Agenda Item: 2
Meeting Date: 11/23/21

2022
Sunset Oversight Review
Submitted January 5, 2022

Respiratory Care Board of California
Est. 1982

Respiratory Care Board of California
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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
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
DOJ	Department of Justice
DMV	Department of Motor Vehicles
NBRC	National Board for Respiratory Care
OAG	Office of the Attorney General
OAH	Office of Administrative Hearings
RCB	Respiratory Care Board of California
RCP	Respiratory Care Practitioner
RCPA	Respiratory Care Practice Act
RRT	Registered Respiratory Therapist
SOI	Statement of Issues

Section 1
Background and Description of the Respiratory Care Board and Respiratory Care Practitioners

BACKGROUND AND DESCRIPTION OF THE RESPIRATORY CARE BOARD

The enabling statute to license Respiratory Care Practitioners (RCPs) was signed into law 40 years ago in 1982, thus establishing the Respiratory Care Examining Committee. In 1994, the name was changed to the Respiratory Care Board of California (RCB).

The RCB 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 RCB had sole responsibility for the enforcement and administration of the Respiratory Care Practice Act (RCPA). At the time the RCB was established, the MBC had a Division of Allied Health Professions (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 RCB 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 RCB'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 (Business and Professions Code (B&P § 3701).

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

In carrying out its mandate, the RCB:

- Screens each application for licensure to ensure minimum education and competency standards are met and conducts a thorough 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 RCB continually strives to enforce its mandate and mission in the most efficient manner, by exploring new and/or revising existing policies, programs, and processes. The RCB also strives to increase the quality or availability of services, as well as regularly provide courteous and competent service to its stakeholders.

The RCB regulates and issues licenses solely for RCPs. The RCPA is comprised of B&P 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 health care 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 health care settings.

On a daily basis, RCPs provide services to patients ranging from premature infants to older adults. 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 conditions or traumas:

Asthma	Bronchitis	Heart Attack
Cystic fibrosis	Emphysema	Stroke
Near-drowning	Lung cancer	Premature infants
Infants with birth defects	High-risk influenza/COVID-19	

RCPs are the key health care professionals that 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:

- 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 arterial lines and umbilical arterial catheters (neonatal patients).
- 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/or heart.

- Obtaining and analyzing sputum specimens.
- Analyzing chest X-rays.
- Interpreting data obtained from diagnostic 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 these settings:

- Hospitals.
- Emergency care departments.
- Adult, pediatric, and neonatal intensive care units.
- Critical care units.
- Neonatal (infant) units.
- Pediatric units.
- Home care.
- Subacute 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.

RESPIRATORY CARE BOARD COMMITTEES

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

Executive Committee

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

President: Ricardo Guzman, M.A., RRT, RCP
Vice President: Mark Goldstein, MPA, RRT, RCP

Enforcement Committee

Members of the Enforcement Committee are responsible for the development and review of RCB-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.

Chair: Mary Ellen Early
Member: Ronald H. Lewis, M.D.

Outreach Committee

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

Chair: Mark Goldstein, MPA, RRT, RCP
Member: Sam Kbushyan, MBA

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 health care industry.

Chair: Raymond Hernandez, MPH, RRT, NPS
Member: Michael Terry, RCP, RRT, NPS, RPFT, CCRC

RESPIRATORY CARE BOARD MEETINGS AND MEMBER ATTENDANCE

The RCB meets at least two times per year and as mandated by B&P §101.7, holds at least one meeting per calendar year each in Northern and Southern California. In 2020, as a result of the COVID-19 State of Emergency, Executive Order N-29-20 was issued which temporarily altered meeting requirements from March 17, 2020 through September 30, 2021. AB 361 was passed in 2021, further extending the altered meeting requirements through January 31, 2022. Meetings were held online via Webex throughout 2020 and 2021.

The RCB has not had any issues with establishing a quorum. Attendance over the last four years has ranged between 66% and 100%, with an average over the last four years of 90% of RCB members in attendance.

Table 1a. Respiratory Care Board Meetings and Member Attendance

	Initial Appointment Date	M.D. Physician; P-Public; RCP-Professional	Appointing Authority: Governor; Senate; Assembly	10/7/16 Sacramento	3/10/17 San Diego	6/30/17 Sacramento	10/13/17 Sacramento	2/2/18 Garden Grove	5/14/18 Monterey	10/26/18 Fresno	3/1/19 Orange	6/7/19 Teleconference	11/1/19 Sacramento	4/3/20 Southern CA-Cancelled	10/23/20 Webex Teleconfer-	3/3/21 Webex Teleconference	6/30/21 Webex Teleconfer-
CURRENT MEMBERS																	
Goldstein, Mark	Jun. 2012	RCP	G	X	X	P	X	X	X	X	A	X	X	-	X	X	X
Early, Mary Ellen	Apr. 2013	P	G	X	X	X	X	X	X	X	X	X	X	-	X	X	X
Lewis, Ronald	Jun. 2013	MD	S	X	X	X	A	X	X	A	X	A	A	-	X	X	X
Kbushyan, Sam	Jun. 2017	P	S	-	-	X	X	X	X	X	X	A	X	-	X	A	X
Guzman, Ricardo	Jan. 2019	RCP	S	-	-	-	-	-	-	-	X	X	X	-	X	X	X
Hernandez, Raymond	Feb. 2020	RCP	A	-	-	-	-	-	-	-	-	-	-	-	X	X	X
Terry, Michael	Oct. 2020	RCP	A	-	-	-	-	-	-	-	-	-	-	-	-	X	X
Williams, Cheryl	Apr. 2021	P	G	-	-	-	-	-	-	-	-	-	-	-	-	-	X
PAST MEMBERS																	
Franzoia, Rebecca	Jun. 2012	P	G	X	X	X	X	X	X	X	X	A	X	-	X	X	-
Hardeman, Michael	Jun. 2013	P	A	A	X	X	X	X	X	X	X	X	X	-	X	X	-
Bose, Sherleen	Apr. 2019	RCP	A	-	-	-	-	-	-	-	-	X	X	-	-	-	-
McKeever, Judy	Feb. 2014	RCP	A	X	X	X	X	X	X	X	A	X	-	-	-	-	-
Roth, Alan	Sep. 2012	RCP	A	X	X	X	X	X	X	X	A	-	-	-	-	-	-
Wagner, Thomas	Jun. 2014	RCP	S	X	X	X	X	X	X								
Romero, Laura	May 2013	P	S	X	X												

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

Table 1b. Current Board Member Roster

MEMBER NAME	APPOINTED	RE-APPOINTED	RE-APPOINTED	TERM EXPIRES	APPOINTING AUTHORITY	TYPE
Early, Mary Ellen	4/13/2013	6/2/2015	5/26/2020	6/1/2023	Governor	Public
Goldstein, Mark	6/7/2012	6/9/2015	5/26/2020	6/1/2023	Governor	Professional
Guzman, Ricardo	1/9/2019	N/A		6/1/2022	Senate	Professional
Hernandez, Raymond	2/6/2020	N/A		6/1/2021	Assembly	Professional
Kbushyan, Sam	6/1/2017	N/A		6/1/2021	Senate	Public
Lewis, Ronald	6/19/2013	1/30/2019		6/1/2022	Senate	Physician
Terry, Michael	11/12/2020	N/A		6/1/2023	Assembly	Professional
Williams, Cheryl	4/27/2021	N/A		6/1/2024	Governor	Public
Vacant					Assembly	Public

INTERNAL STRUCTURE AND OTHER SIGNIFICANT EVENTS/CHANGES

Staffing

The RCB's office leadership—consisting of Executive Officer Stephanie Nunez, Staff Services Manager Christine Molina, and Staff Services Manager Liane Freels—remains unchanged since the last Sunset Review in fiscal year 2016–17. Currently, the RCB has 16 staff members who were employed at the time of the RCB's last Sunset Review.

Strategic Planning

The RCB conducted an extensive strategic planning effort and developed a four-year Strategic Plan in 2017. The plan includes four areas of focus: Enforcement, Education, Practice Standards, and Organizational Effectiveness. The RCB's next plan will be developed following the conclusion of its fiscal year 2021–22 Sunset Review to consider legislative recommendations as well.

Administrative Procedure Manual (attached)

In 2021, the RCB updated its Administrative Procedure Manual that was established in 2009 to assist new members in familiarizing themselves with the RCB, its mandate, and its overall processes and operations.

Baccalaureate Education Review and Integration

In 2017, the California Respiratory Care Workforce Study was completed and was the catalyst for several goals in the RCB's 2017–2021 Strategic Plan. Two findings from the study include the need to develop and strengthen critical thinking and critical reasoning among entry-level therapists, as well as the need for additional time to cover the entire breadth of respiratory therapy. There was strong support from participants in the study, for shifting respiratory therapy education to the baccalaureate degree level. Confirming many concerns raised by members over the years, the RCB included the following goal in its 2017–2021 Strategic Plan:

Develop an action plan to incorporate a baccalaureate degree provision in the Respiratory Care Practice Act (RCPA) to ensure education requirements meet the demand of the respiratory care field.

In February 2021, the RCB's newly appointed Professional Qualifications Committee announced its intention to address this goal beginning with a series of presentations in June 2021, to examine the issue from every aspect to determine the best framework and course of action moving forward. The presentations are engaging, invoke active participation from all parties and are expected to continue over a period of years, not months. The overarching goal is to develop a roadmap that will benefit all California consumers, possibly leading to a national model.

The following article published by *The Hill* in 2019 provides a perspective, widely accepted by evidence, of the benefits respiratory therapists provide to patients, the reduction in health care costs as a result of using respiratory therapists and the need to provide opportunities for increased education levels.

THE HILL

Respiratory therapists lead to better health outcomes

BY JONATHAN B. SCOTT, OPINION CONTRIBUTOR
10/25/19
THE VIEWS EXPRESSED BY CONTRIBUTORS ARE THEIR OWN AND NOT THE VIEW OF THE HILL

In the most recent Democratic debate in Ohio last week, candidates spoke about who would bear health-care costs under their different plans. But none of them seemed to offer new solutions for improving health quality and outcomes while decreasing costs. With Respiratory Care Week almost coming to an end, it seems the perfect time to consider how respiratory therapists can positively influence all three measures.

Respiratory therapists are allied-health professionals who identify, treat and prevent acute and chronic conditions related to the cardiopulmonary system. Their training is diverse and rigorous, and they care for patients across the age spectrum.

Children born prematurely often need a respiratory therapist to help them take their first breath. These medical professionals first assess trauma patients when they arrive at the hospital. Persons with chronic lung disease can often avoid hospitalizations and have improved quality of life thanks to the treatment they receive from a respiratory therapist. They work in hospitals, clinics, home care, research labs and universities.

But too many patients don't know that respiratory therapists may be the best health professional to provide their respiratory care needs

Respiratory therapists are not a solution looking for a problem, they are necessary. According to the Center for Disease Control, chronic lower respiratory diseases are the fourth leading cause of death in the United States, with influenza and pneumonia coming not far behind. Non-respiratory conditions like heart disease, cancer, stroke and kidney disease have a tremendous impact on our society, too.

Respiratory therapists care for patients with all these conditions and more daily.

Respiratory therapists can also be part of the solution for the astronomical costs in health care. A 2018 study demonstrated that they could yield both direct and indirect cost reductions across an array of respiratory care practices.

Cost-savings were noted by the utilization of protocols that guide decision-making, assessment skills, and the performance of some invasive procedures independently. As a respiratory therapist myself, I am pleased to know that we help decrease health care costs.

However, I am more pleased that patient outcomes, such as intensive care unit and hospital lengths of stay, allocation of therapies, and hospital readmissions are improved by our services.

Respiratory therapists can also help close the quality gap for patients that suffer from chronic respiratory conditions. Currently, activists are working to pass legislation that would allow qualified providers tele-health services for patients with chronic obstructive pulmonary disease (COPD).

The Better Respiration through Expanding Access to Telehealth Act (the BREATHE Act) would allow respiratory therapists under the direct supervision of a physician, to provide services such as patient education, inhaler technique evaluation, smoking cessation, and remote physiologic monitoring.

Expanding access to care through means such as telemedicine is particularly timely, as there is a projected shortfall of physicians in the near future. According to the Association of American Medical Colleges, the United States will see a shortage of physicians, of up to nearly 122,000 by 2032. A recent study identified a current shortage of cardiopulmonary care providers, which may worsen further, with the projected overall physician shortage.

To be sure, education standards of the profession have struggled to keep pace with advancements in technology, disease management, and patient care. The relatively low entry-level education requirements have not matched the educational advancement of other allied-health professionals, which has affected the perception of this profession. Fortunately, this is being addressed.

Recently, the American Association for Respiratory Care recommended that all therapists entering the workforce in 2030 obtain a minimum of a bachelor's degree in the field.

This was not an attack on the many qualified respiratory therapists, like myself, who entered the profession with an associate's degree. Instead, this forward-looking

recommendation will better prepare respiratory therapists to meet clinical demands in an ever-changing health care system and to be recognized for their expertise.

There are already several bachelor and master's degree entry-level programs today, and many respiratory therapists are going back to higher education to complete their degrees. As the responsibilities of the respiratory therapist continue to increase, we can expect more of these programs to become available.

Respiratory therapists, like myself, often go unnoticed by patients, even as we oversee the devices that keep them breathing. We are often overlooked by hospital administration, as well. But we may be one of the best-kept secrets in health care.

Respiratory therapists can provide high quality, compassionate, and outcome-driven care, all while reducing costs and improving quality of life. However, much of our work is limited by unnecessary constraints. Updating federal laws can make this happen.

Jonathan B. Scott is a respiratory therapist and associate professor in the Department of Cardiopulmonary Sciences, Division of Respiratory Care, College of Health Sciences at Rush University (Chicago, IL) and a Public Voices fellow with The OpEd Project.

LEGISLATIVE CHANGES AFFECTING THE BOARD SINCE 2017

(All sections are from the Business and Professions Code [B&P] unless otherwise noted.)

SB 796 (Hill) Chapter 600, Statutes of 2017

- Sections 3710 and 3716 were amended to extend the RCB's sunset date to January 1, 2022.
- Section 3772 was amended to clarify that monies in the fund shall be available to the board, upon appropriation by the Legislature.

SB 1003 (Roth) Chapter 180, Statutes of 2018

- Section 3702.5 was added to authorize the RCB to promulgate regulations to further clarify the RCP scope of practice by specifying basic, intermediate, and advanced respiratory tasks, services and procedures, and to prohibit any state agency other than the RCB from defining the practice of respiratory care or developing professional standards unless required by statute.
- Section 3704 was amended to define "state agency."

SB 1491 (Hill) Chapter 703, Statutes of 2018

- Section 3735 was amended to accurately reflect the name(s) of examinations for licensure (Therapist Multiple Choice and Clinical Simulation Examination).
- Section 3751 was amended to require an individual petitioning for reinstatement of licensure to pass the current licensing exams to ensure competency at the current minimum required level.

SB 1474 (Senate BP&ED Committee) Chapter 312, Statutes of 2020

- Sections 3710 and 3716 were amended to extend the RCB's sunset date to January 1, 2023.

REGULATORY CHANGES AFFECTING THE BOARD SINCE 2017

- §1399.395 was amended to increase the renewal, inactive, and delinquent fees (effective 7/1/17):

FEE	FROM	TO
Renewal	$230	$250
Delinquent	$230	$250
Delinquent > 2 years	$460	$500
Inactive	$230	$250

- §1399.395 was amended to increase the renewal, inactive, and delinquent fees (effective 7/1/18):

Effective Dates/Fees	FROM	TO
7/1/2018		
Renewal	$250	$275
Delinquent	$250	$275
Delinquent > 2 years	$500	$550
Inactive	$250	$250
7/1/2019	FROM	TO
Renewal	$275	$300
Delinquent	$275	$300
Delinquent > 2 years	$550	$600
Inactive	$275	$300
7/1/2020	FROM	TO
Renewal	$300	$330
Delinquent	$300	$330
Delinquent > 2 years	$600	$660
Inactive	$300	$330

- §1399.343, §1399.344, §1399.345, and §1399.346 all related to Sponsored Free Health care Events were repealed (effective 8/7/2020).
- §1399.370 and §1399.371 were amended to adhere to AB 2138 intended “to reduce licensing and employment barriers for people who are rehabilitated” (effective 8/17/21).
- Pending approval: §1399.326. Driving Record was amended to make the review of each applicant’s driving history optional (to the RCB) as part of an investigation prior to licensure.
- Pending approval: §1399.329. Handling of Military and Spouse Applications was amended to codify legislation that described applications shall be expedited and describe what constitutes evidence of discharge.
- Pending approval: §1399.374. Disciplinary Guidelines was amended to reflect current revisions to the RCB’s disciplinary guidelines incorporated by reference.

NATIONAL ASSOCIATION PARTICIPATION

Currently, the RCB 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 RCB'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 independently attend the AARC's Annual Conferences or Summer Forums.

NATIONAL EXAM PARTICIPATION

The RCB uses the National Board for Respiratory Care's (NBRC's) "Registered Respiratory Therapist (RRT)" examinations which includes both the Therapist Multiple-Choice (TMC) Examination and the Clinical Simulation Examination for licensure. They are developed, scored, and analyzed by the NBRC. Annually, the RCB 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. 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 both the Therapist Multiple-Choice Examination and the Clinical Simulation Examination will also be awarded the Registered Respiratory Therapist (RRT) credential.

Section 2
Performance Measures and Customer Satisfaction Surveys

CUSTOMER SERVICE FEATURES AND CORE PHILOSOPHIES

The RCB 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 RCB acquired a toll-free number for statewide use. The RCB continues to actively publicize and promote the use of the toll-free number (866) 375-0386.
- E-mail Address: In 2002, the RCB also established an e-mail address (rcbinfo@dca.ca.gov) for consumers and applicants to contact the RCB with any questions. The RCB makes it a point to respond to each e-mail within 24 to 72 hours.
- Human Contact: Since the inception of the RCB, it has rejected automated systems that pick up calls (from the main telephone number) with a recorded phone tree. The RCB 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 RCB's website for consumers, licensees, and applicants to complete online.
- Enforcement Performance Measures: In 2010, the RCB, in concert with DCA, began compiling and reporting average days to complete various aspects of the enforcement process.
- Licensing Performance Measures: In 2015, the RCB, together with the DCA, established target times to process initial applications for licensure.
- Consumer Satisfaction Survey: In 2012, the RCB 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 RCB's procedures to close enforcement cases, staff provide Consumer Satisfaction Surveys to each complainant (primarily those complaints received from patients, family members, and employers). Complaints initiated by rap sheets or similar entities are excluded.

The RCB issued 71 surveys over a period of five years and received nine responses. Respondents answered the following questions as either Very Satisfied, Somewhat Satisfied, Neutral, Somewhat Dissatisfied, or Very Dissatisfied. The percentages below are reflective of responses of Neutral, Somewhat Satisfied, or Very Satisfied.

Table 2a. Consumer Satisfaction (Complaint Handling/Resolution) Survey Results

	2016/ 2017	2017/ 2018	2018/ 2019	2019/ 2020	2020/ 2021
Total Surveys Sent: 71					
Total Surveys Returned: 9					
1. How satisfied were you with knowing where to file a complaint and whom to contact?	100%	50%	100%	100%	100%
2. How satisfied were you with the way you were treated and how your complaint was handled when you initially contacted the Board?	100%	50%	100%	100%	100%
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?	100%	50%	100%	100%	100%
4. How satisfied were you with the time it took to process your complaint and to investigate, settle, or prosecute your case?	100%	50%	100%	0%	75%
5. How satisfied were you with the outcome?	100%	50%	100%	100%	100%
6. How satisfied were you with the overall service provided by the Board?	100%	50%	100%	100%	75%
7. Would you recommend us to a friend or family member experiencing a similar situation?	100%	50%	100%	100%	100%
Number of Surveys Sent by Fiscal Year	**4**	**15**	**14**	**16**	**22**
Number of Surveys Returned by Fiscal Year	**1**	**2**	**1**	**1**	**4**

ONLINE SATISFACTION SURVEY

In 2002, the RCB developed and added an online survey to gauge satisfaction among applicants, consumers, and licensees. The RCB includes a link to the survey or directions to the link in application correspondence and inquiries received through our general email address: rcbinfo@dca.ca.gov. Survey respondents are asked to identify themselves as either an applicant, consumer or licensee and then rate the following areas as either Excellent, Good, Fair, Poor, or Unacceptable. The percentages below reflect those responses that were rated fair, good, or excellent.

Overall satisfaction for each year and category ranged from:

Applicants: 75% to 100%
Consumers: 67% to 100%
Licensees: 88% to 91%

Table 2b. Online Survey Summaries	FY 16/17	FY 17/18	FY 18/19	FY 19/20	FY 20/21
APPLICANTS					
Number of Responses	1	0	0	0	1
Courtesy	100%	N/A	N/A	N/A	100%
Responsiveness	100%	N/A	N/A	N/A	100%
Knowledgeable	0%	N/A	N/A	N/A	100%
Accessibility	100%	N/A	N/A	N/A	100%
Overall Satisfaction	75%	N/A	N/A	N/A	100%
CONSUMERS					
Number of Responses	3	2	0	0	0
Courtesy	100%	100%	N/A	N/A	N/A
Responsiveness	67%	100%	N/A	N/A	N/A
Knowledgeable	100%	100%	N/A	N/A	N/A
Accessibility	67%	100%	N/A	N/A	N/A
Overall Satisfaction	84%	100%	N/A	N/A	N/A
LICENSEES					
Number of Responses	9	4	2	2	2
Courtesy	100%	100%	100%	100%	100%
Responsiveness	88%	100%	100%	50%	100%
Knowledgeable	100%	100%	100%	100%	100%
Accessibility	88%	100%	100%	100%	100%
Overall Satisfaction	94%	100%	100%	88%	100%

Section 3
Fiscal Issues and Staffing

FUND CONDITION

Following several recent fee increases, the RCB's fund is showing stable recovery with a projected 5.8 months in reserve in fiscal year 2022–23 and balanced revenues and expenditures. The RCB has not made any loans to the General Fund in the last 20 years. Loans made prior to that date were repaid in 2000–01.

Table 3a. Fund Condition

DOLLARS IN THOUSANDS	FY 16/17 ACTUAL	FY 17/18 ACTUAL	FY 18/19 ACTUAL	FY 19/20 ACTUAL	FY 20/21 ACTUAL	FY 21/22 PROJECTED	FY 22/23 PROJECTED
Beginning Balance	$1,802	$1,335	$943	$793	$910	$1,405	$1,707
Adjusted Beginning Bal.	$56	$0	$41	($19)	$0	$0	$0
Revenues & Transfers	$2,725	$2,880	$3,153	$3,485	$3,785	$3,827	$3,870
Total Resources	$4,583	$4,215	$4,137	$4,259	$4,695	$5,232	$5,577
Budget Authority	$3,694	$3,715	$3,907	$3,868	$3,752	$3,878	$3,878
Expenditures	$3,218	$3,209	$3,323	$3,307	$3,210	$3,878	$3,878
Fi$Cal	$4	$4	N/A	N/A	N/A	N/A	N/A
Supplemental Pension	N/A	N/A	$36	$76	$76	$76	$76
General Fund Pro Rata[1]	$178	$242	$196	$136	$165	$239	$239
Reimbursements	($152)	($183)	($211)	($170)	($161)	($160)	($160)
Fund Balance	$1,335	$943	$793	$910	$1,405	$1,707	$1,883
Months in Reserve	5.0	3.4	2.9	3.4	4.3	5.3	5.8

[1] General Fund pro rata is payment to central service and general fund agencies (e.g., Department of Finance, State Controller's Office, Department of Human Resources, and the Legislature) for budgeting, accounting, auditing, payroll, and other services. However, the services provided by these agencies benefit not only general fund programs, but also programs supported by special funds and federal funds. Consequently, the Department of Finance uses the pro rata cost allocation and recovery process to recover a fair share of indirect costs from special funds (pro rata). The amounts recovered are transferred to the General Fund.

The RCB is a special fund agency deriving 100% of its funds from fees collected for services. During its 2016 Sunset Review, the RCB noted concerns with costs associated with BreEZe the new licensing and enforcement database. These expenditures coupled with rising pro rata and personnel costs outside the RCB's control, resulted in a spiral-down trajectory of the RCB's fund condition. After nearly 20 years of reengineering processes to avoid fee increases, the RCB was forced to raise its renewal and renewal-related fees to the statutory maximum to maintain a fund balance equal to approximately six months. Since the inception of the RCB, the license renewal cycle has always been scheduled on a biennial basis, based upon the licensee's birth month.

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

§ 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. ..."

EXPENDITURES BY PROGRAM COMPONENT

Reviewing expenditures by program you will find that the majority of expenditures are attributed to the RCB's Enforcement Program followed by DCA pro rata, and then Licensing/Examination and Administration.

Table 3b. Expenditures by Program Component

PROGRAM AREA	FY 2016–17		FY 2017–18		FY 2018–19		FY 2019–20		FY 2020–21*		Average %
	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E	
Enforcement	$997	$760	$1,038	$646	$1,025	$741	$1,096	$686	$1,046	$763	54%
Licensing/Exam	$398	$79	$348	$79	$358	$74	$380	$78	$342	$85	13.7%
Administration	$298	$60	$358	$59	$370	$56	$383	$58	$353	$63	12.7%
DCA Pro Rata	N/A	$626	N/A	$681	N/A	$699	N/A	$626	N/A	$558	19.6%
TOTALS	$1,693	$1,525	$1,744	$1,464	$1,753	$1,570	$1,859	$1,448	$1,741	$1,470	
Budget	$3,218		$3,209		$3,323		$3,307		$3,210		

- Dollars listed in thousands.

* Statewide pay reduction reduced expenses for personnel services affecting all program areas listed.

Of interest is the “Average %” expended for DCA pro rata. Looking back to the RCB’s 2016–17 Sunset Review, the percentage of the RCB's expenditures spent on DCA pro rata was 12% in fiscal year 2012–13. During this reporting period those figures have increased significantly:

DCA Pro Rata

Fiscal Year	Pro Rata $ Amount	% of Actual Expenditures
2016–17	$626,000	19%
2017–18	$681,000	21%
2018–19	$699,000	21%
2019–20	$626,000	19%
2020–21	$558,000	17%
2021–22	$628,000	19%

Historically, DCA pro rata made up 12% to 15% of the RCB's actual expenditures prior to fiscal year 2015–16. Thereafter, figures jumped to between 17% and 21%. Initial one-time costs associated with BreEZe can account for a great deal of this. However, ongoing rates at 17% to 19% are excessive and threaten the stability of the RCB's fund.

Fiscal Year 2021–22 DCA Pro Rata + General Fund/Statewide Pro Rata

Line Item	Pro Rata $ Amount	% of Actual Expenditures
DCA Pro Rata	$628,000	19%
GF/Statewide Pro Rata	$239,000	7%
Total	$881,000	26%

Combine DCA pro rata with General Fund/statewide pro rata and an alarming rate of 26% of the RCB's expenditures are dedicated to funding limited services from other agencies.

