



RESPIRATORY CARE BOARD

2012-2013 Sunset Oversight Review

Response to the “Background Paper for the Respiratory Care Board” prepared by the Senate Committee on Business, Professions and Economic Development and Assembly Committee on Business, Professions and Consumer Protection

April 2013

ISSUE #1 - BREEZE IMPLEMENTATION

The Board states that all of the features and tracking mechanisms in its current multiple 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 was set to take place in early 2013. What is the status of The BreEZe Project?

Staff Recommendation: The Board should provide an update of anticipated timelines, existing impediments and the current status of BreEZe.

Board Response: As a result of the Consumer Protection Enforcement Initiative, 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 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. These features will be all inclusive in the new BreEZe system.

BreEZe was expected to be fully implemented throughout the Department by the end of 2013. However, after careful consideration and consultation with the California Technology Agency, the Department made the very prudent decision to push back the first release to May 2013. The Department believes it would be in the State’s best interest to take all precautions, ensuring that the vendor is putting quality first. This will also push the other tentative releases out to November for Release Two and May of 2014 for Release Three. Although the project is late in its releases, the Department and the Technology Agency are working with the vendor to ensure the quality that was requested and is expected is delivered prior to acceptance and payment.

ISSUE #2 - SCHOOL APPROVALS

What is the Board's role in approving schools and RCP programs in the state? How does the Board work with the Bureau for Private Postsecondary Education to ensure student protections?

Staff Recommendation: The Board should comment on its ability to approve RCP programs with its current resources and staff that have RCP subject matter expertise. The Board should comment on its satisfaction with CoARC approval. The Board should advise the Committee on whether it would be appropriate to provide the Board with additional authority to oversee schools. The Board should provide the Committee with an update on its current working relationship with the Bureau.

Board Response: There are currently 36 approved respiratory care programs in California compared to approximately 20 since the Board was last reviewed in 2002. The Board's authority and oversight of respiratory education programs had a significant shift years ago. In the late 1990s, the oversight body specific to respiratory care programs went defunct, leaving the only oversight to accrediting agencies approved by the US Department of Education, which is generally not specific to disciplines, but rather to the school overall. At that time, the Board developed specific education criteria, including the requirement to possess an Associate Degree, and through the review of each transcript, did its best to determine if those requirements were being met.

Shortly thereafter, in about 2001, a new accrediting agency, the Committee on Accreditation for Respiratory Care, CoARC for short, was formed and assumed oversight responsibility for respiratory programs. Also, following the Board's 2002 review, the Joint Legislative Sunset Review Committee questioned the Board's authority to require an Associate Degree via regulation and recommended a number of changes. In 2002, legislation was enacted to 1) codify the requirement of an Associate Degree, 2) add a definition of approved education to include a program that held CoARC accreditation and school accreditation from an agency approved by the US Department of Education and 3) allow the Board to waive certain educational requirements to prevent roadblocks to reciprocity.

Since this time, transcript review, for the most part, has consisted of ensuring an applicant possesses a minimum of an Associate Degree and has completed an "approved" respiratory care program. The Board's law still provides that the board may "disapprove" a school, but the Board learned in more recent years, that this authority was limited, given the fact that the Board did not actually "approve" schools.

The Board has received a handful of complaints in the last ten years from students that have been referred to the CoARC and if in operation, the Bureau for Postsecondary Education (BPPE). The Board had issue with one school in particular that issued multiple transcripts to students with numerous deficiencies. The Board reviewed this school over a two year period, as a means to hold this school accountable, as the BPPE was defunct at the time.

It was during this review, that the Board was advised that it did not have the authority to actually "disapprove" this school. This paper review was a significant drain on Board resources. The Board was not equipped nor authorized to investigate the school further to determine if greater deficiencies existed. The Board will begin investigating the feasibility of it approving respiratory care programs and working with the BPPE for school and program oversight, to prevent similar roadblocks in the future.

Also, the most commonly expressed concern received from the profession, are that students are not fully competent or seasoned in their clinical practice and require additional clinical training. The Board decided

at its February 1, 2013 meeting that it will be moving forward with establishing the nationally administered more “advanced” Registered Respiratory Therapist examination as the minimum requirement for licensure; The advanced examination tests clinical competency and all current California graduates qualify to take this examination. The Board believes this measure will significantly improve the quality of education and success of our graduates.

ISSUE #3 - CONTINUING EDUCATION AUDITS

Is the Board effectively determining that licensees complete mandatory continuing education?

