed by the OAG, with most being filed within 90 days.
- 4) Investigations Aging (Table 5c) where the number of cases closed within 90 days rose from 42 percent to 68 percent, in the last three fiscal years, of the total cases closed. Overall, investigations were closed in an average of 170 days in FY 2009-10 down to an average of 102 days in FY 2011-12.

PROBATION DATA

SB 1441 (Statutes of 2008), created the SACC charged with developing uniform standards for each healing arts board to use in addressing substance-abusing licensees placed in diversion or on probation (discussed further in Section 9). The "Uniform Standards Regarding Substance-Abusing Healing Arts Licensees" were adopted in April 2011.

One of the caveats in developing Standard 4 concerning drug testing frequency, was to require data collection to better determine if the higher frequency and standards were effective. A computer generated model identifying the mean average days to a positive urine test considering the frequency of drug use vs. the frequency of urine testing, was referenced when developing this standard. As stated in the "Drug Testing Proposed Amendments - Rationale" (**Attachment 4**), "In principal, testing a licensee an average of two times per week sounds like a sound practice to detect alcohol/drug use. However, the number of days substance use is detected in the more chronic user (and therefore, in most scenarios, the greater the risk) varies much less, regardless of the frequency of testing. One could make the argument that this is evidence for more

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frequent testing. However, given consideration to the risk factor of a person who uses once a month or less, the importance of “randomness” in testing, and the need to find a reasonable and pragmatic approach, this solution would appear to be implausible.”

As result of this movement and ultimately the adoption of the standards, the Board increased the number of times probationers were tested for banned substances as follows:

Table 5d. Random Testing Schedule	Random Tests Per Year per Probationer
Prior to 2009	6-8
2009 - February 2011	12-16
March 2011 - June 2011	24
July 2011 - Present (First Year of Probation)	52-104
July 2011 - Present (Second Year-plus of Probation)	36-104

Referencing Table 5b (Extended Probation Data), you will see that the number of tests ordered has more than doubled and that positive test results have nearly doubled. However, closer examination of this data reveals that the number of probationers who tested positive remained unchanged from FY 2009-10 to FY 2011-12. In fact, review of the data showed the number of probationers who actually tested positive for a banned substance, eliminating those probationers with valid (and legitimate) prescriptions, actually fell from five in FY 2009-10 to four in FY 2011-12.

While this data does not take into consideration earlier detection, it does appear to present signs that more frequent testing is *not* conducive to more probationers testing positive. The Board acknowledges that it is far too early to make any conclusions until further data is gathered.

The Board tracks those probationers who surrendered their license in lieu of discipline separate from those who voluntarily request to surrender their license. Table 5b (Extended Probation Data) indicates that since the Board implemented more frequent testing, six probationers have voluntarily surrendered their license. Four of these surrenders were a direct result of the increase in testing. Probationers stated they could not afford all the costs associated with probation (e.g. Cost Recovery, Monthly Probation Monitoring Costs, Drug Testing Costs), specifically citing the costs for drug testing that could be as much as \$3,500 to \$7,000 the first year of probation. While these costs are not a consideration, whatsoever, in enforcing public protection, they should be taken into consideration should it be found that a more frequent testing - especially a one size fits all approach - is not increasing public protection.

Effective July 1, 2012, the Board gained authority to issue “cease practice” notices to probationers for major violations of probation. New data collected in connection with these notices, coupled with additional drug testing data, will allow the Board to evaluate its program more effectively. It is expected that new ideas, approaches, and processes will eventually evolve, that will continue to improve consumer protection.

FORMAL DISCIPLINE PROCESS IMPROVEMENTS

The Board continues to regularly review its enforcement program and make adjustments to streamline workflow processes. It also continues to seek legislative or regulatory amendments as new discoveries are made or clarification is needed. As the Board’s investigators continue to gain training and experience, specific to respiratory care, the Board expects it will see further decreases in “Non-Sworn Investigative” times. It appears the longest processing times of the “Formal Discipline” process that could be significantly improved, are those incurred once the Board requests formal disciplinary action.

Currently, it takes an average of three to four months (90 to 120 days) from the Board’s request, to the time the OAG files an Accusation. Board staff estimate that most stipulations take six to eight months (180 to 240 days) to produce (from the date after the Accusation is filed to the date the stipulation is ready for mail vote by the Board). There are no short time frames for those cases that go to hearing, as a myriad of variables come into play with each case. However, the Board has noticed over the last two years, that Default Decisions are taking months (rather than weeks) to produce.

Given additional resources, the Board would like to assume some of the responsibilities currently held by the OAG. The Board believes it could assist the OAG in producing routine Accusations and Stipulations in half the time. However, the Board has been thwarted in its efforts to obtain additional staff. For several years, boards have been discouraged from submitting budget change proposals (BCPs). However, in light of the CPEI, the Board submitted budget change proposals (BCPs) to augment its enforcement staff by three personnel years (PYs), in 2010 and 2011; both were ultimately denied. Once restrictions are lifted, the Board will again, attempt to gain additional position authority to assume these additional responsibilities.

The most significant delay is associated with those cases that must go to hearing. Many of these cases are the most complex requiring witness and expert testimony, and mounds of evidence. Hearings take anywhere from six to 12 months to schedule with the OAH. Once the hearing is scheduled, there are several variables that may delay the hearing further (e.g. respondent’s request, scheduling witnesses, etc.). While the Board has little control over this process, it goes to great lengths to coordinate

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witnesses, demonstrations, and evidence, thus ensuring delays are not caused on its behalf. After the hearing, an ALJ is required by law to submit a decision within 30 days (Reference: Government Code §11517).

Both the investigative and administrative adjudication processes are lengthy. There is no doubt that improvements could still be made. However, time must be afforded to actually perform these functions and consideration should be given to the numerous delays outside of the Board's, OAG's and OAH's control.

CASE PRIORITIZATION

The Board uses the following guidelines which are intended to assist staff in distinguishing the level of attention and priority in which each complaint is handled. Of course these are merely guidelines, as many complaints have extenuating circumstances that may warrant more or less attention. Overall, these guidelines are in line with the DCA's Complaint Prioritization Guidelines for Health Care Agencies established on August 31, 2009. The flowcharts on pages 70-71 also show how Urgent complaints are handled differently through the Intake and Investigative processes vs. how High Priority and Routine complaints are handled.

With all complaints, special consideration is given to whether a child, any dependent adult (or even an animal) was affected or could have been affected by the willful or negligent behavior or incompetence of the licensee, at or away from work (this information is often found in an arrest or initial report). Such commissions or omissions in the care for children, dependent adults, and animals who cannot fend for themselves and place their trust in their care with the respondent, warrants a higher level of complaint handling and discipline.

Within each level, some complaints take higher priority. In addition, at any time during an investigation, if it is found the complaint poses a greater risk or will require additional analytical or investigative work, the complaint is elevated. Media attention may also warrant the expedient handling of a particular complaint.

Urgent Complaints

Respondent has allegedly engaged in conduct that poses an imminent risk of serious harm to the public health, safety, and welfare. The time that has lapsed since the act occurred may be weighted in the "imminent" risk factor. In general, complaints that rise to this level include, but are not limited to, those complaints where:

- The licensee has allegedly engaged in a lewd act, sexual misconduct, or sexual assault involving a child, patient or unconsenting adult at any time.

- The licensee has allegedly caused bodily injury or death to a patient as a result of his or her gross negligence, incompetence or repeated negligent acts.
- The licensee has allegedly engaged in a murder, rape, or other violent mental or physical assault at any time.
- The licensee has allegedly performed a willful act impacting patient care/pain management.
- The licensee has allegedly stolen or furnished unauthorized prescription drugs.
- The licensee has allegedly been under the influence of drugs or alcohol while at work.
- The licensee has allegedly been charged with DUI on the way directly to a work shift.
- Alleged unlicensed activity resulted in patient injury or death or aiding and abetting such activity.

High Priority Complaints

Respondent has allegedly engaged in conduct that poses a risk of harm to the public health, safety, and welfare. Some complaints that rise to this level include, but are not limited to, those complaints where:

- The licensee has allegedly been negligent or incompetent in his or her practice which resulted, or could have resulted, in patient harm (includes patient abandonment).
- The licensee has allegedly been under the influence of drugs or alcohol while at work and a significant amount of time has passed (>180 days) and no other concerns/reports have been made.
- The licensee has allegedly violated any section of the RCPA and is currently serving Board probation.
- The licensee has been arrested or convicted for an alcohol or drug related conviction (or circumstances suggest alcohol/drugs were involved) and the licensee has a prior complaint of this nature on file.
- The licensee has been arrested or convicted for a crime and a history of prior complaints indicate patterned behavior.
- The licensee has been arrested or convicted for a criminal act, where the circumstances indicate a serious unstable mental or physically abusive condition.

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- The licensee has been arrested or convicted of any other serious misdemeanor or felony offense.
- The licensee involved has had several similar complaints filed in the past.
- A licensee is unable to practice safely as a result of a mental, physical, or physiological impairment.
- The licensee has allegedly violated patient privacy.
- The licensee or unlicensed person has allegedly engaged in false or misleading advertising.
- An investigation or discipline has taken place in another territory.
- Unlicensed activity including misrepresentation, or aiding and abetting such activity has occurred.
- The licensee has allegedly participated in the subversion of a Board-related exam and the exam may be compromised.
- The licensee has allegedly failed to document patient records properly.
- The time to pursue a complaint pursuant to §3750.51, statute of limitations, is of concern (these cases may be elevated to an Urgent Priority, dependent upon time factors).
- Evidence will likely be compromised, destroyed, or made unavailable.

Routine Complaints

Routine complaints are strictly paper cases where no patient harm is alleged. Expert or additional investigation is not anticipated. These complaints do not require medical records, but may require personnel/employment records that are routine in nature and are requested on a regular basis for similar complaints. Some complaints at this level may include, but are not limited to, licensees who have:

- Failed a CE audit.
- Failed to renew his or her license timely and continued to work.
- Failed to report a change of address as required.
- Committed other minor violations that generally result in the issuance of a citation and fine or warning.

MANDATORY REPORTING

Sections 3758, 3758.5, and 3758.6 of the B&P, provide mandatory reporting requirements. The majority of reports received are based on compliance with Section

3758 which provides that any employer of an RCP must report to the Board the suspension or termination for cause for any RCP in their employ. “Suspension or termination for cause” is defined to mean the suspension or termination from employment for any of the following causes:

- (1) Use of controlled substances or alcohol to such an extent that it impairs the ability to safely practice respiratory care.
- (2) Unlawful sale of controlled substances or other prescription items.
- (3) Patient neglect, physical harm to a patient, or sexual contact with a patient.
- (4) Falsification of medical records.
- (5) Gross incompetence or negligence.
- (6) Theft from patients, other employees, or the employer.

Section 3758.5 provides that if a licensee has knowledge that another person may be in violation of the RCPA, that he or she must report that information to the Board.

Section 3758.6 provides that any employer reporting an RCP suspension or termination for cause, pursuant to Section 3758, shall also report to the Board the name and professional licensure type of the person supervising the RCP.

STATUTE OF LIMITATIONS

The Board operates within a statute of limitations as provided for in §3750.51 as follows:

§ 3750.51. Limitations period for filing accusation against licensee

- (a) Except as provided in subdivisions (b), (c), and (e), any accusation filed against a licensee pursuant to Section 11503 of the Government Code shall be filed within three years from the date the board discovers the alleged act or omission that is the basis for disciplinary action, or within seven years from the date the alleged act or omission that is the basis for disciplinary action occurred, whichever occurs first.
- (b) An accusation filed against a licensee pursuant to Section 11503 of the Government Code alleging the procurement of a license by fraud or misrepresentation is not subject to the limitations set forth in subdivision (a).
- (c) The limitation provided for by subdivision (a) shall be tolled for the length of time required to obtain compliance when a report required to be filed by the licensee or registrant with the board pursuant to Article 11 (commencing with Section 800) of Chapter 1 is not filed in a timely fashion.

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(d) If an alleged act or omission involves a minor, the seven-year limitations period provided for by subdivision (a) and the 10-year limitations period provided for by subdivision (e) shall be tolled until the minor reaches the age of majority.

(e) An accusation filed against a licensee pursuant to Section 11503 of the Government Code alleging sexual misconduct shall be filed within three years after the board discovers the act or omission alleged as the ground for disciplinary action, or within ten years after the act or omission alleged as the ground for disciplinary action occurs, whichever occurs first.

(f) The limitations period provided by subdivision (a) shall be tolled during any period if material evidence necessary for prosecuting or determining whether a disciplinary action would be appropriate is unavailable to the board due to an ongoing criminal investigation.

Added Stats 1999 ch 459 § 1.5 (SB 809). Amended Stats 2001 ch 615 § 7 (SB 26), effective October 9, 2001, ch 617 § 3 (AB 1616).

Since this section was enacted in 2000, no cases have been lost or not pursued as a result of these limitations. It is the Board's policy to ensure cases are adjudicated within these timeframes.

UNLICENSED ACTIVITY

The Board has made significant strides in curtailing unlicensed activity as it relates to care provided in homes, pulmonary function testing, and sleep (polysomnography) testing. It held several roundtable meetings from 2002 through 2004, conducted informal surveys, and issued white papers in each discipline. This effort was a result of issues the Board raised during its last Sunset Review and is discussed further in Section 10 (Issue 2). The Board also made numerous outreach efforts to educate the public specifically to the unlicensed practice occurring in homes (discussed further in Section 8).

CITE AND FINE

In 2003, the Board expanded its citation and fine (C&F) program authorizing it to cite and fine for any violation of the RCPA versus a single violation of practicing on an expired license. The Board's C&F program allows the Board to "penalize" licensees rather than pursue formal discipline for less serious offenses or offenses where probation or revocation are not appropriate. Prior to the expansion of the Board's C&F program, the Board would pursue formal disciplinary action for such convictions of petty theft, receiving stolen property, trespassing, driving under the influence of alcohol, public intoxication, and some practice related complaints, primarily to make

a record available to the public and for use in future disciplinary actions should subsequent convictions occur (possibly showing a patterned behavior). Providing no patterned behavior exists and no child, dependent adult or animal was neglected or involved in any crime, the Board will generally issue a C&F in these cases. In May 2012, regulations updating fine amounts to the maximum of \$5,000 pursuant to §125.9 of the B&P (as well as other maximums) were approved. The goal of the C&F program is to provide public notice, inform licensees that repeated actions will negatively affect their licensure, and establish a record should future violations occur that will support formal disciplinary action.