HISTORY OF FEE CHANGES

The authority for the RCB'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 RCB some flexibility by authorizing it to reduce the amount of any fee at its discretion. All fees are current in the RCB's regulations §1399.395 (CCR, title 16, division 13.6).

Over the last 10 years, the RCB has had several changes in fees. As reported in the RCB's 2016–17 Sunset Report, the changes in the RCB's fee structure since 2006 included these changes made in 2012:

- Eliminating the initial license fee (to reduce application processing times).
- Increasing the application fee from $200 to $300 (as part of the effort to reduce application processing times at near neutral cost impact).
- Reducing the endorsement fee from $75 to $25.

Since that time, it was necessary for the RCB to increase its renewal fee in response to rising personnel costs and pro rata expenses that were depleting its fund. In 1998 the RCB's renewal fee was established at $230. However, the RCB did not implement the renewal fee increase to $230 until January 2002. Also in 1998, the RCB gained the authority to increase its renewal fee up to $330. The RCB worked steadfast and reengineered its processes to avoid another fee increase for years. In fact, it was costs outside of the RCB's control that prompted it to increase its renewal fee nearly 20 years after receiving authority to do so. Since the RCB's last sunset review, these fee increases have been implemented and were done in 10% (or less) increments as mandated by subdivision (d) of section 3755 of the B&P:

Effective 7/1/17:	Renewal fee raised to $250 Delinquent fee raised to $250 (was $230) Delinquent fee > 2 years was raised to $500 (was $460)
Effective 7/1/18	Renewal fee raised to $275 Delinquent fee raised to $275 Delinquent fee > 2 years was raised to $550
Effective 7/1/19	Renewal fee was raised to $300 Delinquent fee was $300 Delinquent fee > 2 years was raised to $600
Effective 7/1/20	Renewal fee was raised to $330 Delinquent fee was raised to $330 Delinquent fee > 2 years was raised to $660

It should be noted that for at least the last two decades, the amount of the renewal fee has been the largest concern of licensees in all circles. RCB members and staff continually keep costs in mind whether through efforts directly aimed at reducing costs or moving forward with an action that could have a negative cost impact. The RCB is confident that, barring any significant costs outside its control, renewal fees should remain intact for years to come.

Table 3c. Fee Schedule and Revenue

FEE	Current Fee Amount	Statutory Limit	Revenue FY 16/17	%	FY 17/18	%	FY 18/19	%	FY 19/20	%	FY 20/21	%
Duplicate License	$25	$75	$4	0.1%	$4	0.1%	$4	0.1%	$3	0.1%	$4	0.1%
Endorsement Fee	$25	$100	$15	0.5%	$13	0.5%	$16	0.5%	$16	0.5%	$21	0.6%
Examination Fee	$190-$390	actual cost	$0	0.0%	$0	0.0%	$0	0.0%	$0	0.0%	$0	0.0%
Re-Examination Fee	$150	actual cost	$0	0.0%	$0	0.0%	$0	0.0%	$0	0.0%	$0	0.0%
Application Fee	$300	$300	$299	11.0%	$319	11.1%	$278	8.8%	$356	10.2%	$348	9.2%
Application Fee (OOS)	$300	$300	$47	1.7%	$44	1.5%	$67	2.1%	$59	1.7%	$95	2.5%
Application Fee (Foreign)	$300	$350	$1	0.0%	$0	0.0%	$0	0.0%	$0	0.0%	$0	0.0%
Biennial Renewal Fee[2]	$230-$330	$330	$2,199	80.7%	$2,361	82.0%	$2,616	82.9%	$2,887	82.9%	$3,207	84.7%
Delinquent Fee (< 2yrs)[2]	$230-$330	$330	$73	2.7%	$73	2.5%	$70	2.2%	$67	1.9%	$68	1.8%
Delinquent Fee (> 2yrs)[2]	$460-$660	$660	$7	0.3%	$0	0.0%	$6	0.2%	$0	0.0%	$8	0.2%
Cite and Fine	varies	$15,000	$42	1.5%	$38	1.3%	$38	1.2%	$54	1.5%	$13	0.3%
Enf. Review Fee	varies	actual cost	$12	0.4%	$14	0.5%	$9	0.3%	$13	0.4%	$9	0.2%
Reinstatement Fee	$300	$300	$1	0.0%	$1	0.0%	$0	0.0%	$0	0.0%	$1	0.0%
Miscellaneous	-	-	$25	0.9%	$14	0.5%	$50	1.6%	$29	0.8%	$12	0.3%
TOTAL REVENUE			$2,724		$2,881		$3,154		$3,484		$3,786	

[2] During fiscal year 16–17 the renewal fee was $230, the delinquent fee was $230, and the delinquent fee > 2 years was $460.
During fiscal year 17–18 the renewal fee was $250, the delinquent fee was $250, and the delinquent fee > 2 years was $500.
During fiscal year 18–19 the renewal fee was $275, the delinquent fee was $275, and the delinquent fee > 2 years was $550.
During fiscal year 19–20 the renewal fee was $300, the delinquent fee was $300, and the delinquent fee > 2 years was $600.
During fiscal year 20–21 the renewal fee was $330, the delinquent fee was $330, and the delinquent fee > 2 years was $660.

BUDGET CHANGE PROPOSALS

The RCB has not submitted any budget change proposals during this reporting period, nor does it intend to in the foreseeable future.

STAFFING AND TRAINING

The RCB has been fortunate in retaining a highly-skilled and experienced workforce over the last 20 years. Turnover is extremely rare, with only a handful of employees leaving to pursue other promotional opportunities. At the time of the RCB's last Sunset Review in 2016–17, the RCB had 18 staff members. Since that time, two have retired; one is expected to return as a retired annuitant in the near future. Currently, the RCB has 16 staff members, all of whom were employed during the RCB's last Sunset Review. Organizational charts for the last four fiscal years can be found on pages 112–116.

RCB Staff Receive "Team Superior Accomplishment Award"

In October 2020, the RCB staff were awarded the Team Superior Accomplishment Award by DCA for their outstanding performance and exceptional contributions toward their response to the COVID-19 State of Emergency and its impact on RCB operations. Each staff member was acknowledged for their individual contributions and all staff were recognized for the shared strengths they all have in common including a sincere dedication to the RCB's mission of consumer safety, meaningful customer service, a strong work ethic, and an optimistic outlook. Immediately upon the issuance of the State of Emergency, each staff member ran into the proverbial fire rather than running away. Some were called upon after hours, some took upon new assignments, most had to approach work through different avenues, and all made themselves available to help. While DCA helped tremendously, it is quite remarkable to change your working environment literally overnight, in a nearly seamless transition. They have been dubbed the "Respiratory Care Board Dream Team."

Workforce and Succession Plan 2021–2024

In Spring 2020, the RCB identified the expected upcoming retirements in its workforce, as a threat facing the RCB. In response, the RCB prepared and approved its Workforce and Succession Plan 2021–2024 at its March 2021 meeting.

The RCB's ability to deliver services effectively in the future is at risk due to the projected retirement of nine—or 56%— of the RCB's workforce over the next two to five years. With the departure of experienced employees who possess a wealth of institutional knowledge and perform vital roles, it is important for the RCB to outline opportunities where it can enhance its infrastructure and be proactive in developing workforce planning guidance.

Staff Training

Over the last five fiscal years, the RCB has spent approximately $4,500 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. A list of training completed since 2016–17 is provided in Table 3d.

Table 3d. Staff Training

Course	*# of staff*
FY 2016–17	
Dreamweaver Intermediate Training	2
Human Resource Liaison Training	1
Certified Professional Collector Program	2
Information Security Awareness Fundamentals	18
Sexual Harassment Prevention Training	18
Defensive Driving	4
Ethics	3
FY 2017–18	
Human Resources Liaison Training	1
CDAA National Elder & Dependent Adult Abuse Symposium	2
Planning Your Retirement	1
Information Security Awareness Fundamentals	17
Defensive Driving	1
FY 2018–19	
Accessibility Training	1
HR Liaison Confidentiality & Security	1
Certified Professional Collector Program Specimen Collector	2
Information Security Awareness Fundamentals	17
Sexual Harassment Prevention Training	17
Ethics	4

Course	*# of staff*
FY 2019–20	
HR Liaison Confidentiality & Security	1
Certified Professional Collector Program Specimen Collector	2
Writing Effective and Compliant Duty Statements	1
Best Hiring Practices	1
Certified Professional Collector Program Specimen Collector	2
Introduction to Records Management	1
Information Security Awareness Fundamentals	17
Defensive Driving	1
FY 2020–21	
Certified Professional Collector Program Specimen Collector	2
National Certified Investigator and Inspector Training	4
Intro to MS Teams	2
How to Set Up & Host a Webex Event	2
Regulatory Law Seminar	1
Basic Excel Formatting and Formulas	1
Information Security Awareness Fundamentals	16
Sexual Harassment Prevention Training	16
Defensive Driver Training	3

Section 4
Licensing Program

LICENSEE POPULATION

Since the RCB issued its first license in 1985, it has issued over 44,000 licenses. As of June 30, 2021, the RCB had 20,248 active and current licensees, 2,657 delinquent licensees, and 827 current but inactive licensees. Of these licensees, 1,718 live out of the state or country. An additional 1,017 licenses have been placed in retirement status as of June 30, 2021.

4a. Licensee Population

		FY 16/17	FY 17/18	FY 18/19	FY 19/20	FY 20/21
Respiratory Care Practitioner	Active	19,668	19,588	19,676	20,052	20,248
	Delinquent	3,028	2,968	2,956	2,649	2,657
	Inactive	777	891	858	887	827
	Out-of-State	1,681	1,517	1,542	1,557	1,699
	Out-of-Country	35	12	15	14	19
	Retired	684	775	865	940	1,017

APPLICATION PROCESSING TIMES

The RCB strives to process applications for licensure as quickly as possible. As of June 30, 2021, the average cycle time to process a complete application from date of receipt to date of licensure was seven days. The average cycle time for incomplete applications was 68 days.

4b. Licensing Performance Targets

	Target Processing Times	FY 18–19 Average Processing Times	FY 19–20 Average Processing Times	FY 20–21 Average Processing Times
Complete Applications	60 days	7	9	7
Incomplete Applications	365 days	66	59	68

Below, Table 4c illustrates 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., 375 pending compared to 1,538 received in fiscal year 2020–21). This is a direct correlation with the graduation cycles of respiratory care programs. The largest graduating classes begin submitting applications mid-May through July. Therefore, a count of "pending applications" anywhere from May through August will be significantly higher than at any other time of the year.

INITIAL LICENSURE AND RENEWALS

The RCB currently issues over 1,100 new licenses and renews over 9,500 licenses each year. As discussed in greater detail in Section 11, the RCB increased the level of its competency examination required for licensure effective January 1, 2015. At that time the RCB anticipated the number of initial applications to drop for a period of time. The table below demonstrates that the number of initial applications received has increased from 1215 to 1538 from fiscal year 2018–19 to fiscal year 2020–21 reaching its former level of applications received (prior to implementation of new exam) of 1,560 in fiscal year 2013–14.

Table 4c. Licensing Data by Type

	Application Type	Received (opened)	Approved	Closed *	Initial and Renewed Licenses Issued	Pending Apps at Close of FY	Cycle Times (in days)	
							Complete Apps	Incomplete Apps
FY 18/19	License/Exam	1,215	1,124	112	1,124	387	7	66
	Renewal	9,517	9,594	1,082	9,594	N/A	-	-
FY 19/20	License/Exam	1,424	1,137	152	1,137	492	9	59
	Renewal	9,606	9,761	1,018	9,761	N/A	-	-
FY 20/21	License/Exam	1,538	1,175	237	1,175	375	7	68
	Renewal	9,718	9,841	974	9,841	N/A	-	-

* Closed includes initial license applications that are withdrawn, abandoned, and denied, and open renewal applications that update from delinquent to canceled.

Table 4d. License Denials			
	FY 18/19	FY 19/20	FY 20/21
License Applications Denied (no hearing requested)	1	2	0
Statements of Issue Filed	0	1	1
Average Days to File SOI (from request for hearing to SOI filed)	N/A	69	46
Statements of Issue Declined	0	0	0
Statements of Issue Withdrawn	0	0	1
Statements of Issue Dismissed (licensed granted)	0	0	0
Licenses Denied (after hearing requested)	1	0	0
License Issued with Probation / Probationary Licensed Issued	1	1	0
Average Days to Complete (from SOI filing to outcome)	241	140	87

The RCB denied a total of seven applications for initial licensure between fiscal year 2018–19 and fiscal year 2020–21 regardless of whether a hearing was requested and all seven denials were based on a criminal history as follows:

MARTINEZ
Initial Denial: 1/18/19; Denial Withdrawn/ Strong Warning Letter Issued; License issued, no restrictions

Application denied under B&P sections 3750(d), 3750.5(b), 3752.5, and California Code of Regulations (CCR) section 1399.370(a), (c), and (h).

On August 21, 2014, applicant was convicted of Vehicle Code (VC) section 23153(b), driving with a blood alcohol content of .08% or higher causing bodily injury.

On August 9, 2016, applicant admitted to being in violation of probation.

On August 9, 2016, applicant was convicted of VC sections 23152(a), driving under the influence of alcohol and 23152(b), driving with a blood alcohol content of .08% or higher, upon nolo contendere plea.

NKWO
Initial Denial: 5/7/19; SOI Filed: 8/15/2019; Board Decision: Probation, 3 years, effective 1/2/20; Subsequent Stipulated Decision: License Surrendered 3/12/2020

Application denied under B&P section 3750(d), 3750.5(b), and CCR section 1399.370(a) and (c).

On March 30, 1998, applicant was convicted of VC section 23152(a), driving under the influence of alcohol with admission to two prior convictions for VC section 23152(b), driving with a .08% or more blood alcohol content on July 29, 1994, and October 25, 1995.

On February 22, 2017, applicant was convicted of VC sections 23152(b) and 20002(a), hit and run causing property damage.

WISE
Initial Denial: 5/8/19; No Hearing Requested

Application denied under B&P section 3750(d), 3750.5(b), and CCR section 1399.370(a) and (c).

On May 1, 2009, applicant was convicted of Florida Statute (FS) section 316.193(1), driving under the influence of alcohol.

On October 10, 2011, applicant was convicted of FS section 322.34(2)(a), driving on a suspended license.

On May 12, 2014, applicant was convicted of FS section 322.34(b)(2), driving on a suspended license with a prior conviction.

On March 16, 2016, applicant was convicted of FS section 322.34(5), driving on a suspended license, habitual offender, a felony.

On January 17, 2018, applicant was convicted of VC sections 23152(a), driving under the influence of alcohol and 23152(b), driving with a .08% or more blood alcohol content.

On November 30, 2018, applicant certified under penalty of perjury the information contained in his application for licensure and criminal background statement was true and correct. After review, the RCB determined applicant failed to disclose a felony conviction on the application for licensure. Furthermore, applicant failed to disclose the October 10, 2011, and January 17, 2018, convictions on the criminal background statement.

REED
Initial Denial: 7/20/20; SOI Withdrawn/License Denied

Application denied under B&P sections 3760(d) and (m), 3760.6(a) and (b), 3762, and CCR section 1399.370(a) and (c).

On November 18,2014 applicant was convicted of Arizona Revised Statute (ARS) section 13-3416(A), possession of drug paraphernalia.

On April 8, 2016 applicant was convicted of ARS section 28-1381A1, driving under the Influence of alcohol, drugs or a toxic vapor.

In 2014, applicant dislosed on his Arizona respiratory care practitioner (RCP) license renewal that he had a substance abuse problem. Effective April 2016, applicant entered into an agreement for non-disciplinary rehabilitative probation for three (3) years.

In May 2016, the Arizona Board received information that applicant had consumed alcohol, took undisclosed prescription medications, and failed to comply with a request for a mandatory drug test. In August 2016, the Arizona Board reinstated probation.

In 2017, the Arizona Board issued an Interim Order of Suspension as a result of the applicant providing a bodily fluid sample that was not, observed, within temperature perimeters, or consistent with natural urine. Probation was restored.

On July 18, 2018, applicant was convicted of ARS section 28-1381 A 1, driving under the influence of alcohol, drugs or a toxic vapor.

On December 6, 2018, applicant was arrested for violating ARS sections 28-1383A1, aggravated driving under the influence and 28-3473A, driving with a suspended license, 28-1383A4, aggravated interlock and 28-1383A2, driving under the influence with priors.

CLEMENTS
Initial Denial: 8/23/19; No Hearing Requested

Application denied under B&P sections 3750(d), 3750.5(b), and CCR section 1399.370(c).

On December 28, 2012, applicant was convicted upon plea of guilty to violating VC section 23152(b) driving with a blood alcohol content of .08% or higher (.15% blood alcohol content)

On August 5, 2019, applicant was convicted of VC section 23152(b) with an admission to a prior violation of VC 23152(b) in 2012.

GABALDON
Initial Denial: 1/22/20; Denial Withdrawn / Strong Warning Letter Issued
License issued, no restrictions

Application denied under B&P sections 3750(d), (j), and (q), 3750.5(a), 3752, 3752.5, and CCR section 1399.370(a), (b), (h), and (i).

On July 26, 2001, applicant was convicted of Penal Code (PC) section 148.9, false representation to a peace officer. Applicant failed to disclose this conviction on his background statement.

On December 14, 2006, applicant was convicted of PC section 273.5(a), inflicting corporal injury on a spouse.

On April 4, 2006, applicant was arrested for violating United States Code (USC) Title 19, section 1497, failure to declare controlled substances, USC Title 18, section 545, smuggling or abandoned controlled substance/narcotics, and USC Title 19, section 1595a(a), aiding illegal importation. On April 6, 2006, applicant was convicted of Health and Safety Code section 11359, possession of marijuana for sale.

On March 16, 2007, applicant was convicted of PC section 484/488, petty theft.

On December 15, 2014, applicant was convicted of PC section 29805, convicted person possessing a firearm.

On August 17, 2018, applicant was arrested for violating PC sections 459, commercial burglary, 182(a)(1), conspiracy to commit a crime, and 496, possession of stolen property. On June 17, 2019, applicant was convicted of PC section 415(2), disturbing the peace.

CABRILLOS
Initial Denial: 6/30/2020; No Hearing Requested

Application denied under B&P sections 3750(d), 3750.5(a) and (b), 3752, and CCR section 1399.370(a) and (c).

On July 19, 2019, applicant was convicted of VC section 23103/23103.5, reckless driving involving ingestion or administration of a drug; methamphetamine.

APPLICATION BACKGROUND VERIFICATION/FINGERPRINTS

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

- Department of Justice background check.
- Federal Bureau of Investigation background check.
- Official education transcript(s).
- Licensing examination verification (successful completion).
- RCB-approved Law and Professional Ethics Course verification (successful completion).
- Out-of-state licensure history (as applicable).
- National Practitioner Databank history for applicants where residence or education may be outside of California.

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 RCB, all applicants have been fingerprinted to ascertain any criminal history. The RCB 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. The RCB is current and up to date in notifying DOJ of all records the RCB no longer has jurisdiction over.

The RCB’s application also includes very specific background questions for the rare occasion in which an event is not captured by other means. The RCB 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 RCB will also run a check with the National Practitioner Databank if it appears that an applicant may have resided or obtained his or her education outside of California (this check is not performed on existing licensees during the renewal process). The RCB also requires applicants who reveal they have been licensed out-of-state to have those states where licensure was held, submit a license verification directly to the RCB's office, indicating if there is any history of disciplinary action.

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 RCB has always held those who have or continue to serve as members of the U.S. military in the highest esteem. The RCB 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, in several instances, staff took it upon themselves (instead of the applicant) to contact other state licensing agencies or the national examination provider to obtain necessary verifications. RCB staff often receive thank-you notes from many applicants, including military personnel and their spouses.

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 B&P 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 B&P 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 B&P 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 B&P and provides that every board shall inquire in every application for licensure if the individual applying for licensure is serving on or has previously served in the military.

- SB 1137 (Statutes of 2018)—Section 714 is added to the B&P and provides that the Department of Veterans Affairs and the Department of Consumer Affairs shall both, in consultation with each other, take appropriate steps to increase awareness regarding professional licensing benefits available to veterans and their spouses.

- SB 607 (Statutes of 2021)—Section 115.5 of the B&P is amended effective 7/1/22, and provides that boards waive initial application fees for military spouses who are authorized to practice in another state or territory.

The RCB has promulgated regulations to recognize military service and experience. The following sections 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 lieu of meeting the current associate degree education requirement.

§ 1399.354. Waiver of [CE] Requirements established in the 1990s, this section recognizes military personnel absences or military obligations of one year or more and authorizes the RCB to waive the entire CE requirement for a two-year renewal cycle.

The RCB is also currently in the process of amending section 1399.329 of its regulations as follows:

> § 1399.329. ~~Military Renewal Application Exemptions.~~ Handling of Military and Spouse Applications
>
> (a) Pursuant to subdivision (c) of section 114.3 of the B&P, the Board shall prorate the renewal fee and the number of CE hours required in order for a licensee to engage in any activities requiring licensure, upon discharge from active duty service as a member of the United States Armed Forces or the California National Guard.
>
> (b) The Board shall provide expedited handling of applications for licensure and renewal for military personnel and military spouses as provided in sections 114, 114.3, 115.4, and 115.5 of the B&P.
>
> (c) Evidence of discharge from active duty or from the military may include an order issued by the U.S. Armed Forces on a DD Form 214 or the National Guard on form NGB-22.

The rulemaking package with this amendment is expected to be at the Office of Administrative Law for final review and approval by 1/5/22. You may check the current status of this package on the RCB's website (scroll to the bottom of the page).

In January 2013, the RCB began tracking applicants who indicate they are in a legal union with an active duty member of the armed forces. From January 2013 through June 30, 2016, the RCB had 30 applicants who indicated such union. All 30 applicants were expedited.

In August 2014, the RCB began asking applicants for initial licensure, if they are serving or have ever served in the military. In fiscal year 2014–15, the RCB received 33 affirmative responses and in fiscal year 2015–16, the RCB received 68 affirmative responses. All of those applicants were approved for licensure.

RCB staff continue to expedite and often assist military members and their spouses in securing licensure. As legislation has been introduced changes to the application for initial licensure, the renewal application and the RCB's database have been made to capture this information.

Currently, the first questions asked on the RCB's Application for Initial Licensure are:

- Are you the spouse or domestic partner of an active duty member in the armed forces or the California National Guard?
- Have you ever served or are you currently serving in the United States military?
- Are you requesting expediting of this application for honorable discharged members of the U.S. armed forces? (DD214 or other supporting documentation is required if “Yes”)

Following is data captured as it relates to applications for initial licensure.

Table 4e. Military Applications for Initial Licensure					
	FY 16/17	FY 17/18	FY 18/19	FY 19/20	FY 20/21
Apps Received—Military	77	74	82	97	105
Apps Received— Military Spouse	24	20	24	18	24
Apps Approved—Military	82	71	68	74	72
Apps Approved—Military Spouse	19	12	21	16	17
Military Education Waivers Requested	0	0	0	0	1
Military Education Waivers Approved	0	0	0	0	1

In August 2015, the RCB began asking licensees on their renewal forms if they serve or have served in the military. Since then, approximately 1,400 licensees have been identified as having current or prior military service. The RCB waives renewal requirements for military personnel when they are called to active duty. Renewal requirements waived for military personnel called to active duty include renewal fees, continuing education requirements, and any other requirements as determined by the RCB. Following are the number of military licensees who have requested a waiver.

Table 4f. Military Renewal Application Waivers					
	FY 16/17	FY 17/18	FY 18/19	FY 19/20	FY 20/21
Military Active Renewal Waiver	3	1	0	4	0
Military Inactive Renewal Waiver	0	2	2	1	1

The RCB also added a page dedicated to Military Personnel and Military Spouses/ Domestic Partners on its website. The page provides detailed information on all waivers and expeditious handling of applications.

EXAMINATION

Effective January 1, 2015, the RCB 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) 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 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.

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 42 locations throughout California. Applicants are given three hours to complete the Therapist Multiple Choice Exam and four hours to complete the Clinical Simulation Exam (exceptions are made in accordance with the Americans with Disabilities Act). Once applicants have completed either examination, they are notified immediately of the results. Those results are then shared with the RCB on a weekly basis.

From fiscal year 2016–17 through fiscal year 2020–21, the pass rates for first-time takers averaged near 80% for the written exam and 64% for the clinical exam.

Table 4g. Examination Data			
NATIONAL EXAMINATION FOR LICENSURE AS A RESPIRATORY CARE PRACTITIONER			
Exam Title: **RRT Part I Written Exam**			
			Pass %
FY 16–17	Number of First Time Candidates	954	84%
FY 17–18	Number of First Time Candidates	1,046	82.5%
FY 18–19	Number of First Time Candidates	984	80.5%
FY 19–20	Number of First Time Candidates	1,004	80.5%
FY 20–21	Number of First Time Candidates	1,145	76.2%
Exam Title: **RRT Part II Clinical Simulation Exam**			
			Pass %
FY 16–17	Number of First Time Candidates	938	57.9%
FY 17–18	Number of First Time Candidates	947	60.5%
FY 18–19	Number of First Time Candidates	946	66.2%
FY 19–20	Number of First Time Candidates	921	67%
FY 20–21	Number of First Time Candidates	1,028	67%
Date of Last Occupational Analysis: 2017			
Name of Occupational Analysis Developer: National Board for Respiratory Care			
Target Occupational Analysis Date: 2022			

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 35 respiratory care education programs in California that are approved by the RCB by virtue of their accreditation status. Pursuant to B&P §3740, the RCB requires two components of education for licensure:

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, 34 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. The two community colleges were approved for a pilot program to issue baccalaureate degrees pursuant to SB 850 (Statutes of 2014). AB 927 (Statutes of 2021) permanently established the community college baccalaureate degree program statewide.

RCB staff review each respiratory care program and school one to two times annually to verify the programs and schools continue to hold valid accreditation. In addition, the RCB also confers with the Bureau for Private Postsecondary Education (BPPE) to ensure private institutions continue to hold their approval.

All 35 programs are accredited by CoARC; 26 are accredited by the Western Association of Schools and Colleges (WASC), and the remaining nine 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 RCB 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 10 years.

Further, as a consumer protection benefit, the RCB 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 making a selection among various programs offered within the same geographical area.

CONTINUING EDUCATION

As of July 2017, an active RCP must complete 30 hours of approved CE every two years (previously 15 hours). 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 RCB-approved Law and Professional Ethics Course which may be claimed as three hours of non-clinical CE credit (reference: CCR §1399.350).

After completion of the Respiratory Care Workforce study in 2017, the RCB developed several goals in its Strategic Plan 2017–2021 to improve its CE program, student clinical education, and education outcomes. The RCB drafted and disseminated proposed regulatory language in 2019 and discussed it at several meetings, gaining a tremendous amount of public input. The RCB edited the original proposal several times and has since approved regulatory language that is currently pending the onset of the rulemaking process subject to further legal review.

