2016–2017
Sunset Oversight Review

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Respiratory Care Board of California
3750 Rosin Court, Suite 100, Sacramento, CA 95834
T: 916.999.2190 F: 916.263.7311 www.rcb.ca.gov

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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

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BACKGROUND AND DESCRIPTION OF THE RESPIRATORY CARE BOARD

The enabling statute to license Respiratory Care Practitioners (RCPs) was signed into law 34 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). 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 and serve consumers by licensing qualified respiratory care practitioners, enforcing the provisions of the Respiratory Care Practice Act, expanding the availability of respiratory care services, increasing public awareness of the profession, and supporting the development and education of respiratory care practitioners.

The Board's vision is that all California consumers are aware of the Respiratory Care profession and its licensing Board, and receive competent and qualified respiratory care.

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, 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

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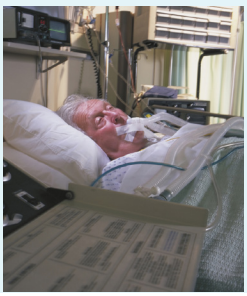
the elderly. RCPs provide treatments for patients who have breathing difficulties and care for those who are dependent upon life support and cannot breathe on their own. RCPs treat patients with acute and chronic diseases, including Chronic Obstructive Pulmonary Disease (COPD), trauma victims, and surgery 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 medical gases and pharmacological agents for the purpose of inducing conscious or deep sedation.
- Administering all forms of extracorporeal life support (ECMO).
- Inserting and maintaining atrial lines.
- 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 the 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.
- Sub acute 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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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: Alan Roth, MS, MBA, RRT-NPS, FCCP, FAARC
Vice-President: Thomas Wagner, BS, RRT, FAARC

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: Mary Ellen Early
Member: Ronald H. Lewis, MD

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: Rebecca F. Franzoia
Member: Michael Hardeman

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, MBA, BS, RRT
Member: Judy McKeever, RCP, RRT

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.

Chair: Alan Roth, MS, MBA, RRT-NPS, FCCP, FAARC

RELATIONSHIP OF COMMITTEES TO THE 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. The Board has not had any issues with establishing a quorum. Attendance over the last four years has ranged between 78% and 100% of Board members present.

Table 1A. Respiratory Care Board Meetings and Member Attendance

		Date Appointed	MD- Physician; P - Public; RCP - Professional	Appointing Authority: Governor; Senate; Assembly	1/31 - 2/1, 2013 - Sacramento	5/6/13 - San Diego	11/15/13 - Anaheim	4/4/14 - Los Angeles	11/7/14 - Sacramento	5/15/15 - Loma Linda	6/23/15 Teleconference (4 sites)	11/6/15 - Sacramento	3/11/16 - San Diego	6/24/16 - Teleconference (5 sites)	10/7/16 - Sacramento
CURRENT MEMBERS															
Early	Mary Ellen	Apr-13	Public	G		X	X	X	X	X	X	X	X	X	
Franzoia	Rebecca	Jun-12	Public	G	X	X	X	X	X	A	X	X	A	X	
Goldstein	Mark	Jun-12	RCP	G	X	X	X	X	X	X	X	A	X	X	
Hardeman	Michael	Jun-13	Public	A			X	X	X	X	X	X	X	X	
Lewis	Ronald	Jun-13	MD	S			X	X	X	X	X	X	X	X	
McKeever	Judy	Feb-14	RCP	A				X	X	X	A	A	A	X	
Romero	Laura	May-13	Public	S			X	X	X	X	X	X	A	A	
Roth	Alan	Sep-12	RCP	A	X	X	X	X	X	X	X	X	X	A	
Wagner	Thomas	Jun-14	RCP	S					X	X	X	X	X	X	
PAST MEMBERS															
Aguilera	Lupe	May-08	Public	G	X	A									
Magana-Cuellar	Sandra	Jun-06	Public	S	A	A									
Olson	Murray	Jan-06	RCP	A	A	X	X								
Spearman	Charles	Aug-06	RCP	S	X	X	X	X							

X - In Attendance; A - Absent; P - Partial Attendance

Table 1b. Board Member Roster as of September 2016

MEMBER NAME	APPOINTED	REAPPOINTED	TERM EXPIRES	APPOINTING AUTHORITY	TYPE
Early, Mary Ellen	4/13/2013	6/2/2015	6/1/2019	Governor	Public
Franzoia, Rebecca	6/8/2012	6/3/2016	6/1/2020	Governor	Public
Goldstein, Mark	6/8/2012	6/9/2015	6/1/2019	Governor	Professional
Hardeman, Michael	6/3/2013	6/29/2016	6/1/2020	Assembly Speaker	Public
McKeever, Judy	2/19/2014	n/a	6/1/2017	Assembly Speaker	Professional
Roth, Alan	9/12/2012	7/9/2015	6/1/2019	Assembly Speaker	Professional
Lewis, Ronald	6/19/2013	n/a	6/1/2018	Senate Rules	Professional (MD)
Romero, Laura	5/8/2013	6/1/2013	6/1/2017	Senate Rules	Public
Wagner, Thomas	6/5/2014	n/a	6/1/2018	Senate Rules	Professional

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 2012–13. Support staff for the Board has also remained relatively unchanged. Of the Board's 18 employees, 16 were employed at the time of the Board's last Sunset Review.

Board Staff Receive "Sustained Superior Accomplishment Award"–BreEZe

In the summer of 2011, DCA moved forward with the development of a Department-wide database, known as the BreEZe project, intended to standardize enforcement and licensing systems for consumers and departments to access online. The BreEZe project required a significant number of staff hours to perform tasks outside of normal work duties with additional demands on time and an interruption of routine. The project was challenging on a number of levels, to say the least.

As one of the first boards to roll out, the Board was extremely fortunate to have exceptional staff willing to persevere all of the obstacles to attain a system configured to maximize efficiency. More importantly, they kept the end game in focus and kept a positive outlook recognizing the benefits of the system.

From Left to Right: Stephanie Aguirre, Christine Molina, Andrea Pina, Katie Pitt, Christine Rust, and Liane Freels.

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This team took the initiative to further explore BreEZe concepts and the contractor's methodology for applying changes in order to adapt. This team ensured that the principles of our free-standing databases (cost recovery and probation monitoring) were included in BreEZe. The probation monitoring database was specifically important, because it was designed to incorporate data reporting requirements as provided in the DCA's uniform standards.

The Respiratory Care Board's BreEZe system rolled out in October 2013. As with most system rollouts, additional obstacles quickly appeared. In good fashion, the team tackled these obstacles and continually conveyed the need to provide even stronger customer care to diffuse any frustrations.

In 2014, six of the Board's employees were recognized and awarded the "Sustained Superior Accomplishment Award" designed "to recognize superior job performance by an individual employee or a team of employees resulting in an exceptional contribution to improving the DCA and California."

Each staff member received a certificate and monetary award as follows:

Christine Molina, Staff Services Manager	$500
Liane Freels, Staff Services Manager	$500
Andrea Pina, Staff Services Analyst	$300
Kathryn Pitt, Staff Services Analyst	$300
Christine Rust, Staff Services Analyst	$300
Stephanie Aguirre, Staff Services Analyst	$300

Each one of these staff members dedicated hours of energy into this project. Their demonstrated intelligence, strong work ethic, initiative and commitment ultimately ensured the success of BreEZe for the Respiratory Care Board.

Strategic Planning

The Board conducted an extensive strategic planning effort and developed a four-year Strategic plan in 2013 (available on the Board's website at: http://www.rcb.ca.gov/media_outreach/strategic_plan_2013.pdf). The plan includes four areas of focus: Enforcement, Practice Standards, Outreach, and Organizational Effectiveness. 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 2016 (attached).

Examination for Licensure Change

Effective January 1, 2015, the Board began using the advanced respiratory credentialing examination as its licensing examination to test competency prior to licensure (AB 1972, Statutes of 2014).

Since the Board's inception in 1985, the National Board for Respiratory Care, Inc. (NBRC) has offered two credentials specific to respiratory care that are both nationally recognized: 1) The Certified Respiratory Therapist (CRT) - entry level credential; and 2) the Registered Respiratory Therapist (RRT) credential - advanced level credential.

Up until 2015, the Board recognized the passage of the CRT examination as the minimum exam requirement for licensure as a respiratory care practitioner (RCP). Advancements in technology and accreditation standards, coupled with the restructuring of nationally recognized exams, made the requirement to pass the CRT examination for licensure as an RCP inadequate, outdated and insufficient in meeting the Board's consumer protection mandate.

The new requirement to pass the RRT exam now aligns the minimum examination requirements for licensure with the natural progression made in the respiratory field, accreditation standards and examination delivery. Evidence of competency at what was once considered the advanced level provides greater consumer protection, improved job performance as a whole, and the ability to measure school outcomes as a part of their program accreditation.

Baccalaureate Degree Pilot Program

On September 28, 2014, California Governor Jerry Brown signed SB 850, authorizing the Board of Governors of California Community Colleges (BOG), in consultation with representatives of the California State University (CSU) and University of California (UC), to establish a statewide baccalaureate degree pilot program at no more than 15 California colleges. The Board of Governors was charged to develop a process for selection of the pilot programs. Two respiratory care programs were selected. Skyline College in San Bruno opened its doors to its respiratory care baccalaureate degree program in the fall of this year and Modesto Jr. College will be opening their program in the fall of 2017.

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LEGISLATIVE CHANGES AFFECTING THE BOARD SINCE 2012

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

SB 1575 *(Statutes of 2012)*

- §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.

SB 305 *(Statutes of 2013)*

- §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.
- §3765 was amended with non-substantive and/or grammar revisions.

AB 1972 *(Statutes of 2014)*

- §3730 and §3735 were amended and §3735.5 was repealed to require a more advanced competency examination for initial licensure effective January 1, 2015. Consideration was also provided for reciprocity and provisions were made to recognize passage of the previous exam if done so prior to January 1, 2015.
- §3739 was amended to include provisions for which the Board may extend a temporary work permit to applicants as part of their application process.

AB 2102 *(Statutes of 2014)*

- §3770.1 was added to require the Board to collect and report specific demographic data relating to its licensees to the Office of Statewide Health Planning and Development.

SB 525 *(Statutes of 2015)*

- §3701 was amended to permit licensees to provide care for patients with non-respiratory conditions, provided training and competencies are in place.
- §3702 was amended to clarify that deficiencies and abnormalities affecting the heart and cardiovascular system is part of the respiratory care scope of practice.
- §3702.7 was amended to clarify that conscious sedation, extracorporeal life support, respiratory care education, and care of patients with sleep and wake disorders are all part of the respiratory care scope of practice.

SB 923 *(2016 Legislation)*

- §3750 was amended to include as a cause for discipline: Providing false statements or information on any form provided by the Board or to any person representing the Board during an investigation, probation monitoring compliance check, or any other enforcement-related action when the individual knew or should have known the statements or information was false.
- §3755 was amended to expand the definition of "unprofessional conduct" to include any act of administering unsafe respiratory care and any act of abuse towards a patient.
- §3754.8 was added to allow the Board to have continuing jurisdiction over disciplinary matters where a license may become invalid during the disciplinary process.

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REGULATORY CHANGES AFFECTING THE BOARD SINCE 2012

§1399.301. Location of Office was amended to reflect the current Board office address.

§1399.326. Driving Record was added to clarify that the review of each applicant's driving history is part of the Board investigation prior to licensure.

§1399.329. Military Renewal Application Exemptions was added to codify section 114.3 of the B&P, and provides the Board shall prorate the renewal fee and the number of CE hours required in order for a licensee to engage in any activities requiring licensure, upon discharge from active duty service as a member of the United States Armed Forces or the California National Guard.

§1399.343.–§1399.346. Sponsored Free Health Care Events were added to codify AB 512 (Statutes of 2013) and established a process for temporary licensure for out-of-state entities and personnel to practice respiratory care in California at a community event of not more than 10 days.

§ 1399.350. Continuing Education Required was amended to increase the number of continuing education hour required for the renewal of a license from 15 to 30 hours (as permitted in section 3719 of the B&P).

§ 1399.351. Approved CE Programs was amended to update respiratory-related credentialing examinations that qualify for continuing education and recognize courses in the assessment and treatment of the acquired immune deficiency syndrome (AIDS) as provided for in Section 32 of the B&P.

§ 1399.352. Criteria for Acceptability of Courses was amended to recognize preparation courses for the advanced level credential as qualified continuing education.

§ 1399.395. Fee Schedule was amended to eliminate the specific dollar amount required for the exam and replace it with "actual cost." Since the Board does not control exam costs that are set by the national examination provider, the Board found it appropriate to cite "actual cost," to provide greater transparency and an accurate representation of costs.

MAJOR STUDIES

California Respiratory Care Practitioner Workforce Study (December 2016)

In 2015, the Board contracted with the Institute for Health Policy Studies at the University of California, San Francisco, to conduct a study to determine:
1) The feasibility and impact of requiring new applicants to obtain a baccalaureate degree;
2) The need to modify current requirements regarding clinical supervision of RCP students;
3) The effectiveness of the current requirement to take a Professional Ethics and Law continuing education course, and
4) The benefit or need to increase the number of continuing education hours and/or its curricular requirements.

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 attend (on their own) the AARC's Annual Conferences or Summer Forums.

NATIONAL EXAM PARTICIPATION

The Board now uses the National Board for Respiratory Care's (NBRC's) "Registered Respiratory Therapist" examination for licensure, which is developed, scored, and analyzed by the NBRC. 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.

The examinations associated with the RRT were developed to objectively measure essential knowledge, skills, and abilities required of advanced respiratory therapists, and to set uniform standards for measuring such knowledge. Effective January 2015, the name of one of the examinations that candidates take to earn the Registered Respiratory Therapist credential changes from the Written Registry Examination to the Therapist Multiple-Choice Examination (TMC). The TMC Examination is designed to objectively measure essential knowledge, skills, and abilities required of entry-level respiratory therapists, as well as determine eligibility for the Clinical Simulation Examination (CSE). Individuals who attempt and pass the Therapist Multiple-Choice Examination at the higher cut score and attempt and pass the Clinical Simulation Examination will be awarded the Registered Respiratory Therapist (RRT) credential.