The Board issues an average of 80 citations per year. Seventy-five percent of the fines issued are for \$250 and only a handful exceed \$1,000. Most of the citations exceeding \$1,000 are for acts of unlicensed practice or misrepresentation.

The five most common violations for which citations are issued include: 1) Driving under the influence of alcohol (with no priors); 2) “Wet Reckless” driving violation (with no priors); 3) Unlicensed practice; 4) Petty theft; and 5) CE violations.

Each year four to five citation reviews by the executive officer, are requested. There has only been one APA appeal made since the inception of the program, as a result of a record-high fine issued in the amount of \$75,000 in FY 2009–10 against a subacute facility for using LVNs to practice respiratory care (discussed earlier on page 14).

COST RECOVERY

In the last three fiscal years, the Board has had between 78 and 96 cases each year that had potential for cost recovery. The Board initially sought full cost recovery in all of these cases. Ultimately, in about six percent of the cases, cost recovery was not ordered. The most common reason the Board does not continue to pursue full cost recovery is either, 1) the ALJ has cited *Zuckerman vs. Board of Chiropractic Examiners* with a very strong argument AND/OR 2) the costs and time to non-adopt the decision do not outweigh the benefit (e.g. revocation) for those cases where the Board believes consumer protection is at imminent risk.

For FY 2011-12, the outcomes of 85 cases where the Board sought cost recovery, are broken down as follows:

42%	Probation (36)
5%	Public Reprimand (4)
12%	Surrendered (10)
36%	Revoked (31)
5%	Extend Probation/Other (4)

Section 5: Enforcement Program

The Board is most successful in collecting costs in those cases that result in probation or a public reprimand (47%), because licensees are more vested in retaining licensure. In nearly all cases, where licensees are surrendering their license (12%), the Board will agree, as a means to expedite stipulated decisions and not accrue additional unrecoverable hearing costs, to forego the collection of costs, until such time those licensees choose to petition to reinstate their license (costs must be paid in full before a petition for reinstatement will be considered). The most difficult cases to collect costs from are those resulting in revocation (36%).

Cost recovery ordered averages \$3,000 per case and is due within one year from the date ordered (though the Board is flexible with payment schedules/extensions as discussed on the next page).

COLLECTION OF FINES AND COST RECOVERY

The Board has employed several mechanisms that have improved collections of costs. Prior to FY 2002-03, the Board collected approximately 33 percent of costs ordered. Since then, the Board now collects approximately 42 percent of costs ordered. Because the dates in which costs are ordered and collected cross over, sometimes, multiple fiscal years, an exact percentage would be difficult to attain. When reviewing several years of data, it is evident the costs actually recovered has increased.

The Board attributes the increase of costs recovered to employing all of the following:

- Franchise Tax Board Intercept Program (1996)
- The Board's Cost Recovery Database (2003)
- Collection Agency Contract (2003)
- Renewal Hold (1990-2012)

The Board began using the Franchise Tax Board Intercept Program in 1996. Beginning in 2002, procedures were in place that ensured costs were tracked and that every case was pursued through this means. Collections from the Intercept Program account for \$8,000 to \$20,000 collected each year.

The Board also has the authority to "hold" a renewal for a licensee's failure to pay probation monitoring costs, once they are off probation (\$3753.1), cost recovery (\$3753.5), or fines (CCR §1399.385). This has proven to be quite effective in collecting costs from those individuals that continue to hold a license.

In 2003, the Board developed its own Cost Recovery Database that tracks all fines, cost recovery, and probation monitoring costs ordered. This system generates regular invoices that are printed weekly. The Board noticed a sharp increase in payments

especially more timely payments, as a result of the regular invoicing. The database has proven extremely beneficial in tracking costs ordered and collected, given the number of sources and types of costs it now collects.

In 2003, the Board entered into a contract with a collection agency to assist in collecting outstanding costs. This contractor is reimbursed for its services by receiving a 13.9% cut of all of the costs it collects. Thus, the Board is careful to only forward those cases where other avenues have been exhausted. Since FY 2003-04, the collection agency has collected nearly \$200,000.

Payment schedules are usually set up on a monthly or quarterly basis, however the Board is very flexible in allowing respondents to set up different schedules, even extend the schedules, so long as a respondent is making a good faith effort to pay the costs. The Board provides regular invoices two to four weeks prior to a due date and sends past due invoices 45 days after a due date. If the respondent is a licensee who has not made any contact with the Board after 60 days beyond the due date, a “hold” is placed on the license (as applicable) to prevent renewal until payment is made and the account is referred to the Franchise Tax Board’s Intercept Program. At the time of renewal, if no payment has been received, the account will be referred to collections. If the respondent is not a licensee and has not made contact with the Board after 60 days beyond a due date, the account is referred to the Franchise Tax Board’s Intercept Program and sent to collections at the same time.

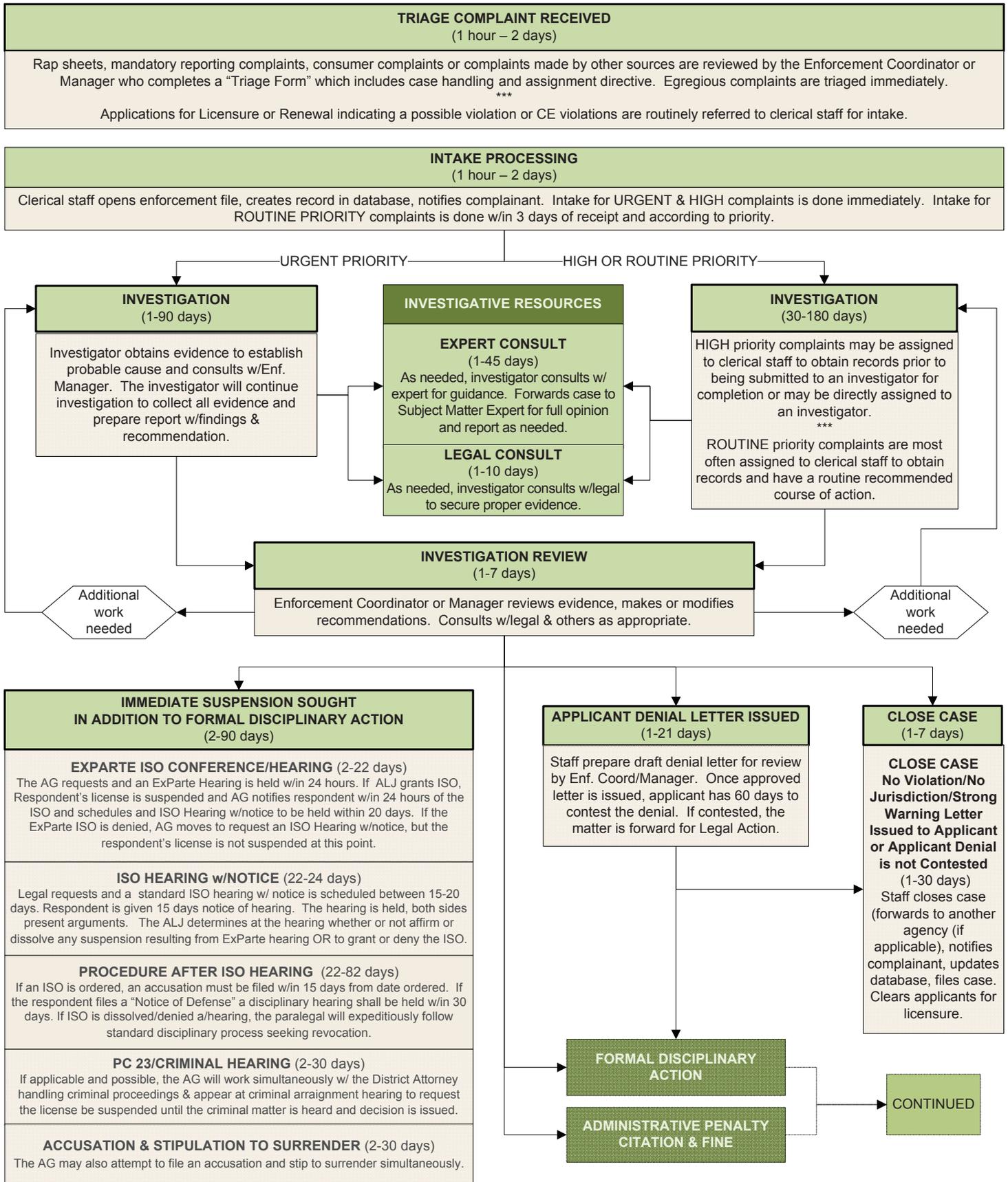
Table 5e. Cost Recovery			
	FY 09/10	FY 10/11	FY 11/12
Total Enforcement Expenditures	\$640,576	\$661,077	\$664,403
Potential Cases for Recovery *	96	78	85
Cases Recovery Ordered	88	74	80
Amount of Cost Recovery Ordered	\$214,040	\$245,009	\$259,648
Amount Collected	\$91,076	\$90,884	\$117,939

* “Potential Cases for Recovery” are those cases in which disciplinary action has been taken based on violation of the license practice act.

Respiratory Care Board of California

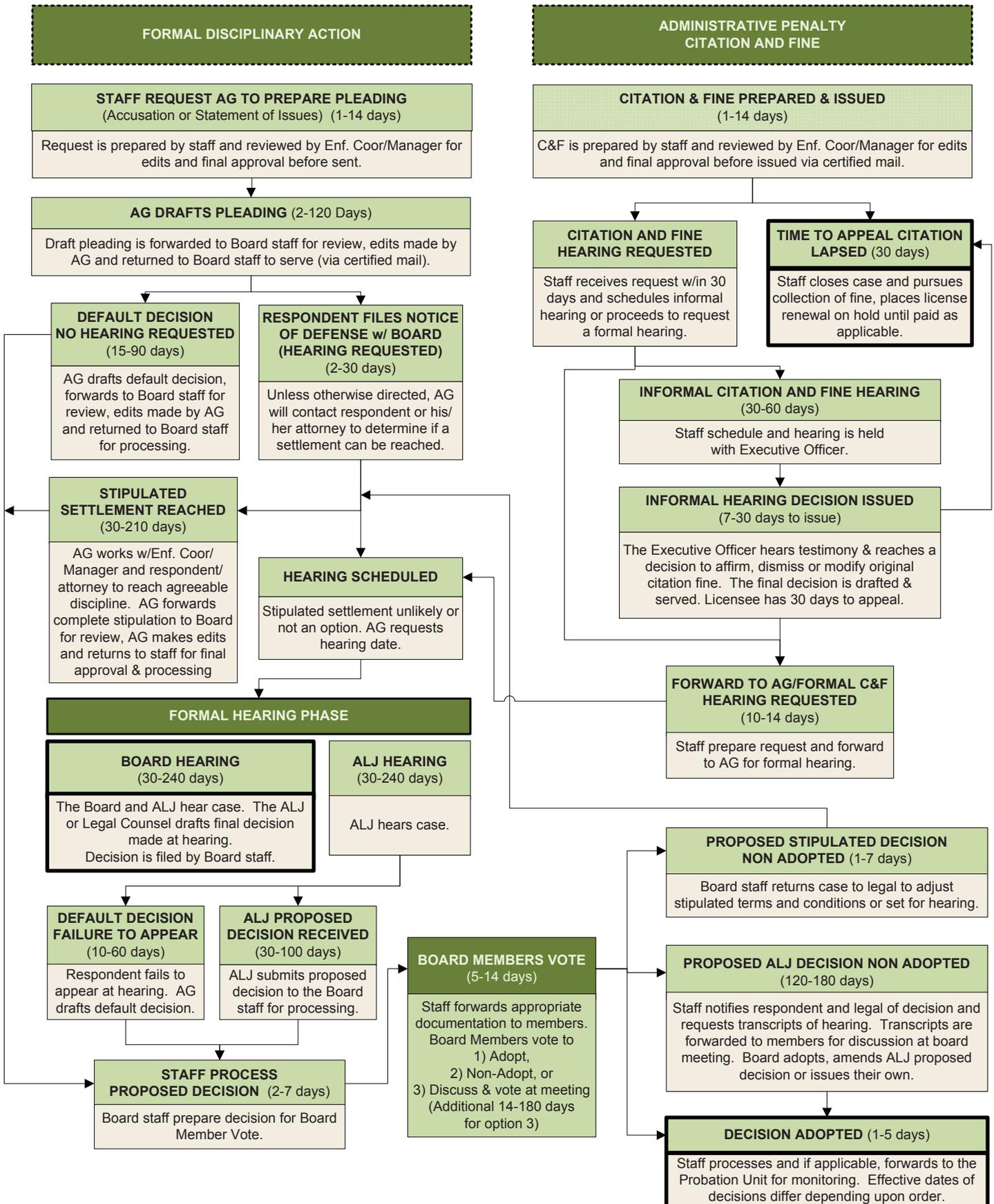
DISCIPLINARY PROCESS

(new 1/4/12)



Respiratory Care Board of California DISCIPLINARY PROCESS

Continued



Section 6: Public Information Policies

WEBSITE

In 2001, the Board began using its website as a tool to provide an array of information and forms to its stakeholders. Since that time the number of visits on the website has climbed from 27,000 to over 204,000 hits per year.

The Board utilizes its website to keep the public informed about Board activities by posting:

- Upcoming Board Meeting Dates and General Locations
- Board Agendas and Related Materials/Attachments
- Board Meeting Minutes
- Proposed Regulation Amendments
- Topics of Interest
- Outreach Events (currently inactive due to limited resources)
- Newsletters
- Strategic Plans

In 2004, an e-mail subscription feature was established, which allows interested parties to provide the Board with their e-mail address (through the website) to receive e-mails with updates, notices and special bulletins.