The framework of the RCB's CE program would be drastically changed from a general requirement that two-thirds or 20 hours of the required 30 hours of CE be directly related to clinical practice in any format. The new framework would require:

- A minimum of 10 hours in leadership,
- a minimum of 15 hours directly related to clinical practice, and
- up to five hours in courses or meetings indirectly related to the practice.

In addition, the new framework requires half or 15 of the 30 hours of required CE be obtained through live courses or meetings that provide interaction in real time.

The two key highlights of the proposed regulations is the requirement for 10 hours of CE in leadership and half (15 hours) of the required CE be taken in a live format.

Leadership
The anticipated gaps in management in the respiratory care field were brought to light by the RCB’s last workforce study. The study revealed the expected retirement of 35% of people in management in the near future, and the need for leadership development among existing licensees to fill that void. In addition, the study revealed the need to improve clinical education and outcomes.

The RCB noted inconsistencies in how preceptors are used in clinical education programs. Preceptors are licensed RCPs employed at the clinical site. They *volunteer* with the education program to take on the additional assignment of providing hands on instruction to students in the real learning environment. Most health care education programs lack skilled preceptors for clinical training at facilities. Resources at most facilities are limited and providing oversight of students requires preceptors to take on additional workload outside their normal job duties on a volunteer basis. The RCB believes imposing any mandate on facilities would be counterproductive.

Several current and past members of the RCB have also been educators and are aware of difficulties in finding placement for students at facilities. Many facilities are reluctant to take students. The RCB believes mandating a facility meet preceptor requirements would result in a sharp decline of participation. After review of the RCB’s Workforce Study and other

underlying documents, the RCB determined providing incentives through its CE program is the best way to effectuate the goals listed in its strategic plan. Rather than mandating required training for preceptors, which was feared to halt facility participation, the RCB instead is offering incentives to its licensees to participate in a preceptor training program.

The addition of this leadership category is expected to prepare more licensees to take on leadership roles, and increase the number of licensees serving as preceptors addressing the need for improvement in clinical education and outcomes as well as management attrition.

Live Format

The other highlight of the proposed CE regulations is requiring half or 15 hours of the required 30 hours of CE be taken in a live, interactive format. The RCB values open oral communication as a learning methodology which allows for broader discussions and responses to questions in real time. The RCB believes there is an important educative component when licensees participate in active, real-time courses and activities broadening the spectrum of learning modalities.

Initially the RCB had pursued in-person courses, but concerns were expressed from many people who live in rural areas regarding their ability to physically attend a course or activity. As a result, the RCB eliminated the “in-person” attendance proposal and instead pursued “live” courses. Live courses as defined by this section includes courses provided online where the provider and the learners can communicate either verbally or in writing with each other during the time the learning activity is occurring.

The addition of the live format requirement is expected to increase and encourage communication and platforms for open dialogue of experiences, concerns, and information as it relates to the role of an RCP.

Until these amended regulations are in effect, 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 these:

(1) Those activities relevant to specialized aspects of respiratory care, which activities include education, supervision, and management.

(2) Health care cost containment or cost management.

(3) Preventive 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) Recertification 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 RCB also accepts the passage of any of these credentialing exams as credit toward 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).

The RCB requires courses to be provided or approved by entities as outlined in subdivision (b) of §1399.352 of the CCR.

Since 2006, each licensee is also required to successfully complete a RCB-approved Law and Professional Ethics Course that may be counted toward CE. 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).

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

Audits

Following the RCB's 2016–17 Sunset Review, the RCB considered recommendations made by the committees and included these goals in its 2017–2021 Strategic Plan:

- *Increase the number of continuing education audits to 10% to ensure compliance.*
- *Research and evaluate whether BreEZe can be modified to increase efficiencies in auditing licensees for continuing education compliance.*

In fiscal year 2018–19, the RCB peaked at reaching nearly 8% of renewals audited. But in the following two fiscal years, the number of renewals audited plummeted to only 3.5%. While the RCB was on target and meeting the 10% mark as of October 2017, the RCB was forced to ease up on audits due to a staff person’s extended medical absence. In fiscal year 2019–20 and fiscal year 2020–21, audits were heavily impacted as a result of the issuance of CE waivers and the RCB's efforts to mitigate the additional stress of undergoing an audit during a pandemic. As of October 2021, the CE waiver in place allows licensees with licenses expiring March 31, 2020 through October 31, 2021 to complete CE by January 26, 2022 (and March 28, 2022 for those licenses expiring October 31, 2021).

Currently, the RCB is again on target of its goal to audit 10% of renewals for CE compliance. CE Audits is discussed in greater depth in Section 11, Issue #4, beginning on page 82.

Table 4h. CE Audits Performed/Failed

	FY 16–17	FY 17–18	FY 18–19	FY 19–20*	FY 20–21*
Renewals Audited	513	560	735	360	327
Failed	9	7	29	19	6

* COVID-19 State of Emergency CE waivers allowed licenses expiring between March 31, 2020 and September 30, 2021 to complete CE by January 26, 2022 and licenses expiring on October 31, 2021 to complete CE by March 28, 2022.

The RCB'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 RCB'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.

An average of 3% of licensees fail the renewal audit. Licensees who fail a CE audit subject their license to being placed in an inactive status. If immediate compliance is not met, 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, 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, such as perjury or unlicensed practice. Below are the guidelines RCB staff rely upon when issuing fine amounts for licensees with no discipline history:

Table 4i. CE Violations/Citation and Fine Guidelines

	Fine Amount
Non-Compliance/No Response to 30-day and 10-day initial requests (and subsequently cleared)	$250
Each CE unit deficient	$15
Perjury on renewal form	$300
Unlicensed practice (per day worked) up to 30 days	$50
Unlicensed practice (per day worked) beyond 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.

Section 5
Enforcement Program

The RCB'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 RCB's success in meeting its mandate and highest priority of consumer protection.

PERFORMANCE MEASURES

In 2010, the RCB established performance targets for measures developed by DCA, as a result of the Consumer Protection Enforcement Initiative. DCA also developed the criteria and program to calculate these days, according to its measures.

The RCB's overall goal for all cases to be completed, from the date the complaint is received to final adjudication, is 540 days (18 months). From fiscal year 2012–13 through fiscal year 2015–16, the RCB averaged 572 days to complete the entire process. Prior to that the RCB had a high of 692 days in the final quarter of fiscal year 2011–12.

By fiscal year 2012–13, the RCB fell way under its target processing times for every category within its control. The only exception was the category that includes prosecution, as the RCB has little to no control over the time spent on cases once they are referred to the Office of the Attorney General (OAG).

On the following page you will see that since fiscal year 2017–18, all of the RCB's averages now fall well below the RCB's maximum targets. A more detailed description of each column is as follows:

- PM1 reflects the number of complaints and rap sheets received.
- PM2 reflects the average cycle time from complaint receipt to the date it is assigned to an investigator.
- PM3 marks the average cycle time from complaint receipt to closure of the investigation process. PM3 does not include cases sent to the Office of the Attorney General.
- PM4 represents the average number of days to complete the entire enforcement process for cases resulting in formal discipline (includes intake and investigation by the RCB, and final disposition by the Office of the Attorney General).
- PM7 reflects the average number of days from probation monitor assignment to the date the monitor makes first contact with the probationer.
- PM8 marks the average number of days from the date a violation is reported to the date an assigned probation monitor initiates appropriate action.

The OAG has made incredible strides to reduce processing times and it is wholly responsible for the marked improvement over the last four years and the RCB meeting its "Intake, Investigation and AG" PM4 target. Since fiscal year 2017–18, every quarter has fallen under the RCB's target of 540 days (18 months) and, in half of these quarters, the processing time fell at or under one year. Under the leadership of Senior Assistant Attorney General Gloria L. Castro, the RCB has enjoyed open dialogue and appreciates her efforts to tackle these processing times.

Table 5a. Enforcement Performance Measures	Volume PM1	Intake (in days) PM2	Intake & Inv. PM3	Intake, Inv. & AG (in days) PM4	Probation Intake (in days) PM7	Probation Violation Response (in days) PM8
TARGETS (in days)	**-**	**7**	**210**	**540**	**6**	**10**
FY 2016–17						
Quarter 1: July–Sept. 2016	254	2	65	592	3	1
Quarter 2: Oct.–Dec. 2016	161	2	66	521	3	2
Quarter 3: Jan.–March 2017	169	2	69	596	2	1
Quarter 4: Apr.–June 2017	159	2	59	537	3	2
FY 2017–18						
Quarter 1: July–Sept. 2017	207	2	57	396	4	1
Quarter 2: Oct.–Dec. 2017	186	2	63	421	2	1
Quarter 3: Jan.–March 2018	195	2	53	344	3	2
Quarter 4: Apr.–June 2018	215	2	58	336	3	1
FY 2018–19						
Quarter 1: July–Sept. 2018	220	1	51	326	3	1
Quarter 2: Oct.–Dec. 2018	171	1	46	324	2	2
Quarter 3: Jan.–March 2019	204	1	46	429	2	1
Quarter 4: Apr.–June 2019	198	2	63	365	4	1
FY 2019–20						
Quarter 1: July–Sept. 2019	217	2	69	363	3	2
Quarter 2: Oct.–Dec. 2019	204	1	58	463	3	1
Quarter 3: Jan.–March 2020	191	1	69	516	2	1
Quarter 4: Apr.–June 2020	130	1	60	305	3	1
FY 2020–21						
Quarter 1: July–Sept. 2020	164	1	59	348	4	1
Quarter 2: Oct.–Dec. 2020	160	1	61	416	3	1
Quarter 3: Jan.–March 2021	182	1	46	496	2	1
Quarter 4: Apr.–June 2021	193	1	49	452	2	1

The overall Intake and Investigative time (PM3) falls well below the RCB's target of 210 days with average days between 46 and 69 over the last four years. In the RCB's previous Sunset Report these days were reported between 97 and 115.

ENFORCEMENT STATISTICS

Enforcement statistics have stayed fairly steady over the past three years, though there are some areas of interest.

Convictions Received

RCB staff noticed a marked decrease in the number of rap sheets it received at the onset of the pandemic through the end of the 2020 calendar year which is reflected in "Convictions Received" for fiscal year 2019–20 and fiscal year 2020–21. In the RCB's prior sunset review, it averaged 533 convictions received each year. During this period, the RCB averaged 434 convictions with only 380 of those received in fiscal year 2020–21. While there is a downward trend, future data is needed to determine if the fiscal year 2020–21 figure of 380 was an anomaly related to the pandemic.

Table 5b. Enforcement Statistics

	FY 18/19	FY 19/20	FY 20/21
COMPLAINT			
Intake			
Received	319	294	319
Closed without Referral for Investigation	30	46	45
Referred to Investigation	290	250	274
Pending (close of FY)	2	0	1
Conviction/Arrest			
Convictions Received	474	448	380
Convictions Closed without Referral for Investigation	21	14	6
Convictions Referred to Investigation	449	438	374
Convictions Pending (close of FY)	4	0	0
Source of Complaint			
Public	31	19	17
Licensee/Professional Group	579	510	542
Governmental Agencies	161	169	107
Other	0	0	0
Anonymous	22	44	33
Average Days to Refer for Investigation (from receipt of complaint/conviction to closure at intake)	1	1	1
Average Days to Closure without Referral to Investigation (from receipt of complaint/conviction to closure at intake)	2	3	2
Average Days at Intake (from receipt of complaint/conviction to closure or referral to investigation)	2	1	1

Table 5b. Enforcement Statistics (continued)			
	FY 18/19	FY 19/20	FY 20/21
INVESTIGATION			
Desk Investigations			
Closed	669	665	604
Average Days to Close	47	61	44
Pending (close of FY)	154	119	113
Non-Sworn Investigation			
Closed	62	52	54
Average Days to Close (from Desk Inv to Expert Review to Inv)	156	163	189
Pending (close of FY)	25	25	23
Sworn Investigation			
Closed	1	1	0
Average Days to Close (from Desk Inv to Inv Closed)	47	126	0
Pending (close of FY)	0	0	0
All Investigations			
Opened (First Assigned)	739	688	648
Closed	732	718	658
Average Days for All Investigation Outcomes (from start inv to inv closure or referral for prosecution)	56	69	56
Average Days for Investigation Only—No Prosecution Referral	51	64	49
Avg. Days for Investigation Only—Cases Referred for Prosecution	133	141	212
Average Days from Receipt of Complaint to Inv Closure	56	70	57
Pending (close of FY)	179	144	136
CITATION AND FINE			
Citations Issued	71	77	36
Average Days to Complete (from complaint receipt to citation issued)	65	74	81
Amount of Fines Assessed	$53,058	$47,563	$16,760
Reduced, Withdrawn, Dismissed	$3,350	$7,475	$110
Amount Collected	$41,413	$44,795	$12,885
CRIMINAL ACTION			
Referred for Criminal Prosecution	1	0	0

Table 5b. Enforcement Statistics (continued)			
	FY 18/19	FY 19/20	FY 20/21
ACCUSATION			
Accusations Filed	36	30	28
Accusations Declined	1	1	0
Accusations Withdrawn	0	1	0
Accusations Dismissed	3	0	0
Average Days to File ACC (from Date Sent to AG to Date Filed)	65	82	70
INTERIM ACTION			
ISOs Issued	6	1	1
PC 23 Orders Issued	0	1	0
Compel Examination Orders	1	0	0
LICENSEE DISCIPLINE			
AG Cases Initiated (cases referred to the AG in FY)	48	43	31
AG Cases Pending Pre-Accusation (close of FY)	5	10	6
AG Cases Pending Post-Accusation (close of FY)	17	21	13
Disciplinary Outcomes			
Revocation	18	5	9
Voluntary Surrender	7	4	4
Suspension	0	0	0
Probation with Suspension	5	6	1
Probation	6	10	18
Public Reprimand	0	0	1
Other	0	0	0
Disciplinary Actions			
Proposed Decisions	3	3	5
Default Decisions	15	5	8
Stipulations	17	17	20
Proposed Decisions (Avg Days from Accusation Filed to Imposing Discipline)	370	409	456
Default Decisions Avg Days from Accusation Filed to Imposing Discipline)	118	144	141
Stipulated Decisions (Avg days from Accusation Filed to Imposing Discipline)	139	201	214
Average Days from Date Accusation Filed to Imposing Discipline	150	215	233
Average Days from Closure of Investigation to Imposing Discipline	225	284	315
Average Days from Date Complaint Received to Final Outcome	350	454	442

Table 5b. Enforcement Statistics (continued)			
	FY 18/19	FY 19/20	FY 20/21
PROBATION			
Probations Successfully Completed	13	14	10
New Probationers	15	18	20
Probationers Tolling (close of FY)	5	6	7
Active Probationers (close of FY)	51	45	51
Cease Practice Orders			
Cease Practice Orders Issued	9	4	12
Orders Upheld	4	1	4
Orders Dissolved	5	3	8
Subsequent Discipline			
Accusation and/or Petition to Revoke Probation	9	3	2
Probations Revoked	2	4	0
Probations Surrendered in Lieu of Disciplinary Action	3	1	2
Probations Voluntary Surrendered (no discipline)	3	4	1
Probations Extended	1	0	1
Substance Abusing Licensees			
Probationers Subject to Drug Testing (entire FY)	42	38	30
Drug Tests Ordered	930	895	703
Positive Drug Tests	127	71	52
Number of Probationers Testing Positive	12	8	8
Positive Drug Tests for Banned Substances			
Positive Drug Tests	4	1	6
Number of Probationers w/Positive Drug Tests	4	1	4
PETITIONS			
Petitions to Modify Probation			
Granted	0	0	0
Denied	1	0	0
Petitions to Terminate Probation			
Granted	5	5	3
Denied	0	0	0
Petitions for Reinstatement of License			
Granted	0	0	0
Granted with Probation	3	1	1
Denied	1	2	0

Average Days for Investigation Only- Cases Referred for Prosecution

On page 42, the "Average Days for Investigation Only—Cases Referred for Prosecution" increased over the three year period from 133 days in fiscal year 2018–19 to 212 days in fiscal year 2020–21. This increase is directly attributed to the retirement of one investigator (November 2020) and the training of a new investigator, as well as delays associated with the pandemic beginning in or around March 2020. Investigators found that response time increased overall from criminal courts and facilities to obtain criminal or patient records. Investigators were also unable to visit facilities for several months. (The two cases referred to Division of Investigation were not typical complaint investigations and were not referred for prosecution. Therefore, those cases were not factored into this figure.) The RCB expects the "Average Days for Investigation when Referring for Prosecution" to improve as pandemic restrictions ease.

Disciplinary Actions

On page 43, under "Disciplinary Actions," the RCB added three additional rows of data:

Proposed Decisions (Avg Days from Accusation Filed to Imposing Discipline)	370	409	456
Default Decisions (Avg Days from Accusation Filed to Imposing Discipline)	118	144	141
Stipulated Decisions (Avg days from Accusation Filed to Imposing Discipline)	139	201	214

Stipulated decisions account for 60%, and default decisions account for 25%, of the total caseload. By breaking down the "Average Days from Accusation Filed to Imposing Discipline" to each decision type, the RCB can better identify where improvements can be made in the processing times at the Office of the Attorney General (OAG). The OAG has much less control over those few cases (between three and five cases) referred for hearing that result in proposed decisions. However, the RCB intends to continue working with the OAG to improve processing times for default and stipulated decisions.

Probation

SB 1441 (Statutes of 2008), created the Substance Abuse Coordination Committee (SACC), which was 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.

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

Random Testing Schedule	Random Tests Per Year Per Probationer
Prior to 2009	6–8
Jan. 2009–Feb. 2011	12–16
Mar. 2011–Jun. 2011	24
Jul. 2011–Present / First Year of Probation	52–104
Jul. 2011–Present / Second Year+ of Probation	36–104
Jul. 2011–Present / Not Working in Health Care Field	12

In the RCB's prior Sunset Report, it reported:

> "*The RCB 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. ..."*

Table 5c reflects data from fiscal year 2013–14 to present. It appears after the initial rollout of increased testing in July 2011, the RCB was successful in detecting continued drug/alcohol use for a high percentage of its probationers subject to drug testing, through fiscal year 2013–14. Thereafter, the percentages decreased and have remained rather constant between 11% and 15% with the exception of fiscal year 2019–20.

Table 5c. Positive Drug Tests for Banned Substances

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
Number of Probationers w/Positive Drug Tests	13	10	7	6	5	4	1	4
Probationers Subject to Drug Testing (entire FY)	61	67	60	47	45	42	38	30
% of Probationers Testing + to Probationers Subject to Drug Testing	21%	15%	12%	13%	11%	10%	3%	13%

The RCB's prior Sunset Report also stated:

> *"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."*

Data from fiscal year 2016–17 through fiscal year 2020–21, as shown in Table 5d. reflects a similar trend with 30% of probationers subject to drug testing, testing positive in the first three months, 55% in the first year, 30% within the second year, and 15% in years 2–5.

Table 5d. Days to Initial Positive Test

	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	Totals	% of 20 Total
0–90 days	2	-	2	-	2	6	30%
0 days–1 year	4	2	3	-	2	11	55%
1–2 years	2	2	1	-	1	6	30%
2+ years	-	1	-	1	1	3	15%

Finally, the RCB looked at the data expressed in Table 5d at another angle identifying the "random testing schedule" that each probationer was assigned at the time of testing positive. Table 5e indicates that 12 (or 60%) of the total 20 positive tests were conducted while the probationer was assigned to be tested 52 times per year. Three or 30% of positive tests were conducted while probationers were on a 36 times per yea" testing schedule.

There are a number of ways this data could be interpreted. However, drawing attention to the "1–2 years" row only, there are three reported at the "36x" and two reported at the "52x" a year testing schedules. After the first year of probation, testing is usually reduced to 36 times per year. A probationer still being tested at the "52x" level indicates there were suspicious drug tests or another reason they are being tested at this level. Based on this very limited data, one could argue that reducing the testing frequency after the first year to 36x a year remains equally effective as randomly testing 52x after the first year. While there is insufficient data to draw any conclusions, the data is interesting nonetheless and may prove beneficial as the probation program evolves.

Table 5e. Testing Schedule at Time of Initial Positive Test

: FY 2016–17–FY 2020–21 Data	12x a year	36x a year	52x a year	Totals
0–90 days	-	-	6	6
0 days–1 year	1	-	10	11
1–2 years	1	3	2	6
2+ years	-	3	-	3
% of 20 Total	10%	30%	60%	-

Enforcement Aging

Table 5f shows that 72% of cases where formal discipline of a license or the denial of an application was sought through the Office of the Attorney General were closed within the first year. This is a marked improvement from the data reported in the RCB's previous Sunset Report where only 26% of these cases were completed in the same time frame. In addition the RCB previously reported for fiscal years 2012–13–fiscal year 2015–16 that 78% of these cases were closed within two years. This reporting period reflects 97% of all cases were closed within two years.

The same trend is reflected in Investigations as well. In the RCB's prior Sunset Report, it indicated 83% of investigations took less than six months to complete. During this reporting period, that figure climbed to 93%.

Table 5f. Enforcement Aging

	FY 2017–18	FY 2018–19	FY 2019–20	FY 2020–21	Cases	Average
Attorney General Cases (Average %)						
CLOSED WITHIN:						
0–1 Year	37	59	17	31	144	72%
1–2 Years	21	5	14	10	50	25%
2–3 Years	3	0	1	1	5	3%
3–4 Years	0	0	1	0	1	1%
Over 4 Years	0	0	0	0	0	0%
Total Cases Closed	61	64	33	42	200	100%
Investigations (Average %)						
CLOSED WITHIN:						
90 Days	583	606	552	545	2286	81%
180 Days	96	77	94	69	336	12%
1 Year	39	44	58	29	170	6%
2 Years	7	3	13	15	39	1%
3 Years	1	1	1	0	3	0%
Over 3 Years	0	0	0	0	0	0%
Total Cases Closed	726	732	718	658	2834	100%

STATUTE OF LIMITATIONS

The RCB operates within a statute of limitations as provided in §3750.51 of the B&P. Since this section was enacted in 2000, no cases have been lost or not pursued as a result of these limitations. It is the RCB's policy to ensure cases are adjudicated accordingly.

§ 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.

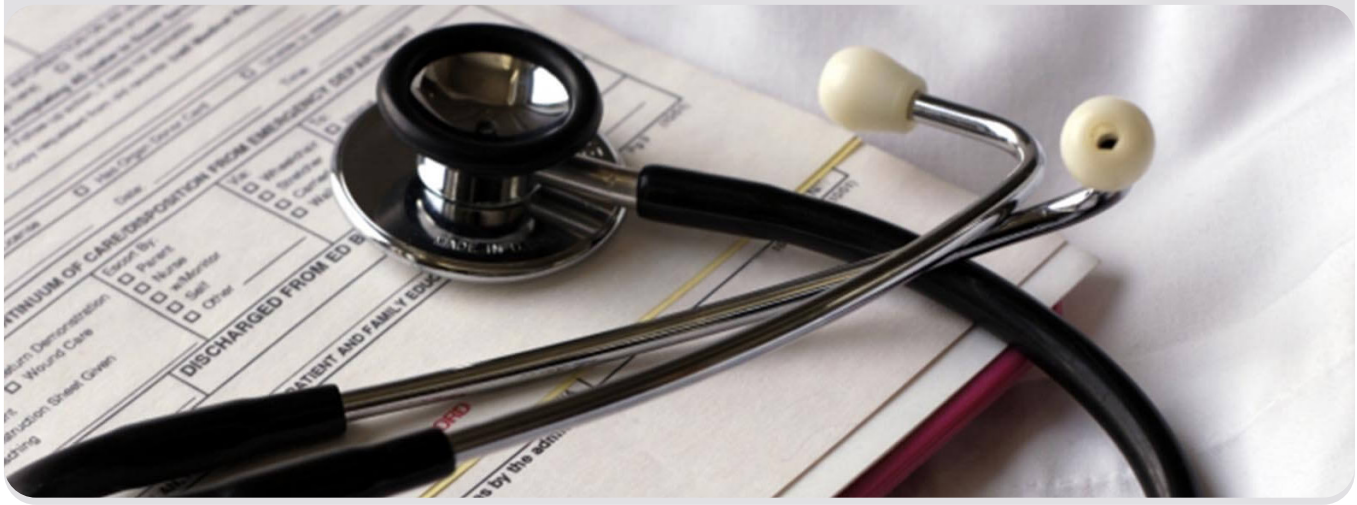
(b) An accusation filed against a licensee pursuant to Section 11503 of the Government Code alleging the procurement of a license by fraud or misrepresentation is not subject to the limitations set forth in subdivision (a).

(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.



CASE PRIORITIZATION

The RCB 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 workflow charts on pages 52–53 also show how urgent complaints are handled differently through the intake and investigative processes versus 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:

- 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.

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:

- 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 generally 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:

High-Level Routine Complaints

- General unprofessional conduct and/or general negligence/incompetence resulting in no injury or minor harm/injury (non-intentional act, non-life 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.