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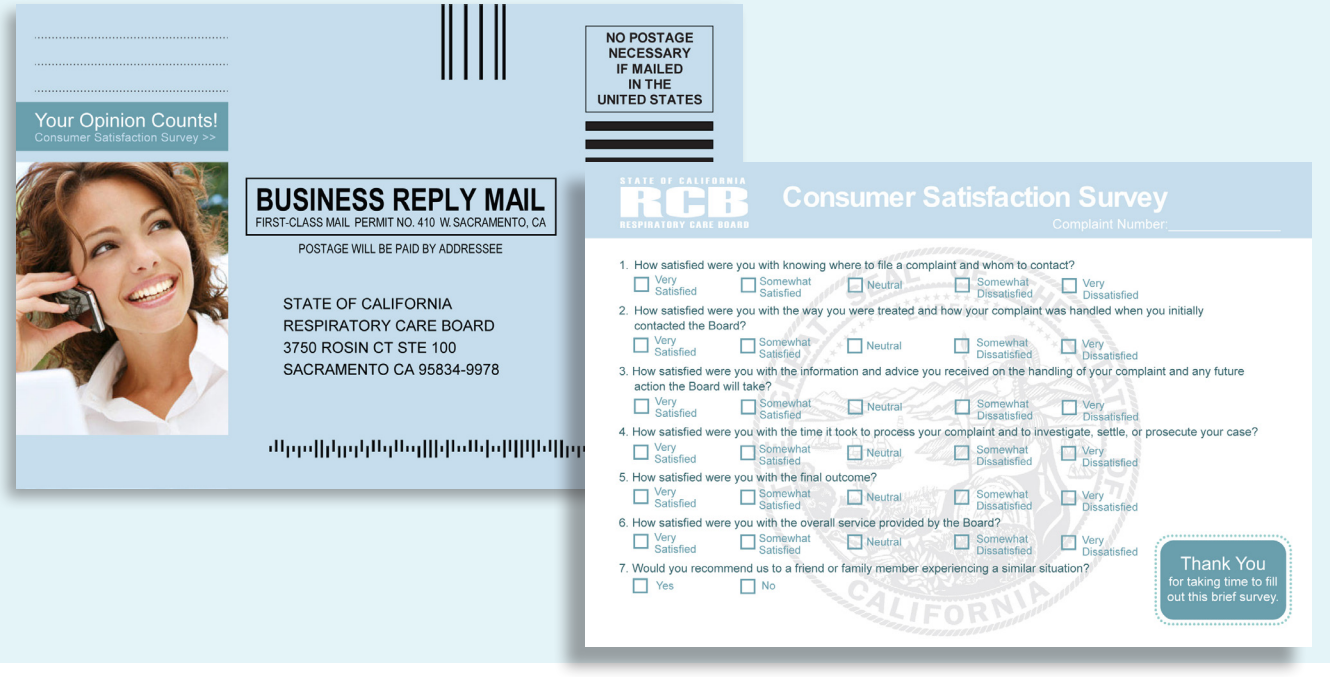
CUSTOMER SERVICE FEATURES AND CORE PHILOSOPHIES

The Board has the following features and has 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 the Board's website for consumers, licensees, and applicants to complete online.
- **Enforcement Performance Measures:** In 2010, the Board, in concert with DCA, began compiling and reporting "average days" to complete various aspects of the enforcement process.
- **Licensing Performance Measures:** In 2015, the Board, together with the DCA, established target times to process initial applications for licensure.
- **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.

Overall, the Board averaged a 3 or higher (on a scale from 1 to 5) for all questions with the exception of one. Question number 4, concerning the time it took from start to finish a case received a 2.7 in FY 12/13 and overall holds the lowest ratings. However, the ratings did increase each year thereafter.

Table 2a. Consumer Satisfaction (Complaint Handling/Resolution) Survey Results	**FY 12/13**	**FY 13/14**	**FY 14/15**	**FY 15/16**
NUMBER OF SURVEYS RETURNED	**3**	**13**	**5**	**3**
1. How satisfied were you with knowing where to file a complaint and whom to contact?	100%	100%	100%	100%
Average Rating (Scale 1-5)	4.3	4.8	5.0	5.0
2. How satisfied were you with the way you were treated and how your complaint was handled when you initially contacted the Board?	100%	92%	100%	100%
Average Rating (Scale 1-5)	4.0	4.3	5.0	4.7
3. How satisfied were you with the information and advice you received on the handling of your complaint and any future action the Board will take?	67%	100%	100%	67%
Average Rating (Scale 1-5)	3.7	4.2	5.0	4.0
4. How satisfied were you with the time it took to process your complaint and to investigate, settle, or prosecute your case?	33%	69%	60%	67%
Average Rating (Scale 1-5)	2.7	3.5	3.6	4.0
5. How satisfied were you with the outcome?	67%	92%	80%	67%
Average Rating (Scale 1-5)	3.7	4.3	4.4	3.7
6. How satisfied were you with the overall service provided by the Board?	67%	100%	100%	100%
Average Rating (Scale 1-5)	3.3	4.5	4.8	4.7
7. Would you recommend us to a friend or family member experiencing a similar situation?	100%	92%	100%	100%
Average Rating (Scale 1-5)	5.00	4.7	5.0	5.0

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: 63% to 100%
Consumers: 0% to 100%
Licensees: 62% to 91%

Table 2b. Online Survey Summaries	FY 12/13	FY 13/14	FY 14/15	FY 15/16
APPLICANTS				
Number of Responses	8	1	1	3
Courtesy	88%	100%	100%	50%
Responsiveness	63%	100%	100%	33%
Knowledgeable	89%	100%	100%	50%
Accessibility	86%	100%	100%	33%
Overall Satisfaction	**63%**	**100%**	**100%**	**67%**
CONSUMERS				
Number of Responses	0	1	1	2
Courtesy	0%	100%	100%	100%
Responsiveness	0%	100%	100%	50%
Knowledgeable	0%	100%	100%	100%
Accessibility	0%	100%	100%	50%
Overall Satisfaction	**0%**	**100%**	**100%**	**100%**
LICENSEES				
Number of Responses	22	13	15	20
Courtesy	95%	83%	87%	85%
Responsiveness	90%	83%	87%	85%
Knowledgeable	90%	82%	87%	85%
Accessibility	91%	64%	87%	84%
Overall Satisfaction	**91%**	**62%**	**87%**	**82%**

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 over the last four fiscal years.

Table 2c. Enforcement Performance Measures

	Volume (in days)	Intake (in days)	Intake and	Formal Discipline (in days)	Probation Intake (in days)	Probation Violation Response (in days)
TARGETS (in days)	**-**	**7**	**210**	**540**	**6**	**10**
FY 12/13						
Quarter 1: July - Sept. 2012	242	2	97	662	1	2
Quarter 2: Oct. - Dec. 2012	187	3	107	657	2	1
Quarter 3: Jan. - Mar. 2013	205	3	104	536	2	1
Quarter 4: Apr. - June 2013	228	4	87	459	2	2
FY 13/14						
Quarter 1: July - Sept. 2013	221	2	104	581	1	2
Quarter 2: Oct. - Dec. 2013	196	2	134	529	2	2
Quarter 3: Jan. - Mar. 2014	219	2	87	585	2	2
Quarter 4: Apr. - June 2014	221	2	114	570	1	2
FY 14/15						
Quarter 1: July - Sept. 2014	219	2	94	732	2	1
Quarter 2: Oct. - Dec. 2014	247	2	67	642	2	2
Quarter 3: Jan. - Mar. 2015	193	2	102	489	1	1
Quarter 4: Apr. - June 2015	201	2	83	568	2	3
FY 15/16						
Quarter 1: July - Sept. 2015	213	2	86	475	3	1
Quarter 2: Oct. - Dec. 2015	194	2	102	597	1	3
Quarter 3: Jan. - Mar. 2016	188	1	79	528	2	1
Quarter 4: Apr. - June 2016	233	2	81	539	2	2

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.

FUND CONDITION

The Board's fund condition (Table 3a) shows that at the end of FY 2013–14 the Board had a balance of $2,612,000, or 9.2 months in reserve. However, future years show a dramatic increase in costs and decline in the months in reserve based on projected annual authorized expenditures. In fact, it is projected that the Board will be facing a deficit by FY 2018/19 if expenditures continue at the same level.

Over the course of four years, from FY 2012/13 to FY 16/17, expenditures jumped nearly 33% from $2,691,000 to $3,552,000, respectively. This increase is primarily attributed to the cost of BreEZe, the Board's Workforce Study, statewide salary increases and benefits and a reduction in reimbursements.

The final cost of the Workforce Study is expected to be $175,000—a one-time cost that has and will be paid for out of FY 2014–15, FY 2015–16, and FY 2016–17 budgets.

Statewide salary increases over the last four years included a 3% increase effective July 1, 2013, 2% increase effective July 1, 2014, and a 2.5% increase effective July 1, 2015. In addition, the Board has seen a $40,000 a year increase, each year, in healthcare costs since FY 2012/13. Statewide salary increases and healthcare costs affect the budget in many areas from personnel services at the Board, as well as statewide and DCA pro rata and Office of the Attorney General expenses.

Reimbursements tied to cost recovery have also seen a dip from $206,000 in FY 12/13 to $144,000 in FY 15/16. This may largely be associated with full costs not being ordered by the Office of Administrative Hearings and the reduction in the number of new probationers.

In October 2016, the Board learned its BreEZe costs for FY 16/17 – FY 18/19 with estimated future charges as follows:

FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17	FY 17/18	FY 18/19	FY 19/20	FY 20/21	FY 21/22	FY 22/23
$ 28,149	$95,950	$104,558	$223,397	$216,950	$212,950	$198,950	$127,146	$113,079	$103,439	$74,521

As a result of all of the increases in expenditures, the Board moved at its October 2016 meeting to increase its renewal fee effective July 1, 2017 by way of regulation. 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 remained at $230 for nearly 15 years. Further, there have been no changes made to fees in the last four years. However, a slight increase in revenues is still noticed, that is primarily attributed to a greater number of licensees maintaining their license (renewal fee). The Board believes this fee increase will maintain fund solvency through FY 18/19 and will revisit the need for an additional fee increase in October 2017.

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... ."

Table 3a. Fund Condition

(DOLLARS IN THOUSANDS)	FY 2012/13 ACTUAL	FY 2013/14 ACTUAL	FY 2014/15 ACTUAL	FY 2015/16 ACTUAL	FY 2016/17 PROJECTED	FY 2017/18 PROJECTED
Beginning Balance	$2,401	$2,596	$2,612	$2,432	$1,795	$1,243
Adjusted Beginning Balance	$2,412	$2,672	$2,660	$2,497	-	-
Revenues and Transfers	$2,688	$2,711	$2,709	$2,710	$2,724	$2,807
Total Revenue	$5,100	$5,383	$5,369	$5,208	$4,519	$4,050
Budget Authority	$3,189	$3,315	$3,566	$3,844	$3,799	$3,799
Expenditures	$2,691	$2,922	$3,074	$3,552	$3,420	$3,799
Disbursements[1]	$17	$14	$3	$5	-	-
Reimbursements	($206)	($166)	($140)	($144)	($144)	($144)
Fund Balance	$2,596	$2,612	$2,432	$1,795	$1,243	$395
Months in Reserve	9.7	9.2	7.8	5.8	3.8	1.2

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

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.

Section 3:
Fiscal Issues and Staffing

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 64% for both FY 2012–13 and FY 2013–14, 62% of FY 2014–15 and 61% of FY 2015–16 total Board expenditures. Expenditures for the Licensing/Examination Program consisted of 16% of FY 2012–13 and 15% of the total expenditures for the following years, followed by the Administration Program expenditures consisting of 7–8% of the total expenditures for each year. Meanwhile, DCA Pro Rata increased from 12% in FY 12/13 to 17% in FY 15/16 to each year's total expenditures.

While there was fluctuation in actual expenditures in each program area, the percentages of the overall expenditures for each year were relatively the same. The most notable changes are seen in DCA pro rata and personnel services (salaries, health insurance) which have steadily increased each year, consuming more of the Board's overall budget.

Table 3b. Expenditures by Program Component

Program Area	FY 12/13		FY 13/14		FY 14/15		FY 15/16		AVG %
	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E	
Enforcement	$870,012	$865,479	$1,004,648	$861,981	$1,037,731	$872,324	$1,073,311	$1,096,805	**63%**
Licensing/ Exam	$303,186	$125,610	$325,033	$110,883	$340,747	$123,002	$367,484	$153,935	**15%**
Administration	$145,001	$60,075	$147,743	$50,402	$170,374	$61,501	$171,918	$66,928	**7%**
DCA Pro Rata	-	$322,251	-	$421,624	-	$469,270	-	$621,168	**15%**
TOTALS	**$1,318,199**	**$1,373,415**	**$1,477,424**	**$1,444,890**	**$1,548,852**	**$1,526,097**	**$1,612,713**	**$1,938,836**	

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 are current in the Board's regulations §1399.395 (CCR, Title 16, Division 13.6).

Over the last ten years, the Board's fees have remained fairly steady. The only fee changes made in the last decade occurred in June 2012, 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 all application types.
- 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.