BOARD MEETINGS

The Board has posted meeting information since 2001. Meeting dates and general locations are posted for the following calendar year, at the end of the preceding year. Agendas (with specific meeting locations) are always posted at least ten days prior to a meeting. The Board began posting meeting materials/attachments beginning with its February 2011 meeting. Minutes are posted within a week from the date they are approved by the Board. The Board continues to post all of this information and has no immediate plans to begin removing dated materials.

Beginning with its February 2011 meeting, the Board began using the services of the DCA to webcast its meetings (technical glitches prevented the May 2012 meeting from being webcast). The DCA has agreed to assist the Board in continuing to webcast, however, the DCA has noted their lack of resources and have asked boards to assume some of the workload in the near future. While the Board would like to continue webcasting its meetings, limited resources will remain an issue.

NEWSLETTERS

In 2001, the Board began the publication of its biannual newsletter, “Breathing Matters.” The newsletters regularly provide upcoming meeting dates, mandatory reporting requirements, disciplinary actions taken, and information on current events and issues. The Board also developed a media kit and had several individuals or companies advertise in its earlier publications. Advertising was discontinued by 2005 based on direction from a previous administration and legal advice.

COMPLAINT DISCLOSURE POLICY

Upon receipt of a consumer inquiry, the Board provides consumers information and records in accordance with the Public Records Act (Sections 6250-6270 of the Government Code). The Board’s Complaint Disclosure Policy (adopted on May 18, 2001, based on legal advice) provides for the disclosure of information once an Accusation or Statement of Issues (SOI) has been filed and includes the complete disclosure of the details contained within those documents. The policy also provides for the disclosure of subsequent formal actions and any public information available concerning whether a district or city attorney has the case for review or has filed charges.

In addition, the following documents are also made public once they have become final or a judge has issued an order:

- Citations, fines, and orders of abatement.
- Interim Suspension Orders (ISOs).
- Suspensions/Restrictions via Penal Code Section 23.

All of the above information is available on the Board’s website and is listed with each individual license record, as applicable, through the Online License Verification component. Non licensees are not listed online, including applicants, until such time they are licensed.

Section 6:

Public Information Policies

WEBSITE POSTING OF ACCUSATIONS AND DISCIPLINARY ACTIONS

Initially, in 2001, the Board posted summary information on all accusations, statements of issues, and decisions that had been filed on its website and also included this information in the Board's newsletters. In 2006, the Board began posting a running list of these records with links directly to accusations, statements of issues, and decisions available in a pdf format. In 2007, the Board was the first to link the actual pdf records directly to individual records through the Online License Verification component for any person who had disciplinary action as of January 1, 2006.

Any interested person may either review a summary of all disciplinary action taken since January 2006, with links to actual pdf documents (<http://www.rcb.ca.gov/consumers/enforcement/citationdisaction.shtml>) or they may use the Online License Verification component to look up an individual and, if applicable, will be advised of disciplinary action taken with links directly to the pdf documents, where there was any disciplinary action as of January 2006.

Currently, citations, fines and orders of abatement are reflected via the Online License Verification, however actual links to pdf records are not yet available. The Board was in the midst of making this feature available when the BreEZe project was fully underway, and requests to modify the legacy system were frozen. The Board is currently working with the BreEZe team and is hopeful links to the actual citation can be made available in 2013.

OUTREACH

The first time the Board participated in an exhibition was in 2001 at the CSRC's annual convention. The Board participated every year at these conventions until travel and outreach restrictions were imposed a couple of years ago. The Board used these conferences as an opportunity to promote new laws and regulations affecting RCP licensure and current affairs and build upon relationships with its stakeholders.

In 2006, the Board stepped up its outreach efforts and began participating in multiple events throughout California, to bring awareness to patient rights and the unlicensed practice of respiratory care occurring in homes, and educate consumers on where and how to file a complaint. The Board developed three brochures on these subjects (also on its website) and invested in materials to create an inviting exhibit "booth" space. The Board reached out to the CSRC and various education program directors who were eager to participate in many of the events. From 2006 through 2008, the Board participated in over 50 events, throughout California, from American Lung Association Walks to several city-sponsored health fairs, to senior events, to the California State Fair.

The Board educated every licensed Home Medical Retail Device Facility in California (2,214) on regulations passed in March 2007 identifying the tasks unlicensed personnel may and may not perform in the home. The Board also used its newsletter to keep licensed RCPs apprized of efforts to address the unlicensed practice of respiratory care occurring in homes and sleep labs.

In 2008, the Board concentrated on its newly developed marketing plan (primarily aimed at the workforce shortage) that began implementation in 2010. Unfortunately, the plan was interrupted by the State's ongoing budget crisis, the CPEI, and the Administration's directive to halt expenditures tied to outreach (discussed further in section 8).

Section 7: Online Practice Issues

RCPs are required to work under the supervision of a Medical Director. They do not have the authority to write prescriptions nor practice independent of a physician. The Board has never had any complaints nor has it been brought to the Board's attention that any person is attempting to practice respiratory care via the Internet. The Board did receive one complaint that a former RCP (license expired) was representing himself online as an RCP, in his ongoing efforts to establish his own California association. The investigation found there was no relationship whatsoever, to practicing respiratory care beyond misrepresentation (and the website was corrected shortly after contact by our Board).

The Board will strive to stay ahead of technology and advancements in delivering healthcare, so that it is adequately prepared to enforce its mandate and regulate delivery alternatives as they arise. With the passage of AB 415 (Statutes of 2011- see B&P §2290.5) and proposed language in AB 1733, the Board will be examining "Telehealth" during strategic planning efforts in 2013.



Section 8: Workforce Development and Job Creation

WORKFORCE DEVELOPMENT

Since the Board was last reviewed in 2001, it has continued to make strides towards workforce development, including assessing licensing delays, communicating with education programs on licensing requirements, and assessing and addressing workforce shortages. The application process was modified so that licenses are now issued three to eight weeks faster, and the number of active licensees and education programs has increased significantly.

APPLICATION PROCESS RE-ENGINEERED

One component of a major undertaking the Board took to re-engineer several processes, was to make the application for licensure process less cumbersome, more efficient, and more transparent to applicants and education programs. Many of the changes were a result of significant input from licensing staff and educational program directors (*Program directors have been an incredible resource to the Board in all workforce and licensing activities*).

Prior to 2001, the Board and the National exam provider offered services to administer the National examination. Applicants were also required to submit fees to sit for the exam to the Board, then the Board turned around and provided test-taker information and “passed-on” the exam fee to the National provider. These processes were duplicative, caused confusion, and education program directors voiced their concerns.

In response, the Board modified its process so that applicants could apply directly with the National examination vendor to sit for the exam (eliminating the dual exam administration services). With the emergence of computerized testing (which eventually led to daily testing), the existing process could not have been timed better and educational program directors were highly satisfied with this change. Applicants may now schedule the date, time, and location of their own exams, making the process as convenient and least burdensome as possible.

Another concern voiced by program directors was the fact that they had no guidelines to provide to potential students with criminal backgrounds, as to whether they might be denied licensure. In 2001, the Board changed its process and notified program directors that students may contact the Board to discuss their specific histories and staff would provide that, based on the information provided, how the Board would currently address those applications. In addition, in 2002, the Board established its “In-House Review and Penalty Determination” guidelines, that address how the Board handles applications with the most commonly reported criminal histories. The new guidelines resulted in greater consistency in case handling, a significant decrease in

Section 8

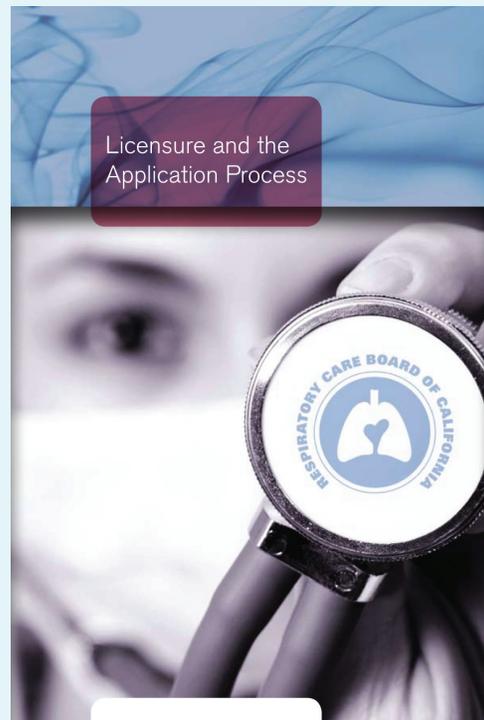
Workforce Development and Job Creation

these type of inquiries and program directors were very satisfied. Programs that had previously discouraged students with any criminal history from enrolling or programs that had allowed students to enroll who were later denied licensure, were now able to align their enrollment information and acceptance with the Board's criteria. The guidelines are also a valuable tool to prospective students, applicants, and licensees in understanding the possible consequences of their actions.

Also, in the late 1990s, the former accrediting body for respiratory education programs disbanded and for a period of time, it was unknown if there would be a successor. In preparation for the disbandment, the Board established specific education criteria and gained the authority to review each transcript for approval. The Board charged applicants an additional \$100, to review their transcripts for a period of about three years. By 2000, a nationally-recognized successor had been named and by 2001 standards were well established. In 2002, the Board modified its education criteria to accept education from approved programs and eliminated the fee for individual detailed transcript review.

In 2002, the Board completely revised its application for licensure package to be clear and concise. All application materials along with guides and policies were placed on the Board's website for access by potential and existing students and program directors.

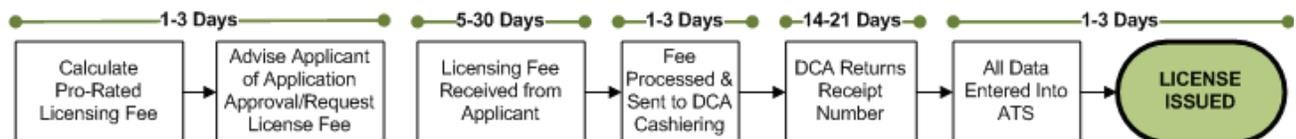
In 2008, in response to requests by program directors, the Board developed a pamphlet titled, "Licensure and the Application Process" and mailed hundreds to program directors throughout the state. The pamphlet is geared for potential and existing students. It provides information and resources to complete the Application for Licensure and also includes the Board's "In-House Review and Penalty Determination" guidelines.



In 2009, the Board added respiratory programs' CRT exam pass/fail rates to the Board's website to assist prospective students with making an informed decision when selecting a respiratory care program.

In FY 2009-10, as part of the CPEI and the Workforce Initiative, the Board again reviewed its application process in detail. The Board found that one of the longest delays in obtaining licensure was the time period from when applicants were eligible for licensure, to the time they were actually licensed.

In response, the Board modified its fee schedule to eliminate its "prorated" licensing fee, thereby allowing applicants to become licensed immediately upon approval. This new process went into effect in July 2012 and the Board expects a reduction in the time it takes to become licensed by three to eight weeks. Allowing applicants to enter the workforce sooner, meets consumer demands and helps stimulate the economy, in line with the goal of the Workforce Initiative.



On 5/11/10, the RCB approved draft regulatory language to eliminate the Licensing Fee to reduce processing times at the tail end of the process. Estimated savings of 3-8 weeks in the overall processing time.

In FY 2010-11, the Board also initiated a requirement to query out-of-state applicants with the National Practitioner Data Bank to ascertain whether an applicant has been disciplined in another state (in any capacity). This is in addition to verification the Board requires from the NBRC (the NBRC also maintains a repository for final disciplinary actions taken against RCPs by state licensure agencies).

In addition, with the implementation of BreEZe approaching, the Board began informing and keeping program directors apprized of the BreEZe status and introducing the idea of the online application module. The Board will review its application in detail and make revisions as needed for the online and hard copy versions at the time BreEZe is launched in 2013.

Section 8

Workforce Development and Job Creation

WORKFORCE DEVELOPMENT DATA

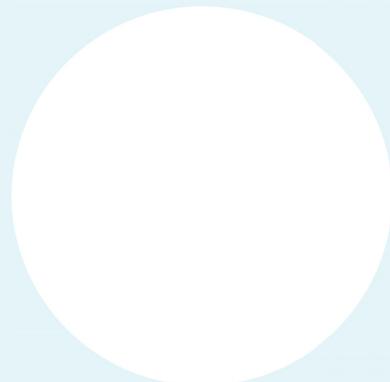
In 2006, the Board contracted the services of the Institute for Social Research of the California State University, Sacramento, to conduct a study to forecast the State's RCP workforce needs. Separately, in 2007, legislation was introduced and chaptered (SB 139) to establish a healthcare workforce clearinghouse under the administration of the Office of Statewide Health Planning and Development. The clearinghouse is to serve as the central source of healthcare workforce and educational data in the State. The Board's Workforce Study that was published in 2007, has been instrumental in assisting the Board to make decisions concerning the workforce, consumer needs, as well as assisting the Office of Statewide Health Planning and Development in establishing its own method to collect data for all healthcare workers.

The Workforce Study found "the potential for a 'perfect storm' scenario driven by a constellation of factors that [would] create serious shortages of RCPs available to meet the needs of the California population in the coming decades." Key factors identified were:

- The age distribution of the current RCP workforce suggesting a large group about to leave the workforce through retirement.
- Indications that a significant portion of those in education programs about to enter the profession is comprised of older individuals returning to school which will result in shorter career spans for individuals entering the profession as new licensees.
- A growing California population and within California's growing population, a disproportionately larger number of 65 and older individuals who consume an especially large portion of available respiratory care services.

OUTREACH

From 2002 through 2005 the Board developed brochures and attended career fairs, education conferences and high school career days, to promote the profession in an effort to increase the number of qualified and competent practitioners. It also developed a web page dedicated to sharing information on careers in this dynamic field. In 2005, the Board developed an informational DVD to use as a recruitment tool and shared this with program directors throughout the state, in addition to allowing any person to obtain a copy through the Board's website (*free of charge*).