Staff Recommendation: The Board should report on any consequences arising from a lack of CE audits during a two year period. The Board should report on whether it has the staffing necessary for these important evaluations.

Board Response: In 2004, the Board targeted five to eight percent of its renewals to audit. However, in 2009, the Board temporarily halted 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 Consumer Protection Enforcement Initiative (CPEI). In 2011, the Board resumed performing CE audits and was on track to audit five percent of its licensees in FY 2012-13 as reported in its Sunset Report submitted in October 2012.

CE Audits Performed					
	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12
Renewals Audited	598	315	0	0	213

However, since January 2013, the Board has been unable to perform any additional CE audits due to the lack of staff resources. There are several contributing factors to the reduction in resources, but the redirection of staff to accommodate the implementation of the BreEZe database and the more recent Administrative directive to reduce banked vacation hours are significant contributors.

The Board’s auditing process is very thorough and demands sufficient and qualified resources. Records submitted by the licensee are reviewed to determine if all required information is present and required “clinical” hours of CE have been obtained. The Board’s auditor will also verify many of the records received with the actual provider to verify authenticity. There are significant written and oral communications that are exchanged. 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.

While there are no “documented” consequences as a result of the Board’s failure to perform continuing education audits from FY 09/10 through FY 10/11, clearly the intended benefit of CE is not being fully realized. Approximately 3-10% of those licensees audited fail to meet the CE requirements. Over a period of time, it is surmised there could be many licensees who miss out on opportunities that could ultimately impact patient care. The Board will be submitting another BCP this year to attempt again, to increase staffing in our licensing program.

ISSUE #4 - SUBSTANCE ABUSE RECOVERY

Have Uniform Standards been adopted?

Staff Recommendation: The Board should update the Committee on the implementation of the "Uniform Substance Abuse Standards" and whether more frequent testing is an appropriate mechanism for monitoring probationers who abuse substances. The Board should also address whether it believes the Uniform Standards are providing the intended consumer protections, for example is increased testing resulting in desired outcomes.

Board Response: SB 1441 (Statutes of 2008), created the Substance Abuse Coordination Committee (SACC) charged with developing uniform standards for each healing arts board to use in addressing substance-abusing licensees placed in diversion or on probation. The "Uniform Standards Regarding Substance-Abusing Healing Arts Licensees" were adopted in April 2011 by the SACC. The Board itself, adopted the Uniform Standards by way of revising its Disciplinary Guidelines through the regulatory process. The rulemaking process was completed on May 25, 2012, and the Board's revised Disciplinary Guidelines became effective on June 24, 2012.

During the development of the Uniform Standards, the Board began to increase the frequency of random drug testing of probationers. Prior to 2009, probationers were tested 6 to 8 times per year. This figure gradually increased and by July 2011, probationers were being tested between 36 and 104 times per year (see Table 5d in the Sunset Report for more specific data).

While the Uniform Standards were being developed, one of the caveats specific to 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 of the Sunset Report**), "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 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 noted in the Board's Sunset Report (Table 5b. Enforcement Statistics/Extended Probation Data) the number of tests ordered has more than doubled and positive test results 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. It is possible, that because the Respiratory Care Board does not generally place chronic substance users/abusers on probation and generally revokes or denies licensure to these individuals, that more frequent testing will not show desired results for this Board. However, the Board acknowledges that it is far too early to make any conclusions until further data is gathered.

The Board has also tracked probationers who surrendered their license in lieu of discipline separate from those who voluntarily request to surrender their license. Of its approximately 100 total probationers, six probationers voluntarily surrendered their license during FY 11/12. Four of these surrenders were a direct result of the increase in testing that jumped to 36-104 times per year in July 2011. These 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 also gained authority to issue “cease practice” notices to probationers for major violations of probation. As of March 31, 2013, the Board has issued 25 cease practice orders. Of all the efforts to develop uniform standards, the authority to “cease practice” is by far the most effective consumer protection measure, allowing the Board to immediately remove alleged dangerous practitioners from practice. It is also an incredibly efficient tool in achieving greater compliance with terms and conditions of probation for those probationers who may commit a violation that is not serious enough to warrant revocation (until a pattern is established or multiple less serious violations have occurred).

The Board plans to collect additional data over the next several years that will allow it 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.

ISSUE #5 - DIFFICULTY OBTAINING LOCAL LAW ENFORCEMENT RECORDS

The Board, as well as other boards at DCA, is having problems obtaining important records from local government agencies pertaining to its licensees. What type of information is the Board having difficulty accessing? How does this potential inability to access records, such as arrest documents, impede the Board’s enforcement efforts?