Table 3c. Fee Schedule and Revenue

FEE	Current Fee Amount	Statutory Limit	FY 12/13 Revenue	%	FY 13/14 Revenue	%	FY 14/15 Revenue	%	FY 15/16 Revenue	%
Duplicate License	$25	$75	$2,375	< 0.1%	$3,050	< 0.1%	$3,250	< 0.1%	$3,475	0.1%
Endorsement Fee	$25	$100	$11,145	0.4%	$12,640	0.4%	$13,350	0.4%	$13,125	0.4%
Initial License Fee[1]	$0	$300	$0	-	$0	-	$0	-	$0	-
Examination Fee	$190 - $390	actual cost	$0	-	$380	<0.1%	$0	-	$0	-
Re-Examination Fee	$150	actual cost	$0	-	$0	-	$0	-	$0	-
Application Fee	$300	$300	$450,405	16.7%	$421,651	15.5%	$364,154	13.4%	$322,700	11.9%
Application Fee (OOS)	$300	$300	$46,200	1.7%	$46,000	1.6%	$49,000	1.7%	$52,550	1.9%
Application Fee (Foreign)	$300	$350	$300	< 0.1%	$600	< 0.1%	$600	< 0.1%	$300	< 0.1%
Biennial Renewal Fee	$230	$330	$2,079,015	77.3%	$2,119,411	78.1%	$2,156,050	79.5%	$2,165,949	79.9%
Delinquent Fee (<2 yrs)	$230	$330	$38,180	1.4%	$40,250	1.4%	$61,385	2.2%	$83,790	3%
Delinquent Fee (>2 yrs)	$460	$660	$7,360	0.2%	$1,150	< 0.1%	$1,380	< 0.1%	$1,840	< 0.1%
Citation and Fine	varies	$15,000	$24,701	0.9%	$23,593	0.8%	$30,469	1.1%	$38,176	1.4%
Enf. Review Fee	varies	actual cost	$19,382	0.7%	$20,221	0.7%	$14,410	0.5%	$11,746	0.4%
Reinstatement Fee	$300	$300	$1,400	< 0.1%	$300	< 0.1%	$0	-	$0	-
Miscellaneous [2]	-	-	$7,972	0.2%	$22,035	0.8%	$15,860	0.5%	$16,847	0.6%
TOTAL REVENUE			**$2,688,435**		**$2,711,281**		**$2,709,308**		**$2,710,498**	

[1] Effective 6/24/12: Initial licensing fee eliminated.

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

Section 3:
Fiscal Issues and Staffing

BUDGET CHANGE PROPOSALS

In 2013, the Board submitted two BCPs requesting a total of five positions. BCP 1110-39 requested three additional staff to address a trend of increasing number of initial applications received and to assist with continuing education (CE) audits. This BCP was not approved. However, immediately following this request, the Board changed its examination required for licensure which resulted in a decrease in initial applications, returning workload to a manageable level.

BCP 1110-38 requested two additional staff. One AGPA was requested to address workload associated with mandatory reporting and consumer complaints. The other AGPA was requested to begin a new in-house program that would have prepared pleadings, stipulated settlements, and default decisions in their final format for the Office of Attorney General final approval. The goal was to reduce time and costs. Unfortunately, the only position approved was the AGPA needed to address increased workload associated with mandatory complaints. This staffing increase has continued to provide the Board with adequate resources to 1) maintain authority and control over its most complex investigations; 2) distribute workload appropriately; 3) allow in-house investigators to develop expertise in the types of cases they are frequently assigned; and 4) increase the number of investigations completed efficiently.

Table 3d. Budget Change Proposals (BCPs)

BCP ID #	Fiscal Year	Description of Purpose of BCP	Personnel Services				OE&E	
			Staff Requested	Staff	**Funds	**Funds	**Funds	**Funds
1110-38	14/15	Enforcement Workload: The Board requested a permanent ongoing staff increase of 2.0 positions to perform desk investigations, prepare pleadings and negotiate stipulated settlements and default decisions in less complex disciplinary cases.	2.0 AGPA	1.0 AGPA	$179	$89	$26	$15
1110-39	14/15	Licensing Workload: The Board requested 3.0 positions to adequately perform all aspects of the licensing program functions.	3.0 PYs 1 SSA 1 MST 1 OT (T)	0	$188	$0	$42	$0

*AGPA - Associate Governmental Program Analyst
** Numbers are in thousands.

STAFFING

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. Sixteen of the Board's current 18 staff were employed at the Board during its last Sunset Review in 2012. Organizational charts for the last four fiscal years can be found on pages 88–91.

Over the last four fiscal years, the Board has spent approximately $1,500 on training and education. Costs are associated with courses taken outside of DCA such as the Certified Professional Collector Program, a course our probation monitors take to maintain certification in collecting specimens for drug testing. However, staff have also participated in numerous courses, free of (direct) charge, offered through DCA. All staff training over the last four fiscal years includes:

First Aid/CPR/AED—10 Staff
Basic Project Management—3 Staff
Certified Professional Collector Program—2 Staff each year
Completed Staff Work—3 Staff
DCA Enforcement Academy—2 Staff
Delegated Contracts Training—3 Staff
Effective Business Writing—3 Staff
Effective Public Speaking—1 Staff
HR Liaison Training—1 Staff
Interpersonal Skills for Analyst—3 Staff
Interviewing Techniques for Investigators—1 Staff
Investigation Subpoena Training—4 Staff
NC State Board Dental Examiners vs. Federal Trade Commission—1 Staff
Planning Your Retirement—1 Staff
Presentation Skills for Analyst—3 Staff
Research Analysis & Problem Solving—3 Staff

In addition, the following courses must be completed by all or some staff and Board members annually or biennially: Sexual Harassment Prevention Training; Information Security Awareness; Ethics Training, and Defensive Driving.

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LICENSEE POPULATION

Since the Board's inception in 1985, it has issued over 38,000 licenses. As of June 30, 2016, the Board had 20,337 active and current licensees and an additional 2,878 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 July 30, 2016, the number of ACTIVE licensees with an address of record "Out-of-State" and "Out-of-Country" were 871 and 11, respectively.

Table 4a. Licensee Population

		FY 12/13	FY 13/14	FY 14/15	FY 15/16
Respiratory Care Practitioner	**Active**	19,833	20,435	21,037	20,337
	Out-of-State	Not Tracked	Not Tracked	Not Tracked	Not Tracked
	Out-of-Country	Not Tracked	Not Tracked	Not Tracked	Not Tracked
	Delinquent	1,640	1,718	1,764	2,878

APPLICATION PROCESSING TIMES

The Board strives to process applications for licensure as quickly as possible. As of June 30, 2012, the average cycle time to process a complete application from date of receipt to date of licensure was 67 days. As of June 30, 2016, the average cycle time is 4 days.

Licensing Performance Targets

	Target Processing Time	FY 15/16 Actual Processing Time
Complete Applications	60 days	4 days
Incomplete Applications	365 days	23 days

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 (and increasing its application fee to balance revenues).

On the following page, Tables 4b and 4c illustrate 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., 483 pending compared to 1,275 received in FY 2015–16). 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.

INITIAL LICENSURE AND RENEWALS

The Board currently issues approximately 1,100 new, and renews approximately 9,300 licenses each year. The following tables demonstrate a decline in the number of initial applications received. The Board believes this continuing decline is temporary and a direct result of increasing the level of its competency examination required for licensure.

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)		
								Incomplete Apps	Combined if unable to separate out
FY 13/14	License/Exam	1,560	1,422	118	1,422	-	-	-	49
	Renewal	9,215	9,170	N/A	9,170	-	-	-	-
FY 14/15	License/Exam	1,392	1,180	176	1,180	483	-	-	57
	Renewal	9,374	9,251	N/A	9,251	-	-	-	-
FY 15/16	License/Exam	1,275	1,146	208	1,146	483	4	23	-
	Renewal	9,417	9,367	N/A	9,367	-	-	-	-

Table 4c. Total Licensing Data

	FY 2013/14	FY 2014/15	FY 2015/16
Initial Licensing Data			
Initial License/Initial Exam Applications Received	1,560	1,392	1,275
Initial License/Initial Exam Applications Approved	1,422	1,180	1,146
Initial License/Initial Exam Applications Closed	118	176	208
License Issued	1,422	1,180	1,146
Initial License/Initial Exam Pending Application Date			
Pending Applications (total at close of FY)	-	483	483
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE)			
Average Days to License Issued (All - Complete/Incomplete)	49	57	23
Average Days to License Issued (Incomplete applications)	-	-	-
Average Days to License Issued (Complete applications)	-	-	4
License Renewal Data			
License Renewed	9,170	9,251	9,367

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 Justice 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 notifies the Department of Justice (DOJ) that it is no longer interested in receiving this follow-up information once a license is cancelled, deceased, retired, surrendered or revoked or an application is denied or abandoned.

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). Since the last Sunset Report in 2012, the Board has tackled the backlog that consisted of approximately 8,000 records that were cancelled prior to July 1, 2005, that still needed to have the "No Longer Interested" notification sent to DOJ. The Board is current and up-to-date in notifying DOJ of all records the Board no longer has jurisdiction over.

The Board's application also includes very specific background questions for the rare occasion in which an event is not captured by other means. The Board takes a tough stance against any type of perjury, and discourages 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.

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.

Applicants with education from Canada must complete an education program recognized by the Canadian Board of Respiratory Care (§3740 (d) of the B&P).

Applicants with foreign education (with the exception of Canada) must have their education evaluated by an approved respiratory program to determine if their education is equivalent to

requirements for all other applicants. Applicants may receive full equivalency or may be required to take some additional education to achieve equivalency (Reference, §3740 (c) of the B&P).

MILITARY APPLICATIONS

The Board has always held those who have or continue to serve as members of the U.S. military in the highest esteem. The Board recognized military experience via regulation in 2004 and has always put forth additional service to military members and their families, understanding sometimes the very quick turnaround time they are faced with after receiving new orders. In fact, staff have, in several cases, took it upon themselves (instead of the applicant) to contact other state licensing agencies or the national examination provider to obtain necessary verifications to assist military personnel and their spouses in obtaining licensure.

Following is legislation that has been passed since 2010 relating to the handling of applications or licenses for occupations for military personnel.

AB 2783 (statutes of 2010) - Section 35 of the Business and Professions Code was amended to include "and the Military Department" as an agency that shall be consulted when a board provides rules and regulations for methods of evaluating education, training, and experience obtained in the armed services.

AB 1588 (statutes of 2012)—Section 144.3 was added to the Business and Professions Code and provides that every board shall waive renewal fees, continuing education requirements and other renewal requirements, as applicable, for any licensee called to active duty.

AB 1904 (statutes of 2012)—Section 115.5 was added to the Business and Professions Code and provides that the board shall expedite the licensure process for an applicant that is in a legal union with an active duty member of the Armed Forces and holds a current similar license in another state.

AB 1057 (Statutes of 2013)—Section 114.5 was added to the Business and Professions Code and provides that every board shall inquire in every application for licensure if the individual applying for licensure is serving in or has previously served in the military.

SB 1155 (2016)—This bill would add section 114.6 to the Business and Professions Code to waive an initial application fee for any individual who is an honorably discharged veteran. *[The Board issued a letter of support to the Honorable Mike Morrell on April 6 ,2016].*

The Board has promulgated regulations to recognize military experience and also in consideration of many legislative bills previously mentioned. The following additions can be found in the California Code of Regulations, Title 16, Division 13.6:

§1399.330. Education Waiver Criteria was added in 2004 recognizing military education and experience in lie of meeting the current associate degree education requirement.

§ 1399.329. Military Renewal Application Exemptions was added in 2015 to clarify that the renewal fee and continuing education units required for renewal are prorated or waived for any person called to active duty, pursuant to AB 1588 (statutes of 2012).

The Board found that AB 1904 and AB 1057 were very straight forward and no additional clarification was necessary.

In January 2013, the Board began tracking applicants who indicate they are in a legal union with an active duty member of the Armed Forces. The Board has had 30 applicants (through June 30, 2016) that have indicated such union. All 30 applicants were expedited. Below is an e-mail from the husband of one applicant thanking staff for her efforts:

> From: [Lieutenant Jr. Grade]
> Sent: Friday, October 24, 2014 3:53 PM
> To: Molina, Christine@DCA
> cc: [omitted for privacy]
> Subject: Expedited Processing
>
> Ms. Molina,
>
> I cannot thank you enough for your actions on [applicant's] and my behalf. Your swift response in helping us process her application has resulted in putting her in the workforce literally the same day you e-mailed with her license number, and only two days after sending my first e-mail requesting assistance. That is an unbelievably fast turnaround and is very, very appreciated.
>
> Thank you on behalf of our family and professionally as a service member. Spousal employment is a large challenge when a family serves in the armed forces and your expedited processing speaks volumes as to the support your office and you personally give to us.
>
> Thank you so much again and please consider yourself a friend of the [applicant] household.
>
> Very Respectfully,
> ~ [Applicant's husband], LTJG
> United States Coast Guard
> Search and Rescue Pilot

In August 2014, the Board began asking applicants for initial licensure if he/she is serving or has ever served in the military. In FY 14/15, the Board received 33 affirmative responses and in FY 15/16, the Board received 68 affirmative responses. All of these applicants have been approved for licensure.

In August 2015, the Board began asking licensees on their renewal forms, if he/she serves or has served in the military. Since then, a total of 1,021 applicants and licensees have been identified as having current or prior military service.

Since July 1, 2014, the Board has received 22 applications that included military education, experience, and training. One of these applications was granted a "waiver" pursuant to CCR §1399.330. All 22 were approved for licensure. The Board has no record of ever denying an applicant who requested an education waiver based on military education and experience.

Section 4:
Licensing Program

However, as it relates to license renewals, the Board has not had an instance brought to its attention, in which military members have been called to active service and inquired if fees or continuing education could be waived (pursuant to AB 1588, Statutes of 2012). It is surmised based on the data received thus far, that the impact on revenues would be insignificant.

EXAMINATION

Effective January 1, 2015, the Board began using the advanced respiratory credentialing examination as its licensing examination to test competency prior to licensure (AB 1972, Statutes of 2014). An applicant must successfully pass both the National Board for Respiratory Care's (NBRC's) "Therapist Multiple-Choice Examination" and the "Clinical Simulation Examination" to qualify for licensure as an RCP.

The Therapist Multiple-Choice 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: 1) patient data evaluation and recommendations, 2) troubleshooting and quality control of equipment and infection control, and 3) initiation and modification of interventions.

The Clinical Simulation Examination is designed to objectively measure essential knowledge, skills, and abilities required of advanced respiratory therapists. The Clinical Simulation Examination consists of 22 problems (20 scored items and 2 pretest items). The clinical setting and patient situation for each problem are designed to simulate reality and be relevant to the clinical practice of respiratory care, clinical data, equipment, and therapeutic procedures.