The Board's continued outreach efforts provided an opportunity to expand its audience and its message. In 2006, the Board began targeting all consumers to increase public awareness to patient rights and the unlicensed practice of respiratory care occurring in homes, and educate consumers on where and how to file a complaint. This was in addition to promoting the respiratory care profession to increase the number of active licensees commensurate with the healthcare needs of California consumers. The Board developed three brochures touching upon these subjects (also on its website) and invested in materials to create an inviting exhibit "booth" space. The Board reached out to the California Society of Respiratory Care and various education program directors who were eager to participate in many of the events. From 2006 through 2008, the Board participated in over 50 events, throughout California, from American Lung Association Walks to state and county fairs, to high school career days.

Following the release of the Workforce Study in 2007, the Board developed its own Marketing Plan aimed primarily, at increasing the number of licensed RCPs and bringing awareness to the value of professional, licensed RCPs. The plan included a background, goals, target audiences, key messages, strategies and tactics, performance measures, and budgetary requirements.

Specifically, the goals of this plan included:

- Increasing the number of active licenses from 15,760 in FY 2008-09 to 16,665 by 2015 (18,000 by 2020, 19,000 by 2025, and 21,000 by 2030).
- Establishing a separate "Career" page on the Board's website and increasing website hits on this page by ten percent from July 2009 through December 2010.
- Increasing the number of new licensees that fit the "25 and under" age category by ten percent by 2015.
- Inclusion of RCP representation on newly legislated healthcare or emergency response boards and committees.
- Strengthening policy developed by government bodies in relation to healthcare and emergency response.
- Establishing communication partnerships with agencies that reach our targeted audiences.
- Implementing marketing guidelines and establishing consistency in public communications.
- Celebrating 25 years of licensure (in 2010).

Section 8

Workforce Development and Job Creation

The key messages identified were:

#1 A career in respiratory care is a smart choice.

- Job opportunities abound as a result of the aging population.
- Diverse opportunities to work in numerous settings and with a variety of patient-types are available.
- There are several opportunities for advancement in the respiratory field.

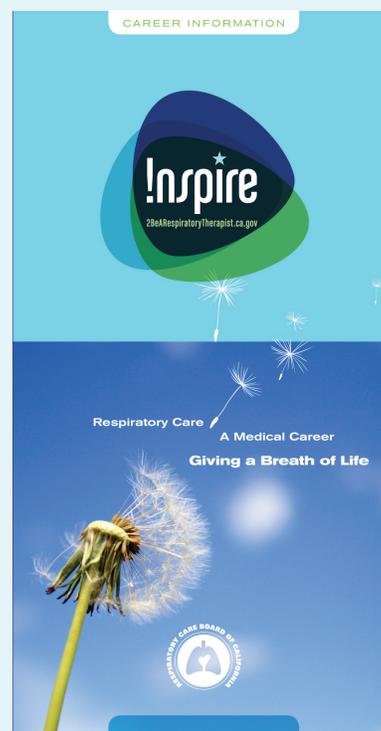
#2 Licensed RCPs are experts in managing all forms of respiratory disease.

- Licensed RCPs' education and training are concentrated solely in respiratory care.
- Licensed RCPs are competency tested.
- Pulmonologists and RNs often rely on the expertise of RCPs.

#3 RCPs provide meaningful services which derive personal satisfaction.

- RCPs provide services that improve the quality of life.
- RCPs are often responsible for saving lives.
- RCPs are an integral part of a healthcare team.

In 2009, the Board finalized its plan and launched its "Inspire" campaign to bring awareness to the profession as a meaningful and smart career choice. Unfortunately, the campaign was halted halfway through implementation, as a result of the previous administration's directive to freeze all expenditures that were not mission critical (including purchasing, travel and contracts). At that same time (2009 through 2010), numerous cuts were being made, the CPEI movement was in full force, and staff resources needed to be redirected in February 2010. In 2011, the current Administration also issued an Executive Order specifically prohibiting any expenditures tied to Outreach which was also interpreted to cease all outreach activities. The latter was not only intended to reduce expenditures, but also improve public perception during the State's ongoing budget crisis.



However, the Board was able to launch some of its key strategies as noted:

#1 Strategy: Bring awareness of the profession and career opportunities in the field to prospective students and the public at large.

Inspire Campaign

- **Internet:** Explore the use of Facebook and You Tube to reach target audience of students in high school, vocational programs and private and community colleges. ***In 2009, the Board established and maintained its own Facebook page and used a clip of the Board's former physician member, Richard L. Sheldon, M.D. that was posted on You Tube. Staffing resources prevented regular updates in 2011 and the page was subsequently removed.***
- **RCP Referral:** Advise RCPs of the Inspire Campaign and recruit their assistance in advance (via newsletters). Provide each RCP with a career brochure (at the same time mailing lapel pin - see Strategy 3) and encourage each RCP to share one brochure to a prospective student. [Referral or a relationship with an RCP comprises approximately one-third of new applicants' reasons as to why they entered the profession] ***This strategy was executed.***
- **Media Kits:** Develop posters, revise brochures, and update DVD as appropriate and in line with the "Inspire" campaign. Ship novelty items and materials (as appropriate) to counseling centers at all public high schools, health-related vocational schools, public community colleges and four-year colleges in California. ***This strategy was partially executed. With assistance from DCA's talented graphic design team, brochures were updated, posters were created, and novelty items with the "Inspire" logo were purchased. Larry L. Renner, RCP and Past President developed an excellent DVD about the profession that was made available through our website, as well. We continue to receive approximately three requests per week for DVD copies.***



Section 8

Workforce Development and Job Creation

Kits were sent to approximately 300 high schools and 70 colleges. The Board had identified several hundred more schools it wanted to reach, but was unable to, due to the interruption of the campaign.

Also, provide advance notice of campaign to health-related vocational schools and four-year colleges that do not currently have a respiratory program, promoting consideration to establish a new program. ***This strategy was partially executed. Of the 70 colleges the Board reached, approximately 20 of those were colleges that did not have a respiratory program at that time.***

- **Scholarships:** Notify the California Thoracic Society, California Society for Respiratory Care (CSRC), American Association for Respiratory Care (AARC) and their foundation, the CSRC's 70 Square Meters and other respiratory related organizations and pharmaceutical companies of the campaign and encourage establishment of scholarships. ***This strategy was not fully executed. Over 80 organizations, including associations and large companies were identified to which the Board made initial contact with each. However, no follow-up contact was made due to the redirection of resources.***
- **Website:** Establish a separate visible page dedicated to careers in respiratory care. Make all media materials available to order online, free of charge. Post available scholarships. ***This strategy was executed, however the website is not updated. The last update provides that the Board is unable to distribute promotional items at the direction of the Governor.***
- **Grass Roots Outreach:** Attend high school career fairs and public events as appropriate. Target students in Advance Placement (AP) high school classes. Design new exhibit backdrop in line with campaign and handouts. ***New exhibit backdrop was designed; however, attendance at fairs was not executed.***
- **Top-Rated Medical Television Shows:** Bring awareness and encourage top-rated television shows (i.e. Grey's Anatomy, ER, Discovery Channel programs) to include an episode with respiratory therapists. Ideally, the Board could reference the program and include the clip on You Tube to show the excitement of being a respiratory therapist. Include novelty item. ***This strategy was not fully executed. Approximately ten shows were identified to which the Board made initial contact. However, follow-up contact was not made due to the redirection of resources.***

#2 Strategy: Bring awareness to the California Legislature and government agencies of the value of the licensed RCP.

Inspire Kits

Provide detailed letter(s) and a short-and-to-the-point brochure(s) along with novelty items to Legislators and their staff and various personnel at the CDPH, the Office of Statewide Health Planning and Development, and the Emergency Medical Services Authority (and related agencies). The letter(s) will describe the Board's outreach efforts, discuss the value of RCPs, and request their consideration for inclusion of expert advice from RCPs in new legislation, as appropriate. The brochure(s) will summarize the letter, and novelty items will be selected with consideration given to continued use and the design/artwork will be captivating. Strategically time the release of this material with the legislative session, the Inspire Campaign, and emergency response planning. ***This strategy was not executed.***

Legislative Watch

Expand the Board's legislative watch to include proposed legislation creating boards and committees and encourage inclusion of RCPs. ***This strategy was implemented to the extent of legislation directly related to respiratory care services.***

#3 Strategy: Commemorate 25 years of licensure with an event that may gain media attention in conjunction with the Inspire Campaign.

2010 California Society for Respiratory Care Annual Convention

Work with the CSRC to hold a special luncheon or event to kick-off the 25-year celebration. Obtain a "Resolution of Appreciation" plaque from the Governor and arrange for the Director of the DCA to present the plaque to the CSRC at the event. Utilize the DCA's resources to gain media attention to the event and career opportunities. Also participate as an exhibitor at the convention, and provide a special/unique handout for those in attendance. Include article in newsletter highlighting the event. ***This strategy was executed.***

Lapel Pins

Send all active and retired RCPs a custom-designed lapel pin. The design of the pin will give consideration to capturing the attention of patients who may then inquire about the profession and the qualifications of the licensed RCP. [Referral or a relationship with an RCP comprises approximately one-third of new applicants' reasons as to why they entered the profession] ***This strategy was executed.***

Section 8

Workforce Development and Job Creation

Included as part of the performance measures were:

- Monitoring and identifying the number of active licenses annually (target: 16,665 by 2015).
- Monitoring and identifying the number of new licensees in the “25 and under” age category annually.

As of June 30, 2012, the Board identified 18,869 active licensees, 2,204 above the target set for 2015 (target: 16,665), 869 above the target set for 2020 (target: 18,000) and shy just 131 active licensees to reach the target set for 2025 (target: 19,000).

Data reflects that as of January 1, 2008, the Board had 479 licensees who were “25 and under” compared to 670 as of January 1, 2012. This is a 40 percent increase and exceeds the Board’s original goal to increase the number of new licensees that fit the “25 and under” age category by ten percent.

While not included in the Board’s goals or performance measures, it is also worthwhile to note that the number of respiratory care educational programs has increased significantly as well:

- June 2004: 25 education programs
- June 2012: 35 education programs



California’s Respiratory Therapists Celebrate 25 Years of Licensure!

Join us in celebrating the Silver Anniversary of Respiratory Care Practitioner (RCP) licensure! The attached pin represents 25 Years of RCP Licensure and the pivotal role this honorable profession plays in improving the lives of Californians, our healthcare delivery system, and in disaster response.

In 1983, the California Legislature recognized the practice of respiratory care as a dynamic and changing art and science, continually evolving to include newer ideas and more sophisticated techniques in patient care. It also recognized the profession’s effect on public health, safety, and welfare, and established the Respiratory Care Board of California (Board) to protect the public from the actions of unprofessional, unauthorized, and unqualified practitioners. Since 1985, nearly 30,000 licenses have been issued. Each licensee must meet rigorous requirements to earn and maintain the title of a California licensed RCP.

Do you know someone like you, who could benefit California as an RCP? Well, pass it on. Earlier this year, the Board launched its “Inspire” campaign to address a projected future shortage of RCPs. It has found that as many as 30% of new licensees enter the profession based on a relationship with a licensed RCP. So we are asking each California RCP to take one of the enclosed career pamphlets and “pass it on” to someone you think would be a credit to the profession.

Congratulations on being part of California’s finest and most valuable healthcare providers! Wear your pin with pride! It symbolizes your hard work in earning your title as an RCP and your contributions to California!



Section 9: Recent Department-Wide Issues

OVERVIEW

In recent years, healing arts boards have been the center of legislation and initiatives aimed to improve outcomes, primarily for better consumer protection. In 2008, legislation was passed to require the development of Uniform Standards, for all healing arts boards to use, in addressing actions taken against licensees for violations of their respective licensing acts. In 2009, the Consumer Protection Enforcement Initiative (CPEI) Model was drafted to increase accountability and achieve greater efficiencies, while strengthening consumer protection. The CPEI was an evolving initiative that was at the center of the Board's focus for several years.

One of the proposals put forth through CPEI, was to replace the aging computer system, used by nearly all of the boards and bureaus under the DCA, that was established over two decades ago. Over the years, many boards, including the Respiratory Care Board, established numerous in-house databases to improve efficiencies and make up for inadequacies of the antiquated system. The DCA spent countless hours to get the new system, referred to as "BreEZe," off the ground and continue to work diligently to ensure its success.

For several years, beginning in 2008, all allied health boards spent innumerable hours working on strategies and drills to achieve the desired outcomes. For the Board, the workload was so significant, it was forced to redirect staff and postpone other objectives. In 2011, the Board adopted a new policy and moved forward with the rulemaking process to make several regulatory changes to implement aspects of the Uniform Standards and the CPEI. The rulemaking process was completed on May 25, 2012, and the Board's revised Disciplinary Guidelines (**Attachment 1**) and regulation changes became effective on June 24, 2012.

Currently, the Board is focused on regrouping while it works closely with the DCA and the vendor, Accenture, on the development and design of its part of the new BreEZe system. Following is a closer look at the status of the Board's implementation of the Uniform Standards, the CPEI, and the new BreEZe system.

UNIFORM STANDARDS

SB 1441 (Statutes of 2008) established under the DCA, the SACC, comprised of the executive officers of the DCA's healing arts licensing boards and a designee of the State Department of Alcohol and Drug Programs. The SACC was required to formulate uniform standards in specified areas that each healing arts board would be required to use in dealing with substance-abusing licensees. SB 1441 also included

several requirements for boards with diversion programs. The Uniform Standards Regarding Substance-Abusing Healing Arts Licensees were adopted in April 2011 (**Attachment 5**).

The Board's mandate is to protect the public from the unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care (B&P, §3701). The Board believes that meeting this mandate is done most effectively through enforcement and disciplinary action, which may include the issuance of probationary licenses. The Board's 1997 Sunset Review Report explains this position which provides:

"... The position of the [Board] is that to offer impaired RCPs entry into a diversion program in lieu of appropriate discipline of a licensed practitioner is in direct conflict with the mandate of the [Board] to protect the public from unsafe practitioners..."