Staff Recommendation: Section 144.5. should be added to the Business and Professions Code as follows:

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

Board Response: Over the last couple of years, the Board has come across some local law enforcement agencies that have refused to release criminal records to our Board without an “authorization to release” from the licensee, citing section 432.7 of the Labor Code. However, this issue is not isolated to just our Board. It is affecting many of the boards and bureaus under the Department of Consumer Affairs’ umbrella.

It is customary for most boards and bureaus to obtain complete arrest, conviction and other-related documentation as part of an applicant or licensee investigation. Each board relies upon various authorities to retrieve documentation, and until two years ago, it was unheard of that a local government agency would refuse to release any such records to a state agency, without an authorization to release records submitted by the party in question.

It is crucial to the mission of every board and bureau of consumer safety, to be able to access all arrest, court and other related documentation through the course of an applicant or licensee investigation. Requiring an authorization to release records impedes the ability of licensing entities’ to efficiently take appropriate disciplinary action or thoroughly investigate applicants. Given that a licensee is not required to provide the release, it could ultimately result in a licensing entity’s inability to take disciplinary action. Furthermore, obtaining an authorization to release records, drastically slows the investigative and disciplinary processes.

The Board believes the Committee-staff suggested amendments to the general provisions of the B&P will resolve the problems. The Board believes that the language is very precise and clearly provides that boards are authorized to receive these records, regardless of any other statute, and that local law enforcement agencies will respond positively to such an amendment.

ISSUE #6 - STAFFING LEVELS CAN BE INCREASED TO BETTER MEET GOALS

The Board's fund condition shows a healthy reserve, the monies of which may need to be spent to prevent the Board from having to pursue a fee decrease or fee suspension. Boards like the Respiratory Care Board have been discouraged from submitting budget change proposals (BCPs) and those that are submitted have typically been denied. What are the Board's current staffing needs to effectively serve consumers and maintain a robust, timely licensing and enforcement program?

Staff Recommendation: The Board should state its current staffing needs and how additional positions could help the Board reduce licensing and enforcement timelines.

Board Response: Since the Board was last reviewed in 2002, it has reduced enforcement processing timelines and timelines associated with obtaining initial licensure, applications for licensure have nearly tripled, several new programs or functions have been added, and a number of other improvements have been established. The Board has made this progress over the last 12 years without any augmentations in authorized personnel.

The Board credits much of this success, to its low turnover rate and experienced staff. Of its currently 18 filled staff positions, the Board has been successful in retaining 14 of the same employees that were employed when the Board was last reviewed in 2002. Most staff members have worked in more than one program area and all have acquired very valuable skill sets. They have been instrumental in identifying weaknesses, areas where improvements can be made, and have made it possible for the Board to operate efficiently while making improvements, without augmenting staff. They have also been extremely committed and reliable - even more so over the last four years when unusual demands on our workforce have been presented. The Board believes that it has peaked in maximizing its resources and cannot sustain, let alone improve, the same production without augmenting staff.

Over the last three years, the Board has faced challenges in acquiring new personnel authority. Not only has the Board's efforts to increase staffing to pursue greater efficiencies been denied, but the most recent cuts to staffing have also placed the Board in a vulnerable position.

Budget change proposals were submitted for fiscal years 11/12 and 12/13 to improve enforcement processing times, including developing a new program where more routine legal pleadings could be prepared in-house. The Board believes this would not only significantly reduce the overall time to complete the formal discipline process for a majority of cases, but that it would also result in cost savings. The Board also submitted a BCP in 11/12 to increase licensing staffing to address increased workload. The Board submitted these BCPs for personnel authority only and would have absorbed the costs for these positions within its existing budget. Despite the fact that the board is funded entirely by special funds collected from its licensees and that it would have absorbed funding for the positions within its existing budget, all of these BCPs were denied.

In addition, last June, 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 Board's two special investigator positions and reduced 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, which unfortunately just occurred last December. The Board is currently pursuing the hire of another uniquely and highly qualified retired annuitant, however new laws and other restrictions have left uncertainty if we will be able to accomplish this. Further, the Board was advised that should the person working full-time in the reduced time base Office Assistant position ever leave, the Board would need to fill it in a part-time capacity. These reductions made last Summer, could ultimately prove to cripple many of the Board's functions.