The NBRC also offers voluntary credentials upon passage of each exam, the Certified Respiratory Therapist for passage of the Therapist Multiple-Choice Examination and the Registered Respiratory Therapist exam for passage of the Clinical Simulation Examination. While passage of the RRT examination is required for licensure, holding the actual credential is not, though the RRT credential is required for various reimbursements and is recognized by the medical community.

Table 4d. Examination Data		
NATIONAL EXAMINATION FOR LICENSURE AS A RESPIRATORY CARE PRACTITIONER		
	Exam Title	**Certified Respiratory Therapist Exam**
FY 12/13	Number of First Time Candidates	1,555
	Pass %	79%
FY 13/14	Number of First Time Candidates	1,340
	Pass %	82%
FY 14/15 1/2 year from 7/1-12/31	Number of First Time Candidates	559
	Pass %	79%
Effective January 1, 2015, the Board established the Registered Respiratory Therapist (RRT) as the minimum exam requirement for licensure. The RRT is comprised of two parts: the Therapist Multiple Choice written exam and the Clinical Simulation exam. Prior to January 1, 2015, applicants were only required to take and pass a single Certified Respiratory Therapist written exam.		
	Exam Title	**RRT- Part I Written Exam**
FY 14/15 1/2 year from 1/1-6/30	Number of First Time Candidates	574
	Pass %	78%
FY 15/16	Number of First Time Candidates	1206
	Pass %	74%
	Exam Title	**RRT- Part II Clinical Simulation**
FY 14/15 1/2 year from 1/1-6/30	Number of First Time Candidates	486
	Pass %	59%
FY 15/16	Number of First Time Candidates	1,083
	Pass %	57%
	Date of Last Occupational Analysis	**2012**[1]
	Name of Occupational Analysis Developer	**National Board for Respiratory Care**
	Target Occupational Analysis Date	**2017**

[1] New test specifications as a result of the 2012 occupational analysis were introduced in January 2015.

The NBRC exams are administered in English on a daily basis and candidates are not permitted to consecutively repeat an examination form previously taken. Applicants may apply to take the examination online or via paper application. Upon verification of meeting entry requirements, applicants may schedule themselves to sit for either examination at one of 15 locations throughout California. Applicants are given three hours to complete the Therapist Multiple Choice

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Licensing Program

Exam and 4 hours to complete the Clinical Simulation Exam (exceptions are made in accordance with the ADA). Once applicants have completed the examination, they are notified immediately of the results. Those results are then shared with the Board on a weekly basis.

Since the implementation of the higher level examination on January 1, 2015, the pass rates for first-time takers averages around 76% for the written exam and 58% for the clinical exam. The pass rate for repeat takers averages 33% for the written exam and 42% for the clinical exam.

The NBRC is sponsored by the American College of Chest Physicians, the AARC, the American Society of Anesthesiologists, and the American Thoracic Society. It is a voluntary health certifying board that 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 Therapist Multiple Choice Exam and the Clinical Simulation Exam (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 38 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. Otherwise, 37 schools in California offer an associate degree in respiratory care and three schools, Loma Linda University, Skyline College and Modesto Jr. College, offer a baccalaureate degree in respiratory care. Two of these three schools are community

colleges that were approved for a pilot program to issue baccalaureate degrees pursuant to SB 850 (statutes of 2014).

Board staff review each respiratory care program and school one to two times annually to verify 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 38 programs are accredited by CoARC; 24 are accredited by the Western Association of Schools and Colleges (WASC), and the remaining 14 are accredited by an agency recognized by the USDOE and are approved by the BPPE. Other respiratory care programs' and schools' accreditation statuses are verified as they are presented. The Board does not have any legal requirements regarding approval of international schools.

CoARC accredits programs in respiratory care that have undergone a rigorous process of voluntary peer review and have met or exceeded the minimum accreditation standards. The CoARC reviews schools annually and performs full-level reviews and site visits once every ten years.

In May 2014, the Board and the BPPE entered into a Memorandum of Understanding to actively share information about schools with respiratory care programs as well as share resources for investigations or compliance inspections, as appropriate.

Further, as a consumer protection benefit, the Board posts the annual exam pass/fail rates for all California programs on its website. The success rate can be an important factor when a student is selecting a program from among various programs offered within the same geographical area.

CONTINUING EDUCATION

Every two years, an active RCP must complete 15 hours of approved CE. Two-thirds of the continuing education 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).

In 2015, the Board promulgated regulations to increase the number of CE hours from 15 to 30 each renewal cycle. Beginning with July 2017 renewals, all licensees must report a minimum of 30 hours of continuing education. This increase will provide more opportunity for licensees to expand their clinical expertise and ultimately provide greater consumer protection. The Board plans to look at this issue further after the completion of its Workforce Study to determine if there are additional benefits to further increasing the number of continuing education hours and/or establishing additional curricular requirements.

Since the Board was last reviewed, the regulations surrounding CE have been amended as follows:

> **§ 1399.350. Continuing Education Required** was amended to increase the number of continuing education hour required for the renewal of a license from 15 to 30 hours (as permitted in section 3719 of the B&P).

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Licensing Program

§ 1399.351. Approved CE Programs was amended to update respiratory-related credentialing examinations that qualify for continuing education and recognize courses in the assessment and treatment of the acquired immune deficiency syndrome (AIDS) as provided for in Section 32 of the B&P.

§ 1399.352. Criteria for Acceptability of Courses was amended to recognize preparation courses for the advanced level credential as qualified continuing education.

Currently, each course or provider shall hold approval from one of the following entities as provided in §1399.352 of the CCR:

(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.

Since 2006, each licensee is required 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 two-thirds of the required hours must be directly related to clinical practice. Licensees may also count up to one-third of the CE hours required, from 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 or advance 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) Adult Critical Care Specialty Exam (ACCS).
(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)
(9) Sleep Disorders Testing and Therapeutic Intervention Respiratory Care Specialist (SDS).

Upon renewing an RCP license, active RCPs must attest, under penalty of perjury, that they have completed the required CE hours.

The Board targets five to eight percent of its renewals for random audit. However, in January 2013, the Board ceased conducting random audits for a period of a year due to lack of staff resources. Redirection of staff to accommodate the implementation of the BreEZe database (rollout October 2013) and an Administrative directive to reduce banked vacation hours were significant contributors. Currently, the Board renews nearly 9,500 licenses each year. In FY 14/15, the Board audited 615 (6.5%) renewals and in FY 15/16, the Board audited 496 (5.2%) renewals. Of those, 12 (2%) failed the audit in FY 14/15 and 11 (2%) failed in FY 15/16.

Table 4e. CE Audits Performed/Failed

	FY 12/13	FY 13/14	FY 14/15	FY 15/16
Renewals Audited	240	308	615	496
Failed	6	7	12	11

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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. 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 in which 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.

5:

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 Respiratory Care Practice Act (RCPA). The enforcement program is key to the Board's success in meeting its mandate and highest priority of consumer protection.

PERFORMANCE MEASURES

In 2010, the Board established performance targets for measures developed by 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 12/13	Actual FY 13/14	Actual FY 14/15	Actual FY 15/16
Intake: Average cycle time (in days) from complaint receipt to the date the complaint was assigned to an investigator.	7	3	2	2	2
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	98	110	87	88
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	583	563	604	**538**
Probation Intake: Average number of days from monitor assignment to the date the monitor makes first contact with the probationer.	6	2	1.5	2	2
Probation Violation Response: Average number of days from date violation is reported to date the assigned monitor initiates appropriate action.	10	1.5	2	2	1.5

In FY 15/16, for the first time, the Board met its "Formal Discipline" target with an average of 538 days to process a case from beginning to end. It should be noted that "Formal Discipline" includes time that cases are out of the Board's control and with the Office of the Attorney General (OAG) and the Office of Administrative Hearings (OAH).

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STATISTICAL DATA ANALYSIS

One of the greatest features of BreEZe is its ability to capture data that could not be captured through the old CAS system. As a result, the Board is able to break down data to help target those areas in need of attention.

Office of the Attorney General

Through BreEZe, the Board is now able to capture data for the time cases actually spend at the OAG. Over the last three fiscal years, cases averaged 309–371 days at the OAG. In FY 15/16, the time cases spent at the OAG dropped to 309 days from 371 the previous year. This is the primary reason the Board was able to meet its "Formal Discipline" target in FY 15/16.

The OAG appears to have made a concentrated effort to reduce the time it takes to file an accusation from the date the OAG receives a case. In FY 13/14, that time was 126 days and two years later in FY 15/16, the time was down to 106 days.

It appears the areas that could be most improved by the OAG are those times associated with processing default and stipulated decisions, which are currently taking between 5-6 months to complete after accusations have been filed. Though it should be noted that the OAG reduced its time drastically in the area of filing a stipulation after an accusation was filed from an average of 240 days in previous years down to an average of 181 days in the most recent year, FY 15/16.

Default and stipulated decisions account for 90% of the decisions processed after an accusation is filed. Cases are resolved through a stipulated settlement prior to a hearing 61% of the time. Default decisions are issued if the respondent does not file a notice of defense or fails to appear for a scheduled hearing. Default decisions account for 29% of case resolution. Only 10% of the Board's cases are brought to resolution through a hearing resulting in the issuance of an ALJ proposed decision.

Decision Type	FY 13/14	FY 14/15	FY 15/16	3 Year Average
Proposed (ALJ)	9	5	3	10%
Default	15	14	20	29%
Stipulated	34	35	34	61%
Totals	58	54	57	100%

Stipulated decisions for applicants are currently taking an average of 7.5 months to complete after statements of issues have been filed. While this time is greater than the time to file stipulations for licensees, applicants pose no risk to the public because they are not practicing, so the priority level is lower.

Average times to process proposed decisions from the date an accusation or statement of issues is filed are the most volatile with the least amount of data. While proposed decisions tied to statements of issues have taken a steady average of 220 to 280 days to complete, proposed decisions tied to accusations took 229 days in FY 13/14, 458 days in FY 14/15, and 350 in FY 15/16. Meanwhile, the number of proposed decisions processed has remained steady over this same time period. Since processing times for proposed decisions include time spent at the OAH, some of which is outside the OAG's control, and the inability to collect data on when a hearing date is chosen, it is difficult for the Board to determine where process improvements could be made.

Investigations

The overall Intake and Investigative time falls well below the Board's target of 210 days with averages between 97–115 over the last four years. These average times include a large number of desk investigations and small numbers of non-sworn and sworn investigations. Desk investigations are closed in an average of 84 days. Non-sworn and sworn investigations are closed in an average of 326 days.

Non-sworn investigations (performed in-house) have taken 291–336 days to complete over the last three years. These are the most difficult cases and generally practice-related. Sworn investigations (performed by the Division of Investigation) averaged 352–359 days to complete.

The cases used to compile the "Average Days to Close" both sworn and non-sworn investigations includes, on average, 5–90 days for the desk investigations that take place prior to being assigned to an investigator, and 40–60 days for nearly half these cases that are also sent for expert review, that occurs toward the end of an investigation.

Closer examination of the investigative processes by the Board and Division of Investigation is warranted to determine if steps can be taken to reduce the overall investigation times.

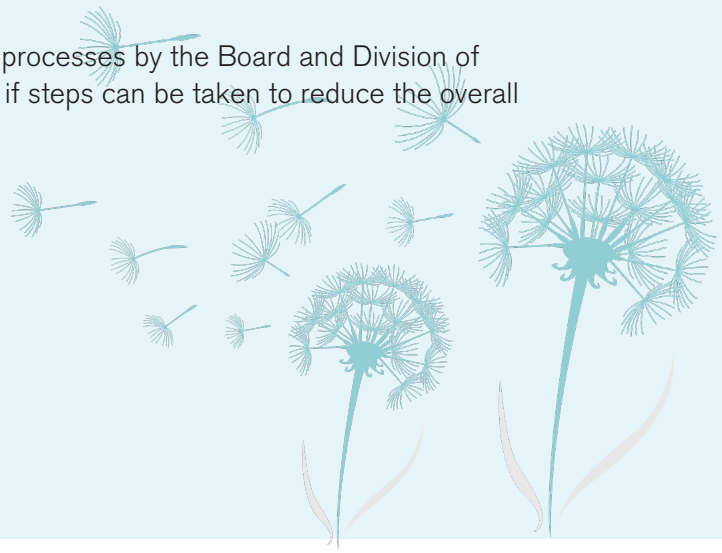

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Table 5b. Enforcement Statistics			
	FY 13/14	FY 14/15	FY 15/16
COMPLAINT			
Intake			
Received	244	326	376
Closed	18	19	18
Referred to Investigation	225	307	357
Average Time to Close or Refer to Investigation	2	2	2
Pending (close of FY)	1	0	1
Source of Complaint			
Public	17	27	17
Licensee/Professional Groups	572	623	610
Governmental Agencies	237	182	180
Other	31	28	21
Conviction/Arrest			
Conviction Received	613	534	452
Conviction Closed or Referred to Investigation	612	535	448
Average Time to Close	2	2	2
Conviction Pending (close of FY)	1	0	4
LICENSE DENIAL			
License Applications Denied	9	14	6
Statement of Issues Filed	10	6	9
Statement of Issues Withdrawn	5	2	2
Statement of Issues Dismissed	0	0	0
Statement of Issues Declined	0	0	0
Average Days to File SOI from Date Sent to AG to Date Filed	83	150	85
Average Days to File SOI - from Date Complaint Rcvd to Date Filed	374	390	356
ACCUSATION			
Accusations Filed	45	45	47
Accusations Withdrawn	0	0	0
Accusations Dismissed	0	1	1
Accusations Declined	2	5	3
Average Days to File Accusation from Date Sent to AG to Date Filed	126	120	106
Average Days to File Accusation from Date Complaint Rcvd to Date Filed	358	383	336
Pending (close of FY)	19	19	9