"The basis for this rationale is twofold. First, literature and statistics document that no one type of rehabilitation is successful for substance abuse. A simplistic analogy is to that of an individual losing weight. There are a myriad of diet reducing plans with various levels of efficacy. The only prominent similarity among them is that programs are successful only when the individual is motivated to change their behavior."

"Second, as an agency mandated to protect 'consumers' entering into the 'rehabilitation arena' appears to blur and compromise [the Board's] mandate. Licensing boards within the DCA are charged with protecting consumers, the [Board] should not 'shield' the practitioner who may pose a threat to consumers due to the high rate of recidivism intrinsic to substance abusers."

"It is the opinion of the [Board] that abuse 'diversion programs' by name and definition are a diversion away from appropriate enforcement."

The Board has implemented the Uniform Standards developed by the SACC, as noted below, through the rulemaking process (regulations effective June 24, 2012) and through a policy adopted by the Board.

Standards 1 and 2. Clinical Evaluations

Standard 1 provides, "If a healing arts board orders a licensee ...whose license is on probation due to a substance abuse problem to undergo a clinical diagnostic evaluation, the following applies." The standard provides criteria and qualifications an evaluator should meet. The evaluator must provide his or her opinion as to: 1) Whether the licensee has a substance abuse problem and 2) Whether the licensee is a threat to himself or herself or others. The evaluator should also provide recommendations for substance abuse treatment, practice restrictions, or other recommendations related to the licensee's rehabilitation and safe practice.

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Standard 2 provides 1) Practice restrictions for licensees who undergo a clinical diagnostic evaluation, including the cessation of practice, 2) That the probation manager shall determine whether or not a licensee is safe to return to practice, and 3) The caveat that no licensee shall return to practice until 30 days have passed with no positive drug tests.

Board Response: The Board has long had the philosophy, as stated in its Disciplinary Guidelines, that “The purpose of the probation monitoring program is to maintain public protection by pro actively monitoring probationers to ensure terms and conditions are met. The purpose is NOT for the Board to rehabilitate the probationer. ...” This philosophy is also stemmed from the belief that licensees are more likely to sustain sobriety if they complete treatment programs and/or establish the needed support system on their own accord, rather than coerced as a result of discipline. As such, the use of clinical or psychological examinations (and treatment programs) have only been used in very rare instances after a person has been placed on probation. Those rare occasions occur when there is reason to believe the licensee has a substance abuse problem or mental disorder, and the evidence in the case is too weak to warrant outright revocation. As written, this new standard, raised concerns that if adopted, could ultimately have had an adverse affect.

The first paragraph of Standard 1 provides that “If a ...board orders a licensee...whose license is on probation due to a substance abuse problem to undergo a clinical diagnostic evaluation...” Literal interpretation of this paragraph would mean either 1) The only time this standard would apply is for a person already serving probation, who had subsequent discipline or action to require the evaluation or 2) The board may order the evaluation at anytime while the person is on probation. It could also be assumed this section was intended to mean that “If the board orders a clinical diagnostic evaluation as a term and condition of probation for a respondent as a result of a substance abuse problem...” The latter would mean that nearly 75 percent of the Board’s probationers, would be required to undergo a clinical evaluation. It is believed these evaluations would be unnecessary for nearly all cases, and costly, both to the probationer and the Board (costs range from an average of \$2,000 to \$3,000). The Board would need additional staff just to coordinate this initial effort. In any scenario, greater concerns exist.

The grounds for invoking this standard is if the licensee is being placed on probation “due to a substance abuse problem.” Evidence of substance related convictions or violations, is not necessarily evidence of a substance abuse problem. In fact, in consideration of defining “substance abuse,” the Board found that according to the Webster’s New World Medical Dictionary, Third Edition, “There is no universally accepted definition of substance abuse.”

However, a definition of substance abuse that is frequently cited is found in DSM-IV, the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) issued by the American Psychiatric Association (1994). The DSM-IV defines, in summary, “substance abuse” as recurrent or continued substance use despite negative consequences and relies on symptoms for its definition. The DSM-IV states that addiction, or dependence, is present in an individual who demonstrates any combination of three or more of the following symptoms (paraphrased for simplicity), occurring at any time in the same 12-month period:

- Preoccupation with use of the chemical between periods of use.
- Using more of the chemical than had been anticipated.
- The development of tolerance to the chemical in question.
- A characteristic withdrawal syndrome from the chemical.
- Use of the chemical to avoid or control withdrawal symptoms.
- Repeated efforts to cut back or stop the drug use.
- Intoxication at inappropriate times (such as at work), or when withdrawal interferes with daily functioning (such as when hangover makes person too sick to go to work).
- A reduction in social, occupational or recreational activities in favor of further substance use.
- Continued substance use in spite of the individual having suffered social, emotional, or physical problems related to drug use.

A single occurrence of a person under the influence on the job or driving under the influence, by itself may not classify that licensee as a “substance abuser.” However, the fact that our role as a consumer protection agency has a direct correlation to a person being under the influence on the job, makes this type of violation an immediate and significant concern. In such instances, the Board automatically seeks an ISO and pursues revocation. Again, the Board’s priority is consumer protection, not rehabilitating a licensee or allowing egregious behavior that places consumers at great risk.

Whereas, a person driving under the influence (outside of work) is considered a lower risk because it indicates a misuse of alcohol and does not directly impact the safety of patients in the person’s role as a healthcare provider. In addition, most individuals do not repeat this behavior after a single incident that results in negative consequences. DSM-IV sites, “At some time in their lives, as many as 90 percent of adults in the U.S. have had some experience with alcohol, and a substantial number (60 percent males and 30 percent females) have had one or more alcohol-related adverse life

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events (e.g. driving after consuming too much alcohol, missing school or work due to a hangover). Fortunately, most individuals learn from these experiences to moderate their drinking and do not develop Alcohol Dependence or Abuse.”

While the Board uses many of the symptoms identified by the DSM-IV, to determine if a licensee may have a substance abuse problem (blood alcohol levels, history of events, other evidence), it is not qualified to determine with absolute certainty that a person does or does not have a problem with substance abuse or substance dependence.

Furthermore, in the 1990s, the Board attempted getting similar evaluations and every single evaluation was returned stating the respondent did not have a substance abuse problem and was okay to work as an RCP with no restrictions; When in fact, it was clear that some form of monitoring was needed, if nothing more than for precautionary measures.

The Board exercises caution in using its existing authority to order a psychological evaluation, because deception nor substance abuse, cannot always be detected when an individual is not forthcoming. Furthermore, an evaluation may weaken a case for revocation (or any formal discipline), depending on remarks or findings made by an evaluator, despite evidence of licensee violations.

In addition to several interpretations and the inability to establish “substance abuse” to invoke these standards, the overarching concern is that they could unravel the Board’s existing position in support of its mandate for consumer protection. As touched upon earlier, the Board seeks revocation in many substance use cases (e.g. use while on the job, multiple convictions, etc...). Standards 1 and 2 give the appearance that there are barriers to prevent practice if there is a substance abuse problem. As written, these standards are deceptive in assuming that a respondent would be forthcoming and an evaluator would not exercise bias. This would undoubtedly lead to many persons currently revoked, being placed on probation to allow “the system” to sort out any problems and lead to outcomes that alter the Board’s philosophy in carrying out its mandate of consumer protection.

Upon further examination, the results of an evaluation could result in the two extremes: 1) Despite the evidence of use on the job, an evaluation could find (based on the RCP’s explanation) that the licensee made a poor error in judgement, and recommend no additional restrictions on the license or 2) The evaluation could find that the RCP has a serious chemical dependency problem and recommend that the licensee be removed from practice. Both scenarios conflict with the Board’s philosophies of consumer protection and purpose of its probation program, but the latter also leads to additional problems.

In addition to the significant resources it would take to manage the additional workload, the greater concern is how the Board would handle these cases. Standards 11 and 12 provide a solution, but, based on DCA legal advice, these standards are appropriately, only applicable to diversion programs. Ultimately, it is likely the “rules” to return to practice may be inconsistent depending upon each evaluation and this would unravel a flurry of other problems. Standard 10 (Major/Minor Violations) also provides a clinical diagnostic evaluation as one consequence for a commission of a major violation (e.g. testing positive for a banned substance). Thereby, allowing a probationer who tests positive to continue to recirculate through “the system.” Had the Board adopted Standards 1 and 2, it would have appeared that the Board’s probation program was a quasi diversion/probation program, clearly, not the intent of SB 1441, nor the Legislature which has made several attempts to extinguish diversion programs.

According to the analysis of SB 1441, the drive to establish standards was to maintain public confidence in different healthcare licensing boards’ “diversion programs.”

The author stated the bill was necessary to “ensure that public safety remains the paramount mission of healing arts licensing boards when dealing with licentiates who are suffering from drug or alcohol abuse or dependency problems.” “The impetus for this bill [was] the repeated failures of the Medical Board of California’s Physician Diversion Program (PDP), and the immediate and grave risks to the public posed by physicians who continue to practice medicine despite their chemical dependency.” Through several amendments, the bill ended up providing standards that also included probation programs. When standards were initially being drafted, it was thought the standards would be specific on how each one applied to diversion programs vs. probation programs, given the significant differences in philosophies. However, instead, there are one set of standards and using clinical evaluations was drafted to be permissive, rather than required, specifically for the probation programs.

Revocation or surrender of the license is the only option for high risk cases (under the influence while at work, numerous alcohol/drug convictions or acts). The Board establishes its role solely as a consumer protection agency and does not find that it is their role, nor are they the best qualified, to provide rehabilitative efforts. The Board also believes that licensees’ commitment to recovery and maintaining sobriety will be stronger, if licensees seek rehabilitation and establish support bases on their own accord. Following the revocation/surrender of a license, licensees may petition to reinstate their license, after a period of three years. At that time, the petitioner may provide evidence and testimony of rehabilitative efforts. Generally, if reinstatement of a license is granted, that licensee will be tested for a set period of time.

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Based on the foregoing, the Board opted to continue using its existing term and condition, titled, Psychological Examination which is generally used in those rare cases when the Board suspects a substance abuse problem or mental disorder, but the evidence in the case is too weak to warrant outright revocation. However, the Board did modify this term to include many of the requirements in this standard (i.e. evaluator experience, prohibit existing relationship, timelines to complete report and notify the Board if an immediate risk exists). The Board also modified its term and condition, Suspension, to include: "Respondents required to undergo a Psychological Evaluation, shall be suspended for a minimum of 30 to 90 days."

Standard 3. Employer Communication

This standard provides, "If the licensee...whose license is on probation has an employer, the licensee shall provide to the board the names, physical addresses, mailing addresses, and telephone numbers of all employers and supervisors and shall give specific, written consent that the licensee authorizes the board and the employers and supervisor to communicate regarding the licensee's work status, performance, and monitoring."

Board Response: The Board strengthened the following terms and conditions in line with this standard: Probation Monitoring Program; Notice to Employer; Biological Fluid Testing; and Abstention from Use of Mood Altering Substances.

Standard 4. Drug Testing

This standard provides numerous requirements, from frequency to exemptions, to testing standards, in relation to drug testing probationers.

Board Response: While the Board relies heavily on contractual services to conduct sample collection and drug screening, the Board's two probation monitors also collect specimens on new probationers and whenever a situation arises, where the monitors believe an unannounced collection at the worksite is necessary.

Prior to 2009, the Board randomly tested probationers six to eight times per year. In 2009, the Board increased this to 12 to 16 times per year. On March 1, 2011, the Board increased this amount to 24 times per year. On May 10, 2011, the Board adopted its "Probation Monitoring Drug Testing Frequency Policy" based on rationale it developed while chairing the SACC Uniform Standard #4 Subcommittee **(Attachment 4)**. The policy provides requirements affecting probation orders effective prior to and after July 1, 2011. Orders effective prior to July 1, 2011 are subject to testing 36 to 104 times per year and orders effective after July 1, 2011 are subject to testing 52 to 104 times per the first year and 36 to 104 times a year,

thereafter. The policy also provides for the exemptions outlined in the standard and the Board's ability to test beyond 104 times per year.

This standard also provided "Other Drug Standards" to which the Board had in place or implemented thereafter. Probation monitors had previously received training from the Division of Investigation years ago, but updated their training in accordance with the standards in early 2012 by completing the Certified Professional Collector Program through the Drug and Alcohol Testing Industry Association. Some of these "Other Drug Standards" can also be found in the Board's revised Disciplinary Guidelines under the following terms and conditions: Biological Fluid Testing; Abstinence from Use of Mood Altering Substance; and Tolling.

One of the caveats in developing Uniform Standard 4 was to require data collection to better determine if the higher frequency and standards were effective. In 2010, the Board modified its Probation Database in order to collect this information. The Board ensured this database was identified as a requirement for the new DCA-wide BreEZe system to allow other boards the opportunity to take advantage of this data collection should it meet the program criteria. (See Section 5 for extended probation statistical data).

Standard 5. Group Meeting Attendance

This standard provides criteria "If a board requires a licensee to participate in group support meetings."

Board Response: The Board opted to not adopt this standard. Many years ago the Board had a similar term and condition for attendance at Alcoholics or Narcotics Anonymous group meetings. Documentation could easily be forged and it was difficult, if not impossible, to verify attendance, given the groups' policy of anonymity. Furthermore, given the Board's philosophy on rehabilitation, it finds that it is crucial for probationers to independently seek resources and rehabilitative efforts to maintain sobriety on their own, to better ensure once license restrictions are lifted, those probationers will continue the lifestyle they developed, rather than were forced to meet for purposes of compliance.

However, the Board's Disciplinary Guidelines do include the term and condition, Alcohol and Drug Treatment. This term is used in rare cases, generally when it is believed the licensee has a current or recent substance abuse problem, but the evidence in the case is too weak to warrant outright revocation. This term and condition is more intense than "group meetings," though group meetings are often a component of the treatment for a period of time.

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Standard 6. Type of Treatment

This standard provides criteria the Board shall consider, "In determining whether inpatient, outpatient, or other type of treatment is necessary."

Board Response: The Board follows these standards continually throughout the discipline process and in those rare cases where evidence in a case may be too weak to warrant outright revocation.

Standard 7. Worksite Monitors

This standard provides requirements for worksite monitors when "A board may require the use of worksite monitors..."