In addition, there are several other factors that are affecting the Board's workforce. Restrictions on hiring retired annuitants and student assistants have had a substantial impact on workload. Over the last four years, staff have been subjected to various furloughs, while being asked to do more with less. Many staff have forgone vacations they would have normally taken to address Administration demands and additional workload. Meanwhile, because of the low turn over rate, the majority of the Board's staff have 20+ years of state service therefore accruing vacation at a higher rate. Last month, the Board received a directive from the Administration advising the Board that it must step up its efforts to ensure staff use banked vacation in excess of the 640 hour maximum and all furlough hours.

In order to maintain processing timelines and address existing workload the Board suspects it needs 2-3 additional PYs. In order for the Board to enhance its Enforcement program, including establishing an in-house program to process routine pleadings, it will need 2-3 additional staff. So in total, the Board estimates it needs 4-6 additional personnel in order to effectively serve consumers and maintain robust and timely licensing and enforcement programs. The Board will again, be seeking additional personnel authority this year.

ISSUE #7 - PROTRACTED PROCESS TO SUSPEND RCP LICENSE

The Board must go through a cumbersome process to suspend the license of a RCP who may pose an immediate threat to patients or who have committed a serious crime and may even be incarcerated. What are the Board's proposed efforts to reduce ISO timelines?

Staff Recommendation: The Board should seek to extend the timeframe placed on the AG to file an accusation. This will allow the AG to utilize the ISO process without being subject to the currently limited timeframe.

Board Response: 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. 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. 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. As discussed in greater detail in the Board's Sunset Report, the current processes to obtain a suspension, prevents early public disclosure and includes several barriers to secure a suspension swiftly.

Combining the proposed alternatives that were presented in the Board's Sunset Report with the "Staff Recommendation" above, the Board is proposing the following language that authorizes the Board to extend the timeframe to file an Accusation and lower the evidence threshold for matters adjudicated through the Interim Suspension Order (ISO) process, as well as have the authority to share arrest information with the public. 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 file an Accusation 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.

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

3769.7. Public information; arrests

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

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

§ 3753. Application of provisions of Administrative Procedure Act

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

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

(c) Notwithstanding section 494 of this code, in all proceedings concerning an Interim Suspension Order, an accusation shall be filed within 60 days from the date an interim suspension is ordered or if the interim suspension order is issued based on an act that results in the filing of criminal charges, within 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.

ISSUE #8 - LACK OF CLARITY IN DEFINITION OF UNPROFESSIONAL CONDUCT MAY DELAY ENFORCEMENT

The Board is concerned that a lack of definition for unprofessional conduct in the RCPA may be impacting its ability to take necessary action against RCPs.

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

Board Response: The Board has encountered barriers within its existing statutory framework in pursuing discipline for acts of unprofessional conduct or the commission of crimes that may not result in a conviction. Many DAGs believe the Board's existing codes do not allow it to pursue administrative suspension or discipline for some sexually related crimes, unless there is 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.

The Board has also 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 Board is also concerned with other behaviors of "unprofessional conduct" at the workplace, that warrant discipline, but are currently not covered by the RCPA.

The Board is seeking to:

- Substantially relate "acts" (not just convictions) for all egregious crimes and sexual misconduct violations.
- Expand the definition of "unprofessional conduct" to include inappropriate behavior in a care setting;

The Board would also like to seek legislative remedies to:

- Substantially relate any crime against a child, dependent adult, or the elderly; and
- Ensure the Board continues to maintain jurisdiction in disciplinary matters that are finalized after a license has cancelled.

The proposed language:

- Amends §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.
- Adds §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.
- Adds §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.
- Amends §3752.7 to provide clarity of sexually related crimes that are grounds for revocation.
- Adds §3754.8 to give the board continuing jurisdiction of a disciplinary matter despite the expiration or cancellation of a license.
- Amends §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.