Table 5b. Enforcement Statistics (continued)			
	FY 13/14	FY 14/15	FY 15/16
DISCIPLINE			
Disciplinary Actions			
Proposed/Default Decisions	24	19	23
Stipulations	34	35	34
Average Number of Days from Date Sent to AG to Complete	327	371	309
Average Number of Days from Date Complaint Rcvd to Complete	563	604	538
AG Cases Initiated	67	85	58
AG Cases Pending (close of FY)	62	81	51
Disciplinary Outcomes			
Revocation	18	15	22
Voluntary Surrender	7	8	8
Suspension	0	0	0
Probation with Suspension	17	13	14
Probation	7	11	9
Public Reprimand (thru OAG and In-house)	7	3	2
Other	2	4	2
Disciplinary Action Processing Times by Decision Type in days (from date ACCUSATION filed to date decision)			
Proposed Decisions	229	458	350
Default Decisions	173	156	152
Stipulated Decisions	234	257	181
Disciplinary Action Processing Times by Decision Type in days (from date STATEMENTS OF ISSUE filed to date)			
Proposed Decisions	219	280	278
Default Decisions	0	0	0
Stipulated Decisions	185	288	226
PETITIONS			
Petitions to Modify Probation			
Granted	0	0	0
Denied	0	0	0
Petitions to Terminate Probation			
Granted	4	5	3
Denied	4	1	1
Petitions for Reinstatement of License			
Granted	0	1	1
Denied	1	1	1

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Table 5b. Enforcement Statistics (continued)

	FY 13/14	FY 14/15	FY 15/16
INVESTIGATION			
All Investigations			
First Assigned	809	816	776
Closed	812	835	821
Average Days to Close (from Inv Open to Inv Closed - ALL Cases)	115	102	97
Pending (close of FY)	226	207	170
Desk Investigations			
Closed	749	756	751
Average Days to Close	97	81	75
Pending (close of FY)	162	146	130
Non-Sworn Investigation			
Closed	57	73	70
Average Days to Close (from Desk Inv to Expert Review to Inv)	291	292	336
Pending (close of FY)	58	61	40
Sworn Investigation			
Closed	6	6	0
Average Days to Close (from Desk Inv to Inv Closed)	352	359	0
Pending (close of FY)	6	0	0
COMPLIANCE ACTION			
ISOs Issued	4	0	6
PC 23 Orders Issued	7	4	2
Cease Practice Orders	41	22	20
Cease and Desist/Warning	236	214	223
Compel Examination	1	1	0
CITATION AND FINE			
Citations Issued	79	80	77
Average Days to Complete	189	142	129
Amount of Fines Assessed	$65,950	$34,600	$44,538
Reduced, Withdrawn, Dismissed	$1,100	$0	$6,900
Amount Collected	$23,593	$30,469	$38,176
CRIMINAL ACTION			
Referred for Criminal Prosecution	1	3	0

Table 5b. Enforcement Statistics / Extended Probation Data			
	FY 13/14	FY 14/15	FY 15/16
New Probationers	24	24	24
Probations Successfully Completed	26	30	6
Probationers (close of FY)	69	62	66
Petitions to Revoke Probation	8	14	5
Probations Revoked	3	2	8
Probations Surrendered in Lieu of Disc Action	4	4	4
Probations Voluntary Surrendered	9	4	2
Probations Extended	1	1	0
Probationers Subject to Drug Testing (entire FY)	61	67	60
OVERALL DRUG TESTS ORDERED/POSITIVE TESTS			
Drug Tests Ordered	1,737	1,411	1,293
Positive Drug Tests	121	156	170
Number of Probationers Testing Positive	21	17	22
POSITIVE DRUG TESTS FOR BANNED SUBSTANCES			
Positive Drug Tests	20	13	8
Number of Probationers w/Positive Drug Tests	13	10	7

Extended Probation Data

SB 1441 (Statutes of 2008), created the SACC, which is 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.

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:

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

The Board has found that since July 2011 when the number of random tests ordered was significantly increased, the number of probationers testing positive for banned substances has more than doubled. In the Board's prior sunset report, the average number of probationers testing positive for banned substances was 4 probationers a year from FY 09/10 through FY 11/12. Whereas, for FY 13/14 through FY 15/16 that average was 10 probationers.

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Further analysis showed that 32% of the total number of probationers who tested positive for a banned substance, did so within the first three months of probation. A total of 61% tested positive in the first year; 25% in the second year; 14% in the third year and 0% in the fourth and fifth years of probation.

Enforcement Aging

The following table shows that 78% of cases in which formal discipline was sought were closed within two years, while 21% took two to four years to complete.

The table also shows that 83% of investigations took less than 6 months to complete, another 10% of investigations took between 6 months and a year to complete, and 6% of investigations took between one and two years to complete.

The noticeable trend in both aging for Attorney General and Investigations is that the average percentage for cases closed within the first year rose 6% for the Attorney General and 10% for Investigations compared to the average in the Board's last sunset report.

Table 5c. Enforcement Aging

	FY 12/13	FY 13/14	FY 14/15	FY 15/16	Cases	Average
Attorney General Cases (Average %)						
CLOSED WITHIN:						
0-1 Year	20	14	14	20	68	26%
1-2 Years	38	38	28	33	137	52%
2-3 Years	7	9	17	11	44	17%
3-4 Years	6	0	2	3	11	4%
Over 4 Years	1	0	0	0	1	<1%
Total Cases Closed	**72**	**61**	**61**	**67**	**261**	**100%**
Investigations (Average %)						
CLOSED WITHIN:						
90 Days	502	520	598	592	2212	67%
180 Days	177	141	98	102	518	16%
1 Year	96	96	81	62	335	10%
2 Years	46	49	54	62	211	6%
3 Years	2	6	4	3	15	<1%
Over 3 Years	0	0	0	0	0	0%
Total Cases Closed	**823**	**811**	**835**	**821**	**3290**	**100%**

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 DCA's Complaint Referral Guidelines for Investigation established in August 2016. The flowcharts on pages 56–57 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, the complaint is elevated.

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 in which:

- Acts of serious patient/consumer harm, great bodily injury, or death.
- Mental or physical impairment of licensee with potential for public harm.
- Practicing while under the influence of drugs/alcohol (including criminal convictions for the use of alcohol/drugs en route to a work shift).
- Repeated allegations of drug/alcohol abuse.
- Narcotic/prescription drug theft; drug diversion; other unlawful possession.
- Sexual misconduct whether or not with a patient.
- Physical/mental abuse of a patient.
- Gross negligence/incompetence resulting in serious harm/injury.
- Media/politically sensitive cases.
- The time to pursue a complaint pursuant to §3750.51, statute of limitations, is jeopardized.

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High Priority Complaints

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

- Prescribing/dispensing without authority.
- Unlicensed practice/unlicensed activity.
- Aiding and abetting unlicensed activity.
- Criminal violations including but not limited to prescription forgery, selling or using fraudulent documents and/or transcripts, use, possession or sale of narcotics, major financial fraud, financial elder abuse, insurance fraud, etc.
- Exam subversion where exam is compromised.
- Mandatory peer review reporting (B&P 805).
- Threat that evidence may be compromised, destroyed, or made unavailable.
- History of similar complaints.

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:

High-Level Routine Complaints

- General unprofessional conduct and/or general negligence/incompetence resulting in no injury or minor harm/injury (non-intentional act, nonlife threatening).
- Subsequent arrest notifications (no immediate public threat).
- Exam subversion (individual cheating where exam is not compromised).
- Patient abandonment.
- False/misleading advertising (not related to unlicensed activity or criminal activity).
- Applicant misconduct.

Low-Level Routine Complaints

- Unsanitary conditions.
- Failure to release medical records.

- Continuing education violations.
- Declaration and record collection (e.g., licensee statements, medical records, arrest and conviction records, employment records).
- Complaints of offensive behavior or language (e.g., poor bedside manner, rude, abrupt, etc.).
- Quality-of-service complaints.
- Complaints against licensee on probation that do not meet category 1 or 2.
- Anonymous complaints unless Board is able to corroborate that it meets category 1 or 2.
- Other minor violations that generally result in the issuance of a citation and fine or warning (e.g. failed to renew license timely and continued to work, failed to report a change of address).

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.

Section 5:
Enforcement Program

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.

(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 time frames.

UNLICENSED ACTIVITY

Unlicensed activity of respiratory care has been noticed most often in home care, sleep labs, and sub acute facilities. It can range from providing breathing treatments to more complicated tasks of manipulating ventilator settings and/or circuits.

As it pertains to polysomnography (sleep testing), RCPs practicing polysomnography, who allow their license to lapse are cited and fined by the Board. Other individuals who hold no credentials or licensure are forwarded to the Medical Board of California for appropriate discipline. SB 132 (statutes of 2009) empowered the Medical Board of California to oversee the licensure and enforcement of polysomnographic technologists.

Unlicensed practice occurring in homes (including home medical device retail facilities) and sub acute care facilities is addressed through joint efforts of the Board and the California Department of Public Health and the Department of Health Care Services. The Board has provided presentations to inspectors to familiarize them with respiratory care and shared investigative resources.

The Board may issue a citation and fine to employers as well as unlicensed or unauthorized persons practicing respiratory care. Egregious cases of unlicensed practice are sent to the appropriate district attorney for consideration to file criminal charges.

CITE AND FINE

The Board's Cite and Fine (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. The Board amended its regulations, effective July 1, 2012, to increase fine amounts to the maximum of $5,000 pursuant to §125.9 of the B&P. 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 issued an average of 79 citations and fines over the last three years. The five most common violations for which citations are issued include: 1) Driving under the influence of alcohol (with no priors); 2) Unlicensed practice; 3) CE violations; 4) Perjury, and 5) Petty theft. To be eligible for a citation and fine, no patterned behavior may exist and no child, dependent adult or animal may be neglected or involved in a crime as a victim or otherwise.

Over half 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 where fines are assessed on a sliding scale on the number of facilities or shifts worked unlicensed.

Of the 303 citations issued over the last three fiscal years, seven (2%) have appealed; Five by way of informal conferences and two by way of a hearing with an ALJ.

COST RECOVERY

In the last four fiscal years, the Board has had between 58 and 85 cases each year that had potential for cost recovery. The Board initially sought full cost recovery in all of these cases. Ultimately, in about eight 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) evidence supporting *Zuckerman vs. Board of Chiropractic Examiners* 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.

Section 5:
Enforcement Program

For FY 2013–14 through FY 2015–16, the outcomes of 184 cases in which costs were ordered, are broken down as follows:

36%	**Probation (66 Cases)**	**Average Cost $2,936**
35%	**Revocation (65 Cases)**	**Average Cost $4,779**
19%	**Surrendered (35 Cases)**	**Average Cost $3,981**
10%	**Public Reprimand (18 Cases)**	**Average Cost $1,727**

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, in which licensees are surrendering their license (19%), 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 (35%).

Cost recovery ordered averages $3,667 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).

Table 5d. Cost Recovery

	FY 12/13	FY 13/14	FY 14/15	FY 15/16
Total Enforcement Expenditures	$505,030	$519,252	$497,726	$648,387
Potential Cases for Recovery *	85	73	58	66
Cases Recovery Ordered	76	68	55	61
Amount of Cost Recovery Ordered	$250,655	$236,091	$187,241	$251,520
Amount Collected	$98,285	$77,685	$65,623	$63,105

* "Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on violation of the License Practice Act.

COLLECTION OF FINES AND COST RECOVERY

The Board employs several mechanisms to recover costs, including:

- Franchise Tax Board Intercept Program
- Renewal Hold
- Board Database Billing
- Collection Agency Contract

The Board began using the Franchise Tax Board Intercept Program in 1996. In the last four years, the Board has collected $14,000 to $21,000 each year from the Intercept Program.

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 to track all fines, cost recovery, and probation monitoring costs ordered. In 2013, the Board employed a similarly configured component in BreEZe. This system generates invoices which has been most beneficial in receiving timely payments from persons on probation or those that have been issued a public reprimand.

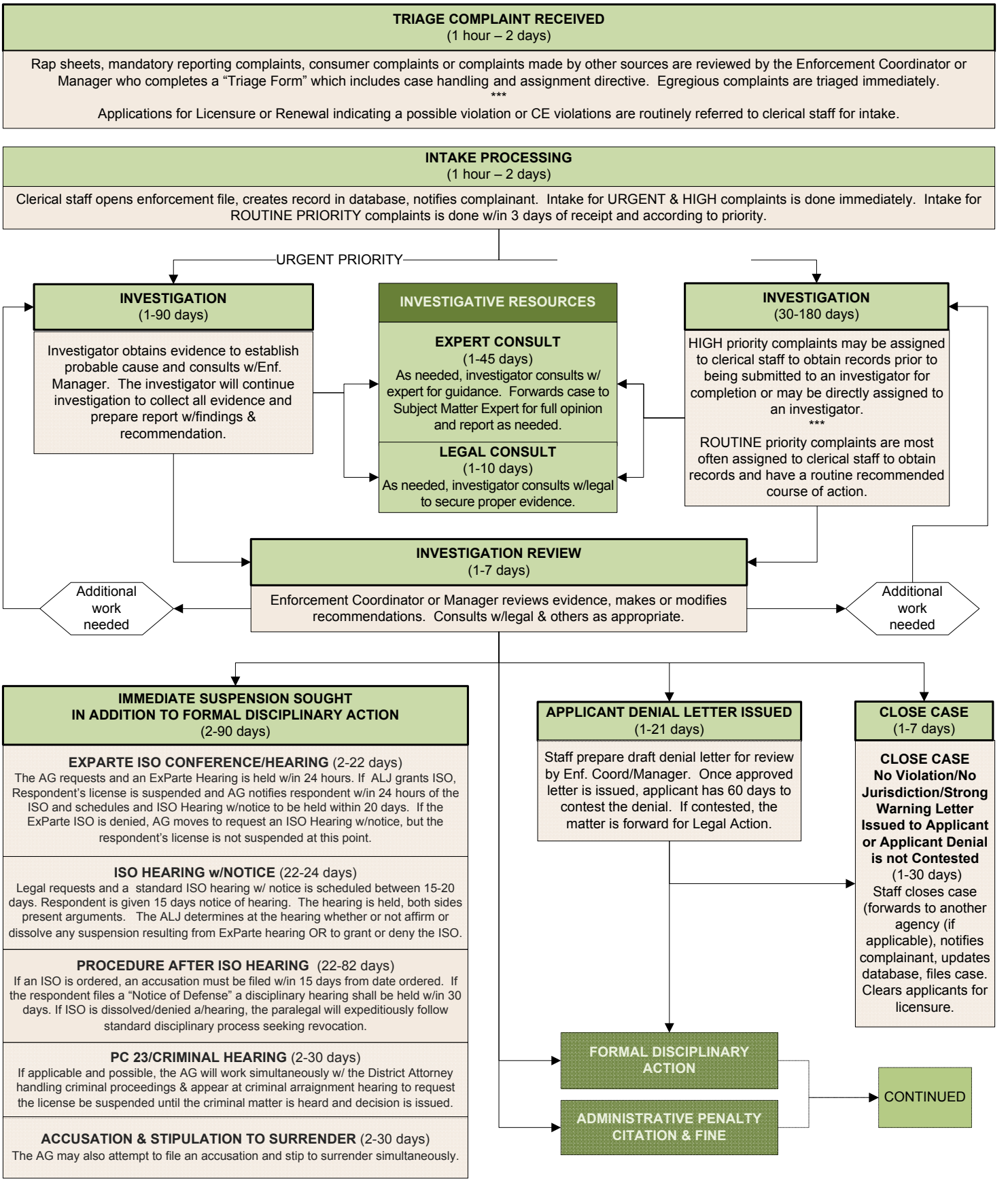
Payment schedules are usually set up on a monthly or quarterly basis, however the Board is very flexible in allowing respondents to set up different schedules, even extend the schedules, so long as a respondent is making a good faith effort to pay the costs. The Board provides regular invoices two to four weeks prior to a due date. If the respondent is a licensee who has not made any contact with the Board by the due date, a "hold" is placed on the license to prevent renewal until payment is made. Once the account is 90 days past due, a notice is issued advising the respondent that if payment is not made the account will be referred to the Franchise Tax Board's Intercept Program in 30 days. If the respondent is not a licensee and has not made contact with the Board within 90 days after a due date, a final notice is sent advising him/her that the account will be referred to the Franchise Tax Board's Intercept Program in 30 days.