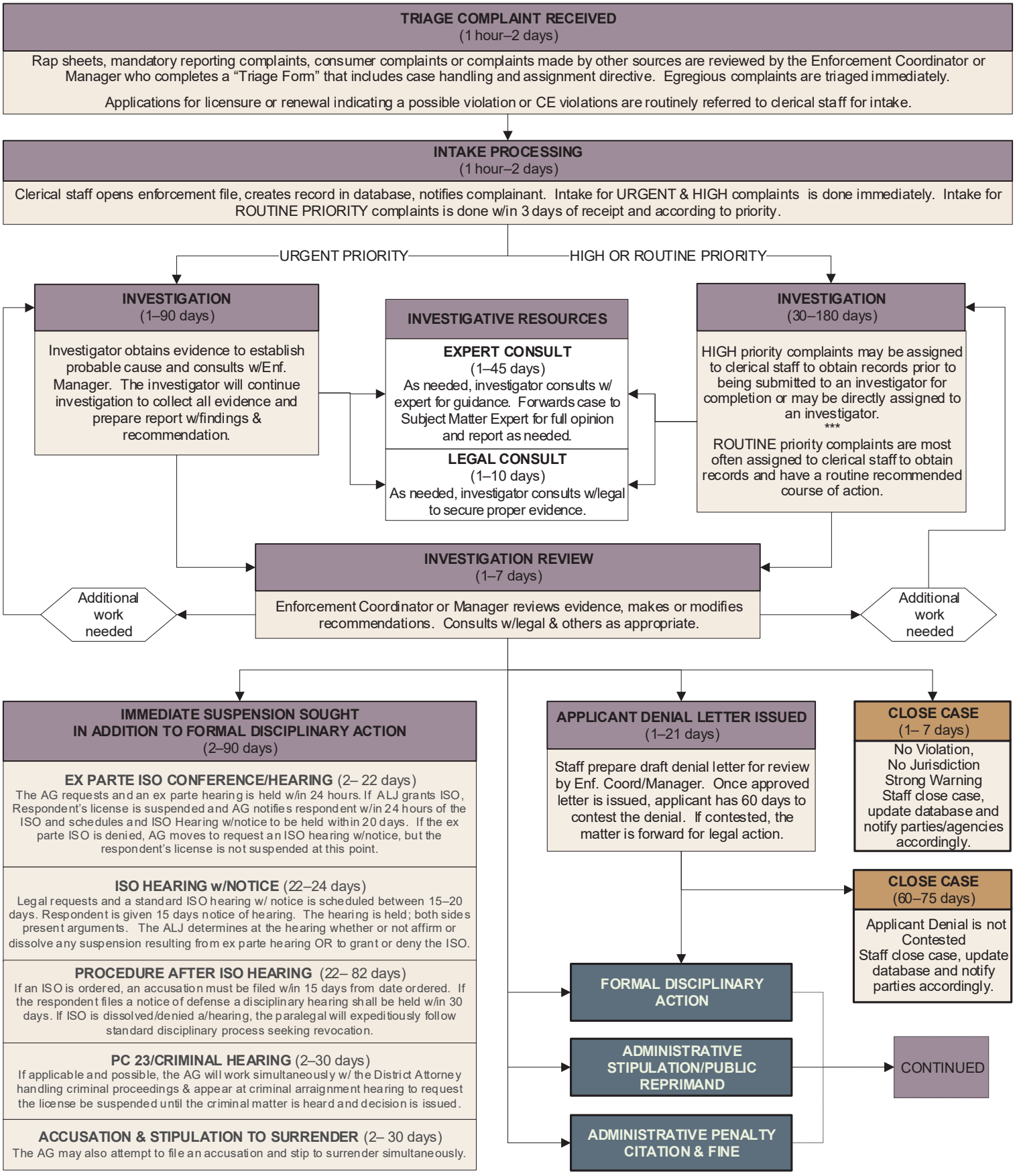
Low-Level Routine Complaints

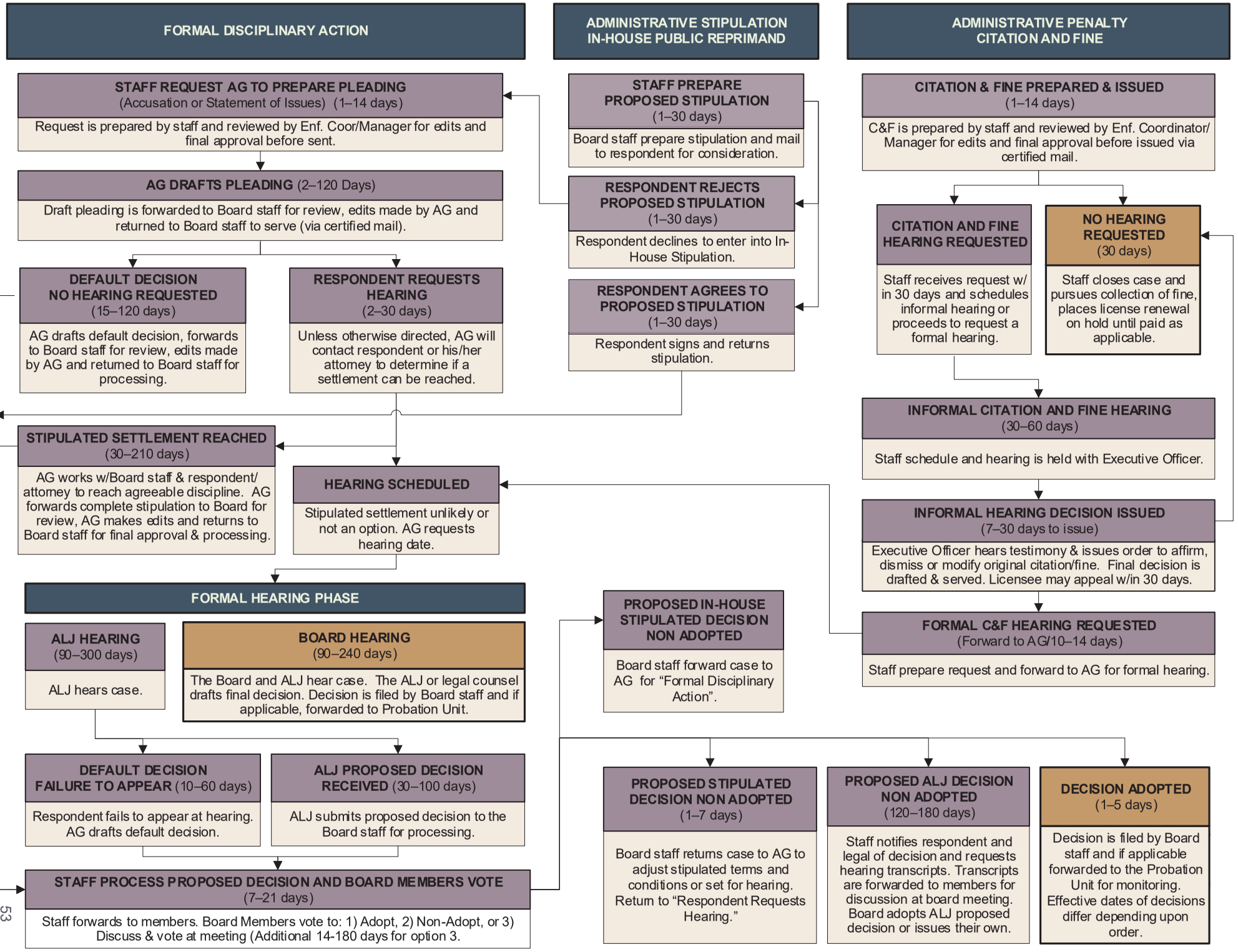
- Unsanitary conditions.
- Failure to release medical records.
- Continuing education violations.
- Declaration and record collection (e.g., licensee statements, medical records, arrest and conviction records, employment records).
- Complaints of offensive behavior or language (e.g., poor bedside manner, rude, etc.).
- Quality-of-service complaints.
- Complaints against licensee on probation that do not meet other category criteria.
- Anonymous complaints unless RCB corroborates it meets other category criteria.
- Other minor violations that generally result in the issuance of a citation and fine or warning (e.g., failed to report a change of address).

Respiratory Care Board of California

ENFORCEMENT PROCESS OVERVIEW

(Revised 10/14/21)




FORMAL DISCIPLINARY ACTION
ADMINISTRATIVE STIPULATION IN-HOUSE PUBLIC REPRIMAND
ADMINISTRATIVE PENALTY CITATION AND FINE
STAFF REQUEST AG TO PREPARE PLEADING (Accusation or Statement of Issues) (1–14 days)
Request is prepared by staff and reviewed by Enf. Coor/Manager for edits and final approval before sent.
AG DRAFTS PLEADING (2–120 Days)
Draft pleading is forwarded to Board staff for review, edits made by AG and returned to Board staff to serve (via certified mail).
DEFAULT DECISION NO HEARING REQUESTED (15–120 days)
AG drafts default decision, forwards to Board staff for review, edits made by AG and returned to Board staff for processing.
RESPONDENT REQUESTS HEARING (2–30 days)
Unless otherwise directed, AG will contact respondent or his/her attorney to determine if a settlement can be reached.
STAFF PREPARE PROPOSED STIPULATION (1–30 days)
Board staff prepare stipulation and mail to respondent for consideration.
RESPONDENT REJECTS PROPOSED STIPULATION (1–30 days)
Respondent declines to enter into In-House Stipulation.
RESPONDENT AGREES TO PROPOSED STIPULATION (1–30 days)
Respondent signs and returns stipulation.
CITATION & FINE PREPARED & ISSUED (1–14 days)
C&F is prepared by staff and reviewed by Enf. Coordinator/ Manager for edits and final approval before issued via certified mail.
CITATION AND FINE HEARING REQUESTED
Staff receives request w/ in 30 days and schedules informal hearing or proceeds to request a formal hearing.
NO HEARING REQUESTED (30 days)
Staff closes case and pursues collection of fine, places license renewal on hold until paid as applicable.
INFORMAL CITATION AND FINE HEARING (30–60 days)
Staff schedule and hearing is held with Executive Officer.
INFORMAL HEARING DECISION ISSUED (7–30 days to issue)
Executive Officer hears testimony & issues order to affirm, dismiss or modify original citation/fine. Final decision is drafted & served. Licensee may appeal w/in 30 days.
FORMAL C&F HEARING REQUESTED (Forward to AG/10–14 days)
Staff prepare request and forward to AG for formal hearing.
STIPULATED SETTLEMENT REACHED (30–210 days)
AG works w/Board staff & respondent/ attorney to reach agreeable discipline. AG forwards complete stipulation to Board for review, AG makes edits and returns to Board staff for final approval & processing.
HEARING SCHEDULED
Stipulated settlement unlikely or not an option. AG requests hearing date.
FORMAL HEARING PHASE
ALJ HEARING (90–300 days)
ALJ hears case.
BOARD HEARING (90–240 days)
The Board and ALJ hear case. The ALJ or legal counsel drafts final decision. Decision is filed by Board staff and if applicable, forwarded to Probation Unit.
DEFAULT DECISION FAILURE TO APPEAR (10–60 days)
Respondent fails to appear at hearing. AG drafts default decision.
ALJ PROPOSED DECISION RECEIVED (30–100 days)
ALJ submits proposed decision to the Board staff for processing.
STAFF PROCESS PROPOSED DECISION AND BOARD MEMBERS VOTE (7–21 days)
Staff forwards to members. Board Members vote to: 1) Adopt, 2) Non-Adopt, or 3) Discuss & vote at meeting (Additional 14-180 days for option 3.
PROPOSED IN-HOUSE STIPULATED DECISION NON ADOPTED
Board staff forward case to AG for “Formal Disciplinary Action”.
PROPOSED STIPULATED DECISION NON ADOPTED (1–7 days)
Board staff returns case to AG to adjust stipulated terms and conditions or set for hearing. Return to “Respondent Requests Hearing.”
PROPOSED ALJ DECISION NON ADOPTED (120–180 days)
Staff notifies respondent and legal of decision and requests hearing transcripts. Transcripts are forwarded to members for discussion at board meeting. Board adopts ALJ proposed decision or issues their own.
DECISION ADOPTED (1–5 days)
Decision is filed by Board staff and if applicable forwarded to the Probation Unit for monitoring. Effective dates of decisions differ depending upon order.

MANDATORY REPORTING

The RCB receives an average of 25 mandatory reporting complaints each year. 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 RCB 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 these 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, he or she must report that information to the RCB.

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

UNLICENSED ACTIVITY

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

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

The RCB may issue a citation and fine to employers as well as to 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 RCB’s Cite and Fine (C&F) program allows the RCB to penalize licensees rather than pursue formal discipline for less serious offenses or offenses where probation or revocation are not appropriate. 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 RCB amended its regulations, effective July 1, 2012, to increase nearly all fine amounts to the maximum of $5,000 pursuant to §125.9 of the B&P. The RCB also has authority to cite and fine other specific violations up to $15,000 as follows:

§3717 Failure of an employer to provide records as part of an investigation (Maximum fine: $10,000 per violation).

§3758 Failure to report the suspension or termination for cause of a licensed RCP (Maximum fine: $10,000 per violation).

§3758.6 Failure to report the supervisor of the licensee who was suspended or terminated for cause. (Maximum fine: $10,000).

§3767 Unlicensed Practice or knowingly employing unlicensed personnel (Maximum fine: $15,000 per violation).

The number of citations issued in fiscal year 2020–21 was reduced by nearly half as shown on page 42. In 2018–19, 71 citations were issued compared to 36 in 2020–21. This reduction is a direct result of the drastically reduced number of CE audits performed due to the COVID-19 pandemic. In 2019–20 there were 31 citations issued for CE violations, compared to 6 citations issued in 2020–21.

Over the three-year period, 50% of citations issued were for driving under the influence of alcohol (with no priors within seven years), 25% were issued for CE violations, and the remaining 25% were issued for various violations including unlicensed practice, perjury, and other less egregious criminal convictions. 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. The most common fine amounts for approximately 90% of these cases are either $250 or $500. Of the 184 citations issued over the last three fiscal years, seven (4%) have appealed: six by way of informal conferences and one by way of a hearing with an Administrative Law Judge (ALJ).

COST RECOVERY

In the last four fiscal years, the RCB has had between 25 and 47 cases each year that had potential for cost recovery. The RCB initially sought full cost recovery in all 140 of these cases. Ultimately, costs were ordered in all cases except one. The most common reasons the RCB would 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 RCB believes consumer protection is at imminent risk.

Table 5g. Cost Recovery

	FY 2017–18	FY 2018–19	FY 2019–20	FY 2020–21
Total Enforcement Expenditures	$449,451	$554,121	$491,261	$550,879
Potential Cases for Recovery	47	35	25	33
Cases Recovery Ordered	47	35	24	33
Amount of Costs Ordered	$215,805	$237,486	$187,908	$234,234
Amount Collected	$84,386	$135,019	$119,867	$106,721

Over this four year period, the total "Amount of Costs Ordered" and "Amount Collected" were $875,433 and $445,993, respectively. The RCB collected 51% of the costs ordered during this time frame. The RCB is most successful in collecting costs in cases that result in probation or a public reprimand, because licensees are more vested in retaining licensure. In nearly all cases, in which licensees are surrendering their license the RCB 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 from which to collect costs are those resulting in revocation.

Cost recovery ordered averages $6,253 per case and is due within one year from the date ordered (though the RCB is very flexible with payment schedules/extensions).

The RCB employs several mechanisms to recover costs, including:

- Franchise Tax Board Intercept Program.
- Renewal hold.
- RCB database billing.
- Collection agency contract.

The RCB began using the Franchise Tax Board Intercept Program in 1996. If the licensee is scheduled to receive a tax refund, those monies are intercepted and paid to the RCB. The RCB also has the authority to “hold” a renewal for a licensee’s failure to pay 1) probation monitoring costs once they are off probation (§3753.1), 2) cost recovery (§3753.5), or 3) 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 RCB developed its own Cost Recovery Database to track all fines, cost recovery, and probation monitoring costs ordered. In 2013, the RCB employed a similarly configured component in BreEZe. This system also generates invoices which have proven to be 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 RCB 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 RCB 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 RCB by the due date, a “hold” is placed on the license to prevent renewal until payment is made. If the respondent is not a licensee and has not made contact with the RCB 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.

Since 2003, the RCB has also employed the services of a collection agency. The contractor is reimbursed for its services by receiving approximately 15% of all the costs it collects. Thus, the RCB is careful to only forward those cases in which other avenues have been exhausted.

Section 6
Public Information Policies

WEBSITE/EMAIL

The RCB's website is an effective tool in sharing information with its stakeholders. The RCB redesigned its website in 2017, to provide a user-friendly experience and keep the public informed about RCB activities. The RCB's website includes many materials and references including all of the following:

- Upcoming RCB meeting dates and general locations.
- RCB agendas and related materials/attachments.
- RCB meeting minutes.
- Proposed regulation amendments.
- Topics of interest.
- Newsletters.
- Strategic plans.

The RCB's website was also instrumental in conveying up-to-date information at the onset of the COVID-19 State of Emergency when information was rapidly coming about. DCA's Internet Team was very responsive with incredible turnaround times in getting our posts updated within minutes or hours.

The RCB also uses email to distribute updates and notices. Any person may sign up to receive all updates and notices via the RCB's website. In addition, the RCB now has the functionality to use email addresses provided by licensees in the BreEZe system. The BreEZe mass email is only used for rare, high-priority updates and notices.

BOARD MEETINGS

The RCB 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 10 days prior to a meeting. Once an agenda is posted, the RCB sends email notices to interested parties with a link to the agenda and materials. A very small number of hard-copy agendas and materials are mailed to members and interested parties. Since February 2011, agenda materials or attachments have been posted online at the same time agendas are posted. Minutes of each meeting are approved at the following meeting and then promptly added to the website.

Beginning with its February 2011 meeting, the RCB began using DCA's services to webcast its meetings where schedules permit. Those meetings are posted on YouTube and date back as far as 2016. With temporary authority to hold meetings online to reduce travel during the COVID-19 pandemic, the RCB held five meetings in 2020 and 2021 via Webex. DCA has been phenomenal in setting up online access and moderating each meeting.

COMPLAINT DISCLOSURE POLICY

Upon receipt of a consumer inquiry, the RCB provides information and records in accordance with the Public Records Act (ssections 6250–6270 of the Government Code).

The RCB'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, these documents are 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 RCB'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 they are licensed.

The RCB also returned to providing disciplinary summaries, a practice that was halted at the time BreEZe was implemented in 2013. Reinstating the summaries was prompted by recommendations following the RCB's last Sunset Review in 2016-17. Rather than looking up a specific person for a record, you can look at the summary of all the disciplinary action taken each quarter. The information posted dates back to October 2016.

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

OUTREACH

The RCB uses several methods to perform outreach. Annually, the RCB publishes an online newsletter with pertinent information to all its licensees. The RCB 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.

The RCB also uses direct email communication to education program directors regarding new requirements or information that impacts their program, existing students, or incoming students. Program directors have proven to be a valuable resource in disseminating information to students.

RCB members have also contributed to articles published by the DCA including:

President Ricardo Guzman's Contribituons to DCA Blog: *Children at Risk for Using the Wrong Asthma Inhaler Technique*.

Member Michael Terry's contribution to an upcoming article that will be featured in DCA's *Consumer Connection* titled: *The Hidden Danger of Wildfire Smoke*.

Section 7
Online Practice Issues

Telehealth is becoming an integral part of the delivery of healthcare today. This is especially important, as studies show that telehealth reduces hospital readmissions, improves quality of life, and reduces costs.

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 healthcare 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 healthcare while the patient is at the originating site and the healthcare 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 healthcare 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."

Telehealth provided by respiratory therapists may include:

- Patient assessment and education.
- Diagnostic evaluation.
- Sleep testing.
- Home ventilator monitoring and management.
- Monitoring patient health and activities.
- Managing patients with chronic conditions.
- Disease prevention.
- Health promotion.
- Patient consultations.
- Rehabilitation.

Respiratory therapists are uniquely qualified to provide telehealth services, given their understanding of respiratory disease states ranging from routine outpatient services to the most acute emergency care.

The RCB does not have any laws, regulations or policies that are specific to telehealth. To date, the RCB has not received any complaints involving telehealth practice. At this time, the RCB's existing statutes and regulations could and would be applied to any act of incompetence, negligence, unprofessional conduct, or any other violation of the Respiratory Care Practice Act.

Section 8
Workforce Development and Job Creation

The RCB's 2007 workforce study suggested California would need an available supply of 19,000 RCPs by 2025 and 21,000 RCPs by 2030. At the end of fiscal year 2020–21, California had 20,248 active licenses. Outside of any reductions that may result from vaccine mandates, the RCB does not foresee a workforce shortage.

However, the RCB's 2017 Workforce Study highlighted the expected retirement of 35% of people ***in management*** in the coming years. The following indicators suggest the RCB is currently witnessing this attrition.

	FY 16/17	FY 17/18	FY 18/19	FY 19/20	FY 20/21	Difference/ Sum
Active	19,668	19,588	19,676	20,052	20,248	580
Retired*	684	775	865	940	1,017*	333
New Licenses Issued	1,146	1,105	1,124	1,137	1,175	5,687

*A licensee has the option of placing their license in a retired status at any time, though it is not required. Many licensees still allow their license to lapse and then eventually cancel. As of October 1, 2021, the RCB had 1,139 retired licenses.

While there have been 5,687 new licenses issued since fiscal year 2016–17, the number of active licenses has only increased by 580, leaving 5,107 licenses that either retired or allowed their license to become delinquent (delinquent licenses cancel after three years) over a period of five years. There is no data to determine how many of these are held by RCPs in management. However, with a workforce at any given time of 20,000, the 5,107 figure represents that roughly 25% of the workforce has gone from an active and current status to a non-working license status.

The California Employment Development Department (EDD) published the following occupational outlook for respiratory therapists:

Estimated Year–Projected Year	Employment		Employment Change		Annual Average Openings
	Estimated	Projected	Number	Percent	
2018–2028	17,600	22,500	4,900	27.8%	15,490

The U.S. Bureau of Labor Statistics provides:

> "Employment of respiratory therapists is projected to grow 23% from 2020 to 2030, much faster than the average for all occupations.
>
> About 10,100 openings for respiratory therapists are projected each year, on average, over the decade. Many of those openings are expected to result from the need to replace workers who transfer to different occupations or exit the labor force, such as to retire. [Generally, the California RCP workforce represents 10% of the national RCP workforce.]"

The RCB also remains aware of the need to process applications timely and remove unnecessary barriers. Education programs are kept informed by direct e-mail of any changes that may impact incoming or existing students as it relates to the application and licensure process. The RCB periodically revises its booklet, "Licensure and the Application Process" and disseminates multiple copies to each education program. The last revisions were completed in August 2020.

In 2010, the RCB examined its application process to determine if it could be re-engineered to further speed the process. 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 RCB 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 money before the license could be issued. The RCB amended its fees through regulation by eliminating the initial licensing fee altogether (and increasing its application fee to balance revenues). As a result, completed applications now take an average of seven days to process.

Other barriers exist outside the licensure process to successfully enter the respiratory profession. The RCBs 2017 Workforce Study outlined some of the challenges facing new graduates:

> *Students' supervised clinical experiences obtained through their education programs are not consistent. Many do not experience the full range of clinical pathology, procedures, and equipment used in respiratory care, leaving them at a disadvantage for new employment.*
>
> *Students need additional education to develop and strengthen their clinical thinking and clinical reasoning skills to be competitive for entry-level therapist positions*.

The RCB is making strides to improve education programs in both of these areas. Partially through regulation and more wholly through examining the incorporation of a bachelor degree into the Respiratory Care Practice Act. Currently, nearly all graduates have completed 100 units of education: 25 units shy of the 125 units needed for most bachelor degrees. The RCB is looking at whether increasing the level of minimum education could fill the gaps found in the 2017 workforce study. Further detail of the study and the RCB's response can be found in Section 11, Issue #1 UCSF Workforce Study.

Section 9
Current Issues

UNIFORM STANDARDS FOR SUBSTANCE ABUSING LICENSEES

In the RCB's 2012–2013 Sunset Oversight Review Report, the RCB 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 RCB's 2012–2013 Sunset Oversight Review Report, the RCB detailed its implementation of proposals that were part of the CPEI. Proposals implemented by the RCB 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.
- Obtaining a legislative mandate to revoke the license of any person convicted of specific sexual misconduct crimes.

BreEZe (ENFORCEMENT AND LICENSING SYSTEM)

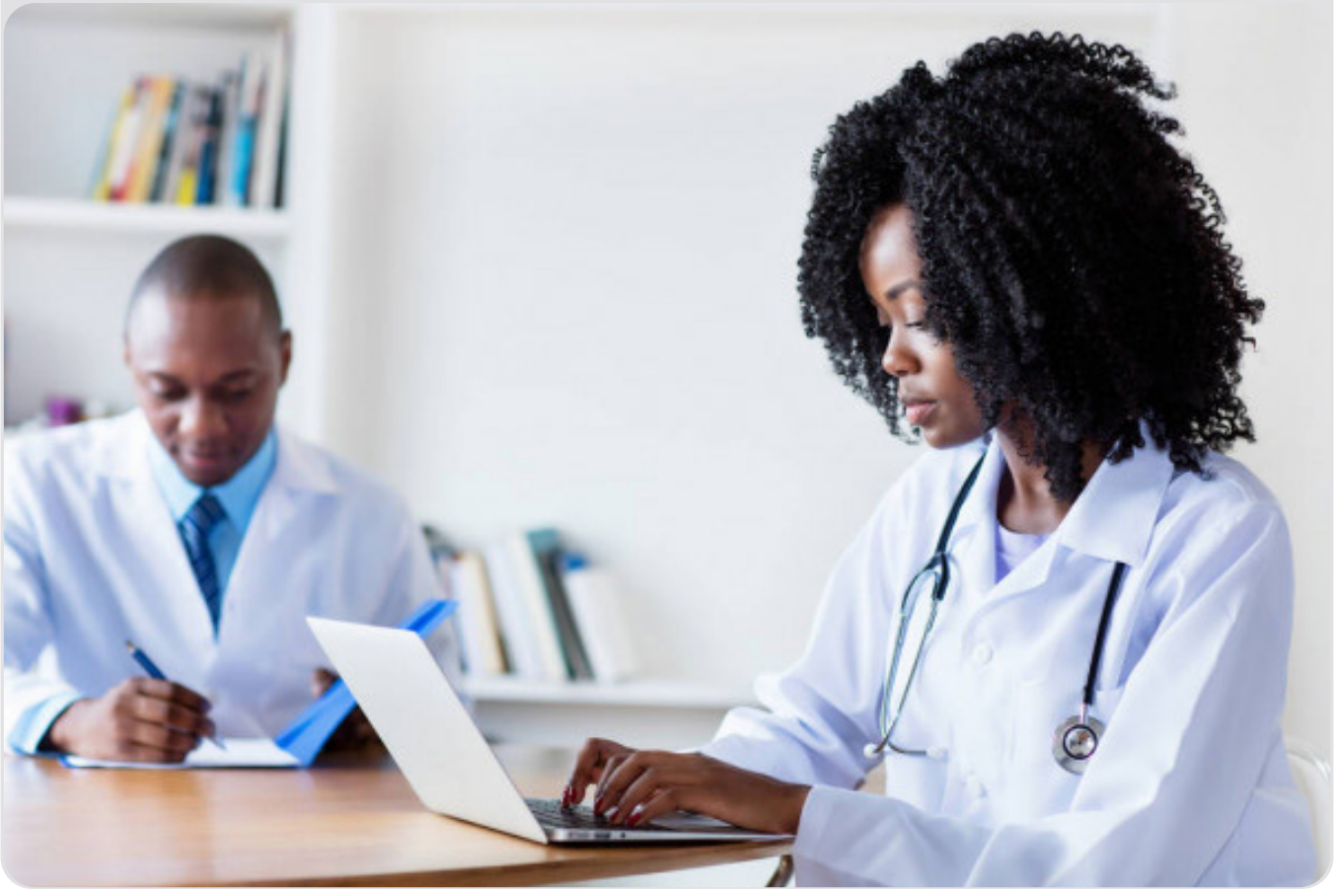
As a result of the CPEI proposals in 2010, DCA relaunched its effort and was successful in acquiring the support and resources needed to establish a system that would replace the antiquated licensing and enforcement database referred to as CAS (Consumer Affairs System), and the numerous independent workaround databases.

The RCB was in the first rollout of BreEZe in October 2013. The system was designed to include all the elements from several other databases the RCB had including the RCB's cost recovery database, probation monitoring database and several tracking spreadsheets. The initial rollout was relatively smooth. Within the first six months of the rollout, the RCB had submitted nearly 130 change requests. All of these requests were resolved to the satisfaction of the RCB in a timely manner. The DCA staff who led this project did an exceptional job in the first rollout. The level of commitment they demonstrated then, as now, is commendable.