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

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

- (a) Advertising in violation of Section 651 or Section 17500.
- (b) Fraud in the procurement of any license under this chapter.
- (c) Knowingly employing unlicensed persons who present themselves as licensed respiratory care practitioners.
- (d) Conviction of a crime that substantially relates to the qualifications, functions, or duties of a respiratory care practitioner. The record of conviction or a certified copy thereof shall be conclusive evidence of the conviction.
- (e) Impersonating or acting as a proxy for an applicant in any examination given under this chapter.
- (f) Negligence in his or her practice as a respiratory care practitioner.
- (g) Conviction of a violation of any of the provisions of this chapter or of any provision of Division 2 (commencing with Section 500), or violating, or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision or term of this chapter or of any provision of Division 2 (commencing with Section 500).
- (h) The aiding or abetting of any person to violate this chapter or any regulations duly adopted under this chapter.
- (i) The aiding or abetting of any person to engage in the unlawful practice of respiratory care.
- (j) The commission of any fraudulent, dishonest, or corrupt act which is substantially related to the qualifications, functions, or duties of a respiratory care practitioner.
- (k) Falsifying, or making grossly incorrect, grossly inconsistent, or unintelligible entries in any patient, hospital, or other record.
- (l) Changing the prescription of a physician and surgeon, or falsifying verbal or written orders for treatment or a diagnostic regime received, whether or not that action resulted in actual patient harm.
- (m) Denial, suspension, or revocation of any license to practice by another agency, state, or territory of the United States for any act or omission that would constitute grounds for the denial, suspension, or revocation of a license in this state.
- (n) Except for good cause, the knowing failure to protect patients by failing to follow infection control guidelines of the board, thereby risking transmission of blood-borne infectious diseases from licensee to patient, from patient to patient, and from patient to licensee. In administering this subdivision, the board shall consider referencing the standards, regulations, and guidelines of the State Department of Health Services developed pursuant to Section 1250.11 of the Health and Safety Code and the standards, regulations, and guidelines pursuant to the California Occupational Safety and Health Act of 1973 (Part 1 (commencing with Section 6300) of Division 5 of the Labor Code) for preventing the transmission of HIV, hepatitis B, and other blood-borne pathogens in health care settings. As necessary, the board shall consult with the California Medical Board, the Board of Podiatric Medicine, the Board of Dental Examiners, the Board of Registered Nursing, and the Board of Vocational Nursing and Psychiatric Technicians, to encourage appropriate consistency in the implementation of this subdivision. The board shall seek to ensure that licensees are informed of the responsibility of licensees and others to follow

infection control guidelines, and of the most recent scientifically recognized safeguards for minimizing the risk of transmission of blood-borne infectious diseases.

- (o) Incompetence in his or her practice as a respiratory care practitioner.
- (p) A pattern of substandard care or negligence in his or her practice as a respiratory care practitioner, or in any capacity as a health care worker, consultant, supervisor, manager or health facility owner, or as a party responsible for the care of another.
- (q) Commission of 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.

3754.8. The expiration, cancellation, forfeiture, or suspension of a license, practice privilege, or other authority to practice respiratory care by operation of law or by order or decision of the board or a court of law, the placement of a license on a retired status, or the voluntary surrender of a license by a licensee shall not deprive the board of jurisdiction to commence or proceed with any investigation of or action or disciplinary proceeding against the licensee, or to render a decision suspending or revoking the license.

§ 3755. Action for unprofessional conduct

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

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).

ISSUE #9 - INCREASED DEMAND FOR RCPs WITH AFFORDABLE CARE ACT IMPLEMENTATION AND AGING CALIFORNIANS NEEDING RESPIRATORY SERVICES

How will the Board meet increased demand for RCPs? What trends has the Board noticed in its licensing numbers? Is the Board prepared for an increase in the potential number of applicants and licensees?

Staff Recommendation: The Board should explain what additional efforts it can take or models it can follow to increase the RCP workforce and ensure participation of its licensees in the state's health care delivery system.

Board Response: 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. The Study was completed in 2007 and 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;
- Indication 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; and
- 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.

The workforce study was prepared prior to the Affordable Care Act and therefore, no consideration was given to the workforce demands that the Act will present.

At the time the study was completed, the Board had approximately 15,000 active licensees. The Study projected that the Board would need:

16,665 licensees by 2015;
18,000 by 2020;
19,000 by 2025; and
21,000 by the year 2030.

The Board currently has over 20,000 active licensees, and expects to be at the Study's projected growth needs for the year 2030 within the next 12 months.

The number of active licensees has grown significantly and is largely attributed to new applications for licensure. Since the Board was last reviewed in 2002, the number of applications received each year has nearly tripled from approximately 600 applications received in 2002 to nearly 1,600 applications received last fiscal year.

There are a number of efforts that may have contributed to this jump including:

- 1) The US Department of Labor's publication of the RCP shortage as found in the Board's 2007 Workforce Study;
- 2) The number of education programs increasing from 25 in 2005 to 36 in 2012;
- 3) Significant outreach conducted by the Board including attendance at numerous high school fairs and career search events in 2006 and 2007. And of course, many of our education programs have and continue to attend various career fairs as well; and
- 4) In 2009, the Board developed a media kit which included new brochures, a DVD that the Board developed, and posters and give aways that pointed them to a new website the Board created to recruit new students into RCP education programs. The Board was able to distribute approximately 370 of these media kits to high schools throughout California, concentrating on those geographical areas with greater need.