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 14.9% cut of all of the costs it collects. Thus, the Board is careful to only forward to the collection agency those cases in which other avenues have been exhausted.

Respiratory Care Board of California

DISCIPLINARY PROCESS

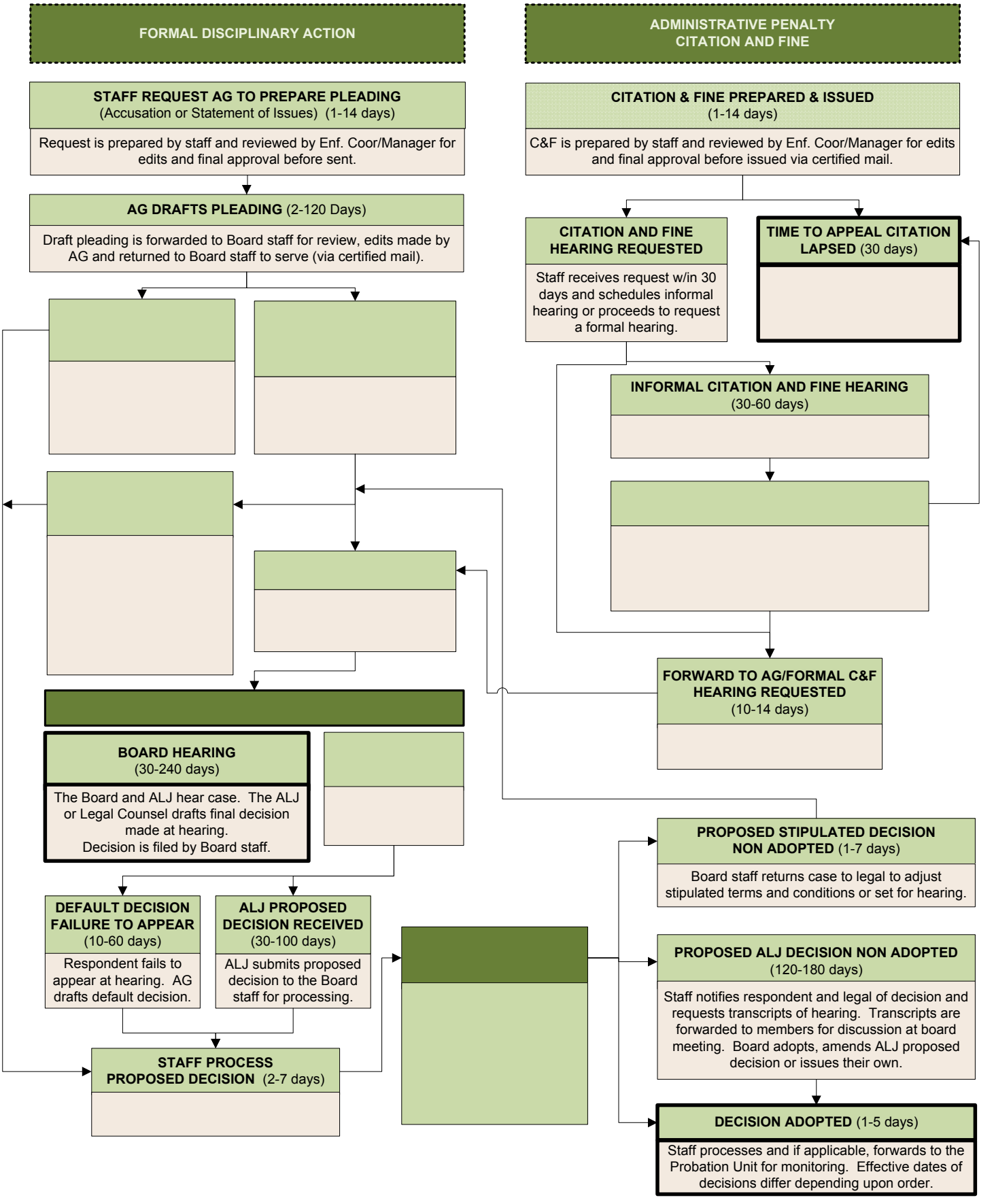
(new 1/4/12)



Respiratory Care Board of California

DISCIPLINARY PROCESS

Continued



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INTERNET

The Board has found the Internet to be an effective tool in sharing information with its stakeholders. It 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

The Board also uses an e-mail subscription feature to distribute updates, notices and special bulletins. The Board is currently redesigning its website with a tentative release date of January 1, 2017.

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 has not deleted any materials. However, as part of the website redesign, materials older than five years will be removed.

Beginning with its February 2011 meeting, the Board began using the services of DCA to webcast its meetings. The two teleconference meetings held in June of the last two years were not webcast. The webcast recordings have been available on YouTube since 2013.

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.

Every record request made pursuant to the Public Records Act for information not listed above is reviewed by the Board's legal counsel to determine which records are legally permitted to be released and or which records must be redacted. The Board receives between one and three public records act requests per year.

OUTREACH

The Board uses several methods to perform outreach. Periodically, the Board publishes and distributes a hard copy newsletter with pertinent information to all its licensees. The Board also distributes information relative to new license renewal requirements through renewal inserts and through letters sent via U.S. mail to respiratory care department managers.

In 2015, the Board increased the number of continuing education units required for renewal from 15 to 30 effective with July 2017 renewals. In July 2015, the Board began including notices in license renewals. This information was also included in the Board's May 2015 and June 2016 newsletters. Board staff also sent small posters and leaflets to respiratory department managers requesting they share the information with their RCPs.

The Board uses its website's home page and the e-mail subscription services found on its website to inform interested parties of new requirements, news, and Board activities.

Board staff also e-mail respiratory care education program directors periodically with new information relevant to the application process and requirements.

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RCPs are required to work under the supervision of a Medical Director. They do not have the authority to write prescriptions nor practice independently 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.

However, telehealth is emerging in the respiratory care field. With the passage of AB 415 in 2011, telehealth was recognized by defining certain terms and providing certain conditions. B&P §2290.5 defines "*Telehealth*" as:

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

The American Association for Respiratory Care also defines two additional terms:

"*Remote patient monitoring* is conducted via a coordinated system that uses one or more home-based or mobile monitoring devices that automatically transmit vital sign data or other information as part of a patient's plan of care wirelessly, or through a telecommunications connection to a server, allowing review and interpretation of that data by a health care professional.

Store-and-Forward Telehealth involves the acquisition and storing of clinical information (e.g. data, image, sound, video) that is then forwarded to (or retrieved by) another site for clinical evaluation (e.g., analogous to sending a picture via text message). For Medicare, this means the information would be transmitted from the originating site where the beneficiary is located to the distant site where the physician/practitioner is located for review at a later date."

Current federal legislation, H.R. 2948, the Medicare Telehealth Parity Act, proposes to cover RCPs and other health providers and various locations where services are offered, such as patients' homes. The Board expects to see an expansion of Telehealth upon the passage of H.R. 2948 specific to care provided in the home and with durable medical equipment. The Board is currently supporting this legislation as a means to make RCP expertise more readily available and to achieve greater efficiency in patient care.

WORKFORCE DEVELOPMENT

The Board continues to support data collection by the Healthcare Workforce Clearinghouse under the administration of the Office of Statewide Health Planning and Development. The clearinghouse serves as the central source of healthcare workforce and educational data in the State.

The Board had a workforce study performed in 2007. This study suggested the following supply of active RCPs needed as: 16,665 by 2015; 18,000 by 2020; 19,000 by 2025, and 21,000 by 2030. At the end of FY 15/16, California had 20,337 active licenses.

APPLICATION PROCESS RE-ENGINEERED

As reported in its 2012 sunset report, the Board re-engineered its application for licensure process in several areas to make its process less cumbersome, more efficient, and more transparent to applicants and educators. Many of the changes were a result of significant input from licensing staff and educational program directors. As a result, once an applicant fulfills all the requirements for licensure, he or she is licensed in an average of four days. Allowing applicants to enter the workforce sooner meets consumer demands and helps stimulate the economy.

The Board is currently looking forward to launching the Versa online initial application for licensure by the end of 2016. Board staff previously notified educational program directors about this component of BreEZe and its delay in implementation. Once the new online feature has been tested with a confirmed release date, program directors will be notified to share with students its availability.

BACCALAUREATE DEGREE PILOT PROGRAM

SB 850 (Statutes of 2014) authorized the Board of Governors of the California Community Colleges Chancellor's Office to establish a statewide baccalaureate degree pilot program at 15 community college districts, with one baccalaureate degree program each. Skyline College (Bay Area) and Modesto Junior College were selected to pilot respiratory care baccalaureate degree pilot programs among many interested applicants. Skyline College began its program in the fall of 2016 and Modesto Junior College will begin their program in the fall of 2017.

Increasingly, RCPs are taking on responsibilities formerly held by physicians, requiring a greater level of critical thinking and analytical skills. Education at the baccalaureate level will advance the knowledge and skills in neonatal, pediatric, and adult critical respiratory care; management; clinical practice, teaching, and research. These graduates will be highly prepared to serve as members of multidisciplinary teams in patient education and disease management of acute and chronic illnesses and to contribute to the diverse field of respiratory care.

UNIFORM STANDARDS FOR SUBSTANCE ABUSING LICENSEES

In the Board's 2012–2013 *Sunset Oversight Review Report*, the Board detailed its implementation of the Uniform Standards developed pursuant to SB 1441 (Statutes of 2008). Implementation of all applicable standards was completed in June 2012.

CONSUMER PROTECTION ENFORCEMENT INITIATIVE (CPEI)

In the Board's 2012–2013 *Sunset Oversight Review Report*, the Board detailed its implementation of proposals that were part of the CPEI. Proposals implemented by the Board prior to 2012 include:

- Providing license status and discipline on the Internet;
- Obtaining authority to recover actual costs for disciplinary proceedings as well as probation monitoring;
- Contracting with a collection agency to recover outstanding costs;
- Using in-house, non-sworn investigators;
- Granting the executive officer authority to adopt stipulated settlements to surrender a license; entering into stipulated settlements for the issuance of public reprimands;
- Immediately issuing a "cease practice" to probationers as a result of a major violation;
- Acquiring subpoena authority;
- Requiring mandatory reporting;
- Obtaining authority to deny a license for mental illness or chemical dependency;
- Utilizing the National Practitioner Databank as an additional source for background checks prior to licensure; and
- Obtaining a legislative mandate to revoke a license of any person convicted of specific sexual misconduct crimes.

BreEZe (NEW ENFORCEMENT AND LICENSING SYSTEM)

As a result of the CPEI, 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 Board was in the first rollout of BreEZe in October 2013. The system was designed to include all the elements from several other databases the Board had including the Board's cost recovery database, probation monitoring database and several tracking spreadsheets. The initial rollout was relatively smooth. There was one major function that failed and required a manual work around (e.g. fingerprint clearances), but this issue was quickly resolved and more importantly, licensees and the public were not impacted. Within the first six months of the rollout, the Board had submitted nearly 130 change requests. All of these requests were resolved to the satisfaction of the Board in a timely manner. Currently, the Board has 13 change requests pending that are less than a year old.

The highlight of the system is the on-line renewal function. Approximately 75% of licensees use the system to renew their licenses and feedback indicates they are extremely pleased this service is available.

The more recent completion of the reports module, has been an extremely beneficial tool that did not previously exist. Staff are able to extract data in so many ways allowing management to further identify strengths and weaknesses.

The Board expects to rollout its online initial application module in the near future. This will give applicants immediate access to the status of their application and any deficiencies and complete the Board's rollout of all modules.

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.

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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?

2013 Joint Committee Staff Recommendation: *The Board should provide an update of anticipated time lines, existing impediments and the current status of BreEZe.*

2013 Board Response: As a result of the Consumer Protection Enforcement Initiative, 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 case loads. 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.

Action Since 2013: The Board's BreEZe rollout took place in October 2013. The Board discovered a problem with the clearance of DOJ prints, but found other manual means to work around this problem until it was fixed shortly thereafter. Other than this, the rollout was nearly seamless. The application component is expected to rollout in the next six months.

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?

2013 Joint Committee 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.*

2013 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 U.S. 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 U.S. 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.

Section 10
Board Action and Response to 2012-2013 Sunset Oversight Review Issues

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.