The highlight of the system is the online renewal function. Approximately 90% of licensees use the system to renew their licenses and the initial feedback indicated they were extremely pleased this service was made available.

The reports module has been an extremely beneficial tool that did not previously exist. Staff are able to extract data in so many ways which also allow management to further identify strengths and weaknesses.

In April 2021, the RCB rolled out its online initial application module. Applicants may now apply online and have immediate access to the status of their application. While initial use of this feature was low, the feedback has been very positive. The RCB expects use of the online system to dramatically increase over the next two years as students and program directors have the opportunity to familiarize themselves with the application module.



Section 10
Board Action and Response to COVID-19

In response to the COVID-19 State of Emergency Order (issued on March 4, 2020), a dramatic shift in how the RCB conducted business occurred virtually overnight. Throughout March and April 2020, while RCB staff were implementing safety protocols and transitioning to telework, they were also working fervently to respond to floods of calls and emails requesting information and waivers.

The first and most profound challenge the RCB identified in response to the State of Emergency was the possibility of an insufficient number of RCPs available to respond to a virus that was known to attack the lungs in serious cases. Respiratory therapists are the experts in diagnosing and treating respiratory ailments across the medical spectrum. Severe cases of COVID-19 lead to low oxygen saturation levels, and extreme cases almost always result in the need for mechanical ventilation: both of which are areas of RCP specialty. Knowing that the lives of patients would be dependent upon having enough respiratory therapists available to respond made finding legal pathways to supplement the workforce the RCB's top priority.

At the same time, it was not only imperative for staff to be up and running to respond to emergency needs, but also to continue to be productive and responsive to consumers. This required the review of duties, configuring access to outside databases, following large-gathering restrictions, and 100% team participation to make sure we were successful.

Every team member played a part in our seamless transition. At exactly the time the emergency hit, staff members were contending with divorce, family deaths, children in daycare and school, and maternity leave. Yet, every single team member was still eager to go above and beyond to help with the transition. RCB President Ricardo Guzman was in touch with executive staff almost daily for several weeks. The president took care of several issues himself, including responding to the California Department of Public Health's requests to find therapists needed at subacute facilities. From the staff answering telephones to the RCB president, and even those from other state agencies, every person encountered was invested in helping.

Teleworking

Within one week from the issuance of the order, all staff began teleworking with the exception of two staff members who remained in the office full time to answer telephones and distribute mail. All other staff were placed on staggered schedules to be in the office one to two days a week and work from home the remaining days. The RCB recognizes and appreciates DCA Director Kimberly Kirchmeyer and then-IT Chief Jason Piccone for the exceptional job in getting all staff trained and accessing our network safely from home within the first week of this event.

Overall, teleworking has proved to be successful, with increased productivity in many areas. RCB management received feedback from staff that they felt more productive and data included in this report supports those claims. In fiscal year 2020–21, the RCB received a record-high number of initial applications for licensure, yet the average processing time still remained at seven days. Nearly all of the processing times for enforcement workload remained the same and some processing times are even showing record improvements since January 2021.

The RCB currently has teleworking agreements as applicable for all staff. However, the State Administrative Manual was recently updated to include revisions to the statewide telework policy. The RCB will be working with DCA to update and revise existing telework procedures to conform to the new statewide telework policy prior to the October 1, 2022 deadline.

Legal Waivers

As soon as the State of Emergency was declared, our office immediately began working with Legal Counsel to determine the RCB's authority to allow various waivers and allow students, retirees, and out-of-state licensees to fill anticipated gaps. The daily calls and emails requesting guidance and action were mounting in intensity as each day passed.

At this same time, the Administration wanted to have a unified response, so the RCB turned our attention to working with DCA for waiver approvals. DCA's waiver process resulted in a cohesive and uniform response for the entire Department, which was appreciated in the months that followed. The RCB recognizes and appreciates Christine Molina, Liane Freels, and Kathryn Pitt as well as its legal counsel Fred Chan-You for being available and responsive all hours of the day, and making web updates and disseminating information as soon as it became available.

All waivers the RCB requested were ultimately approved pursuant to the Governor's Executive Order N-39-20, which provides the director of the California Department of Consumer Affairs may waive any statutory or regulatory renewal requirements pertaining to individuals licensed pursuant to Division 2 of the B&P during the State of Emergency. See DCA Waivers and Guidance for more detailed information on each waiver.

CE Requirements

Every two years, a licensee must complete 30 hours of CE to renew a license. The following waivers allow license holders with expiration dates of March 31, 2020 through September 30, 2021 to complete the required CE by January 26, 2022. The final waiver, DCA-21-194, was specific to licenses that expired on October 31, 2021, allowing CE to be completed by March 28, 2022.

DCA Waiver Number	Issue Date	Affecting Licenses with Expiration Dates
DCA Waiver DCA-20-01	3/31/20	3/31/20–6/30/20
DCA Waiver DCA-20-27	7/1/20	7/31/20–8/31/20
DCA Waiver DCA-20-53	8/27/20	3/31/20–10/31/20
DCA Waiver DCA-20-69	10/22/20	3/31/20–12/31/20
DCA Waiver DCA-20-89	12/15/20	1/31/21–2/28/21
DCA Waiver DCA-21-117	2/26/21	3/31/21
DCA Waiver DCA-21-134	3/30/21	3/31/20–5/31/21
DCA Waiver DCA-21-152	6/3/21	3/31/20–7/31/21
DCA Waiver DCA-21-175	7/26/21	3/31/20–9/30/21
DCA Waiver DCA-21-194	9/28/21	10/31/21

Inactive, Retired, Cancelled Licenses

Inactive Licensees: An inactive license is a current license where fees have been paid but CE was not completed at the time of renewal. To make an inactive license active, the licensee must submit proof of completion of CE (fees are current). The waivers listed below issued by DCA allowed licensees to waive this CE requirement through January 1, 2022.

Retired Licenses: Individuals holding a retired license for less than five years and who had no prior discipline were permitted to apply through a temporary reinstatement application form developed by DCA. If approved, retired licenses became active allowing practice through January 1, 2022. All fees and requirements were waived.

Cancelled Licenses: Individuals who allowed their license to expire and cancel within the last five years who were free from discipline were also allowed to apply through the temporary reinstatement application form. If approved, the cancelled license became active allowing practice through January 1, 2022. All fees and requirements were waived.

DCA Waiver Number	Issue Date
DCA Waiver DCA-20-02	3/31/20
DCA Waiver DCA-20-57	9/17/20
DCA Waiver DCA-20-91	12/15/20
DCA Waiver DCA-21-165	7/1/21
DCA Waiver DCA-21-187	8/13/21
DCA Waiver DCA-21-200	10/29/21

Vaccine Administration

These waivers allowed students and former licensees with expired, inactive, or delinquent licenses to administer COVID-19 vaccinations:

> DCA Waiver DCA-21-139 Order Waiving Restrictions on Health Care Students Administering COVID-19 Vaccines in Association with State and Local Vaccination Efforts (issued March 30, 2021)
>
> DCA Waiver DCA-21-140 Order Waiving Restrictions on Health Care Providers with Expired, Inactive, or Lapsed Licenses Ordering and Administering COVID-19 Vaccines in Association with State or Local Vaccination Efforts (issued March 30, 2021)

Additional guidance was also provided by the RCB for students and out-of-state practitioners.

Students

Business and Professions Code section 3741 provides that students enrolled in an approved respiratory care training program may render respiratory care services when they are incidental to his or her course of study. However, any such student partaking in activities covered by Business and Professions Code section 3741 must identify himself or herself as a student respiratory care practitioner. The RCB's law does not prohibit students from receiving financial compensation. The approved accrediting agency normally prohibits financial compensation, but temporarily lifted this standard during the COVID-19 pandemic.

Out-of-State Practitioners

Respiratory therapists licensed in a state other than California, may apply for temporary authorization to practice in California through the Emergency Medical Services Authority: a CA state agency. DCA coordinates lists of approved providers and communicates these names to the RCB office in the event any other inquiries or communications are received. As of August 2021, there were 880 approved providers from all over the United States, with nearly half coming from Florida (132), Texas (119), Arizona (64), and Georgia (62). The overwhelming majority work/worked through a temporary or traveling placement agenda.

LEGISLATIVE AMENDMENTS

Within the first three months of the issuance of the COVID-19 State of Emergency Order (issued on March 4, 2020), the RCB identified areas where statutes could be improved from its perspective. Looking to the future, the RCB suggests the review of the following statutes to determine if amendments would be beneficial to responding to future public disasters and emergencies.

Subdivision (e) of section 3765 of the B&P is flawed and can easily be interpreted to mean any person could perform respiratory care services during an emergency.

> B&P §3765.
> "This act does not prohibit any of the following activities: ...
>
> (d) The performance of respiratory care in an emergency situation by paramedical personnel who have been formally trained in these modalities and are duly licensed under the provisions of an act pertaining to their specialty.
>
> **(e) Respiratory care services in case of an emergency. 'Emergency,' as used in this subdivision, includes an epidemic or public disaster.** ..."

The RCB offers the following amendment:

> B&P §3765.
> This act does not prohibit any of the following activities:
> ...
> **(e) The temporary performance, by other healthcare personnel, students or groups, of ~~R~~respiratory care services as identified and authorized by the Board, in the event ~~case of an emergency. "Emergency," as used in this subdivision, includes~~ of an epidemic, pandemic, or public disaster or emergency.** ...

In addition, the following language is provided for your consideration to determine if this or similar language would be beneficial to consumers during a State of Emergency. The RCB would have the means to provide a *temporary* response in as little as two days.

> B&P §3723.
> a) In the event a state of emergency is declared, the Board may, for a period of up to 60 days from the date of the declaration, temporarily waive any requirement in the Respiratory Care Practice Act it deems necessary and as commensurate in response to the circumstances known surrounding the cause of the state of emergency, provided there are no gubernatorial objections.
>
> b) For purposes of this section, the Board may hold an "Emergency Meeting" as provided in section 11125.5 of the Government Code. The Board may hold the meeting, open to the public, through the means of information technology, however the Board shall not be subject to the provisions in sections 11123 or 11123.5 of the Government Code requiring a physical location be made available to the public.

PRESIDENT'S MESSAGE

At the time of the preparation of this report, staff were also preparing the RCB's annual newsletter. "The President's Message," prepared by Ricardo Guzman, M.A., RRT, RCP, summarizes and arguably represents the experiences and spirit of the entire respiratory profession. RCB staff were compelled to reprint and share this article here, noting that staff have witnessed the same sentiments from other RCPs expressed throughout his message.

> "We must recognize that 2021 was a difficult year for everyone, but even more so for those on the front line fighting the COVID-19 pandemic. Respiratory care practitioners, along with other health care workers, have reported stress, anxiety, and depressive symptoms because of the challenges associated with taking care of those afflicted with COVID-19. As a bedside practitioner of 38 years, I can attest that this has been unlike anything we have ever experienced.
>
> Those of us in critical care had grown accustomed to enjoying moderate to high success in preventing patients from having to go on life-support and/or in liberating them when they required it. Over the past two years, we have had to adjust our expectations in the realization that so many of our patients would not be going home to their loved ones. Week after week, our patients got sicker faster and for longer than before, despite our knowledge, our sophisticated equipment, and the evolving recommendations from the health care community. All of this, while having to manage our own health and that of our families and friends during lockdowns, travel restrictions, and while having to wear a mask everywhere we went, even in our break rooms.
>
> Yet, the courage and determination I see every day is nothing short of amazing. Although at the end of our shifts we are exhausted and sometimes discouraged, we remain committed to do it again on our next shift and to offer greater compassion to not only our patients and their families, but also to each other as we recognize that we are in this together. As an educator for two decades, I have been a great proponent of the important role we play in the lives of our patients. Today, I am more proud to be a respiratory therapist than ever before. May we not lose heart as we head into a new year for brighter days are ahead. We will win this fight and emerge stronger, and at the same time gentler than we used to be."
>
> Gratefully,
> Ricardo Guzman
> Respiratory Care Board President

Section 11
Board Action and Response to 2016–2017 Sunset Review Issues

ISSUE #1: UCSF Workforce Study

The RCB recently contracted for completion of a study on a number of aspects of the RCP practice and experience required to safely practice as a license RCP. What is the status of the study? Does the RCB believe statutory changes may be necessary following release of the study?

Background: In 2015, the RCB contracted with the Institute for Health Policy Studies at the University of California, San Francisco (UCSF), to conduct a study to determine the feasibility and impact of requiring new applicants to obtain a baccalaureate degree, the need to modify current requirements regarding clinical supervision of RCP students, the effectiveness of the current requirement to take a professional ethics and law continuing education course, and the benefit or need to increase the number of continuing education hours and/or its curricular requirements.

Staff Recommendation: The RCB should provide the Committees with an update on the study, including when it will be released and finalized and what steps the RCB plans to take following the release of the study.

2017 RCB Response: The RCB expects to receive the completed study in April 2017. The RCB has scheduled a strategic planning session for June 30, where it will review the findings of the study, the feedback received from this committee and any other input to determine how it should move forward and if the action plan will include any legislative changes.

2021 RCB Update: The California Respiratory Care Workforce Study was completed in 2017 and was the catalyst for two significant goals listed in the RCB's 2017–2021 Strategic Plan:

- Develop an action plan to establish laws and regulations or accrediting standards for student clinical requirements to increase consumer protection and improve education outcomes.
- Develop an action plan to incorporate a baccalaureate degree provision in the Respiratory Care Practice Act (RCPA) to ensure education requirements meet the demand of the respiratory care field.

Regulatory changes are underway to address issues raised concerning clinical education and it is expected that statutory changes will be sought to incorporate a bachelor's degree in the future.

Clinical Education Standards

Medical education has traditionally employed a form of apprenticeship when training new clinicians to work in the hospital environment. In this format, a more experienced clinician takes on the title of preceptor and serves as both an educator and guide for the student during his/her clinical rotation as part of his/her education program. “Clinical preceptor,” as defined by the Commission on Accreditation for Respiratory Care (CoARC), is "[a] registered respiratory therapist, employed by the clinical site, who teaches, supervises, and evaluates students while completing an assigned standard patient load.”

The 2017 California Respiratory Workforce Study revealed these clinical training challenges:

> ***1) Preceptor Training.*** *It was noted there is a lack of consistency in the organization of respiratory therapy students’ supervised clinical experiences. When asked to choose a scenario that best describes how supervision of students’ clinical training is organized at their facility, 48 percent of surveyed respiratory care directors reported that respiratory therapy students “train with any available staff therapist.”*
>
> *With few exceptions, education directors also reported that program faculty had limited contact with students in the clinical setting and confirmed that the most common arrangement was for students to train with any available staff therapist, acknowledging that there is an element of randomness to the student/preceptor relationship. Nearly 60 percent of surveyed respiratory care directors indicated that inconsistency in the clinical preceptor/student relationship negatively affects the quality of instruction. Education directors emphasized that learning outcomes were better at clinical sites where student precepting is a job requirement, while granting that they cannot limit clinical placements to such sites or require that staff RTs who precept their students complete formal preceptor training.*
>
> ***2) Availability of Clinical Internships.*** *Nearly all education directors cited competition for access to clinical placements as a major challenge associated with providing high quality clinical education. It is common for programs to place only one or two students per clinical site, which means that programs need many different sites to accommodate all of their students. Increasingly, there are multiple education programs competing for access to the same facilities; as a result, some programs need to rely on placements in sites where students are less likely to experience the full range of clinical pathology, procedures, and equipment used in respiratory care.*

At its March 2019 meeting, the RCB reviewed several alternatives to improve clinical education and establish standards. The initial proposal included an alternative to mandate qualifications for clinical preceptors and it was met with objection by several members of the RCB and the public. Several concerns were raised including the inability to enforce a mandate (given hospitals are not beholden to education programs or the RCB and employee staff turnover), and the likely possibility of losing hospital participation in clinical education.

Following the March 2019 meeting, the RCB’s Executive Committee met with staff to review this issue in greater detail. During the discussion, with then-President Goldstein, member Ricardo Guzman, and staff Christine Molina and Stephanie Nunez present, the following materials were reviewed:

1) Minutes from the March 2019 RCB meeting.
2) CoARC Proposed Standards Related to Clinical Practice.
3) Proposed Preceptor Laws/Regulations (also discussed at the March 1, 2019 RCB meeting).

It was noted that many concerns with clinical practice are currently being addressed by CoARC including these new proposed standards:

- Standard 1.03: Requires programs to “ensure” students have access to clinical sites (standard strengthened).
- Standard 2.07: The Director of Clinical Education would now be responsible for providing “evolving practice skills” as part of clinical education for “all students.” (standard strengthened).
- Standard 2.10: Proposed change would include “frequent” visits by the Director of Clinical Education with students, clinical faculty and clinical affiliates at all program locations. The interpretive guideline demonstrates that the clinical director must be accessible to all parties.
- Standard 3.06: “Employer and graduate” surveys must be completed as part of the program’s annual assessment of program outcomes. Deficiencies identified must be resolved by the program. Beginning 7/1/20, accreditation decision will again be based on survey results that cover the prior three years. CoARC’s “outcomes threshold grid” provides the threshold as “at least 80% of returned employer surveys rating overall satisfaction 3 or higher on a 5-point Likert scale.”
- Standard 3.10: Evidence of compliance for “Clinical Site Evaluation” now includes “Clinical evaluation mechanisms that document the progressive independence of the student in the clinical setting” and “detailing required student competencies.”
- Standard 4.01: “Clinical evaluation mechanisms that document the progressive independence of the student in the clinical setting” will be added as “evidence of compliance” for minimum course content. The interpretative guideline for this standard is also beefed up heavily providing that “Each clinical experience should be of sufficient quality and duration to meet the objectives/competencies identified in the clinical syllabi for that rotation. The program must document that each clinical site provides student access to the physical facilities, patient populations, and supervision necessary to fulfill program expectations for the clinical experience at that site. The number of hours per semester devoted to clinical practice should increase as students progress in the program. Programs must ensure that students are exposed to all the categories of patient encounters necessary to prepare them for entry into practice as Registered Respiratory Therapists. At a minimum these should include preventive, emergent, acute and chronic patient encounters.
- Standard 4.03: Curriculum must be based on competencies performed by RRTs as established by the NBRC and must be updated anytime the NBRC’s TMC matrix is updated. This standard broadly defines the scope of practice.
- Standard 4.04: Provides that “Graduates must be competent to perform all respiratory care diagnostic and therapeutic procedures required of a Registered Respiratory Therapist entering the profession.” Evidence of Compliance includes “Evaluations that document the student’s ability to perform all required diagnostic and therapeutic procedures safely and effectively in patient care settings.”

- Standard 4.08: Provides all learning experiences for each program's students must be equivalent.
- Standard 4.09: Provides that "The program must be solely responsible for the selection and coordination of clinical sites as well as ensuring that the type, length, and variety of clinical experiences are sufficient for students to acquire all required competencies." The Evidence of Compliance includes "Detailed clinical schedules" and "current, formal clinical affiliation agreements or memoranda of understanding with all sites." The interpretative guideline also states in part, "The coordination of clinical experiences involves identifying, contacting and evaluating clinical sites for suitability as a required or elective rotation experience, which is a responsibility usually assigned to the Director of Clinical Education (DCE). When program clinical faculty will not be involved at a given site, the DCE should work with employer representatives on the Advisory Committee (when applicable) and/or with department supervisors at the clinical sites, to identify suitable preceptors to supervise students when they are on site.
- Standard 5.09: Provides that students must be appropriately supervised at all times during clinical education. Students must not be used to substitute for clinical, instructional, or administrative staff. Students are not to be paid, however they may be paid interns in states where this is allowed. The standard provides that interns shall not receive educational credits for this experience.

As previously discussed at the RCB's March 2019 meeting, it was noted that mandating preceptor requirements would likely result in less clinical opportunities. Then-President Goldstein and then-member Ricardo Guzman determined that in addition to changes being made by CoARC, the RCB could make great strides in promoting qualified preceptorship by allowing RCPs to obtain CE credit. This proposed change would strengthen clinical education programs, expand leadership opportunities, and ultimately increase consumer protection.

As a result of this meeting with the Executive Committee and staff, language was drafted and included with the pending CE regulatory language for review and approval by the RCB. The proposed language adds considerable CE incentives to participate in preceptor training and as a preceptor for clinical education students. It also provides an incentive for hospitals to provide the training in the interest of developing leaders and improve the quality of training for future prospective employees.

At its November 2019 meeting, the RCB reviewed the proposal, requested additional edits and approved the RCB to move forward with the regulatory process.

As of October 2021, several required documents of the proposed regulatory package are being edited between staff and the Department of Consumer Affairs' regulation unit. Once the final language is filed with the Office of Administrative Law, it will be posted on the RCB's website.

Baccalaureate Degree Provision

The 2017 California Respiratory Workforce Study provides the majority of participants supported movement to a bachelor's degree with the single most important factor being the need to develop and strengthen critical thinking and critical reasoning among entry-level therapists. The summary provides in part:

"Directors of respiratory therapy education programs identified critical thinking as the single most important competency area that should receive greater emphasis in entry-level respiratory therapy education. It underpins every facet of professional practice, including effective communication, the ability to evaluate clinical literature and evidence-based practice, comparing therapies in terms of both cost and therapeutic effectiveness, but most of all clinical reasoning. Many of the education directors noted that employers consistently provide feedback that students' diagnostic skills are "not where they should be." RTs that participated in the focus groups reported new graduates' diagnostic and clinical reasoning skills are underdeveloped, describing new graduates as having conceptual knowledge of tests, procedures, equipment and modes of therapy, but being unable to connect what they have learned with the patient they need to treat.

Evidence-based medicine plays an increasingly critical role in the clinical practice of respiratory therapy. Only 42 percent of surveyed RC directors reported they believe that new graduates are prepared to incorporate evidence-based medicine into their clinical decision-making. Education directors reported that evidence-based medicine is woven into all aspects of the curriculum, however, it was acknowledged that there is substantial variation in the extent to which students are exposed to evidence-based practice during their supervised clinical experiences. RTs that participated in the focus groups underscored this point; they cited the importance of students having the opportunity to complete rotations at clinical sites that have a highly engaged respiratory care department, with a progressive view of the RT scope of practice, and where therapists consistently reference the evidence base in their clinical practice.

Although there was support among participants for maintaining the current standard of requiring an associate degree for entry into professional practice, overall, there was stronger support for shifting respiratory therapy education to the baccalaureate degree level. RC directors felt strongly that moving respiratory therapy education to the bachelor's level would raise the field's professional standing and help create career opportunities. RTs in the focus groups saw value in the additional didactic and clinical training, believing it would produce therapists who are clinicians as opposed to technicians. Focus group participants also cited the need for RTs to keep pace with the general trend toward higher degrees in health professions education. Education program directors expressed the belief that shifting to the bachelor's degree would allow more in-depth coverage of topics that are highly compressed in the current curriculum due to time constraints, and that it would likely increase students' exposure to clinical procedures. However, the most important factor driving support among education directors was the expectation that a bachelor's degree program would further encourage the development of critical thinking and clinical reasoning."

In 2014, SB 850 authorized the Board of Governors, in consultation with the California State University and the University of California, to establish a statewide baccalaureate degree pilot program at not more than 15 community college districts, with one baccalaureate degree program each, to be determined by the chancellor and approved by the Board of Governors beginning January 1, 2015. The bill required a district baccalaureate degree pilot program to commence by the beginning of the 2017–18 academic year, and required a student participating in a baccalaureate degree pilot program to complete his or her degree by the end of the 2022–23 academic year. Two of the 15 baccalaureate degree pilot programs were granted to respiratory care education.

The RCB invited both baccalaureate degree pilot programs to the February 2018 meeting:

Skyline College: Raymond Hernandez, MPH, RRT, NPS; Dean of Science, Math, and Technology (RCB Member 2020–present and Professional Qualifications Committee Chair).

Modesto Junior College: Alan Roth, M.S., MBA, RRT-NPS, FAARC, FCCP (Member and RCB President 2012–2018).

Skyline College: Hernandez noted the pilot program is really helping the profession move forward, setting the stage across the nation in terms of how we can build more capacity for further education. Presentation highlights included:

- In 2014, the nation had been talking about the need for the bachelor's degree to meet the workforce needs. The Legislature looked at the capacity of public education and how it could help and authorized 15 community college districts to offer bachelor's degrees on a pilot basis, with the restriction that each pilot community college district must not duplicate a bachelor's degree already offered by one of the universities.

- A study was conducted throughout the Bay Area, contacting 90 institutions with 30 responses. The outcome was an overwhelming need for the bachelor's degree program to further the education and training of RCPs. Two tracks were identified in terms of what was needed above the entry level associate degree program. One identified more education and training for direct care. The second track included leadership roles and specialty areas as future retirements will cause the industry to look at what is needed to move forward. Both tracks could not be provided, so the leadership and specialty area tracks are what the program followed.

- A regional effort of 30 members—including educators, employers, graduates, and lead experts—developed the curriculum. The major content areas include case management, education, leadership management, research, and neonatal pediatrics. A comprehensive, project-based curriculum was developed.

- Cohort 3 will launch in the fall of 2018, which will be fully online and will reach all Californians. Preference will be given to residents of California but will be open to outside of the state if any seats are left to fill.

- Hernandez ended by thanking everyone for their hard work stating this is a major step forward for the respiratory care profession in California. He added he hopes these two programs become beacons for more use within the community college system once they see their success.

Modesto Junior College: Roth stated one of the goals was to increase the diversity of the program to reflect the community at large and to advance the profession to reflect that same diversity. Roth also noted it was important to emphasize other program elements including research, management, and education.

March 2021 Professional Qualifications Committee
At the RCB's March 2021 meeting, it announced that Ray Hernandez, RCP, MPH, RRT, NPS (Chair) and Michael Terry, RCP, BSRT, RRT, RPFT, CCRC would serve as the RCB's Professional Qualifications Committee, having expressed the interest in implementing the RCB's goal to:

> *"Develop an action plan to incorporate a baccalaureate degree provision in the Respiratory Care Practice Act (RCPA) to ensure education requirements meet the demand of the respiratory care field."*

June 2021 Board Meeting
At the RCB's June 2021 meeting, the new Professional Qualifications Committee provided the RCB with a two-hour presentation briefly recapping the history of the profession and the multiple factors supporting the need for further education. It was the first of a series of study sessions focused on educational preparation and requirements to support RCP competency. All those in attendance were actively engaged and provided valuable, thought-provoking feedback. Numerous reference materials were presented.

Additional presentations are expected at most, if not all, future RCB meetings as this issue is presented for dynamic public discussion and examined from every aspect to determine the best framework and course of action moving forward. The goal is to incorporate a baccalaureate degree provision in the Respiratory Care Practice Act (RCPA) to ensure education requirements meet the demand of the respiratory care field that will benefit all California consumers, possibly leading to a national model.

ISSUE #2: Website Enhancements

Access to timely, accurate information about licensees is a fundamental means by which patients and the public are informed about medical services provided to them. The RCB posts information on its website and has improved these efforts. Further enhancements can be made, particularly related to ease of access of information related to disciplinary action taken by the RCB. What features have changed since the implementation of BreEZe? What RCB website updates are pending? Are there changes that may result in patients being better able to navigate the website to review enforcement actions?