Board Response: The Board does not use "Worksite Monitors." However, it may order "Direct Supervision" and every order will include "Notice to Employer" and "Supervisor Quarterly Reports." "Direct Supervision" requires the probationer to be assigned to a person for direct monitoring and new revisions require that no personal/financial preexisting relationship exists. The "Notice to Employer" term and condition requires the probationer to "inform all current and subsequent employers, directors, managers, supervisors, and contractors during the probation period, of the discipline imposed by this decision, by providing [each person] with a complete copy of the decision and order..." This term also requires any of these supervisors to report a suspicion of drug/alcohol use immediately to the Board. In addition, the term "Supervisor Quarterly Reports" requires the supervisor to complete a detailed report every three months regarding the probationer's performance.

Standards 8 and 9. Testing Positive for a Banned Substance

These standards provide procedures to be followed when a licensee tests positive for a banned substance.

Board Response: The most recent revisions to the Board's Disciplinary Guidelines includes the addition of "Violation Standards" which identifies testing positive for a banned substance as a major violation. The Board also added Section 1399.375, Cease Practice-Probation to its regulations (effective June 24, 2012) which provides procedures (incorporating standards 8 and 9) for the Board to issue a notice to cease practice as a result of a major violation.

Standard 10. Major/Minor Violations

This standard identifies major and minor violations and the consequences of such.

Board Response: The Board's recent revisions to its Disciplinary Guidelines includes "Violation Standards" which provides a list of all Major and Minor violations. It includes all of the items in Uniform Standard 10 that are applicable, as well as other violations

that may not be related to substance use/abuse (i.e. Any act that presents a threat to a patient, the public, or the respondent himself/herself). In addition, this section provides, that “If a Respondent commits a major violation, the Board shall issue a notice to cease practice, pursuant to section 1399.375 of Division 13.6, Title 16, California Code of Regulations, and the Board shall refer the matter for formal disciplinary action.” Regulatory section 1399.375 provides the procedures for issuing a notice to cease practice.

Standards 11 through 15

These standards are only applicable to diversion programs.

Standard 16. Annual Reporting

Each board shall report the following information on a yearly basis to the DCA and the Legislature as it relates to licensees with substance abuse problems..”

Board Response: Below is the data required to be reported as it applies to “probation” programs.

Table 9a. Uniform Standard #16 Annual Reporting				
	FY 08/09	FY 09/10	FY 10/11	FY 11/12
Abstention/Testing Term	99	115	97	96
Alcohol/Drug Treatment	11	11	7	4
Abstention and Suspension	21	20	11	7
Successful Completions	9	23	14	18
Referred to OAG	6	18	15	12
Early Terminations	0	3	1	9
Successful Completions	9	20	13	9
Modified	0	1	1	2
Surrendered	2	5	7	5
Revoked	4	12	7	4

The Board does not have any data to report pertaining to “cease practice” notices for FY 2011-12 or prior years. Authority to issue these notices was obtained in June 2012 and implemented in July 2012.

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CONSUMER PROTECTION ENFORCEMENT INITIATIVE

The CPEI was aimed at overhauling the enforcement and disciplinary processes of our healing arts boards. The overarching goal was to reduce the average enforcement case completion timeline from 36 months to between 12 and 18 months. The Board was instrumental in developing goals for the CPEI and co-drafting proposed legislation. In fact, many of the proposals were derived from existing statutes specific to the RCPA. Unfortunately, few proposals made it through the legislative process, and boards were urged to use other means including the regulatory process to adopt as many of the proposals that fell within their legal framework.

Following are proposals that were at one point or another part of the CPEI that have been implemented by the Board:

1. Information Provided on the Internet

This provision proposed to require healing arts boards to post the following on the Internet:

- (1) The status of every license.
- (2) Suspensions and revocations of licenses issued and other related enforcement action.
- (3) Licensee's address of record. However, the licensee may provide a post office box number or other alternate address, instead of his or her home address as the address of record.
- (4) Any felony convictions reported after a specified date.
- (5) All current accusations filed by the OAG as defined.
- (6) Any malpractice judgment or arbitration award reported to the board after a specified date.
- (7) Any hospital disciplinary actions that resulted in the termination or revocation of a licensee's hospital staff privileges for a disciplinary cause or reason.
- (8) Any misdemeanor convictions that results in a disciplinary action or an accusation that is not subsequently withdrawn or dismissed.
- (9) Appropriate disclaimers and explanatory statements including an explanation of what types of information are not disclosed.

As previously discussed, the Board provides numbers 1, 2, and 5 on its website. In reference to items 4, 6, 7, 8, and 9, the Board does not provide this information on its website. While the Board is not opposed to providing

this information, it does not currently track its cases in a manner where this information could be easily identified. Given the authority and resources, the Board would be willing to explore this further.

However, the Board was opposed to posting a licensee's address of record, item 3. Nearly all of the RCP licensees use their home mailing address as their address of record which is already public information. Anyone who requests an address must put their request in writing. In instances where the requests do not appear to be of official business, we notify the licensee to determine if there is any legitimate (safety) reason the address should or cannot be released. This process was developed as a result of one notable case where a licensee, her boyfriend and her boyfriend's father, were victims of a brutal event that led to all three of their throats being slashed. The boyfriend and the father were killed, however the licensee survived. The licensee was set to testify in the murder trial and the District Attorney confirmed that a "murder for hire bounty" had been placed on the licensee. Providing a PO Box or an alternate address would only have threatened more lives and/or provided information that could still have led to her discovery.

The Board has only had about four instances in the last decade in which licensees requested their address not be provided because they were in fear for their life. Placing addresses on the website will put licensees at grave risk of being a victim of stalking, retaliation or other fatal crimes. Making their home address public serves no purpose. It does not increase consumer protection in any manner and it actually endangers licensees who are also consumers.

2. Cost Recovery for Actual Costs and Probation Monitoring Costs

This provision proposed to allow all healing arts boards to recoup "actual" costs for the investigation and prosecution of an enforcement case, as well as actual costs boards incur from probation monitoring.

In 1993, the Board amended its cost recovery authority to obtain the "actual" costs of the investigation and prosecution of an enforcement case (B&P §3753.5 and §3753.7). The Board also gained the authority to recoup probation monitoring costs in 1994 (B&P §3753.1).

3. Contract w/Collection Agency

This provision proposed to allow all healing arts boards to contract with a collection agency by allowing the release of personal information for the purposes of collecting outstanding fees, fines or cost recovery. The proposal

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supports the concept that licensees should bear the responsibility for a portion of costs incurred as a result of those licensees' violations, which consume a large percentage of the boards' resources.

In 2004, the Board gained this authority. Since FY 2003-04, the Board has collected approximately \$200,000 in outstanding fees, fines and cost recovery, an estimated ten percent of outstanding costs.

4. Investigative Services - Non Sworn Investigators

There were several provisions to provide healing arts boards the option of using other investigative services. Many healing arts boards had difficulties in achieving thorough and timely investigations, that was partly attributed to the need for investigators to have ongoing education and experience specific to the regulation of each board's practice. The DCA was instrumental in finding an alternative that did not require additional authority, to allow all healing arts boards to hire non-sworn investigators.

For over a decade, the Board has conducted its own paper investigations, using analysts to obtain documents usually related to criminal convictions. In recent years, the number of patient-related complaints have increased requiring more skilled investigators. The Board took advantage of this new opportunity and reclassified two of its positions to the non-sworn investigator classification. The Board arranged for additional training of an existing staff person and it was also extremely fortunate to hire a very well-seasoned retired annuitant, formerly with the CDPH. As a result, costs have been contained, and cases are investigated faster and specific to the Board's needs.

5. Authority for Executive Officers to Adopt Stipulated Settlements

This provision proposed to allow executive officers to adopt default decisions and stipulated settlements to surrender a license. This provision would have expedited the disciplinary process by eliminating the processing time and members' time to review and vote on these cases, that have historically been adopted 100 percent of the time.

Upon legal counsel advice, the Board did not pursue the adoption of default decisions through the regulatory process. However, the Board did amend §1399.303 to give the executive officer the authority to adopt stipulated settlements to surrender a license (effective June 24, 2012). Board staff track these cases so that they may be reviewed by the Board at any time.

6. Boards to Enter Into Stipulated Settlements Without Filing an Accusation

This provision proposed to allow healing arts boards to enter into a settlement with a licensee or applicant prior to the board's issuance of an accusation or statement of issues. This proposal provided boards the opportunity to pursue other pathways to achieve the same end result in a more efficient manner.

In 2005, the Board gained authority (B&P §3769.3) to enter into a stipulated settlement to issue a public reprimand. At about the same time, the Board had developed its citation and fine program which proved to be a more plausible avenue to pursue, then. However, the Board remains sensitive to the fact that the citation and fine process should not be used or perceived to be used as a revenue-generating program. With the increase in patient-related complaints and as staff become more seasoned to processing those complaints, the Board is contemplating the issuance of “public reprimands” in lieu of citation and fines for these types of complaints. The Board is currently working toward developing a scheme using this authority, to address patient-related complaints, where outright revocation or probation is not being sought.

7. Authority to Immediately Suspend a License

This provision proposed to allow the Director of the DCA to immediately suspend a license for violations where ISOs are generally sought. This provision would have drastically reduced the time to suspend a license as a result of egregious violations.

The Board continues to pursue similar legislation that would allow the Board a mechanism to suspend a license immediately (discussed further under Section 11). However, SB 1172 (statutes of 2010) gave all healing arts boards the authority to order a “cease practice” to probationers, as a result of a major violation. In June 2012, the Board adopted its new Disciplinary Guidelines which identifies major violations along with §1399.375 of its regulations that provides the process for issuing a “cease practice” notice.

8. Access to Records - Subpoena Authority

There were several provisions that proposed to provide greater authority to access medical records, criminal records and other records from other governmental agencies. It was found that one of the most time-consuming hurdles of the enforcement process was obtaining records from sources that were resistant or refused to provide information, as part of an investigation.

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The Board's authority to inspect and copy records as part of an investigation (B&P §3717), was amended in 2002, to authorize the issuance of a \$10,000 fine for the failure of a facility to provide requested documentation. While this measure made a significant impact, the Board continued to face delays in getting records for a handful of cases. The Board received Subpoena authority in January 2010, which, to date, has been effective in obtaining medical and personnel records. Prior to the Board gaining this authority, it took three to nine months for an outside investigative agency to issue a subpoena and obtain records in those handful of cases where employers were not cooperative. Now, the Board can issue a subpoena and obtain those records in less than two weeks.

Occasionally, the Board has encountered delays in obtaining arrest and court records from their originating agencies. The Board proposed legislation this year to ensure all boards would have access to these records. However the language was removed from SB 1575, due to opposition expressed by the American Council of Engineering Companies. The Board may pursue similar legislation in the future should it continue to encounter similar delays.

9. Mandatory Reporting - Licensees/Employers

There were two provisions that proposed to require employers to report terminations or suspensions for specific causes and licensees to report convictions to their respective health licensing board.

In 1999, as a result of the infamous "Angel of Death" case, the RCPA was amended to include mandatory reporting requirements for employers and licensees. B&P §3758 provides that employers must report terminations or suspensions for specific causes and that failure to do so may result in a fine up to \$10,000. B&P §3758.5 requires any licensee with the knowledge that another licensee has violated the RCPA to report that information.

In 1992, B&P §3773 was added to require licensees to report convictions on license renewals. In 2009, this section was amended to require licensees to provide additional information as requested by the Board within 30 days, or the license would become inactive.

Any person who fails to report a conviction and it is later discovered, through subsequent criminal background reports, that the person did in fact have a conviction, he or she will be subject to disciplinary action. The commission of perjury is an aggravating factor when establishing discipline.

In addition, all of the Board's licensees have been fingerprinted and subsequent arrest and conviction information is reported to the Board by the DOJ.

10. Deny License for Mental Illness or Chemical Dependency

This provision proposed to give all healing arts boards the authority to deny a license to an applicant who may be unable to practice safely because of mental or physical illness.

In 1992, B&P §3757 was added, which allows the Board to refuse to issue a license or an authorization to work as an applicant, if it appears the applicant may not be able to practice safely due to mental illness or chemical dependency. This section also authorizes the Board to order the applicant to be examined by a physician or psychologist. [The Board also relies on B&P §820, §821 and §822 to compel licensees to a psychological or medical evaluation.]

11. National Practitioner Databank

This provision proposed to require healing arts boards to conduct a search of the National Practitioner Databank prior to granting a license to an applicant who is licensed by, or from another state. It also proposed a requirement to search individuals licensed in another state, prior to renewing those licenses.

In 2000, the Board began reporting discipline information to the National Practitioner Databank. In 2010, the Board began performing searches on all applicants who were from or were licensed in another state. The Board attempted to enter into a contract for these services, however the U.S. Department of Health and Human Services were not permitted to enter into a contractual agreement. The DCA provided clearance for the Board to use its Visa card to pay for each search, which continues to be the current practice. Fortunately, the State's budget has been passed timely for two consecutive years, however, there undoubtedly will be a time when it will be delayed. The Board will then not be permitted to use its Visa and licensing may be delayed or disciplinary action would have to be taken should the Board decide to issue a license without this search, pursuant to B&P §3754.5.

The Board has no mechanism to know if existing licensees are licensed in another state or to track that information for purposes of renewal. This provision would have required unlimited resources to provide checks on its approximately 20,000 licensees and could lead to lengthy delays to renew.

Licensees who have discipline in another state may omit that they hold another license and then a check would never be done. Further, the Board's existing CAS database does not track if an applicant holds an out-of-state license.

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Recent Department-Wide Issues

Until such time when the DCA has the means and cooperation of the U.S. Department of Health and Human Services to perform an automated cross-check, it would be grossly ineffective and inequitable to require a database check prior to renewal.

12. Sexual Misconduct - Revocation

This provision proposed to require all healing arts boards to deny an application or revoke a license of any person convicted of a crime related to sexual misconduct.