Action Since 2013: In May 2014, the Board and the BPPE entered into a Memorandum of Understanding in the review and approval of respiratory care education program providers. Since the last review, the Board has not had any problems with education providers, but it remains in contact with the BPPE on various issues that come about. As previously noted, the Board also established the nationally-recognized, more "advanced" Registered Respiratory Therapist exam as the minimum requirement for licensure effective January 2015.

ISSUE #3 - CONTINUING EDUCATION AUDITS

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

2013 Joint Committee 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.*

2013 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 a 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.

Action Since 2013: In 2013, the Board submitted a BCP request for additional staffing in the FY 14/15 budget. The BCP was denied. Once the Board's resources were redirected away from BreEZe (after the transition), the Board was able to resume CE audits. Since July 2014, the Board has maintained an audit rate above 5% as noted below:

CE Audits Performed			
	FY 13/14	**FY 14/15**	**FY 15/16**
Renewals Audited	308	615	496

Section 10
Board Action and Response to 2012-2013 Sunset Oversight Review Issues

ISSUE #4 - SUBSTANCE ABUSE RECOVERY

Have Uniform Standards been adopted?

2013 Joint Committee 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.*

2013 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 [2012-2013] 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 [2012-2013] 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 [2012-13 report]) 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.

Action Since 2013: The Board has collected and analyzed additional data collected since 2012 to determine:

1) If increased frequency in testing is beneficial adding to consumer protection;
2) If increased costs associated with increased testing is continue to cause license surrender with no added public protection; and
3) The outcomes of cease practice notices issued to probationers for major violations.

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Increased Random Testing Frequency

Below is a chart that demonstrates the number of times probationers were randomly drug tested each year and the probation data reported in Section 5 of this report along with data reported in the Board's 2012–13 Sunset Report.

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

* Probationers not working in the health care industry are tested 12 times per year.

Table 10b. Enforcement Statistics / Extended Probation Data from FY 09/10

	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16
New Probationers	41	30	39	35	24	24	24
Probations Successfully Completed	30	23	22	16	26	30	6
Probationers (close of FY)	105	92	98	91	69	62	66
Petitions to Revoke Probation	21	9	10	15	8	14	5
Probations Revoked	15	7	6	6	3	2	8
Probations Surrendered in Lieu of Disc	6	6	1	2	4	4	4
Probations Voluntary Surrendered	0	2	4	4	9	4	2
Probations Extended	1	1	2	2	1	1	0
Probationers Subject to Drug Testing	115	97	96	77	61	67	60
OVERALL DRUG TESTS ORDERED/POSITIVE TESTS							
Drug Tests Ordered	1,153	1,325	2,368	2,061	1,737	1,411	1,293
Positive Drug Tests	115	101	216	202	121	156	170
Number of Probationers Testing Positive	30	26	30	27	21	17	22
POSITIVE DRUG TESTS FOR BANNED SUBSTANCES							
Positive Drug Tests	5	5	4	22	20	13	8
No. of Probationers w/Positive Drug Tests	5	3	4	11	13	10	7

The Board has found that, since July 2011 when the number of random tests ordered was significantly increased, the number of probationers testing positive for banned substances has more than doubled. In the Board's prior sunset report, the average number of probationers testing positive for banned substances was four probationers a year from FY 09/10 through FY 11/12. Whereas for FY 12/13 through FY 15/16 the average was 10 probationers.

In addition, the average number of probationers subject to drug testing from FY 09/10 through FY 11/12 was 103 probationers, whereas the average number of probationers subject to drug testing from FY 12/13 through FY 15/16 was 66. Putting this data into context with the number of probationers subject to drug testing shows an increase in the number of probationers testing positive for banned substances from 4% to15%—nearly a 300% increase.

Further analysis showed that 32% of the total number of probationers who tested positive for a banned substance, did so within the first three months of probation. A total of 61% tested positive in the first year; 25% in the second year; 14% in the third year and 0% in the fourth and fifth years of probation.

The Board will continue to collect and analyze this data to determine long-term trends. As for now, the evidence suggests that increased frequency in random testing is beneficial in carrying out the Board's mandate of consumer protection.

License Surrender Associated with Costs of Increased Random Testing

As noted on the chart on page 70, the number of probationers who voluntarily surrendered their license went from zero in FY 09/10, gradually climbing and peaking at nine in FY 13/14 and then began to decline down to two in FY 15/16. Given the results of increased random testing, coupled with the decline of voluntary surrenders, the Board no longer sees this matter as an issue.

Cease Practice Notices

In July 2012, the Board began issuing cease practice notices to probationers who committed a major violation as prescribed by the Board's disciplinary guidelines as follows:

MAJOR VIOLATIONS

1. Any act that presents a threat to a patient, the public, or the respondent him/herself;
2. Failure to timely complete a Board-ordered program or evaluation;
3. Committing two or more minor violations of probation;
4. Practicing respiratory care or making patient contact while under the influence of drugs or alcohol;
5. Committing any drug or alcohol offense, or any other offense that may or may not be related to drugs or alcohol, that is a violation of the Business and Professions Code or state or federal law;
6. Failure to make daily contact as directed, submit to testing on the day requested, or appear as requested by any Board representative for testing, in accordance with the "biological fluid testing" term and condition;
7. Testing positive for a banned substance;
8. Knowingly using, making, altering or possessing any object or product in such a way as to defraud a drug test designed to detect the presence of a banned substance;

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9. Failure to adhere to any suspension or restriction in practice; and
10. Falsifying any document in connection with the terms and conditions of probation.

MINOR VIOLATIONS
Minor violations include, but are not limited to, the following:
1. Failure to submit complete and required documentation in a timely manner to the Board, an employer, or any other party, in accordance with the terms and conditions of probation;
2. Unexcused absence at required meetings;
3. Failure to contact a monitor as required;
4. Failure to submit cost recovery or monthly probation monitoring costs in a timely manner.
5. Any other violation that does not present a threat to the Respondent or public.

Cease practice notices are issued pursuant to CCR, Title 16, §1399.375. The probationer (and employer if applicable) are notified that the licensee is not permitted to practice respiratory care. The probationer may appeal the cease practice notice within ten days and the Executive Officer must make a determination to uphold or dissolve the cease practice notice within ten days from the date an appeal is made.

The following chart displays how many notices have been issued and how many were upheld or dissolved.

	FY 12/13	FY 13/14	FY 14/15	FY 15/16
Cease Practice Notices Issued	39	41	22	20
Upheld	11	12	13	5
Dissolved	28	29	9	15

The most common cause for the issuance and dissolution of a cease practice notice is for a probationer's failure to make daily contact in accordance with the Biological Fluid Testing term and condition of probation. When a probationer has no other violations, the cease practice notice will most often be dissolved however, it is likely that random testing frequency will increase, determined on a case-by-case basis. The second most common reason for the issuance of a cease practice notice is testing positive for a banned substance where no valid prescription is produced. These notices will be upheld and pursued with formal disciplinary action. The Board also has several cases of multiple violations that are not related to Biological Fluid Testing. All of these cases have been pursued for formal disciplinary action as well.

The authority to issue a cease practice notice to probationers has been an incredible tool for the Board's probation program, significantly benefiting the consumers of California.

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?

2013 Joint Committee 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.

2013 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.

Action Since 2013: SB 305 (statutes of 2013) added section 144.5 to the Business and Professions Code. The new language resolved this problem.

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?

2013 Joint Committee Staff Recommendation: *The Board should state its current staffing needs and how additional positions could help the Board reduce licensing and enforcement time lines.*

2013 Board Response: Since the Board was last reviewed in 2002, it has reduced enforcement processing time lines and time lines 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 time lines 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.

Action Since 2013:

In 2013, the Board submitted two BCPs requesting a total of five positions. BCP 1110-38 requested two additional staff. One AGPA was requested to address workload associated with mandatory reporting and consumer complaints. The other AGPA was requested to begin a new in-house program that would have prepared pleadings, stipulated settlements, and default decisions in their final format for the Office of the Attorney General's final approval. The goal was to reduce time and costs. Unfortunately, the only position approved was the AGPA needed to address increased workload associated with mandatory reports and consumer complaints.

BCP 1110-39 requested three additional staff to address a trend of increasing number of initial applications received and assist with continuing education (CE) audits. This BCP was not approved. However, immediately following this request, the Board changed its examination required for licensure which resulted in a decrease in initial applications, returning workload to a manageable level. In addition, demands on resources dedicated to BreEZe were lifted in 2014.

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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 time lines?

2013 Joint Committee Staff Recommendation: *The Board should seek to extend the time frame 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 time frame.*

2013 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 time frame 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.

Action Since 2013: In 2014, the Board attempted to find an author to carry this language to no avail. In 2015, with the California Society for Respiratory Care's support and willingness to cosponsor the language, Assemblyman Steinorth agreed to carry the language in AB 923. The language was not agreeable to legislative committee staff and it was removed from the bill. However, it was noted that these issues may be put forth to become cross-cutting issues at the time of the next sunset review for the Department of Consumer Affairs to consider for all boards.

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.

2013 Joint Committee 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.*

2013 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

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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

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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 act~~s~~ 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).

Action Since 2013:

In 2014, the Board attempted to find an author to carry this language to no avail. In 2015, with the California Society for Respiratory Care's support and willingness to cosponsor the language, Senator Steinorth agreed to carry the language in AB 923. Some of the language was not agreeable to legislative committee staff and it was removed from the bill. Section 3754.8 was added as proposed and section 3755 was amended with alternative language to carry out the original intent.

Section 10
Board Action and Response to 2012-2013 Sunset Oversight Review Issues

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?

2013 Joint Committee 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.*

2013 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 U.S. 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 one-third 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.

Action Since 2013: Currently, the Board has 20,337 active licensees with no reports of a shortage of RCPs. As presented at the Board's May 2013 meeting, the number of new applicants dropped as expected, from its peak in FY 13/14 at 1,560 down to 1,275 in FY 15/16, as a result of raising the minimum competency examination to advance level effective January 1, 2015. The Board will continue to watch this trend and plan accordingly.

Section 10
Board Action and Response to 2012-2013 Sunset Oversight Review Issues

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?

2013 Joint Committee 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.*

2013 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 U.S. 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).

Action Since 2013: The current registration and regulation of polysomnography by the Medical Board of California has been successful. Periodically reports of unlicensed practice are made to our Board. Licensed RCPs who allow their license to lapse and are practicing polysomnography are addressed by the Board. Complaints of unlicensed practice where there is no prior respiratory care application or licensure are referred to the Medical Board of California. The Board is not aware of how the Medical Board of California addresses cases of unlicensed practice.

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?

2013 Joint Committee 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.*

2013 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.

11: New Issues

FUND CONDITION

The Board's fund condition has gone from 5.8 months at the end of FY 15/16 to a projected 1.2 months in FY 17/18. Pursuant to § 3775 of the B&P, the Board is required to fix its renewal fee so that the Board's reserve is equal to approximately six months of annual authorized expenditures. Section 3775 also provides a cap for any increase to be no greater than 10% from the fee in the preceding year (and not to exceed $330).

As provided in greater detail on pages 22 and 23, Board revenues have remained fairly steady, while expenditures had a sharp increase in FY 2015/16. With the exception of the one-time cost for the workforce study ($175,000 over three fiscal years) the increases in expenditures have been outside the Board's control. Ongoing costs for salaries, health care, and BreEZe expenditures will have a significant impact on the Board's fund condition.

The Board has already begun the rulemaking process to raise its fee from $230 to $250 effective July 1, 2017. The Board fully expects this increase to keep the Board's fund solvent through FY 18/19. The Board plans to review the fund condition annually for additional increases as needed. Provided there are no significant and sudden changes in revenue or expenditures, the Board has sufficient time and legislative authority to adjust its renewal fee over the next four years to regain a six month reserve.

RESPIRATORY CARE BOARD ADMINISTRATIVE MANUAL

The Board's Administrative Manual is attached.

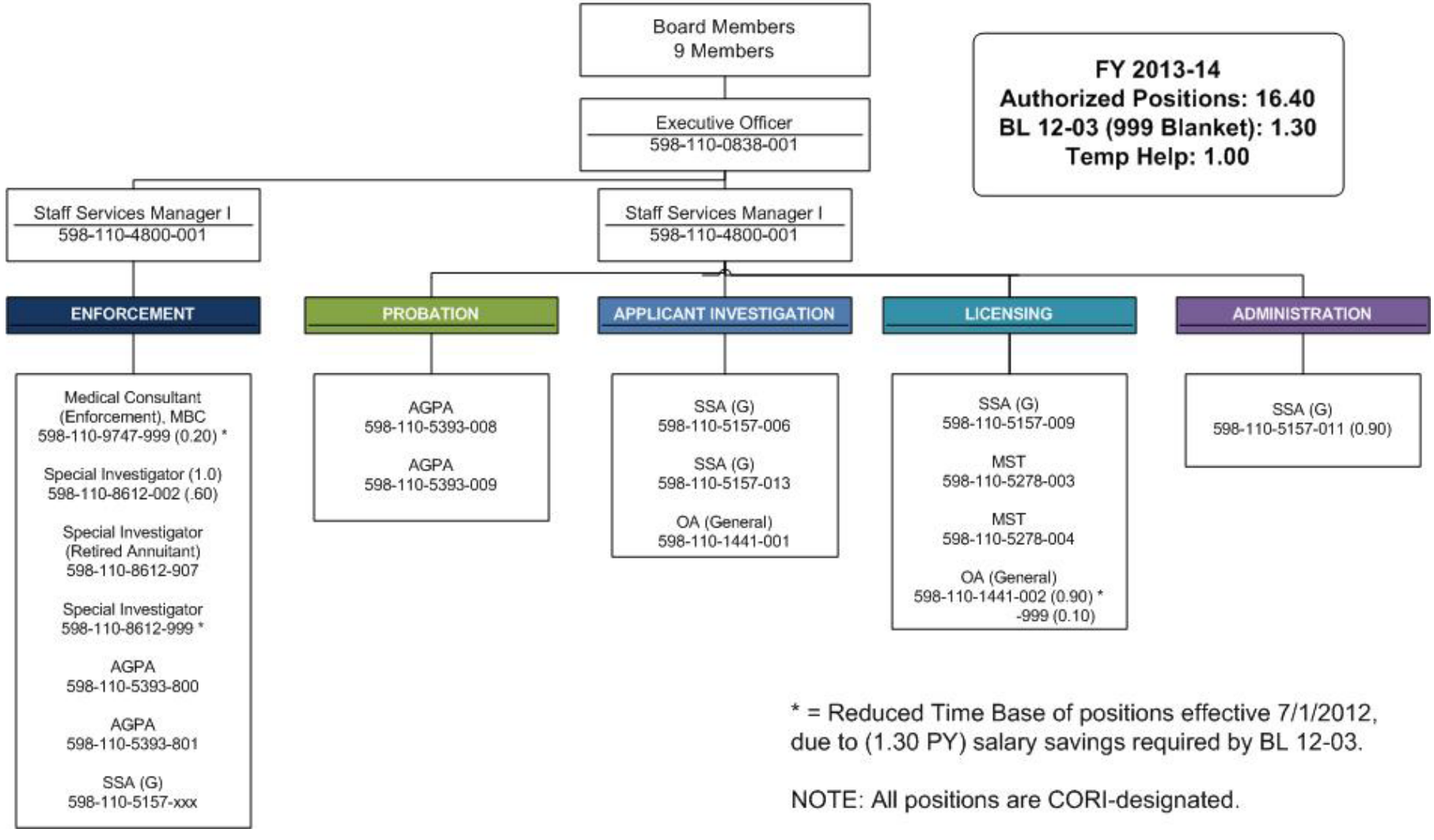
COMMITTEE/BOARD ORGANIZATIONAL CHART

An Organizational chart showing the relationships of committees to the Board and membership of each committee can be found on page 9.