Background: The RCB notes that it anticipates website enhancements in early 2017, including the ability for online application for licensure. It would be helpful for the Committees to better understand what enhancements are underway and when they will take effect.

In 2001, the RCB began posting summary information on its website and in its newsletter for all accusations, statements of issues, and decisions that had been filed against licensees. In 2006, the RCB began posting a running list of these records with links directly to accusations, statements of issues, and decisions available in a PDF format. In 2007, the RCB was the first at DCA to provide a hyperlink to the actual records through the online license verification component for any person who had disciplinary action as of January 1, 2006. Prior to BreEZe and related website updates to boards that came onto the BreEZe system, the public could either review a summary of all disciplinary action taken by the RCB since January 2006, with links to actual documents or utilize the prior online license verification component to look up an individual and, if applicable, be advised of disciplinary action taken with links directly to the documents. The RCB's website also used to feature

summary information on all accusations, statements of issues, and decisions that have been filed against licensees with documents available once they were final or a judge has issued an order, including citations, fines and orders of abatement, interim suspension orders (ISOs), and suspensions and restrictions. The RCB's website now directs users to the BreEZe system rather than listing information directly on the site. While it is true that important information is available on the website and through BreEZe, a key issue for the Committees remains how easily available it is for California patients to access understandable information about practitioners, particularly those who have been the subject of disciplinary action. Users have to start at the RCB's website and are redirected and navigated to BreEZe—looking up a RCP requires a few additional clicks to get to the actual disciplinary action and findings, information that may be easier to understand in summary form similar to the way it is presented in newsletters.

Staff Recommendation: Given that public disclosure of disciplinary action for health professionals has been a legislative priority for many years, the RCB should provide an update to the Committees on efforts to ensure patients and the public are able to easily access information, particularly information about enforcement actions taken by the RCB, about licensees and RCB activity.

2017 RCB Response: The RCB's revamped website launched February 21, 2017. The new site is easier to navigate and provides a better representation of the RCB. It is clean, professional, and very user-friendly.

Committee staff raised concerns about public disclosure of disciplinary information and noted the RCB's history in being very proactive in this area. Upon completion of the RCB's sunset hearing and discussions with legislative staff, the RCB understands that the former display of disciplinary action, as was done in 2001, is a preferred method of display for consumer access and public benefit. The RCB's Executive Committee intends to raise this issue at its strategic planning session on June 30, for consideration to include the display of disciplinary information in a summarized format in its new plan.

2021 RCB Update: In September 2019, the RCB updated it website to include "Final Disciplinary Actions" displayed in a summarized format as requested by the Sunset Review Committee. RCB staff went back and included all final disciplinary actions from October 1, 2016 and continues to maintain updates quarterly.

ISSUE #3: New Exam

The RCB recently began requiring passage of a higher level national exam for RCP licensure. What has been the impact of this change? How are pass rates impacted?

Background: Since the RCB'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: The Certified Respiratory Therapist (CRT)—entry level credential and the Registered Respiratory Therapist (RRT) credential—advanced level credential.

Up until 2015, the RCB recognized the passage of the CRT examination as the minimum exam requirement for licensure as a RCP. Advancements in technology and accreditation standards, coupled with the restructuring of nationally recognized exams, led the RCB to determine that the requirement to pass the CRT examination for licensure as an RCP is inadequate, outdated, and insufficient in meeting the RCB's consumer protection mandate.

The RCB now requires applicants to pass the RRT exam, an effort seen as aligning the minimum examination requirements for licensure with the natural progression of the respiratory care field.

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 program accreditation. The RCB's most commonly expressed concern from RCPs was the lack of full competency and clinical preparedness of RCP students.

Staff Recommendation: The RCB should provide the Committees an update on implementation of the new RRT requirement and the impact of the new higher standard for licensure on examination rates in general.

2017 RCB Response: In 2015, the RCB began requiring passage of a higher level national exam for RCP licensure. Implementation of the new exam was incredibly smooth as a result of in-depth planning. The RCB first looked at this issue in 2011 to determine if increasing the exam requirement was feasible. At that time it was not, due to the previous structure of the exams. In May 2013, the RCB revisited the issue and prepared a detailed transition plan identifying all the areas that would be impacted. Prior to and upon passage of AB 1972 in 2014, notice was provided to all pending applicants, education programs, and students so they were fully prepared to pass the old examination prior to January 1, 2015 or pass the advanced examination thereafter. Provisions were put in place to allow graduates to work up to six months under supervision with a work permit provided he or she passed the CRT portion of the exam, allowing for additional time to pass the RRT exam. In addition, reciprocity was taken into consideration and provisions were made to recognize passage of the CRT exam prior to January 1, 2015 as meeting exam requirements.

The RCB had projected the pass rate for first time takers to change from roughly 80% passage for the lower level exam down to 53% for the advanced level exam. The actual passage rate has averaged 58%. However, the passage rate for repeat takers is higher for the advanced exam as projected. While the entry level CRT exam hovered around a 30% pass rate for repeat takers, the advanced-level RRT exam has a pass rate of 41% for repeat takers. The RCB also projected that new applicants would drop from 1350 to 920 a year. New applicants actually dropped to only 1,150 a year. While the reduction of revenue for new applications was expected and is minor, the RCB also suspects there will be increases in the number of new applications received as soon as this fiscal year.

The new requirement to pass the advanced level RRT exam is an effort seen as aligning the minimum examination requirements for licensure with the natural progression of the respiratory care field. Employers have responded favorably to the new requirement. 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 program accreditation.

2021 RCB Update: Since the RCB moved to requiring passage of the advanced exam in January 2015, the RCB has not experienced any anomalies outside those associated with the number of applications received and the timing of the COVID-19 State of Emergency that was ordered in March 2020.

Below you will see the number of applications received each fiscal year. The average for fiscal years 2016–17, 2017–18 and 2018–19 is 1,129 applications per year. The high influx of applications received in 2019–20 and 2020–21 is partly attributed to the COVID-19 pandemic, though the RCB also noticed an uptick of out-of-state applications prior to the pandemic as well as in-state graduates. It is too early to tell whether the RCB will maintain 1,100–1,200 new applications a year or if an increased baseline will be established.

	FY 16–17	FY 17–18	FY 18–19	FY 19–20	FY 20–21
Apps Received	1,158	1,015	1,215	1,424	1,538

The RCB has also seen moderate increases in passage rates for first-time and repeat test takers.

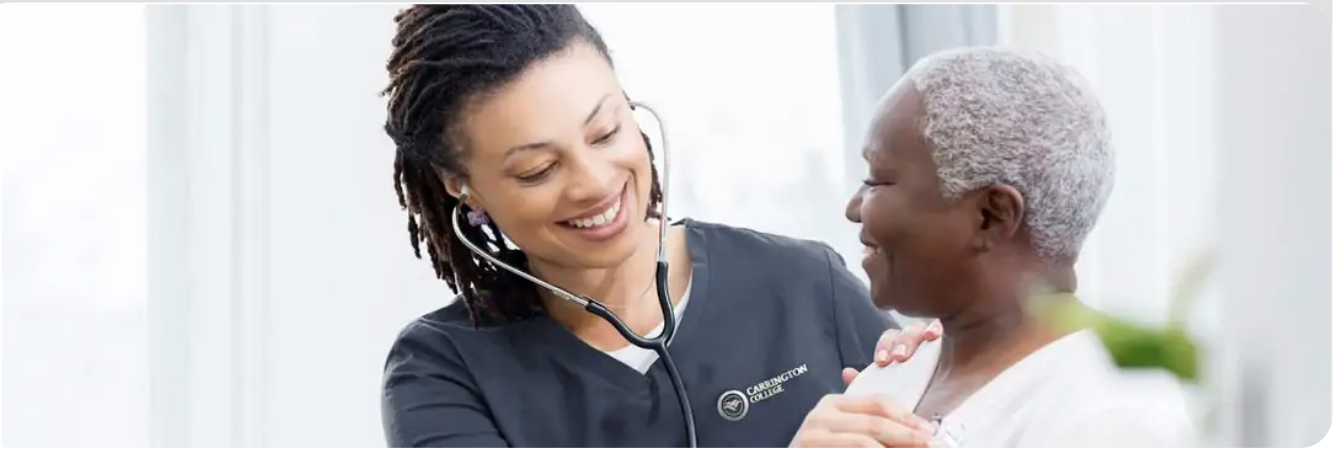
Previous minimum requirements included passing the lower-level written exam. After January 2015, applicants were required to pass the advanced exam consisting of two parts: written and clinical simulation. In order to sit for Clinical Simulation Exam, a test taker must first pass the written examination. When referring to the passage rates below for the advanced exam, the figures represent the passage rate for the Clinical Simulation Exam.

In spring 2017, as noted above, the RCB reported the following pass rates:

- First attempt passage rate prior to 2015 (entry level exam): 80% (approx.)
- First attempt passage rate after 2015 (advanced exam): 58% (5%> than initial projection)
- Repeat passage rate prior to 2015 (entry level exam): 30% (approx.)
- Repeat passage rate after 2015 (advance exam): 41%

A review of the data on the next page shows:

- Since this reporting in 2017, the passage rate for first-time test takers continued to climb each year from 58% topping out at 67% in fiscal year 2019–20.
- The repeat test taker passage rate also continued to climb from 41% in Spring 2017 to as high as 54.3% in 2019–20 and then dropping to 47.6% in 2020–21.



	Written Examination			Clinical Simulation Exam		
FY 20–21	Total	Passed	Pass %	Total	Passed	Pass %
First-time Test Takers	1,145	873	76.2%	1,028	689	**67.0%**
Repeat Test Takers	866	436	50.3%	614	292	**47.6%**
Totals	2,011	1,309	65.1%	1,642	982	59.8%
FY 19–20	Total	Passed	Pass %	Total	Passed	Pass %
First-time Test Takers	1,004	808	80.5%	921	617	**67.0%**
Repeat Test Takers	990	466	47.1%	597	324	**54.3%**
Totals	1,994	1,277	64.0%	1,518	941	62.0%
FY 18–19	Total	Passed	Pass %	Total	Passed	Pass %
First-time Test Takers	984	792	80.5%	946	626	**66.2%**
Repeat Test Takers	1,072	483	45.1%	711	347	**48.8%**
Totals	2,056	1,275	62%	1,657	974	58.8%
FY 17–18	Total	Passed	Pass %	Total	Passed	Pass %
First-time Test Takers	1,046	863	82.5%	947	573	**60.5%**
Repeat Test Takers	926	426	46.0%	762	361	**47.4%**
Totals	1,972	1,293	65.6%	1,709	934	54.7%
FY 16–17	Total	Passed	Pass %	Total	Passed	Pass %
First-time Test Takers	954	801	84.0%	938	543	**57.9%**
Repeat Test Takers	952	441	46.3%	891	407	**45.7%**
Totals	1,906	1,244	65.3%	1,829	950	51.9%

It appears the State of Emergency had little to no impact on passage rates. The data suggests that an adjustment to the higher minimum exam requirement has been made and that pass rates will remain at the levels presented over the last two years for the time being.

ISSUE #4: Continuing Education:

The RCB requires completion of Continuing Education (CE) hours as a condition of RCP license renewal. Verifying that CE courses have actually been taken and hours actually earned is a challenge for many boards. Are there more effective means by which the RCB can verify that CE was completed other than conducting random audits for a small number of licensees at the time of renewal?

Background: Every two years, a RCP holding an active license from the RCB must complete 15 hours of approved CE, with the requirement increasing to 30 hours of CE beginning in July 2017.

Verifying that licensees actually complete required CE is something that many boards struggle to achieve. Most boards rely on licensees to self-report at the time of renewal that the individual completed CE courses and provide information about those courses, including the CE provider, course description and other data points. To confirm that an individual actually completed what they reported, boards conduct random audits of licensees. Given the workload associated with board staff verifying all of the information provided by licensees, the number of CE audits most boards conduct are extremely low, as compared to the number of licensees renewing licenses.

Since July 2014, the RCB has audited about 5% of licensees at the time of renewal to ensure CE hours were actually completed.

CE Audits Performed

	FY 13–14	FY 14–15	FY 15–16
Renewals Audited	308	615	496

The RCB notes that its 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. In a CE audit, RCB staff verifies whether a RCP actually completed courses with the actual course provider directly. This is a lengthy and time-consuming process, resulting in only a fraction of renewals being subject to audit to verify that CE units were actually earned. 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 (records that are also verified by RCB 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.

The new executive officer of the Board of Registered Nursing recently proposed an innovative solution to receipt of information from third-party sources, specifically uploading materials directly into a cloud that DCA manages. The RCB may consider whether there are more efficient ways to ensure CE completion such as proof of completion provided directly to the RCB through the DCA cloud. The RCB may wish to explore how the receipt of documents in this model could then be noted in BreEZe so that, when a RCP attempts to renew a license, this information data piece is readily available.

Staff Recommendation: The RCB should explore innovative methods to confirm CE completion and update the Committees on steps it is taking to streamline processes.

2017 RCB Response: Committee staff have brought forward a very innovative suggestion to improve continuing education audits that warrants further discussion as a cross cutting issue for all boards at DCA.

Currently the board requires the completion of 15 hours, soon to be 30 hours of continuing education as a condition for the renewal of a license. The RCB strives to randomly audit a minimum of 5% of renewals each month, though this percentage may fluctuate up or down, depending on workload.

This equates to roughly 500 licensees audited each year.

The auditing process includes contacting the licensee to submit records, and RCB staff then verifying those records. In most cases, this is a straightforward process, but does require a great deal of tedious manual labor and tracking. The more intensive labor is associated with the 2% of those audited who fail for either having an insufficient number of CEs or an insufficient number of the correct CEs. Two percent equates to about 10 licensees per year given that only 5% are audited. Two percent of all licensees would be close to 200 licensees that would fail the audit each year. And those that fail either have their license placed in an inactive license status and/or are referred to enforcement where a citation and fine may be issued.

One idea that has come forward is to have providers upload evidence of completion to a DCA cloud.

In our initial response, we offer the following:

- Currently, there is a work order request to modify DCA's BreEZe system so it will randomly select a percentage or number of renewed licenses for audit and automatically send a letter to those licensees to submit records. Licensees will be able to upload their certificates of completion or submit hard copies of the information.
- Given the investment in BreEZe, we believe any automated tracking should be within the BreEZe system. Also given the fact that the wheels are already in motion for licensees to upload data, it is imperative that the idea of providers uploading data must be incorporated into the existing plan.
- Ultimately, we believe it would be beneficial for providers to have a mechanism to voluntarily upload data directly to BreEZe. However, prior to investing resources into modifying BreEZe, all boards should contact their providers to get a general consensus of the likelihood of their participation and a DCA-led conversation should take place.

Again, this issue will be raised at the RCB's strategic planning session this year and RCB staff will reach out to DCA to see how the process handling of CE audits may be improved for all boards to achieve greater efficiencies.

2021 RCB Update: The RCB's 2017–2021 Strategic Plan provides these goals:

- *Increase the number of continuing education audits to 10% to ensure compliance.*
- *Research and evaluate whether BreEZe can be modified to increase efficiencies in auditing licensees for continuing education compliance.*

The goal to increase CE audits to 10% was made in part with the understanding that BreEZe would be modified to randomly select licensees and issue a letter to licensees who had renewed their license. Unfortunately, the modification was limited to boards that have the same CE requirements every year. Further, the letters cannot be modified. Because the RCB requires an ethics course every other year, its CE requirements change for each licensee. Therefore, the RCB is unable to take advantage of this function.

In addition, the RCB inquired about the suggestion made by the then-executive officer of the Board of Registered Nursing to have all providers upload proof of completion. It is our understanding that an interface would have to be developed for each provider making this a cost-prohibitive alternative with no guarantee of the intended outcome. However, through these discussion the "attachment transaction" feature was born. This DCA-developed feature allows applicants and licensees to upload documents to their account. Licensees are encouraged to upload their CE certificates as they earn them or at the time of renewal.

RCP licenses are randomly selected for CE audits which are tracked manually in BreEZe. In October 2017, the RCB was hitting its mark of auditing 10% of renewals (approximately 1,000/year or 83/month). Immediately following this success, the RCB was forced to ease up on audits due to a staff person's extended medical absence. In 2019–20 and 2020–21, audits were heavily impacted as a result of the issuance of CE waivers and the RCB's efforts to mitigate the additional stress of undergoing an audit during a pandemic.

	FY 16–17	FY 17–18	FY 18–19	FY 19–20	FY 20–21
Renewals Audited	513	560	735	360	327

Currently the RCB, is again on target to hit its goal of auditing 10% of renewals for CE compliance in fiscal year 2021–22.

ISSUE #5: DMV History

Studies conducted at the federal level and recently in California by the Little Hoover Commission have focused on barriers to employment and provided suggestions as to where certain requirements for employment should be streamlined, particularly for certain populations of employees. The RCB requires applicants to provide a 10-year driving history from DMV for licensure as an RCP. Is this requirement necessary to ensure patients are receiving high quality respiratory care services from a safe, qualified RCP?

Background: The RCB requires applicants for licensure to provide a 10-year driving history during the application process, a requirement that seems onerous and potentially not providing important information to the RCB about an applicant's background or ability to safely practice as an RCP.
Recent studies and reports have focused on the impacts of licensing requirements for

employment and on individuals seeking to become employed. According to a July 2015 report on occupational licensing released by the White House, strict licensing creates barriers to mobility for licensed workers. In October 2016, the Little Hoover Commission (LHC) released a report entitled "Jobs for Californians: Strategies to Ease Occupational Licensing Barriers." The report noted that one out of every five Californians must receive permission from the government to work and, for millions of Californians, that means contending with the hurdles of becoming licensed. The report noted that many of the goals to professionalize occupations, standardize services, guarantee quality, and limit competition among practitioners, while well intended, have had a larger impact of preventing Californians from working, particularly harder-to-employ groups such as former offenders and those trained or educated outside of California including veterans, military spouses, and foreign-trained workers. The study found that occupational licensing hurts those at the bottom of the economic ladder twice: first by imposing significant costs on them should they try to enter a licensed occupation, and second by pricing the services provided by licensed professionals out of reach.

Given that the RCB receives background information about licensees through DOJ and FBI fingerprint checks, it would be helpful for the Committees to understand why the DMV history is necessary and how it ensures consumers are better protected. It would be helpful for the Committees to know whether other boards require this information and the benefit it has on patients, as well as the insight it provides to the qualification of an applicant for RCP licensure.

Staff Recommendation: The RCB should advise the Committees as to why the 10-year DMV history prior to licensure is necessary, what role this has played in license denials and whether patients will still be protected if the RCB does not require this information as a condition of licensure, particularly since this is the only information applicants are required to provide that does not come directly from the source to the RCB. The Committees may wish to amend the Act to remove this requirement.

2017 RCB Response: As part of the RCB’s licensing process, it performs a thorough background check on all of its licensees. In addition to DOJ and FBI fingerprint checks, the RCB also requires each applicant to submit a 10-year DMV history check. The purpose of the DMV history check is to capture violations that include drugs or alcohol. Prior to or about 2008, most DUI violations were not reported on rap sheets and those DUIs that resulted in a “wet reckless” very rarely appeared. It has remained a requirement to capture any pattern behavior and to get a complete picture of an applicant prior to licensure. Seeing this issue raised by Committee staff, we performed a cursory review which reveals that the DMV background check is no longer necessary, except perhaps in those cases where additional information is needed.

Currently, section 1399.326 of the California Code of Regulations requires the RCB to review the driving history for each application prior to licensure. In light of the perceived barrier and the rare need for the DMV background information, staff have been directed to submit a proposal to the RCB to amend or repeal this regulation as appropriate at its next meeting on June 30, 2017.

2021 RCB Update: In 2017, the RCB included the following goal in its 2017–2021 Strategic Plan:

> *"Eliminate the submission of a Department of Motor Vehicles history as a standard application requirement to increase efficiency in the application process."*

The DMV history submission was no longer required as part of the standard application process effective October 15, 2017. However, the RCB still maintains the authority to require a driving history for an applicant as part of its investigation prior to licensure as deemed necessary. Proposed regulatory amendments were noticed in January 2021 that include the following amendment:

> § 1399.326. Driving Record. The ~~b~~Board ~~shall~~ may review the driving history for each applicant as part of its investigation prior to licensure.

Since October 15, 2017, the RCB has requested driving histories for eight applicants where circumstances warranted further investigation.

The RCB appreciates the Committees' insight on this requirement.

ISSUE #6: Continued Regulation by Respiratory Care Board of California

Should the licensing and regulation of respiratory care practitioners be continued and be regulated by the current RCB membership?

Background: Patients and the public are best protected by strong regulatory boards with oversight of licensed professions. The RCB has shown a strong commitment efficiency and effectiveness, responding to practice and operational issues in a proactive, forward-thinking manner. The RCB should be continued with a four-year extension of its sunset date so that the Committee may review once again if the issues and recommendations in this Background Paper and others of the Committee have been addressed.

Staff Recommendation: The licensing and regulation of respiratory care practitioners should continue to be regulated by the current board members of the Respiratory Care Board of California in order to protect the interests of the public. The RCB should be reviewed again in four years.

2017 RCB Response: The RCB's highest priority is consumer protection and it aims to provide this through effective application review and investigative services and meaningful application of the law. Moreover, the RCB strives to provide excellent customer service and efficiency in state government. The RCB would like to acknowledge and sincerely thank both the Senate Business, Professions and Economic Development Committee and the Assembly Business and Professions Committee, as well as your staff for your thorough review of the RCB and bringing to light several recommendations that lead to greater efficiency and/or consumer protection.

2021 RCB Update: The RCB appreciates the continued opportunity to present its work and highlight issues of interest for the Senate Business, Professions and Economic Development Committee and the Assembly Business and Professions Committee's feedback.

Section 12
New Issues

ISSUE #1: Unqualified Practice of Respiratory Care, Licensed Vocational Nurses (LVNs)

The RCB is looking for guidance and assistance from the Legislature in establishing a final resolution to an issue that continues to resurface every few years. The RCB contends that, while licensed vocational nurses (LVNs) are absolutely invaluable to health care teams, some facilities in California have allowed LVNs to practice respiratory care to the detriment of patients (and LVNs). The RCB has attempted numerous times to rectify the matter through various outlets, but the issue historically returns to the Board of Vocational Nursing and Psychiatric Technicians' (BVNPT's) permitting the practice in violation of the Nursing Practice Act.

The problem first appeared in 1996 when the BVNPT drafted and disseminated to multiple healthcare agencies and education programs a "policy" that provided LVNs are permitted to adjust ventilator settings.

The RCB requested the BVNPT rescind the policy, citing it was an underground regulation and compared the education training and competency testing of both LVNs and RCPs. Exchanges and meetings between the two boards occurred from 1996 to 1999 with no resolution. The RCB also raised the issue in its 1997 Sunset Report.

During the BVNPT's 2002 Sunset Review, the Joint Legislative Sunset Review Committee raised the issue that "professional nursing organizations are challenging the [BVNPT's] authority to interpret its laws governing LVNs and claiming that it is illegally interpreting its statutes and regulations." There was reference to underground regulations that allowed LVNs to administer intravenous (IV) fluids.

In 2005, it came to the RCB's attention that the BVNPT was continuing to advise the public that LVNs were authorized to manage ventilator patients.

> *The BVNPT provided section CCR 2518.5 as a basis for allowing LVNs to manage ventilators. However, when that regulation was passed, the RCB made a written objection to the section and the BVNPT responded that "the manipulation of ventilator settings by LVNs is not the subject of the proposed regulations."*

The RCB requested the BVNPT cease advising the public that adjusting settings or managing ventilators is within the LVN scope of practice, rescind the May 1, 1996 policy and notify all the same agencies previously advised of the rescission.

At the BVNPT's September 2, 2005 meeting, BVNPT legal counsel recommended the BVNPT rescind all previous scope of practice policy statements and modify its responses to scope of practice inquiries to state they are “mute” on the matter or there is “no prohibition.” “The board may decide to promulgate regulations in the future should it find that LVNs are needed to perform these skills as necessary to ensure safety for stable or chronic ventilator dependent patients in long term care settings such as skilled nursing facilities, rehabilitation centers, home health and similar non-acute settings." On September 29, 2005, the BVNPT notifies the RCB they accepted these recommendations.

In June 2006, the RCB received a copy of correspondence issued by the BVNPT wherein again the BVNPT provides that LVNs are authorized to perform ventilator care. The RCB provides detailed objections and states, "Even fully aware of this dangerous trend in sub-acute facilities and over a year later, the BVNPT continues to support the unauthorized practice of respiratory care by LVNs. The fact that the BVNPT is not prohibiting this activity is alarming. The fact that the BVNPT is promoting and supporting this dangerous trend is appalling.” The RCB points out:

> *B&P 2860 provides the Vocational Nursing Act “confers no authority to practice medicine or surgery or to undertake the prevention, treatment or cure of disease, pain, injury, deformity, or mental or physical condition in violation of any provision of law.”*

In December 2006, the BVNPT president responds and provides that LVNs “should most certainly have the ability to decide, for example, **whether or not to listen to breath sounds in a patient previously diagnosed with pneumonia** and then report it to the R.N. or physician directing the LVN.”

In response to this specific claim, the RCB sought a legal opinion from its liaison at the Office of the Attorney General. Mara Faust, DAG, provided :

> *“‘Basic assessment or data collection’ does not anticipate the independent assessment of breath sounds and is therefore outside [the] scope of practice of an LVN. Clearly respiratory care therapist[s] can interpret breath sounds in the scope of their practice under Business and Professions Code section 3702....” “While a respiratory care therapist and a physician can assess a patient’s respiratory status and alter the ventilator setting, in my opinion, an LVN who does so acts outside their scope of practice.”*

It was also brought to the attention of the RCB in May 2008 (and is still true today) that the scope of practice for licensed practical nurses (equivalent to LVNs in CA) in New York prohibit caring for ventilator patients. The New York State Board of Nursing reviewed and approved scope of practice for Licensed Practical Nurses (LPN) which provides that Licensed Practical Nurses may ***not*** "“interpret clinical data; take independent action on clinical data; do patient assessments; triage, either in person or phone; develop a nursing care plan; ***care for a person on mechanical ventilation (i.e., a respirator or a ventilator) in a community setting; ... change tracheostomy tubes. An LPN cannot intervene sufficiently, nor assess the patient sufficiently, in situations where the outer cannula of a tracheostomy needs to be reinserted.”***

The RCB continues to issue cease and desist orders to subacute facilities for violations of the Respiratory Care Practice Act including employing unqualified personnel to practice respiratory care, practicing respiratory care without qualifications to do so, and misrepresentation through titles such as "respiratory nurse." A few cases have also resulted in fraudulent billing allegations that are referred to the appropriate agency. By 2015, the same time complaints began to resurface, facilities had reached out to professional associations to defend their illegal practice. Those professional associations cite the BVNPT authorizing such practice as their defense.