However, the Board's Marketing Plan that had just been put into motion in 2009, was halted as a result of various administrative directives, before the board could complete many of the strategies it had outlined.

The Board does not anticipate additional spikes in applicants anytime in the near future. The Board generally receives notice of a new education program opening between 12 and 24 months in advance of the first graduating class. Therefore, the Board does have a small window of opportunity to request additional resources if needed.

In regard to the Affordable Care Act, the Board believes California's Respiratory Care Practitioners play a key role in filling the workforce gap to meet the demand of an estimated 4-7 million more California consumers who will be seeking care. Moreover, the Board believes that moving toward a Physician-led "team" approach in delivering care would now allow all patients to receive the expertise offered by RCPs, in treating ailments affecting the pulmonary and associated aspects of the cardiopulmonary systems. Millions of people, many of whom are baby boomers, suffer from COPD and would now have access to providers specializing in this area, with the team approach. Not to mention, the millions of people who are treated for other respiratory ailments or trauma victims who rely on artificial ventilation.

The RCP scope of practice does create somewhat of a barrier for allowing RCPs to practice to their full scope of practice. Approximately 1/3 of RCPs hold a baccalaureate degree or higher and the Board believes these practitioners, as well as some others, are highly qualified to be direct providers. The Board is currently working toward proposals to provide RCPs greater authority to write orders, as well as a number of other proposals that will still fall within their speciality and their scope of practice, yet provide better care and greater access.

As one of the three most common bedside practitioners, who can improve outcomes and reduce costs pursuant to evidence-based research, the Board intends to keep RCPs on the radar as reform takes place to fully implement the Affordable Care Act as intended.

ISSUE #10 - POLYSOMNOGRAPHY TECHNICIAN REGULATION

The Board took efforts over a number of years to license technicians working in sleep laboratories. What is the Board's impression of regulation by the Medical Board of California of polysomnography technicians? Does the Board still get complaints about these individuals? How do the two boards interact to promote consumer protection for individuals receiving services at sleep labs?

Staff Recommendation: The Board should outline its view on the current registration and regulation of those who engage in the practice of polysomnography, including any continuing problems and ideas for more robust consumer protections if applicable.

Board Response: Legislation (SB 132) enacted in 2009 established the regulation of polysomnography personnel by the Medical Board of California (MBC). Between the enactment of this legislation and the time the MBC actually began "registering" trainees, technicians and technologists in April 2012, the MBC developed regulations necessary to successfully implement the regulatory program. Since then, the MBC has registered near 300 polysomnography personnel. The Board's interaction with the MBC in this regard has been limited to providing comments on proposed regulations and referring approximately five complaints a year to the MBC.

However, following legislation requiring polysomnography technicians to be registered with the Medical Board, the California Department of Public 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.

As this profession evolves, the Board hopes that, in the interest of strengthening consumer protection, the definition of "Approved polysomnographic education program" as found in Section 1379.40 of Chapter 4.3 of Title 16 of the California Code of Regulations (CCR) will be modified to only include formal bona fide education programs accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or by the Commission on Accreditation for Respiratory Care (CoARC). Currently, this section also recognizes programs accredited by the American Academy of Sleep Medicine (AASM) and the Board of Registered Polysomnographic Technologists (BRPT). When the Board reviewed these programs prior to the implementation of this program, these educational programs consisted primarily of on-the-job training programs and were not recognized by the US Department of Education. Further, the Board believes it is in the best interest of consumers that the education component be separate from the organization offering the professional credential (BRPT), as well as the organization that is highly vested in representing physicians' interests and advocating for recognition of the profession (AASM).

ISSUE #11 - CONTINUED REGULATION BY RESPIRATORY CARE BOARD

Should the licensing and regulation of respiratory care therapists be continued and be regulated by the current Board membership?

Staff Recommendation: Recommend that the respiratory care professional profession continue to be regulated by the current Board members in order to protect the interests of the public and be reviewed once again in four years.

Board Response: The Board is firmly committed to its mandate and continually strives to increase consumer protection in the most efficient manner through its licensing and enforcement programs. The Board concurs with this recommendation that the Respiratory Care Board of California regulation of RCPs should be extended.