The Board has a long history of being extremely vigilant in denying and revoking licenses surrounding violations of sexual misconduct. In 1992, B&P §3752.6 was added to the RCPA and provides that “a crime involving sexual misconduct or attempted sexual misconduct, whether or not with a patient, shall be considered a crime substantially related to the practice.”

In 1994, B&P §3752.7 was added to the RCPA which provides that an ALJ shall order revocation (that may not be stayed) in any case where there are findings of sexual misconduct, whether involving or not involving a patient. This section cites numerous crimes, similar to the language that was proposed as part of CPEI. The Board, itself may stay the revocation, but to date, it has never done so.

Through regulation, the Board also amended §1399.370, making the commission of an act or conviction of a crime involving human trafficking substantially related to the practice (effective June 24, 2012).

The Board continues to work on strengthening consumer protection as it relates to these types of acts and is hopeful it will find a path to provide for immediate suspension (discussed later in Section 11).

BreEZe (NEW ENFORCEMENT AND LICENSING SYSTEM)

As a result of the CPEI, the DCA relaunched its effort and was successful in acquiring the support and resources needed to establish a system that would replace the antiquated licensing and enforcement database, referred to as CAS (Consumer Affairs System), and the numerous independent work-around databases.

The new BreEZe system promises to provide all applicant, license and enforcement tracking, eliminating the need for the numerous independent databases created by boards over the years. BreEZe will also provide many web-enabled processes for users, such as applying for licensure, renewing a license, and filing a complaint online. Users will also be able to monitor the status of any of these processes and make updates to their records.

Currently, the Board uses a separate Cost Recovery Database, Probation Monitoring Database and complex spreadsheets to track caseloads. The Cost Recovery database also provides for automated invoicing of outstanding cost recovery, monthly probation monitoring fees, and fines as a result of citations issued. Invoicing has proven beneficial in collecting outstanding costs.

In addition, in September 2011, with the assistance of the DCA, the Board launched its online license renewal application. Approximately 30 percent of licensees currently use this application to renew their license. Though we expect this rate to increase significantly, once BreEZe is rolled out, which is expected to have a much more user-friendly format.

All of the features and tracking mechanisms in these databases and spreadsheets are expected to be included in the new BreEZe system.

The Board is included in the first phase of the rollout which is expected to take place in 2013. Board staff have been meeting with DCA staff and vendor representatives to assist in the design, development, conversion, and acceptance testing of the system as it relates to the Board. The Board's Executive Officer also serves as a member of the Change Control Board and the Executive Steering Committee.

The DCA staff leading this project have done an exceptional job in organizing this effort, keeping lines of communication open and addressing concerns that arise. The level of commitment they have demonstrated is commendable. The Board looks forward to transitioning its technology into the 21st century with BreEZe.

Section 10: Board Action and Response to Prior Sunset Issues

ISSUE #1: Should the licensing and regulation of respiratory care therapists be continued by the Respiratory Care Board?

2002 Joint Committee Recommendation: Recommend the continuance of the Respiratory Care Board and the regulation of respiratory care therapists.

2002 Comments: The Board's sunset should be extended so that the Board may continue to carry out its consumer protection mandate and its licensing function. Respiratory care providers perform critical lifesaving and life support procedures prescribed by physicians that directly affect major organs of the body. Clearly, the enormous health implications of this care necessitate a vigilant regulatory program.

Action Since 2002: The following bills extended the Board's sunset date: SB 1955 (Statutes of 2002); SB 232 (Statutes of 2005); SB 1476 (Statutes of 2006); AB 1071 (Statutes of 2009); and SB 294 (Statutes of 2010). The Board is currently scheduled to be inoperative on January 1, 2014.

ISSUE #2: Should the Board continue to study the need for regulation of home medical device providers, pulmonary function technicians, and polysomnography technicians?

2002 Joint Committee Recommendation: The Department and the Joint Committee support a) the Board's effort to review the function and skill of currently unlicensed technicians and b) further study to determine the need for regulation of these technicians.

2002 Comments: With an increasing reliance on home healthcare providers, in the homes of patients without supervision, it is possible that unqualified personnel are providing respiratory care services. Consumers who receive healthcare services in their homes are more vulnerable than those receiving care in a hospital setting and should be assured of quality, safe, care by skilled providers.

Action Since 2002: The Board reviewed each of these areas that culminated into issues papers that prompted further action:

Home Medical Device Retail Facility Providers (HMDRFs): The Board has met with the HMDRF section of the California Department of Public Health (CDPH) and even jointly investigated an HMDRF for the unlicensed practice of respiratory care. With input from the community and the CDPH, the Board gained authority and promulgated regulations that clearly delineate the services unlicensed personnel may and may not perform (CCR, Title 16, Division 13.6, Section 1399.360). The CDPH has been supportive of the Board's role and both agencies share information as appropriate.

Pulmonary Function Technicians: The Board found that simple pulmonary function tests (PFTs) are being performed by unlicensed personnel (i.e. medical assistants) in physician offices and some Health Maintenance Organizations (HMOs). The Board attempted to seek legislation to exempt certain tests, provided certain education requirements were met. However, it was found that the Board's attempt to create education and training requirements as part of the exemption overstepped its oversight authority. At this time, the Board is re-examining this issue to determine an alternative course of action. It is expected that this issue will be included in the Board's 2013 strategic plan.

Polysomnography Technicians: Following the completion of the Board's issue paper, it prepared proposed legislation to regulate polysomnography technicians and attempted to secure an author in 2005 and 2006. In 2007, as a result of an unlicensed person being arrested for sexual misconduct with several patients, one of several concerns the Board had identified in its issue paper, the Board determined it would begin citing and fining for unlicensed practice, while continuing to seek an author for its proposed legislation. This culminated into a meeting in Monterey, where the Board's decision to pursue citations and fines was met with much resistance from physicians and physician groups. Board staff encouraged, and the fifty-plus in attendance followed suit, and formed their own California association. SB 1125, sponsored by the Board, was subsequently introduced in January 2008 but never made it to committee. However, the California association was now willing to come to the table and wanted to be more involved with the regulation. The association insisted that the Medical Board of California have oversight and pursued their own bill, SB 1526, which was introduced the following month (February 2008) and made it to the Governor's desk. Unfortunately the bill was vetoed by the Governor due to unrelated State budget issues. In 2009, SB 132 reintroduced the same language found in SB 1526, with an "urgency clause" and the bill was signed and in effect as of October 23, 2009. SB 132 met the goals of the Board in that it requires unlicensed personnel performing polysomnography to be registered, requires these personnel 1) to meet education requirements; 2) successfully pass a competency exam; and 3) undergo criminal background checks; and California RCPs are completely exempt from meeting any additional requirements to perform polysomnography.

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ISSUE #3: Should the Board adopt a substantial relationship policy for disciplining licensees?

2002 Joint Committee Recommendation: Recommend a comprehensive review of the Board's disciplinary policies to ensure that its disciplinary actions are relevant to consumer protection and appropriate to the violations. In addition, the Board's statute should ensure that penalties are based on the facts of each case. In particular, the statute should ensure that in situations where license revocation is sought, such action is taken only if necessary to protect the public.

2002 Comments: The Board continues to direct a significant portion of its resources toward enforcement. The Board has demonstrated its commitment to consumer protection through a vigorous enforcement program. There is a concern that the Board's enforcement efforts may be excessive. While the DCA commends the Board's proactive approach to enforcement, we believe the Board should ensure that its disciplinary actions are not excessive.

Action Since 2002: In 2002, the Board developed and implemented its In-House Review Policy and promulgated regulations (effective May 21, 2003), which included revisions to its Disciplinary Guidelines along with developing a comprehensive Citation and Fine Program which satisfied this recommendation. The Board also gained authority (SB 1955, Statutes of 2002) to allow licensees currently serving on probation to petition for early termination of probation, if the cause for discipline would be addressed differently based on the new policies and guidelines.

ISSUE #4: Should the Board designate a staff liaison to work with the International Medical Graduates and the programs that assist them?

2002 Joint Committee Recommendation: The Board should designate a staff liaison to work with IMGs and programs devoted to facilitating their licensure and re-entry into their profession.

2002 Comments: The Task Force on Culturally and Linguistically Competent Physicians and Dentists, co-chaired by the DCA Director, has been examining issues pertaining to the need to increase access to healthcare for low-income consumers living in medically underserved areas. The Task Force has heard from International Medical Graduates (IMGs) who wish to practice in the U.S. healthcare delivery system in some capacity, but may need additional education and training for licensure. In an effort to assist these IMGs in their effort to re-enter either their chosen profession or an alternative health related profession, programs have been established that

assess their skills, identify possible professions and educate them about licensing and education requirements. It is possible that many of these IMGs may be qualified for careers as respiratory care therapists, but are unaware of the licensing requirements and professional options that exist. The Task Force intends to look more closely at the barriers to residency and licensure encountered by IMGs. In the meantime, the Department recommends the Board designate a staff liaison to work with IMGs and the programs devoted to facilitating their licensure and reentry into their profession.

Action Since 2002: In March 2002, Board staff was appointed as the Board's liaison to work with the International Medical Graduates (IMG) in their efforts to facilitate IMGs licensure and re-entry into healthcare professions. The liaison attended a "Welcome Back" presentation held at the DCA on May 10, 2002 and personally met with the Director of the Welcome Back program on July 31, 2002. The Board liaison explained the Board's plans to modify its law to allow educational programs to evaluate applicants and place them with an advanced standing to gain additional education and/or experience necessary to successfully perform as an RCP in California (SB 363, Statutes of 2003). The Welcome Back Director stated this was in line with the Welcome Back program's goals. No additional information or assistance was requested by the Welcome Back program.

ISSUE #5: Should the Board require an AA Degree as a requirement of licensure and by what means is the Board approving schools?

2002 Joint Committee Recommendation: The Board's changes in educational requirements and reliance upon national accreditation should be ratified by the Legislature by enacting a statute that (i) codifies the new two-year and AA requirements; and (ii) specifically permits the Board to fulfill its school approval obligations by using national accreditation; however, if the Board is to rely solely upon national accreditation, it must also annually contact the postsecondary schools bureau to see if any of the schools are or have been disciplined or investigated. In the meantime, the Board should immediately cease requiring an AA degree until, at most, the new statutes are enacted or, at least, the Board's current regulations are changed to permit requiring an AA.

2002 Comments: In 1997, the Board adopted regulations (operative January 10, 1998) to 1) establish and define the educational curriculum for an approved respiratory care program and 2) require, on and after July 1, 2000, license applicants to have completed two years of qualifying education. Prior to 1998, the Board's regulations did not address educational requirements. The Board's statutory provisions

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(last amended in 1994) require only that an applicant be a graduate of an accredited respiratory therapy program and consider any program accredited by an association or agency recognized by the US Department of Education to be approved unless determined otherwise by the Board. Because of the lack of specificity, Board staff noticed significant inconsistencies in the curriculum provided to respiratory therapy students. While many programs required two years of study, others required only one year. Comments received by the Board during the public comment period, requested only technical clarifying changes. These comments were accepted by the Board and incorporated into the regulations prior to their adoption.

The JLSRC expressed concern that the Board had significantly altered the educational requirements through regulations rather than in statute and questioned the Board's legal authority to make such a significant change through the regulatory process. The Board acknowledges these concerns and is conducting a comprehensive review of its educational requirements. Specifically, the Board is considering the need to clarify the requirement for an AA degree; possible exemptions to allow credit for experience of licensure in another state in lieu of some education requirements; the need to enhance the clinical experience requirements for foreign applicants; the need to approve schools and/or evaluate whether accreditation agencies are performing quality reviews; and the need for the transcript review by Board staff.

Action Since 2002: Upon receiving the Joint Committee's recommendations in 2002, the Board temporarily stopped requiring an Associate Degree for licensure and sponsored legislation to modify its statute. Legislative authority and processes were enacted January 1, 2003 (SB 1955, Chapter 1150, Statutes of 2002) and addressed 1) codifying the AA requirement; 2) gaining authority to waive education to prevent roadblocks to reciprocity; 3) providing a pathway for foreign applicants; and 4) repealing the Board's authority to approve schools and eliminating the transcript review fee. The Board reviews the accreditation status (as well as the status with the Bureau for Private Postsecondary Education as applicable) of respiratory care programs and institutions in California at least once each year and verifies accreditation status for programs and institutions outside California, as they are used as a basis for meeting the Board's education requirements.

Section 11: Current Issues to Address

IMMEDIATE TEMPORARY SUSPENSION

For several years, the Board has pursued avenues that would allow it to immediately suspend a license upon learning of an arrest related to sexual misconduct or serious bodily harm. The existing pathways to achieve suspension have a number of caveats that can allow a licensee to continue to practice for weeks, months, sometimes years, placing the public at serious risk. Given that many respiratory care patients are vulnerable, including children, dependent adults, and the elderly, the Board is committed to finding a means to better protect this population and adhere to its mandate. The Board is also concerned with other behaviors at the workplace, that warrant discipline, but are currently not covered by the RCPA. The Board is proposing several alternatives, that would achieve the goals set forth below.

Proposal Goals

The goals of this proposal are to ensure the Board is carrying out its mandate and its highest priority of consumer protection (B&P §3701 and §3710.1) by gaining the authority to:

- Secure an order containing suspension swiftly.
- Give public notice and ensure employers are informed of allegations within 24 hours.
- Substantially relate “acts” (not just convictions) for all egregious crimes and sexual misconduct violations.
- Substantially relate any crime against a child, dependent adult, or the elderly.
- Expand the definition of “unprofessional conduct” to include inappropriate behavior in a care setting.

Summary of Current Suspension Process

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

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

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The Board has given consideration to due process rights weighted against the potential severity for grossly negligent or malicious and potential harm to patients. The Board believes this proposal strikes an appropriate balance between consumer safeguards and due process rights.

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

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

Current Suspension Order Roadblocks

Licensed RCPs who are arrested or convicted for malicious and egregious crimes such as lewd and lascivious acts against a child under 14, possession of child pornography, and attempted murder, to name a few, are permitted to continue practicing while waiting for their case to be adjudicated. As previously mentioned, RCPs work in many settings, including homes and children's hospitals, and with all types of vulnerable patients, including children and the elderly. In most cases, those RCPs who have been arrested for malicious and egregious crimes can continue to work for weeks, months, even years, all the while with no public notice, placing

the public health, welfare, and safety at immediate and significant risk. The current processes to obtain a suspension, prevents early public disclosure and includes several barriers to secure a suspension swiftly.