In or about 2015, the RCB searched the BVNPT website and located several cases of gross incompetence of LVNs caring for ventilator patients: three deaths resulted; two were children. For context, as outlined in the following summaries, the RCB has never had a complaint where a therapist panicked or failed to act in an emergency situation. Shortly after these cases were brought to the BVNPT's attention, all disciplinary cases were removed in the format that allowed the public to search for identifying terms. It appears this is still the case today.

***Christina Lim VN 232597*—Licensed Surrendered**
Stipulated Decision Effective 1/18/2014
13-year old death

Patient was 13 year old boy with history of Spinal Muscular Atrophy. He lived at home with father and received 24 hour nursing care. Patient had tracheostomy and was ventilator and G-tube dependent. Patient was also on a cough assisting machine, pulse oximeter, oxygen concentrator, nebulizer and suction machine. Patient received medication and feedings through a G-tube.

On 6/22/10, respondent was assigned to provide nursing care for patient from 11pm to 7am. This was respondent’s first time assigned to this home patient.

At 6am respondent administered medications and feeding to patient through G-tube and stated that patient seemed “lethargic and different.” Respondent stated that the pulse ox reading was either 90% or 92%. At approx. 6:30 am, respondent stated that patient was unresponsive and his pulse was thread. At approx 6:45 am, respondent stated that the pulse ox began alarming and patient’s heart rate was dropping. Respondent did not record any vital signs during this time.

Respondent stated that she disconnected the ventilator and administered two breaths using an Ambu bag. At approx. 6:55 am, respondent stated that the doorbell rang and she reconnected the ventilator and went to the door to let the oncoming shift LVN into the home (patient’s regularly assigned nurse).

At about 7am both nurses entered the room. Patient was unresponsive with faint pulse and the pulse ox machine was alarming. The ventilator then began alarming. Respondent told the other nurse that it had been about 10 minutes since she had gotten a pulse. The oncoming nurse asked why she did not call 911. Respondent replied “it just happened so fast.”

Respondent went to wake patient’s father who instructed respondent to call 911. The father began CPR. Paramedics arrived while CPR was in process and transported patient to hospital where he was pronounced dead at 7:49 am.

***Jerrilynn Roberson VN 199206*—Licensed Revoked**
ALJ Decision Effective 6/13/15
9-year old death

Respondent was employed as home health nurse. Patient was a nine-year old boy whose principal diagnosis was congenital muscular dystrophy. He also suffered from developmental delay, chronic respiratory failure and ventilator dependence. He had tracheotomy cannula that was inserted into a stoma in his neck.

Respondent's duties included repositioning patient every two hours and caring for his trach tubing. Patient's mother informed respondent that patient's cannula could become dislodged during repositioning and would therefore require immediate reinsertion to ensure the flow of oxygen. In addition to the tracheotomy cannula inserted in patient's stoma, a secondary sterile cannula was taped near patient's bed to replace primary cannula if needed.

On 10/22/11 patient was stable. Patient's family left residence at approximately 4pm. At 6:55pm respondent repositioned patient to his right side. Within 10 minutes, patient's oxygen saturation decreased after the cannula dislodged. Respondent disconnected trach tubes from ventilator in response and used room air with the Ambu bag to provide more oxygen to patient. Respondent used stethoscope to listen to patient's chest and did not hear a heartbeat. Respondent began CPR.

At approximately 7:05 pm, respondent called patient's mother and asked her to come home immediately because "something happened with [patient]." The mother called respondent back and could hear the ventilator alarms and pulse ox alarms sounding in the background. According to patient's mother, Respondent was "screaming" and "crying" and did not listen to the mother as she attempted to calm respondent and instruct her to put the cannula back in the patient's stoma.

At 7:14pm patient's family arrived home. Patient's face was purple and blue. The inner cannula was lying on the patient's chest. When respondent pressed the Ambu bag to provide oxygen to patient, the air from the bag was blowing over patient's chest instead of into his outer tube. Patient's mother reinserted the inner cannula and took over performing CPR while the father took over the Ambu bag.

Respondent's first call to 911 was at 7:11pm. Several calls were made after the family returned home. Paramedics arrived at 7:19pm. Patient transported to hospital and pronounced dead at 7:50pm.

***Myriam Ovalle Calvert VN 204350*—Licensed Surrendered**
Stipulated Decision Effective 9/24/14
Patient Death

Patient was bedridden and on a ventilator due to Amyotrophic Lateral Sclerosis and resided with her daughter and son-in-law requiring 24 hour care. On 12/30/11 three nurses were scheduled to care for patient on three different shifts.

At approximately 8:47pm, respondent suctioned patient's trachea and emptied the water trap connected to the ventilator. Respondent did not properly replace the water trap. At approximately 8:49pm the vent alarm began beeping and flashing showing patient's oxygen saturation level was below 85%.

At approximately 8:52 pm, respondent frantically and hysterically called patient's daughter. Patient's daughter instructed respondent to call 911 and check the vent for circuit leaks. Several calls between the respondent and the daughter were made and dropped. When respondent spoke to the daughter again, she was still hysterical and reported that patient's oxygen saturation levels were at 30%. The daughter once again instructed respondent to call 911 and further instructed her to use the Ambu bag.

Respondent then called 911. At approximately 9:02pm respondent began using the Ambu bag. Paramedics arrived about 15 seconds after respondent first started using the bag. Patient was transported to hospital and it was determined she suffered acute brain damage due to anoxia. She was taken off life support and passed away on 1/6/12.

***Barbara Elise Frye VN 234797*—Probation 3 years**
ALJ Decision Effective 2/16/14
(Probation Subsequently Revoked 6/29/17)
7-year old emotional/physical harm

Patient was wheelchair bound and was also tracheotomy and ventilator dependent. She suffered from facial deformities and had "giant cell tumors" on her neck and in her nose and mouth (but not immediately noticeable upon a visual inspection). Suctioning of her nose and mouth caused great pain and respondent was notified that suctioning was to be avoided. The patient also had a port-a-cath (PAC) permanently in place to facilitate administration of intravenous medications.

On 9/29/09, patient removed her tracheotomy tube and respondent called 911. When they arrived at the emergency room, respondent was told to "stand aside" by emergency room staff.

However, it was established that she had a duty to inform the hospital staff that suctioning should not be used and the patient had a PAC. Respondent did not inform the emergency room staff of any of the patient's medical conditions.

As such, the patient suffered through a suctioning episode as well as multiple attempts to insert an IV tube.

The ALJ determined that the respondent either panicked or lacked the self-confidence to speak up and tell emergency room staff of the patient's condition.

Respondent was also upset and intimidated when an emergency room doctor asked respondent what the patient's ventilator reading was and respondent couldn't remember. At this point, the doctor became angry at respondent and respondent began to cry.

***Nwadiuto Jane Nwaohia VN 244485*—License Surrendered**
Stipulated Decision Effective 1/8/2015
Pediatric ventilator patient in home (with priors)

Respondent was assigned to pediatric in home care of patient who required mechanical ventilation when fatigued or dozing, preparation of soft or pureed foods, periodic nebulizer treatment with a mist collar, which required close monitoring

followed by one hand suction and one hand clean techniques with a mixture of one part distilled water to one part peroxide.

On April 15, 2013, a complaint was received alleging: 1) Respondent was found sleeping while caring for patient and while patient had a mist collar in place without mechanical ventilation and was beginning to fall asleep. 2) Respondent was observed attempting to feed patient large pieces of food without pureeing them. 3) Respondent was observed failing to maintain one hand clean technique by touching the suction catheter with an unclean hand. 4) Respondent was observed attempting to clean patient's trachea stoma with water used for suctioning rather than with the proper distilled water/peroxide mixture.

Respondent also performed several previous acts while working in a prison including using a contaminated needle to administer insulin to numerous inmates, saving contaminated medication for future use, failing to administer ordered dose of insulin, incorrectly recording insulin administered and failing to secure, maintain and account for an insulin syringe with needle.

Respondent failed to pass a medication skills examination required by her then employer.

These cases amplify that LVNs—by licensure alone—are not educated or trained to perform respiratory care. Many of these LVNs lost their livelihood because employers assured them they were qualified to provide respiratory care: a practice that is far outside the scope of the LVN practice with absolutely zero competency testing. So not only are patients the ultimate victims, but LVNs also suffer repercussions. Many LVNs have expressed they do not feel qualified or comfortable providing respiratory care. Since LVNs are not educated or legally authorized to perform any level of assessment, it makes sense they are hesitant to be plunged into a level of patient care beyond their scope. Employers bear the blistering weight of these travesties and the BVNPT has propelled the underlying problems since they published their "policy" in 1996.

At the latter part of 2015, the RCB was prepared to send a notice to all California subacute facilities that identified the most common respiratory tasks being performed by unqualified or unlicensed personnel. (The notice was later revised to be an education advisory, but was never disseminated based on legal advice and concerns with a North Carolina case that had just emerged.)

At this time, the RCB's executive officer also reached out to and met with the BVNPT's acting executive officer to review education and training of LVNs versus RCPs. Copies of exam matrices, education program curricula, and community standards were provided. A copy of the RCB's notice was provided to BVNPT's acting executive officer who consulted with the BVNPT's ***supervising nurse education consultant*** during his review. The BVNPT's acting executive officer responded by stating he "highlighted the sections where ***we*** feel that it is within the scope of practice for an LVN to perform" as follows:

EDUCATION ADVISORY
The Practice of Respiratory Care

December 1, 2015
~~**NOTICE**~~
~~**ease & Desist The Unauthorized**~~
~~**Practice of Respiratory Care**~~
~~**Performed by Licensed Vocational Nurses, Certified Nursing Assistants, and all other unauthorized or unlicensed personnel.**~~

It has come to the attention of the Respiratory Care Board of California (RCB) that various facilities, predominately skilled nursing and sub acute facilities are considering the employment of, or are employing, Licensed Vocational Nurses (LVNs), Certified Nursing Assistants (CNAs) or unlicensed personnel to illegally provide respiratory care.

The RCB is mandated by law to protect the public from the unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care. Many patient deaths may result from unlicensed and/or unqualified practice, though it is generally overcasted in documentation by a patient's physical condition and/or failure to respond to treatment.

The laws contained in the Respiratory Care Practice Act (RCPA) include a broad scope of practice relating to the respiratory care practice. The RCPA requires licensure as a respiratory care practitioner (pursuant to B&P § 3760, § 3761, and § 3766), to provide "therapy, management, rehabilitation, diagnostic evaluation and care of patients with deficiencies and abnormalities which affect the pulmonary system and associated aspects of cardiopulmonary and other systems functions" (B&P § 3702).

Following is a list of illegal practices that have been found to be taking place at one or more skilled nursing facilities. LVNs, CNAs, or any other unlicensed personnel are NOT legally authorized to do any of the following (this list is not all inclusive):

- Make any medical assessment or evaluation, regardless of the purpose.
- **Collect respiratory data (e.g. breath sounds, etc...).**
- **Change any setting on a ventilator - with** or without **a physician's order.**
- **Change cannulas at any time.**
- Assess for placement of a speaking valve or trach plugging.
- Assess a patient's response to ventilator adjustments or current settings.
- Reconfigure or change aerosol or ventilator circuits.
- **Manipulate a ventilator breathing circuit, including disconnecting the circuit, for any purpose (e.g. nebulized medication administration, etc.).**
- Troubleshoot artificial airway problems, ventilator-related controls and alarms.
- Titrate and/or adjust oxygen liter flow in response to the changes in patient oxygen demands or change in condition.
- Pre or post patient assessment required as part of a bronchodilator treatment.

- **Pre or post patient assessment of all medications delivered in any form including those through nebulizers.**
- **Make an evaluation of individualized interventions related to the care plan or treatment plan.**
- Engage in the transport of ventilator-dependent patients to their daily activities and/or scheduled shower days, which may require disconnection and/or manipulation of the ventilator circuit and ventilator power supply. They shall not be responsible for ensuring the security of the artificial airway and related functionality of the ventilator before, during and after transport.
- Use of the employment classification or working title of Respiratory LVN or any derivative of respiratory or respiratory care practitioner, respiratory therapist, etc...

It has also come to our attention that some facilities are also not documenting services and/or treatments provided to patients correctly. No person who provides services or treatment to a patient is permitted to omit, falsify, or make illegible entries into the patient record. **Nor is it acceptable to chart activity performed by another person in the record or "pre-chart" activity prior to the service.** Both the Board of Vocational Nursing and Psychiatric Technicians and the Respiratory Care Board have laws and/or regulations that this activity is grounds for license discipline. In addition, failure to keep accurate and clear patient records in accordance with laws and regulations enforced by the California Department of Public Health may also result in additional disciplinary or administrative fines against the facility.

Please be advised that the RCB has and will continue to issue citations with fines up to $15,000 (per occurrence), to any person and his or her employer or contractor, if the RCB has probable cause that the person is practicing respiratory care without a license, as prescribed by the RCB (Reference California Code of Regulations, Title 16, Division 13.6, Section 1399.381). In addition, please note that licensed respiratory care practitioners and their employers are legally required to report violations to the RCB (Reference B&P, Sections 3758 and 3758.5).

Questions: Please submit questions in writing via e-mail to: rcbinfo@dca.ca.gov. If you require immediate assistance, please contact the RCB by telephone at (916) 999-2190.

References

B&P, Sections 2859, 2860, 2860.5, 2861, 3701, 3702, 3702.7, 3758, 3758.5, 3760, 3761, 3765, 3766, and 3767

Health and Safety Code, Sections 1276.8, and 1337

California Code of Regulations, Title 22, Sections 70217, 70405, 70615, 72543(f), and 74707

California Code of Regulations, Title 16, Sections 2518.5, 2518.6, 1399.379, 1399.380, and 1399.381

Beginning in March 2016, an association began to question the RCB's authority to investigate and cite and fine subacute facilities. It became apparent that the association was representing one, possibly two facilities that had recently been issued a cease and desist by the RCB, and that the association had been consulting with a newly appointed executive officer at the BVNPT. Despite numerous attempts over several months, the new executive officer at the BVNPT would not return the calls or messages from the RCB's executive officer. In September 2016, another representative of the association reached out to the then-director of the Department of Consumer Affairs (DCA) erroneously interpreting laws and regulations as later verified by legal counsel.

In December 2016, the DCA director invited all parties to attend an ***in-person*** meeting at its headquarters. Present were the DCA director, legal counsel for both boards, several deputy directors, the RCB's executive officer and president and the BVNPT's ***supervising nurse education consultant*** who was now appointed as the BVNPT's acting assistant executive officer. While there, we all learned that the BVNPT executive officer and two BVNPT board members were joining by telephone, and quickly adjustments were made so they could participate. Ultimately, the DCA director attempted to arrange for both boards to get together to discuss the issue. However, the BVNPT executive officer stated she did not have the authority to agree to a meeting with the RCB.

Following this meeting, several members of the California Association for Respiratory Care and the RCB attended the BVNPT meeting in Sacramento to approach the BVNPT members for authorization to meet. The BVNPT executive officer was directed to meet with the RCB.

The RCB's executive officer reached out to the BVNPT's executive officer to see if they could use the DCA's Training Office to facilitate a meeting of both boards. The BVNPT executive officer rejected this idea and instead suggested another outside agency that was proficient in facilitating such discussions. The BVNPT's executive officer insisted that we use facilitation services through another agency and asked the RCB's executive officer to work with them. Shortly after the RCB's executive officer contacted the other agency, the Business, Consumer Services and Housing Agency then stepped in and chose to facilitate the discussion.

In 2017, the committees performing legislative sunset review delivered harsh though warranted criticism of the BVNPT stating, "It appears as if a majority of the [BVNPT] members are turning a blind eye to the issues that have been raised by the Monitor and others, and continue to ignore ongoing mismanagement of [the BVNPT]." Legislative staff suggested reconstituting the BVNPT and cautioned against extending the BVNPT's sunset date without significant staff/member changes.

In April 2017, the Deputy Secretary Legal Counsel at the Business, Consumer Services and Housing Agency (Agency) hosted a meeting with the following representatives in attendance (please note that most personnel currently in these positions have changed):

DCA: Deputy director legal counsel and senior legal counsel.
Respiratory Care Board: The president and executive officer.
BVNPT: The ***supervising nursing education consultant*** who was now appointed as the BVNPT's acting assistant executive officer, the president and another board member (the BVNPT executive officer was not available and soon thereafter no longer in the position).

At the meeting, each board was provided a legal opinion (drafted by DCA legal counsel) regarding the authority of each board. The RCB was correct in its interpretation of the law. The legal opinion for the BVNPT was not shared despite requests for such.

Also during this meeting, it is **important to note** that the respiratory task list included above with highlighted text was reviewed again. The same ***supervising nursing education consultant*** that reviewed it previously and identified those tasks that LVNs could perform, now took a different position. The ***supervising nursing education consultant,*** the BVNPT president and other BVNPT board member now claimed that LVNs could perform **all** the tasks on the list. Yet the ***supervising nursing education consultant*** denied any knowledge of the list prior to the day of this meeting. The BVNPT board member stated that LVNs could do anything an RCP could do except wean patients from ventilators. That board member is no longer on the BVNPT as of approximately December 2018. The ***supervising nursing education consultant/acting assistant executive officer*** is also no longer actively employed with the BVNPT as of approximately May 2017.

The Agency's deputy secretary legal counsel believed the problem had to do with the fact that nursing ratios were to blame and that there needed to be respiratory therapist ratios. He stated he would reach out to his colleagues at the California Department of Public Health to see if ratios could be established for RCPs. No action was taken.

In 2017, the RCB proposed legislation that would have amended the LVN Practice Act to prohibit practice of respiratory care. Three SEIU factions were asked by a legislative staff member to weigh in: One faction was not opposed, one faction did not respond, and one faction was opposed. Due to the lack of agreement, the legislator denied the RCB's request to carry. However, it would behoove unions to support this legislation and their members, many of whom are fearful of performing respiratory care from being coerced into performing duties by an employer that could easily result in the loss of their license.

In December 2017, the governor announced the appointment of a new executive officer for the BVNPT effective January 2, 2018. Shortly thereafter, the RCB reached out to the BVNPT's new executive officer to discuss the long history of this issue and existing concerns. Both the executive officer and assistant executive officer of the BVNPT displayed genuine concern and interest to resolve this issue. Over 12 months the executive officers and assistant executive officers of both boards met several times and built an amiable relationship with mutual respect and the same goal: consumer protection. Together they brought all the key players together for several meetings in 2018 and 2019.

In order to produce an open and honest discussion, both executive officers agreed it would benefit all parties if the discussion was facilitated by the Department of Consumer Affairs' SOLID Training and Planning Solutions team. Arrangements were made and these representatives participated in a series of meetings that began in June 2018:

Respiratory Care Board
- President.
- Vice president.
- Executive officer.
- Assistant executive officer.
- Enforcement manager.
- Investigators.

Board of Vocational Nursing and Psychiatric Technicians
- President.
- Vice president.
- Executive officer.
- Assistant executive officer.

Experts
- Supervising nursing education consultant (on staff w/BVNPT).
- Nursing education consultant (on staff w/BVNPT).
- Respiratory care practitioner expert (contracted w/RCB).

Legal Counsel
- Legal counsel representing BVNPT.
- Legal counsel representing RCB.

Administration
- DCA assistant deputy director.

Business, Consumer Services and Housing Agency
- Several representatives in attendance at various meetings.

The goal for the RCB was to have an agreed-upon interpretation of existing law concerning which services LVNs are authorized to perform. Specifically, RCB had noticed increases in complaints, primarily in Southern California, of subacute facilities using LVNs to perform respiratory care. Incidents which included failure to respond timely or appropriately, to emergencies to failing to plug in a ventilator, all leading to the deterioration of patients. It was also found that employers were asking the one or two licensed RCPs on staff to co-sign or sign for work that was not performed by them.
Employers had given new titles to LVNs, calling them "respiratory nurses." Employers were caught telling their employees to lie to our investigators about LVNs performing respiratory care. All of these acts violate the Business and Professions Code. Respiratory tasks require comprehensive assessment, formal education and training, and competency testing. Both boards agreed and repeated on numerous occasions that consumer protection was the utmost priority in developing the joint statement.

The main focus throughout the discussions was on long-term care, specifically subacute facilities. In these meetings, it was suggested that home care be included. While home care was ultimately included in the joint statement, RCB understands that it is unique and has a different set of circumstances. But RCB also has evidence of five separate incidents of child deaths that occurred as a result of incompetence and/or negligence of the LVN care provider and therefore it did not object to its inclusion.

In April 2019, a joint statement was reached and published by both boards. The joint statement was not pursued as a regulation, because it was understood to interpret existing law. However, once the joint statement was published in April 2019, several entities came forward in objection to the joint statement, primarily home care and adult and pediatric day care facilities. As a result, the Department of Consumer Affairs suggested that the items in the joint statement be placed in regulation allowing the public to comment. An update to the joint statement was released in May 2019, which read in part:

> *"In the next few months, both the RCB and the BVNPT intend to pursue regulations on the issues identified on the joint statement. As part of the rulemaking process, draft regulatory language will be issued and considered at upcoming board meetings. The RCB plans to consider such regulatory language as part of its June 2019 meeting, and the BVNPT plans to do the same at its August 2019 board meeting."*

In June 2019, the RCB reviewed and considered regulations to this effect. There were numerous home care providers at RCB's teleconference board meeting who provided comment. It was noted that approving or not approving the regulations did not change the existing law. By passing the regulations, it would have given the appearance that the RCB was not moved by the testimony. As a result, the RCB did not approve the regulations and instead passed a motion to "exclude home care from [the] language and continue to work with the BVNPT to modify the joint statement accordingly."

The RCB minutes from its June 2019 meeting reflect:

> *"While the Joint Statement still stands as written, because of the way home care is set up, there appears to be a need for some type of exemption or certification training for LVNs to perform some respiratory tasks in home care only. The proposed language was based on communication prior to receiving much feedback from the home care industry. The legislation passed last year, which this regulatory language is based on, allows the [RCB] to define basic, intermediate, and advanced tasks and creates an avenue to allow for public comment. Currently, the language does not include or exclude home care. It has however picked up the momentum that it is tied to home care."*

In June 2019, BVNPT and RCB held a stakeholder meeting. Those in attendance were overwhelmingly from the home care industry, adult and pediatric day care facilities and congregate living.

Following RCB and stakeholder meetings in June, the joint statement was revised for the final time as follows:

Respiratory Care Board of California and Board of Vocational Nursing and Psychiatric Technicians Joint Statement – April 2019 (Revised July 2019)

The Respiratory Care Board (RCB) and the Board of Vocational Nursing and Psychiatric Technicians (BVNPT) began meeting in 2018 to discuss concerns related to reports of scope of practice issues occurring in sub-acute facilities, long-term care, and skilled nursing facilities in California. Board members, staff, legal counsel and experts weighed in on the issues by considering current laws, education and training. Prioritizing both boards' highest priority of public protection, the boards have agreed on a joint statement.

Both boards agree that respiratory care practitioners (RCPs), licensed vocational nurses (LVNs) and psychiatric technicians (PTs) are invaluable members of the patient care team in providing optimum care to patients. Each health care professional relies on others to perform their practice well. They establish a therapeutic interface among all health care personnel that benefits patients in their care and safety.

Both boards' mandates require 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." (*Business and Professions Code sections* 2841.1, 3710.1 and 4501.1) Each board's oversight responsibility is summarized below:

Respiratory Care Board of California (RCB)	Board of Vocational Nursing and Psychiatric Technicians (BVNPT)
Responsible for licensing and regulating the practice of respiratory care pursuant to the Respiratory Care Practice Act *(Business and Professions Code section 3700 et seq.)*. The RCB is statutorily charged with protecting the public from the unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care (*Business and Professions Code section 3701)*.	Responsible for licensing and regulating the practice of vocational nurses and psychiatric technicians pursuant to the Vocational Nursing Practice Act and the Psychiatric Technicians Law *(Business and Professions Code Section 2840 et seq. and Section 4500 et seq., respectively)*.

The boards jointly agree that stakeholders should be aware that RCPs, LVNs and PTs must follow their respective scopes of practice for patient safety. Violating the respective scope of practice could lead to patient harm and the license being formally disciplined by the respective boards.

A concern to both boards is unlicensed and/or unqualified vendors instructing health care professionals to provide ventilator care. Both boards agree this is an unsafe practice. Further, section 3702.7 of the Business and Professions Code provides that the education of health care professionals about respiratory care, including clinical instruction and the operation or

application of respiratory care equipment and appliances is within the respiratory care scope of practice and would require licensure as an RCP.

Given that numerous patients admitted to sub-acute facilities, long-term care, and skilled nursing facilities require respiratory care, with some dependent upon ventilators to sustain life, and given concerns for care that is being provided at some facilities in California, the RCB and the BVNPT issues this joint statement to inform administrators and staff at sub-acute facilities, long-term care, and skilled nursing facilities on the following issues:

PATIENT CARE PRACTICES

Invasive Mechanical Ventilation

Invasive mechanical ventilation is a lifesaving intervention for patients with respiratory failure and is at the core of respiratory care practitioners' education, training, and competency testing. Given the clinical knowledge of the hazards, indications, contraindications of mechanical ventilation, and complexity associated with invasive mechanical ventilation, and that extensive and formal education and training is required to provide such care.

Respiratory Care Practitioners are authorized to provide the following types of care (LVNs and PTs are not authorized to provide this care):	Licensed Vocational Nurses and Psychiatric Technicians role in patient care:
• Changing any setting on a ventilator, with or without a physician's order. • Routine and/or emergent changing inner and/or outer cannulas. • Reconfiguring or changing aerosol or ventilator circuits. • Manipulating ventilator breathing circuits including disconnecting or reconnecting the circuit, for any purpose, including, but not limited to administering bronchodilator or nebulizer treatments. • Troubleshooting artificial airway problems and ventilator-related controls and alarms. • Assessment of a patient's response to ventilator adjustments or current settings. • Assessment for the placement and/or placement of a speaking valve or trach plugging. • Transporting patients intra or inter facility to daily activities and/or scheduled shower days.	The LVN and PT are authorized to provide care to the patient receiving invasive mechanical ventilation when the care is **not** specifically related to the mechanical ventilation but is within the LVN or PT's scope of practice. That care includes but is not limited to: • Basic Assessment (data gathering) of total patient. • Administration of ordered medications that do not require manipulation of the mechanical ventilator. • Provision of ordered treatments. • Hygiene care. • Comfort care. • Patient and family education. • LVNs and PTs are not responsible for ensuring the security of the artificial airway and related functionality of the ventilator before, during and after transport. However, LVNs and PTs can go as part of the team, but they are not responsible for the ventilator or related care.

CARE/TREATMENT PLANS

Respiratory Care Practitioner	Licensed Vocational Nurses and Psychiatric Technicians
Recommend appropriate respiratory care intervention/s, and manage, or modify, respiratory care interventions based on the patient's response to therapy and written protocols approved by the medical staff.	Contribute data to the registered nurse needed for the evaluation process. However, LVNs and PTs cannot make clinical diagnosis of the patient's respiratory condition, and/or make respiratory care recommendations based on their clinical findings.