YEAR-END ORGANIZATIONAL CHARTS

Year-end organizational charts for the Board office are on pages 88–91.

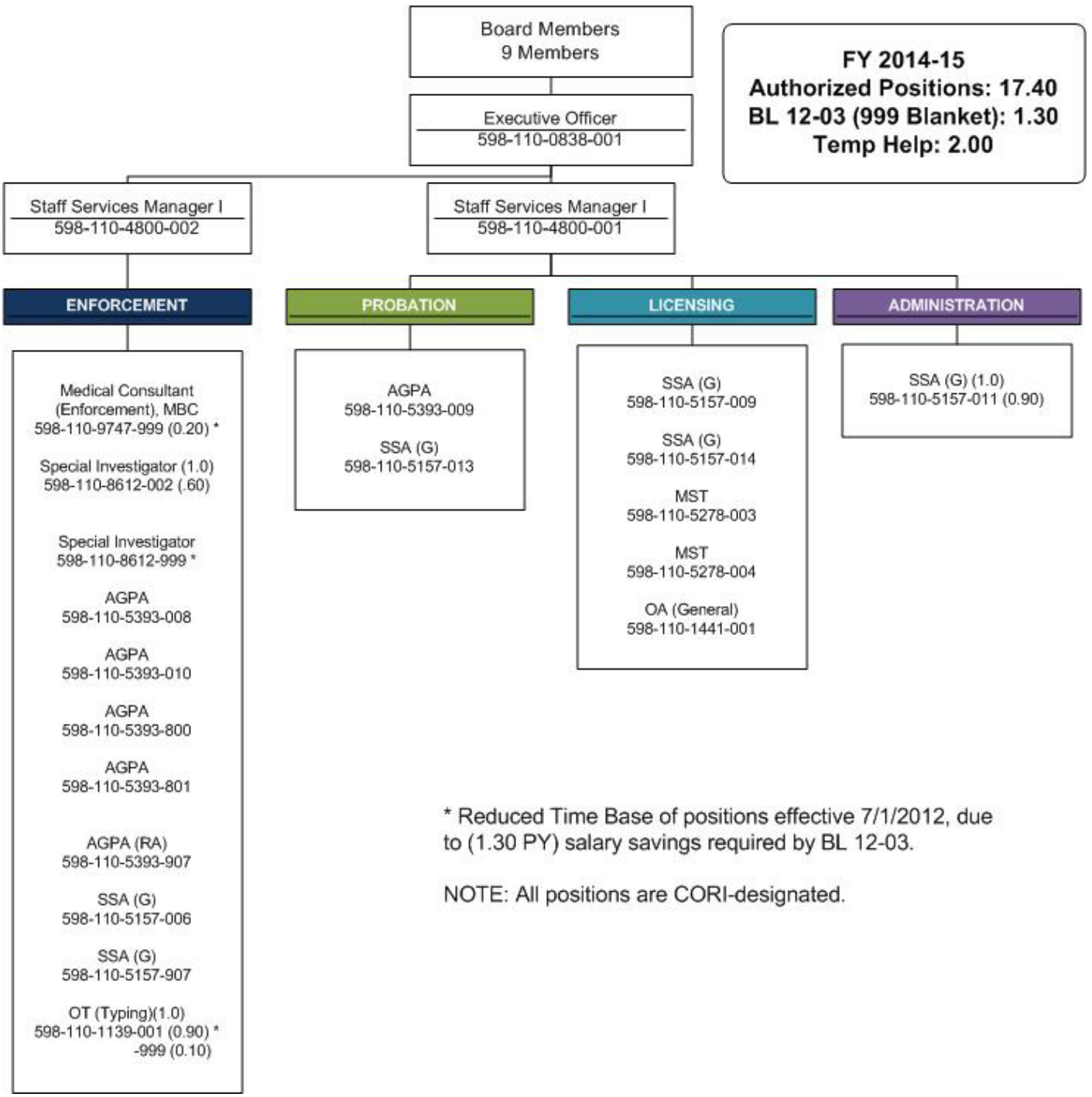
Department of Consumer Affairs
RESPIRATORY CARE BOARD OF CALIFORNIA
July 1, 2013



* = Reduced Time Base of positions effective 7/1/2012, due to (1.30 PY) salary savings required by BL 12-03.

NOTE: All positions are CORI-designated.

Department of Consumer Affairs
RESPIRATORY CARE BOARD OF CALIFORNIA
July 1, 2014



* Reduced Time Base of positions effective 7/1/2012, due to (1.30 PY) salary savings required by BL 12-03.

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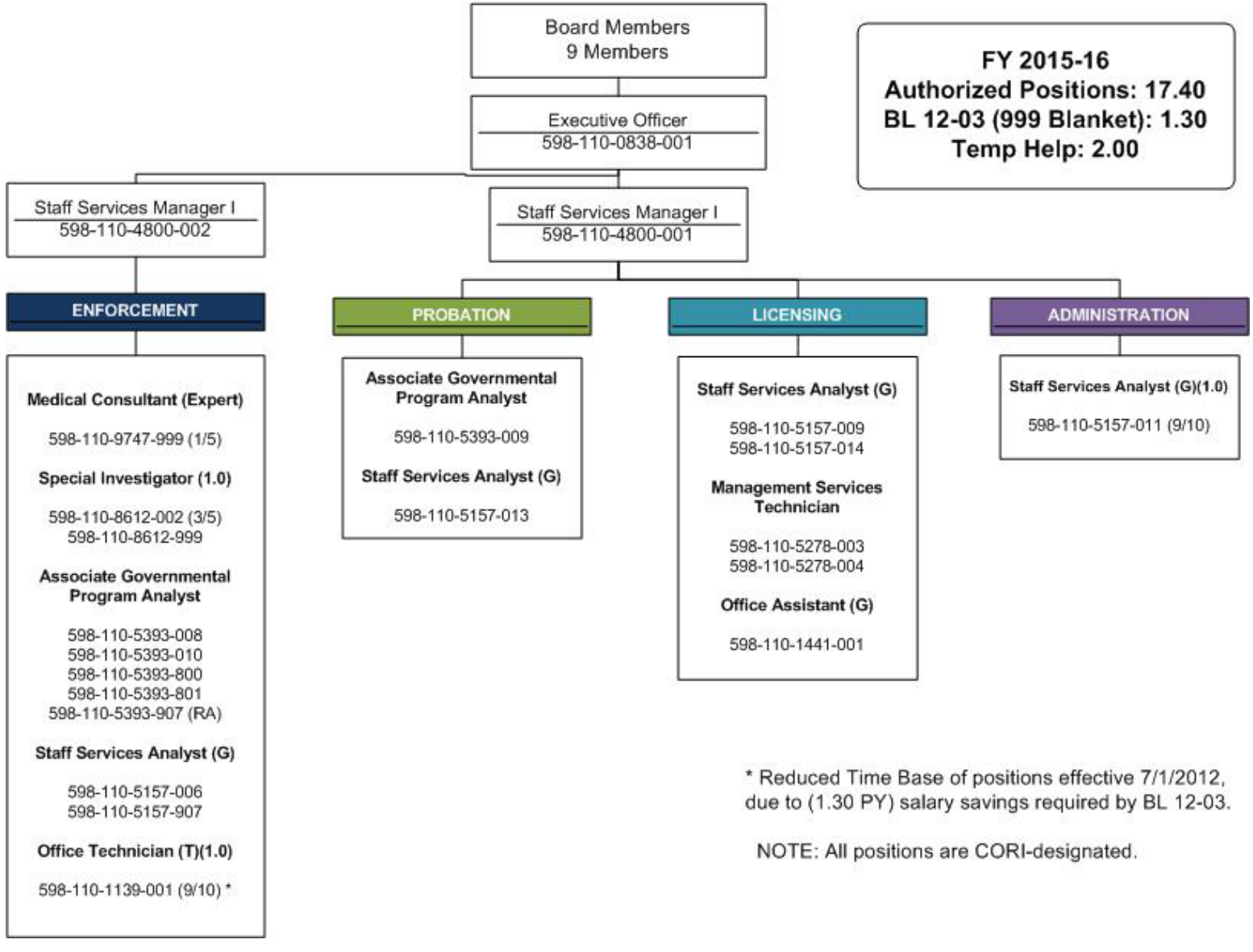
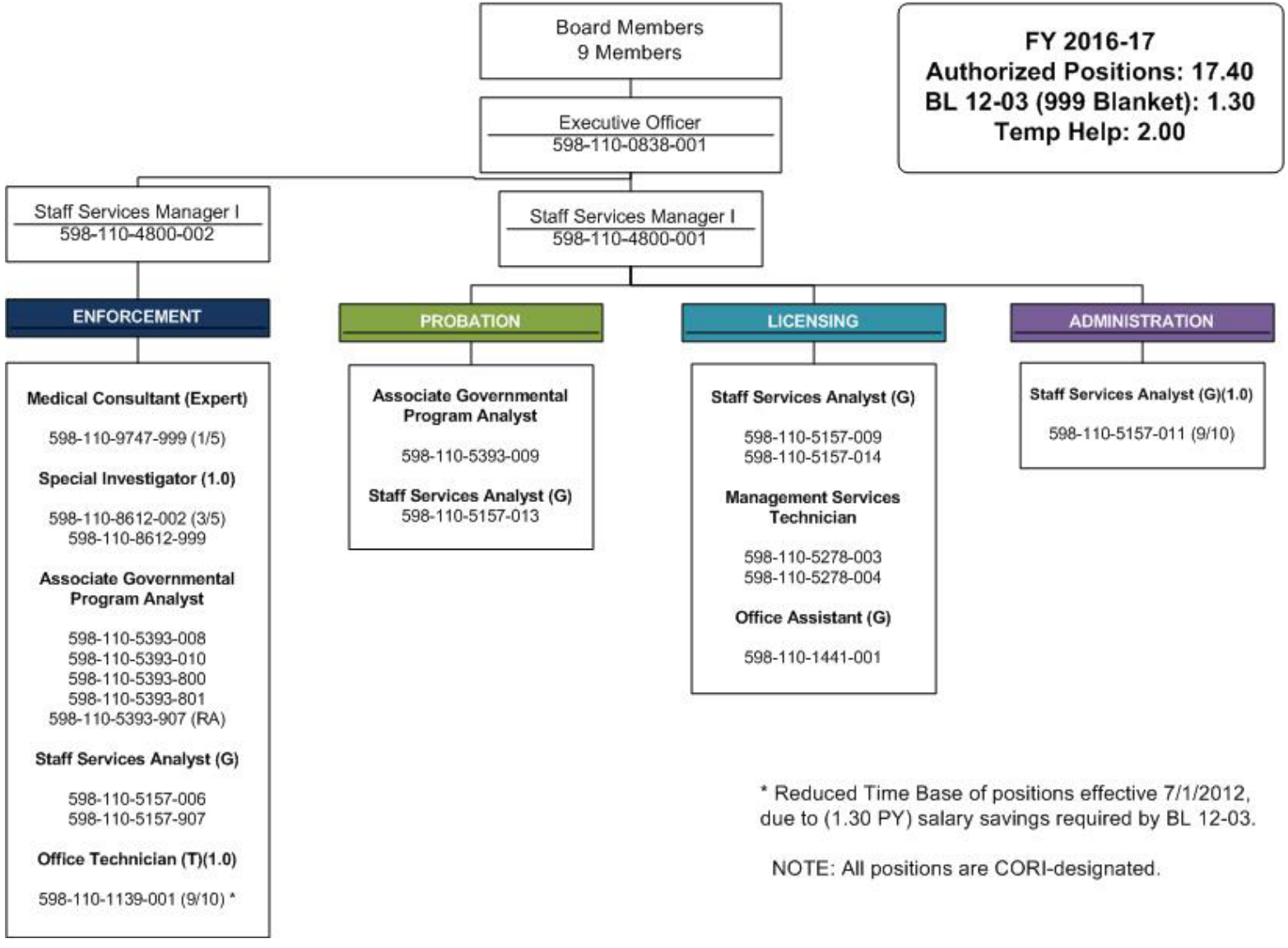
Department of Consumer Affairs
RESPIRATORY CARE BOARD OF CALIFORNIA
July 1, 2015



* Reduced Time Base of positions effective 7/1/2012, due to (1.30 PY) salary savings required by BL 12-03.

NOTE: All positions are CORI-designated.

Department of Consumer Affairs
RESPIRATORY CARE BOARD OF CALIFORNIA
July 1, 2016



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