Public Notice

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

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

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

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

In one record-setting case, the DAG was exceptional and visited the subject and obtained a stipulation to suspend his license, the same day the Board learned of the arrest. In contrast, another case with allegations of lewd conduct with a child under 14, took two years to make a public record via an Accusation. The RCP continues to practice today, because the victim would not come forward after the initial arrest was made. The charges were reduced to “luring a child” and the DAG felt it would be unethical for him to move forward with a hearing because he believed the Board did not have legal grounds to pursue discipline since the conviction was reduced to “luring a child” which was not sexually related, and that we would lose the entire case. The case was ultimately settled, ordering terms and conditions of probation.

However, there are several cases that fall in between, where criminal prosecution can take months even years, to adjudicate, which in turn, affects the Board's ability to discipline the license. The barriers present in securing an order of suspension, directly correlate, to delays in making public notice.

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Securing an Order of Suspension

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

PC 23 Suspension/Criminal

Obtaining a PC 23 suspension is the preferred route to obtain a suspension when the complaint is based on an arrest with egregious criminal charges. A PC 23 suspension can be made, usually sooner than obtaining an ISO, and remains in effect until the criminal case is adjudicated and prevents a collateral estoppel effect.¹

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

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

Reasonable Notice

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

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

Evidentiary Showing

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

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

Interim Suspension Order/Administrative

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

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

The standard of proof for administrative cases is clear and convincing evidence to a reasonable certainty (*Ettinger v. Board of Medical Quality Assurance, Department of Consumer Affairs (1982)*). The “clear and convincing” standard of proof previously applied even in the case of an interim license suspension authorized by Government

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Code section 11529 (*Silva v. Superior Court (1993) 14 Cal.App.4th 562, 569-571.*) However, the adoption of §494 of the B&P in 1993, reduced this standard to “a preponderance of the evidence.” The standard of proof for criminal cases is clear and convincing evidence without a reasonable doubt. So while the standard of proof is slightly less in an administrative proceeding than that of a criminal proceeding, the Board must still have some key piece of evidence or testimony in addition to certified arrest records to pursue an ISO, given the short time frame until the hearing to consider revocation will be held, where the “clear and convincing standard” must be met.

The evidentiary showing for an ISO is usually not the barrier. Rather, the barrier comes from the requirement tied to an ISO, that the Board must file an Accusation within 15 days and if requested by the licensee, hold a hearing within 30 days to consider revocation of the license. Obviously, since the criminal hearing will be ongoing in nearly every instance, there is a very good chance the evidence will remain minimal based on those same reasons previously discussed (e.g. collateral estoppel effect). If the Board were to proceed with minimal evidence, it could result in lesser or no discipline, depending upon the circumstances.

Other Roadblocks: Clarification of Substantially Related Acts/ Unprofessional Conduct

The Board has also encountered barriers within its existing statutory framework. Many DAGs believe the Board’s existing codes do not allow it to pursue administrative suspension or discipline for some sexually related crimes, unless there is a conviction (despite that the Board has had several cases filed using existing codes). [This same problem also arose in a case where the RCP was arrested for attempted murder.] In these cases, the administrative ISO is not even an option, as the DAG will only pursue administrative discipline upon a conviction.

Sections 3752.5 and 3752.6 clearly show sexual misconduct and attempted bodily injury cases are substantially related to the practice. However, the authority to take action is limited to either §3750(d), conviction of a crime; §3750(j), a corrupt act; or §3755, unprofessional conduct.

Absent a criminal conviction, some DAGs have been reluctant to take action solely based on §3750(j) and §3755 because the language is too broad. One example cited was that the term “corrupt” has never been defined by the courts.

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

On a side note, the Board recently received two complaints involving serious allegations of sexual harassment (that did not result in an arrest) and has since found

that it has no basis to pursue disciplinary action in these types of cases. The proposed alternatives include amending §3755, Unprofessional Conduct to address this problem (separate from the Board's pursuit to immediately suspend licenses for more egregious serious acts).

Proposed Solutions

The Board is proposing three alternatives to address the issues outlined:

Proposed Alternative 1

- Amend §3750 to add that “Commission of any crime substantially related to the qualifications, functions, duties or practice of an RCP or the respiratory care practice” and “Commission of any act in violation of any provision of Division 2” are grounds to deny, suspend, revoke or impose probationary terms and conditions upon a license.
- Add §3752.3 to make the commission of a crime involving a minor, any person under 18 years of age, substantially related to the qualifications, functions or duties of an RCP.
- Add §3752.4 to make the commission of a crime involving an elder, any person 65 years of age or older, or dependent adult, as described in Section 368 of the Penal Code, substantially related to the qualifications, functions, or duties of an RCP.
- Amend §3752.7 to provide clarity of sexually related crimes that are grounds for revocation.
- Amend §3755 to include inappropriate behavior, including but not limited to, verbally or physically abusive behavior, sexual harassment, or any other behavior that is inappropriate for any care setting, as unprofessional conduct.
- Add §3769.7 to authorize the Board to publicly disclose any criminal arrest for a period of up to 60 days after the matter has been adjudicated and all appeals have been exhausted or the time to appeal has elapsed.

Justification: This alternative addresses most of the problems identified, including allowing the Board to provide public notice of arrests. However, it does not address the more imminent need to suspend a license swiftly for egregious acts that jeopardize the health, safety and welfare of the public.

Proposed Alternative 2

This alternative includes Alternative 1 and adds a provision making “a preponderance of evidence” the standard of proof for all matters adjudicated pursuant to the RCPA.

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Justification: This alternative would allow the Board to pursue an ISO immediately, under the existing framework. Currently, the standard of proof to obtain an ISO is a “preponderance of evidence.” However, an Accusation (to revoke the license) must be filed and a hearing must be afforded within 30 days: The standard of proof for this proceeding is “clear and convincing evidence.” As described earlier, there are a number of roadblocks in meeting this level of proof in this short time.

Furthermore, the Department of Social Services revokes and **excludes licensees for life**, based on the “preponderance of evidence” standard for all violations of their laws (Reference: § 1596.887(b), §1596.889, and §1596.8897(e) of the Health and Safety Code). This proposal would not exclude the licensee for life and would not change the licensee’s opportunity to petition for reinstatement after three years.

Proposed Alternative 3

This alternative includes Alternative 1 and reduces the standard of proof for an ISO to “substantial evidence” or “some credible evidence” and would allow a hearing to be held within two years or within 150 days after all criminal matters are adjudicated and all rights to an appeal are exhausted.

Justification: This alternative would allow the Board to use the existing framework of the ISO process with the exception of reducing the level of proof for the ISO process from a “preponderance of evidence” to “substantial evidence.” The “clear and convincing” standard would continue to apply to the matter concerning the Accusation to Revoke the license. However, instead of having to hold a hearing within 30 days, the Board would be afforded sufficient time to gather evidence needed to meet the “clear and convincing” standard of proof and prevent an estoppel effect.

Alternative 1 Proposed Language

§ 3750. Causes for denial of, suspension of, revocation of, or probationary conditions upon license

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

- (a) Advertising in violation of Section 651 or Section 17500.
- (b) Fraud in the procurement of any license under this chapter.
- (c) Knowingly employing unlicensed persons who present themselves as licensed

respiratory care practitioners.

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

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guidelines pursuant to the California Occupational Safety and Health Act of 1973 (Part 1 (commencing with Section 6300) of Division 5 of the Labor Code) for preventing the transmission of HIV, hepatitis B, and other blood-borne pathogens in health care settings. As necessary, the board shall consult with the California Medical Board, the Board of Podiatric Medicine, the Board of Dental Examiners, the Board of Registered Nursing, and the Board of Vocational Nursing and Psychiatric Technicians, to encourage appropriate consistency in the implementation of this subdivision. The board shall seek to ensure that licensees are informed of the responsibility of licensees and others to follow infection control guidelines, and of the most recent scientifically recognized safeguards for minimizing the risk of transmission of blood-borne infectious diseases.

- (o) Incompetence in his or her practice as a respiratory care practitioner.
- (p) A pattern of substandard care or negligence in his or her practice as a respiratory care practitioner, or in any capacity as a health care worker, consultant, supervisor, manager or health facility owner, or as a party responsible for the care of another.
- (q) Commission of any crime substantially related to the qualifications, functions, duties or practice of a respiratory care practitioner or the respiratory care practice.
- (r) Commission or the attempted commission of any act in violation of any provision of Division 2, including, but not limited to, any act that if convicted, would be grounds for discipline.

Added Stats 1982 ch 1344 § 1, operative July 1, 1983. Amended Stats 1987 ch 839 § 6; Stats 1991 ch 654 § 25 (AB 1893); Stats 1992 ch 1289 § 28 (AB 2743), ch 1350 § 7.5 (SB 1813); Stats 1993 ch 589 § 8 (AB 2211); Stats 1994 ch 1274 § 16 (SB 2039); Stats 1997 ch 759 § 27 (SB 827). Amended Stats 1998 ch 553 § 3 (AB 123). Amended Stats 2003 ch 586 § 11 (AB 1777).

[NOTE: The change to subdivision (p) is language included in SB 1575 submitted this year]

§ 3752.3. Crime involving a minor

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

§ 3752.4. Crime involving an elder/dependent adult

For purposes of Division 1.5 (commencing with Section 475) and this chapter, the commission of a crime involving an elder, any person 65 years of age or older, or any

dependent adult, as described in subdivision (a) of section 368 of the Penal Code, whether or not the elder or dependent adult was a patient, shall be considered a crime substantially related to the qualifications, functions or duties of a respiratory care practitioner.

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

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

§ 3755. Action for unprofessional conduct

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

Added Stats 1986 ch 1347 § 3. Amended Stats 1988 ch 1396 § 3, effective September 26, 1988; Stats 1990 ch 1072 § 3 (AB 3256); Stats 1991 ch 654 § 31 (AB 1893); Stats 1992 ch 1289 § 31 (AB 2743); Stats 1994 ch 1274 § 22 (SB 2039).

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3769.7. Public information; arrests

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

Alternative 2 Proposed Language

§ 3753. Application of provisions of Administrative Procedure Act

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

(b) Notwithstanding Ettinger v Board of Medical Quality Assurance, Department of Consumer Affairs (1982) 135 Cal.App.3d 853, in all proceedings conducted in accordance with this chapter, and all proceedings relating to the appeal of a citation, the standard of proof to be applied shall be by the preponderance of the evidence.

Alternative 3 Proposed Language

§ 3753. Application of provisions of Administrative Procedure Act

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

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

(c) Notwithstanding section 494 of this code, in all proceedings concerning an Interim Suspension Order, an accusation shall be filed within 30 days from the date an interim suspension is ordered.

(d) Notwithstanding section 494 of this code, if the licentiate files a Notice of Defense, the hearing shall be held within two years from the date the Notice was received or within 150 days after all criminal matters are adjudicated, all rights to an appeal are exhausted or all time periods to appeal have lapsed, whichever is greater.

There is a recent movement in public awareness through the media and efforts by law enforcement agencies to put a halt to child sex predators and their horrific sexual acts against children. This proposed language gives the Board the authority to prevent additional children and other vulnerable patients from becoming victims of sexual offenses and other egregious crimes. Recognizing due process and the constitutional rights of the accused, the Board has proposed two alternatives affecting the process for immediate suspension, that would better position the Board to protect the public. Within the existing APA framework, the Board is proposing to either reduce the standard of evidence or extend the time frame in which to hold a hearing, to prevent a collateral estoppel effect.

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

B&P §3710.1 provides “Protection of the public shall be the highest priority for the [Board] in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.”

Additionally, B&P §3752.7 states, “... any proposed decision ... that contains any finding of fact that the licensee or registrant engaged in any act of sexual contact, ...shall contain an order of revocation.”

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

Section 12: Attachments

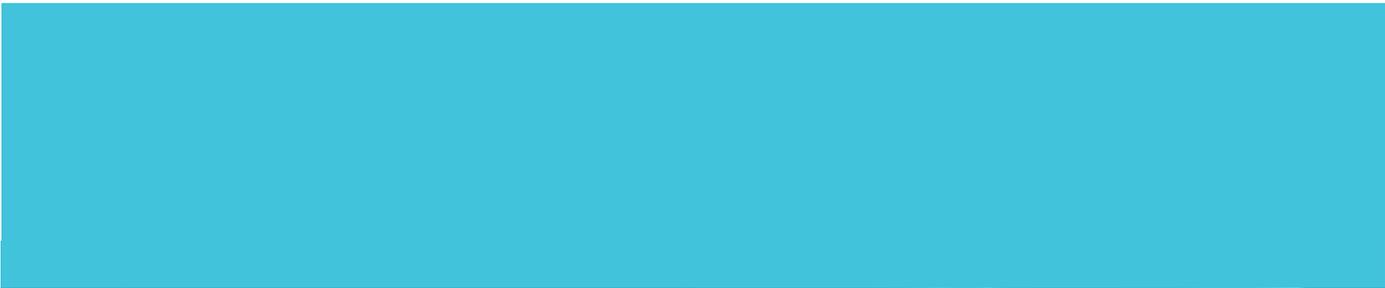
- ATTACHMENT 1** **Board Member Administrative Manual** *(Revised 2012)*
Includes: Disciplinary Guidelines *(2011 Edition)* **and**
Respiratory Care Practice Act

- ATTACHMENT 2** **California Respiratory Care Practitioner**
Workforce Study *(June 2007)*

- ATTACHMENT 3** **Organizational Charts FY 2008-09 through FY 2012-13**

- ATTACHMENT 4** **Probation Monitoring Drug Testing Frequency Policy**
(Adopted May 10, 2011)
Drug Testing Proposed Amendments - Rationale
(March 2011)

- ATTACHMENT 5** **Uniform Standards Regarding Substance-Abusing**
Healing Arts Licensees *(Adopted April 2011)*



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