Both boards recognize that working titles using any derivative or synonymous meaning of the word "respiratory" for LVNs and PTs is prohibited. This includes but is not limited to: Respiratory Aide, Respiratory Nurse, Inhalation Nurse, etc.

Scope of Practice Questions and Information

Both Boards prefer written inquiries to ensure accurate and complete responses. Phone calls are accepted, and you will be requested to submit the inquiry in writing. Responses to written inquiries may take up to five business days depending on the complexity of the question.

Respiratory Care Board	Board of Vocational Nursing and Psychiatric Technicians
E-mail: rcbinfo@dca.ca.gov Telephone: 916.999.2190 Toll-free: 866-375-0386 Website: www.rcb.ca.gov	Email: bvnpt.sop@dca.ca.gov Telephone: 916.263.7843 Website: www.bvnpt.ca.gov

July 2019 Revision

Both boards agreed to remove "home care locations" from the Joint Statement in response to numerous comments received at the RCB's teleconference board meeting held June 7, 2019 and a stakeholder meeting held June 27, 2019. At the RCB meeting, the board passed a motion "to move forward with excluding home care and continuing working with the BVNPT to modify the Joint Statement."

It was noted at all meetings that services provided in home care, as well as Adult Day Health Care Facilities, Congregate Living Health Facilities, and Pediatric Day Health & Respite Care Facilities [including transport to/from and care during daily outside activities (e.g. school)] serve a population who may need greater access to care and may hold different expectations for care given consideration to patients' quality of life and health care reimbursement allowed. For this reason, both the BVNPT and the RCB will continue conducting research in this area to determine how greater consumer protection safeguards may be put in place such as possible standardization of training in some areas. Any such actions are expected to be addressed through regulations and/or legislation where public comment is encouraged.

The update in the July 2019 revision included this language:

> *"Both boards agreed to remove 'home care locations' from the Joint Statement in response to numerous comments received at the RCB's teleconference board meeting held June 7, 2019 and a stakeholder meeting held June 27, 2019. At the RCB meeting,the board passed a motion 'to move forward with excluding home care and continuing working with the BVNPT to modify the Joint Statement.'*
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> *It was noted at all meetings that services provided in home care, as well as Adult Day Health Care Facilities, Congregate Living Health Facilities, and Pediatric Day Health & Respite Care Facilities [including transport to/from and care during daily outside activities (e.g. school)] serve a population who may need greater access to care and may hold different expectations for care given consideration to patients' quality of life and healthcare reimbursement allowed. For this reason, both the BVNPT and the RCB will continue conducting research in this area to determine how greater consumer protection safeguards may be put in place such as possible standardization of training in some areas. Any such actions are expected to be addressed through regulations and/or legislation where public comment is encouraged."*

In August 2019, an issue arose that hinted the BVNPT had changed course. On September 25, 2019, RCB staff was made aware through an outside source that BVNPT was preparing language for a legislative change though it was presented as a regulation change up to the date of release. On October 1, 2019, BVNPT confirmed that it had changed course after the release of the joint statement in April 2019 in response to objections to the joint statement. This action placed a strain on relations between the two boards, but some positive interactions have taken place since.

On October 9, 2019, BVNPT held the final stakeholder meeting presented as a joint meeting of the BVNPT and the RCB. The sole focus of the meeting was to get feedback from the stakeholders on BVNPT proposed legislation. BVNPT proposed draft legislation provided an avenue for LVNs and psychiatric technicians to take a continuing education course to qualify to provide mechanical ventilator care. The legislation did not specify or limit any tasks or any locations. It did not require formal education or training or competency testing. Currently, LVN formal education consists of a cursory course that includes an overview of respiratory care. The proposed legislation was never picked up by an author.

As of August 2021, the RCB continues to display the original and revised joint statements on its home page. However, BVNPT at some point in 2020 or 2021 removed the joint statements from its website and replaced it with the following notice completely reversing course. Needless to say after entering discussions with key players in good faith and coming to a **joint agreement,** it is disheartening and concerning to see the recent turn of events.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
Board of Vocational Nursing and Psychiatric Technicians
2535 Capitol Oaks Drive Suite 205, Sacramento, CA 95833-2945
Phone 916-263-7800 Fax 916-263-7855 www.bvnpt.ca.gov

Clarification of Current Licensee Practice

Mechanical Ventilation Care

As reported in earlier joint statements from the Board of Vocational Nursing and Psychiatric Technicians (BVNPT) and the Respiratory Care Board (RCB), the Boards met multiple times in 2018 and 2019 to discuss concerns related to scope of practice specific to mechanical ventilation. As a result of those discussions, the BVNPT determined that there is a need for legislation and associated regulations to specify the roles of vocational nurses (VNs) and psychiatric technicians (PTs) when caring for patients on mechanical ventilation.

The BVNPT is working to develop a legislative proposal, which, pending Board approval, will authorize the BVNPT to offer Board-Certification to VNs and PTs related to the care of patients on mechanical ventilation. The certification will include completion of a certified course approved by the Board and a mechanism for demonstrating clinical competency. The BVNPT recently held Stakeholder Meetings to obtain input from nursing/medical professionals, clinical organizations, current course providers, healthcare advocates and other interested parties regarding this legislation.

Although the BVNPT has begun the process of developing the appropriate legislation, it must be noted that the legislative process takes time. Until new legislation and associated regulations are approved, the Board is, by virtue of this statement, clarifying that the existing scope of practice of licensees governed by this Board **has not changed**.

If you have further questions about this information, please contact the Board through the following scope of practice email address:

bvnpt.sop@dca.ca.gov

Given the extensive history, the RCB is now turning to the Senate Committee on Business, Professions and Economic Development and the Assembly Committee on Business and Professions providing Sunset Review Oversight to consider the following legislative alternatives to resolve this issue and/or provide input and feedback.

ALTERNATIVE RESOLUTION #1

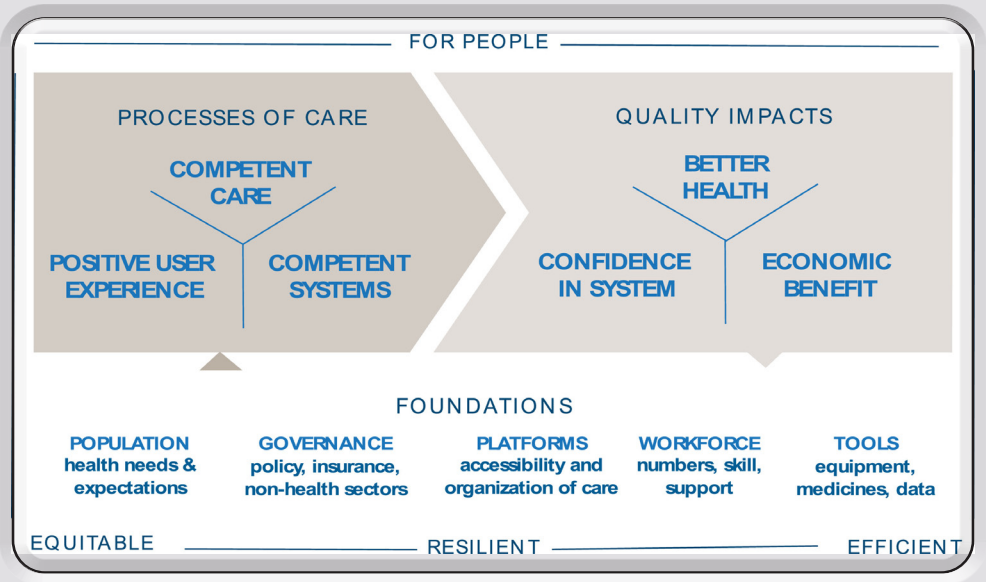
Amend B&P § 2860 (LVN Practice Act)

(a) This chapter confers no authority to practice medicine or surgery, respiratory care services and treatment, or to undertake the prevention, treatment or cure of disease, pain, injury, deformity, or mental or physical condition in violation of any provision of law.

(b) Notwithstanding subdivision (a), a licensed vocational nurse who has received training satisfactory to their employer and when directed by a physician and surgeon may perform respiratory tasks and services expressly identified by the Respiratory Care Board of California pursuant to subdivision (a) of section 3702.5.

(c) Notwithstanding subdivision (a) a licensed vocational nurse may qualify to perform respiratory services identified by the Respiratory Care Board through their employment with a home health agency licensed by the California Department of Public Health in a non-licensed home setting upon demonstrating competence in patient-specific tasks as provided by the Respiratory Care Board of California.

(d) The Respiratory Care Board of California shall adopt regulations to effectuate subdivisions (b) and (c) of this section. In adopting rules and regulations, the Respiratory Care Board of California shall comply with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.



ALTERNATIVE RESOLUTION #2

Amend B&P § 2860 (LVN Practice Act)

(a) This chapter confers no authority to practice medicine or surgery, respiratory care services and treatment, or to undertake the prevention, treatment or cure of disease, pain, injury, deformity, or mental or physical condition in violation of any provision of law.

(b) Notwithstanding subdivision (a), a licensed vocational nurse who has received training satisfactory to their employer and when directed by a physician and surgeon may perform respiratory tasks and services expressly identified by the Respiratory Care Board of California pursuant to subdivision (a) of section 3702.5.

Amend B&P § 3765 (Respiratory Practice Act)

3765.

This act does not prohibit any of the following activities:
(a) The performance of respiratory care that is an integral part of the program of study by students enrolled in approved respiratory therapy training programs.
(b) Self-care by the patient or the gratuitous care by a friend or member of the family who does not represent or hold himself or herself out to be a respiratory care practitioner licensed under the provisions of this chapter.
(c) The respiratory care practitioner from performing advances in the art and techniques of respiratory care learned through formal or specialized training.
(d) The performance of respiratory care in an emergency situation by paramedical personnel who have been formally trained in these modalities and are duly licensed under the provisions of an act pertaining to their specialty.
(e) Respiratory care services in case of an emergency. “Emergency,” as used in this subdivision, includes an epidemic or public disaster.
(f) Persons from engaging in cardiopulmonary research.
(g) Formally trained licensees and staff of child day care facilities from administering to a child inhaled medication as defined in Section 1596.798 of the Health and Safety Code.
(h) The performance by a person employed by a home medical device retail facility or by a home health agency licensed by the State Department of Public Health of specific, limited, and basic respiratory care or respiratory care related services that have been authorized by the board.
(i) The performance by a vocational nurse licensed by the Board of Vocational Nursing and Psychiatric Technicians, employed by a home health agency licensed by the California Department of Public Health, with patient-specific training as identified by the board, of respiratory tasks and services identified by the board.
(j) The performance of pulmonary function testing by persons who are currently employed by Los Angeles County hospitals and have performed pulmonary function testing for at least 15 years.

PROPOSED REGULATORY LANGUAGE IN SUPPORT OF LEGISLATIVE CHANGES

The following language is presented solely for the purpose of demonstrating how proposed regulations would be organized if either legislative proposal came to fruition. Should legislation move forward, the RCB would invite consumers, BVNPT, home care associations, unions, and all other stakeholders to engage in one or multiple discussions on the details of the following language. The RCB would not establish proposed regulations or begin the rulemaking process until extensive input was received. The overarching goal is to make sure consumers continue to have access to respiratory care in all settings, while minimizing the risks in the quality of respiratory care to meet consumer demands for their and their loved ones quality of life. Either legislative proposal combined with regulations formulated by stakeholders will accomplish this goal.

1399.3xx Basic Respiratory Tasks and Services (Manual/Technical Respiratory Tasks)

a) Pursuant to subdivision (a) of section 3702.5 of the B&P, basic respiratory tasks and services that do not require a respiratory assessment and only require manual, technical skills or data collection include:

1) Data collection. This does not include assessment of chest auscultation.

2) Use and monitoring of the pulse oximeter.

3) Medication administration by aerosol that does not require manipulation of an invasive or non invasive mechanical ventilator. This does not include pre-treatment assessment, use of medical gas mixtures other than oxygen, preoxygenation, endotracheal or nasal suctioning, or post treatment assessment.

4) Replacement of heat moisture exchanger and oxygen tank replacement for patients who are using non-invasive mechanical ventilation. This does not include the initial set-up, change out or replacement of the breathing circuit or adjustment of oxygen liter flow or oxygen concentration.

5) Hygiene care including but not limited to: replacement of tracheostomy tie and gauze and cleaning of the stoma site. This does not include tracheal suctioning, cuff inflation/deflation, use or removal of an external speaking valve or removal and replacement of the tracheostomy tube or inner cannula.

6) Use of a manual resuscitation device and cardio-pulmonary resuscitation (basic life support level) in the event of an emergency.

7) Appropriate documentation of care provided. This may include data retrieved from performing a ventilator check or a breath count. This does not include respiratory assessments.

[Note: Employers and/or BVNPT would be responsible for ensuring appropriate training and competency are established by a licensed respiratory care practitioner or registered nurse, as appropriate.]

1399.3xx Intermediate Respiratory Tasks and Services

Pursuant to subdivision (b) of section 3702.5 of the B&P, intermediate respiratory tasks, services and procedures that require formal respiratory education and training as provided in section 3740 of the B&P includes, but is not limited to:

1) Ventilator set-up and change-out and configuration.

2) Alarms: Set, test, respond to, reset or silence.

3) Proper fitting of non-invasive ventilation mask and straps.

4) Initiating or changing any setting on a ventilator, with or without a physician's order. This includes but is not limited to oxygen concentrations.

5) Reconfiguring, manipulating or changing aerosol or ventilator circuits.

6) Manipulating ventilator breathing circuits including disconnecting or reconnecting the circuit, for any purpose, including, but not limited to administering bronchodilator or nebulizer treatments.

7) Troubleshooting artificial airway problems and ventilator-related controls and alarms.

8) Complete management of ventilator weaning.

9) Assessment of a patient's response to ventilator adjustments or current settings.

10) Complete medication administration by aerosol including pre-treatment assessment, use of medical gas mixtures, preoxygenation, endotracheal or nasal suctioning, and post treatment assessment.

11) In-line respiratory related medication delivery via ventilator circuit.

12) Complete oxygen tank, heat moisture exchanger or other humidification device set-up or replacement. This includes the initial set-up, change out or replacement of the breathing circuit or adjustment of oxygen liter flow or oxygen concentration.

13) Complete tracheostomy care including replacement of tracheostomy tie and gauze, cleaning of the stoma site, tracheal suctioning, cuff inflation/deflation, use or removal of an external speaking valve or removal and replacement of the tracheostomy tube or inner cannula.

14) Routine and/or emergent changing inner and/or outer cannulas.

15) Insertion, removal or replacement of the inner cannula.

16) Assessment for the placement and/or placement of a speaking valve or trach plugging.

17) Tracheostomy tube cuff inflation or deflation.

18) Removal or replacement of tracheostomy tube.

19) Endotracheal and nasal suctioning.

20) Instruction and observation of breathing exercises.

21) Ongoing observation of patients and management of signs and symptoms of respiratory distress and dysfunction.

22) Conducting respiratory assessments of any kind and/or taking action based on those assessments.

23) Administering life support protocols under physician's orders.

24) Development of respiratory care treatment plans.

25) Make recommendations to physicians and other medical staff pertaining to respiratory care and treatment.

26) Appropriate documentation of care provided, including respiratory assessments.

27) Intra or inter facility transportation including but not limited to, placement of a patient on portable life support ventilator or reattachment of patient to stationary life support equipment.

28) Ambulation of patient attached to mechanical ventilator.

29) Interpreting test data from capnography, ventilator graphics, laboratory data from blood drawn for arterial/venous blood gases, co-oximetry, continuous oxygen saturation during sleep, obtaining and analyzing sputum samples and results, reviewing chest x-ray data from report or films.

30) Obtaining arterial blood samples for blood gases ordered by physician, interpreting the results and contacting the physician.

31) The treatment, management, diagnostic testing, control, education, and care of patients with sleep and wake disorders as provided in Chapter 7.8 (commencing with Section 3575).

32) Patient education related to smoking cessation, proper use of metered dose inhalers and other respiratory equipment, including safety related to the use of oxygen.

33) Education of consumers about the operation or application of respiratory care equipment and appliances.

1399.3xx Advanced Respiratory Tasks and Services

Pursuant to subdivision (c) of section 3702.5 of the B&P, advanced respiratory tasks, services, and procedures that require supplemental education, training, or additional credentialing consistent with national standards include:

1) Mechanical or physiological ventilatory support used in whole or in part to provide ventilatory or oxygenating support through a catheter.

2) Administration of medical gases and pharmacological agents for the purpose of inducing conscious or deep sedation.

3) All forms of extracorporeal life support, including, but not limited to, extracorporeal membrane oxygenation (ECMO) and extracorporeal carbon dioxide removal (ECCO2R).

4) Education of respiratory core courses or clinical instruction provided as part of a respiratory educational program.

5) Education of healthcare professionals about the operation or application of respiratory care equipment and appliances.

1399.3xx. LVN Home Care and Patient-Specific Training

(a) A licensed vocational nurse may perform respiratory services as identified in subdivision (b) through their employment with a home health agency licensed by the California Department of Public Health, in a non-licensed home setting when all the following requirements are met:

1) The vocational nurse license is issued by the California Board of Vocational Nursing and Psychiatric Technicians, the license is current and valid, and the license has had no disciplinary action taken in the prior twenty-four (24) months.

2) The person holds evidence that they have demonstrated competency to a licensed respiratory care practitioner as identified in subdivision (c) **in each respiratory task to be performed for each patient.**

(b) Following are respiratory care tasks and services as identified in subdivision (a):

1) Suctioning

2) possibly sleep apnea devices/tasks

3) Routine changing inner and/or outer cannulas.

4) Changing aerosol or ventilator circuits.

5) Manipulating ventilator breathing circuits including disconnecting or reconnecting the circuit, only for the purpose of suctioning.

6) Transporting patients in the home to daily activities and/or as needed for hygiene care.

7) Need input in this area from Home Health Agencies to cover all tasks.

(c) A respiratory care practitioner as identified in subdivision (a)(2) must meet all the following requirements:

1) The person shall hold a valid and current license issued by the Board with no disciplinary or administrative action taken against their license in the previous twenty-four (24) months.

2) The person shall hold a Registered Respiratory Therapist (RRT) credential issued by the National Board for Respiratory Care, have been licensed by the Board on or after January 1, 2015 Respiratory, or have been employed in one or more facilities licensed by the California Department of Public Health for a period of no less than two years.

(d) Documentation related to competency for each person, shall be held by the licensed vocational nurse and the licensed vocational nurse's employer for a period of no less than seven (7) years.

"No work is insignificant. All labor that uplifts humanity has dignity and importance and should be undertaken with painstaking excellence."

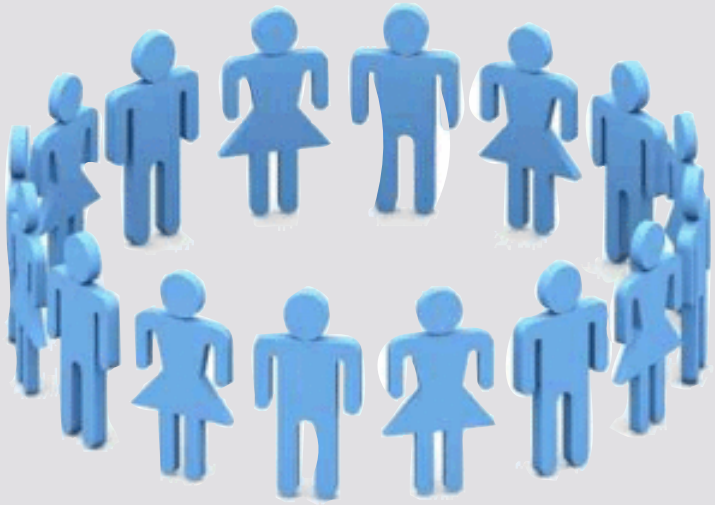
Dr. Martin Luther King Jr.

Issue 2: Registries and Mandatory Reporting Statute Request

The RCB has encountered several respiratory care practitioners who were not reported by facilities because they were advised to resign instead of face termination, or facilities rightfully claimed they did not have to report RCPs who were employed by registries. Instead, facilities using registry employees notify the registry that they do not want the employee assigned to their facility ever again. And while in most instances the registry is made aware of the reason the facility refuses assignments by certain RCPs, the registry (nor the facility) is obligated to inform the RCB, even in those cases of serious violations as outlined in section 3758 of the B&P.

This proposal **adds** additional categories or types of employment that would be subject to mandatory reporting for violations already defined in law. Specifically, the proposal would add 1) persons placed on leave, 2) persons who resign, and 3) persons employed by a registry, subject to the RCB's mandatory reporting requirement if they are also suspected of or have committed a serious violation. This proposal also adds "suspected" serious violations as a basis for reporting.

The RCB seeks to amend §3758 to require all employers of respiratory care practitioners to adhere to mandatory reporting requirements of serious offenses as outlined in section 3758 of the B&P. Amending section 3758 as proposed is in line with the RCB's mandate by ensuring mandatory reporting is completed on all respiratory care practitioners for suspected or actual 1) use of controlled substances or alcohol to such an extent that it impairs the ability to safely practice respiratory care, 2) 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, and 6) theft from patients, other employees, or the employer. This amendment enables the RCB to conduct a timely investigation and prevent harm to consumers.



PROPOSED LANGUAGE

Section 3758 of the Business and Professions Code is amended to read:

3758. (a) Any employer of a respiratory care practitioner shall report to the Respiratory Care Board ~~the~~ any leave, resignation, suspension or termination for cause of any practitioner in their employ. The reporting required herein shall not act as a waiver of confidentiality of medical records. The information reported or disclosed shall be kept confidential except as provided in subdivision (c) of Section 800, and shall not be subject to discovery in civil cases.

(b) For purposes of the this section, "leave, resignation, suspension of termination for cause" is defined to mean any administrative leave, employee leave, resignation, suspension or termination from employment for any of the following reasons:

(1) Suspected or actual ~~U~~use of controlled substances or alcohol to such an extent that it impairs the ability to safely practice respiratory care.

(2) Suspected or actual ~~U~~unlawful sale of controlled substances or other prescription items.

(3) Suspected or actual ~~P~~patient neglect, physical harm to a patient, or sexual contact with a patient.

(4) Suspected or actual ~~F~~falsification of medical records.

(5) Suspected or actual ~~G~~gross incompetence or negligence.

(6) Suspected or actual ~~T~~theft from patients, other employees, or the employer.

(c) The provisions provided in subdivisions (a) and (b) shall also apply to owners, directors, partners or managers of any registry or agency who places one or more respiratory care practitioners at facilities to practice respiratory care and is asked to place the practitioner on a "do not call" list or other status indicating the facility does not want that practitioner placed at their facility for any behavior described in subdivision (b).

~~(c)~~ (d) Failure of an employer to make a report required by this section is punishable by an administrative fine not to exceed ten thousand dollars ($10,000) per violation.

(Added by Stats. 1998, Ch. 553, Sec. 4. Effective January 1, 1999.)

Section 13
Attachments

Organizational Charts

Fiscal Year 2017–18 Organizational Chart

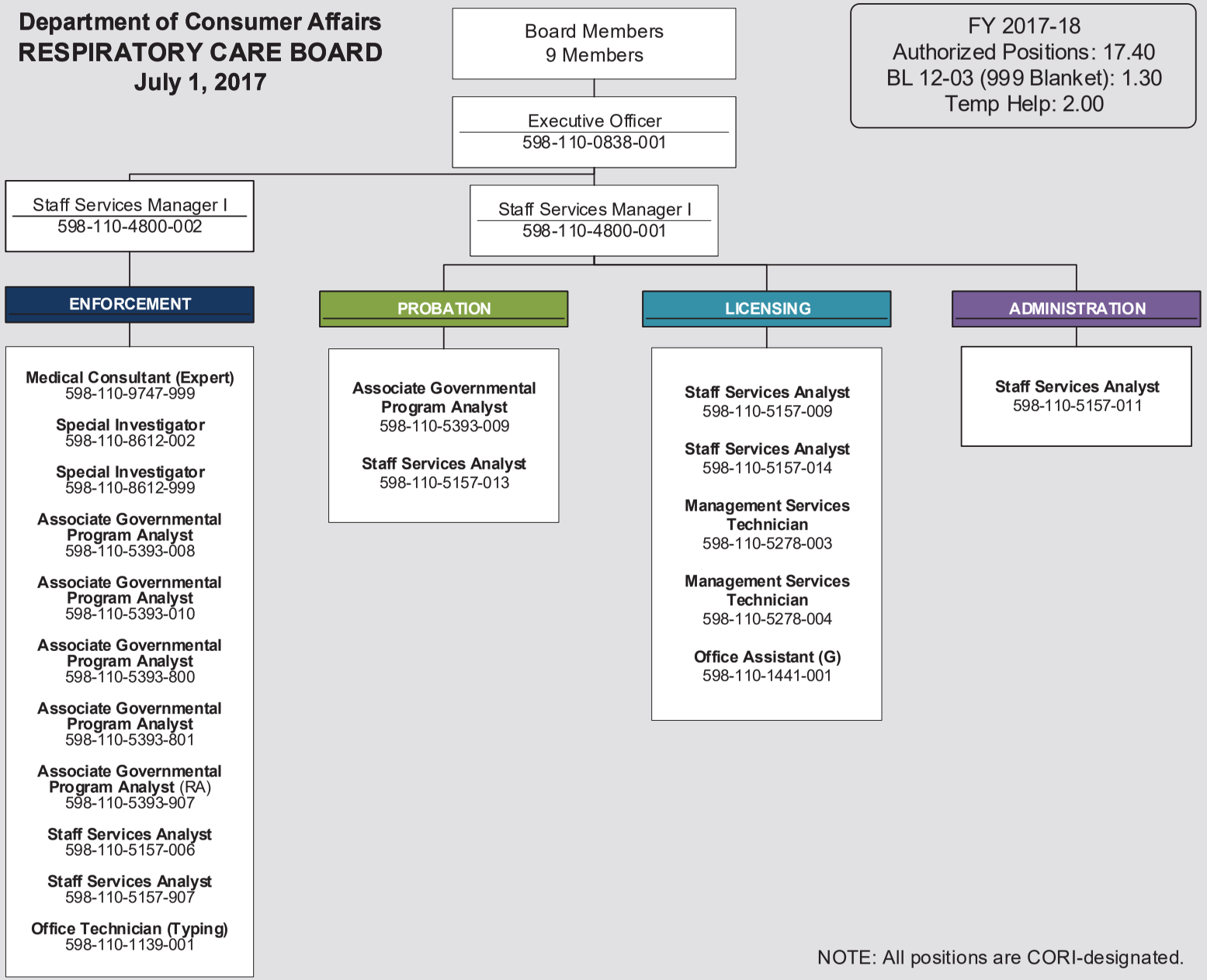
Fiscal Year 2018–19 Organizational Chart

Fiscal Year 2019–20 Organizational Chart

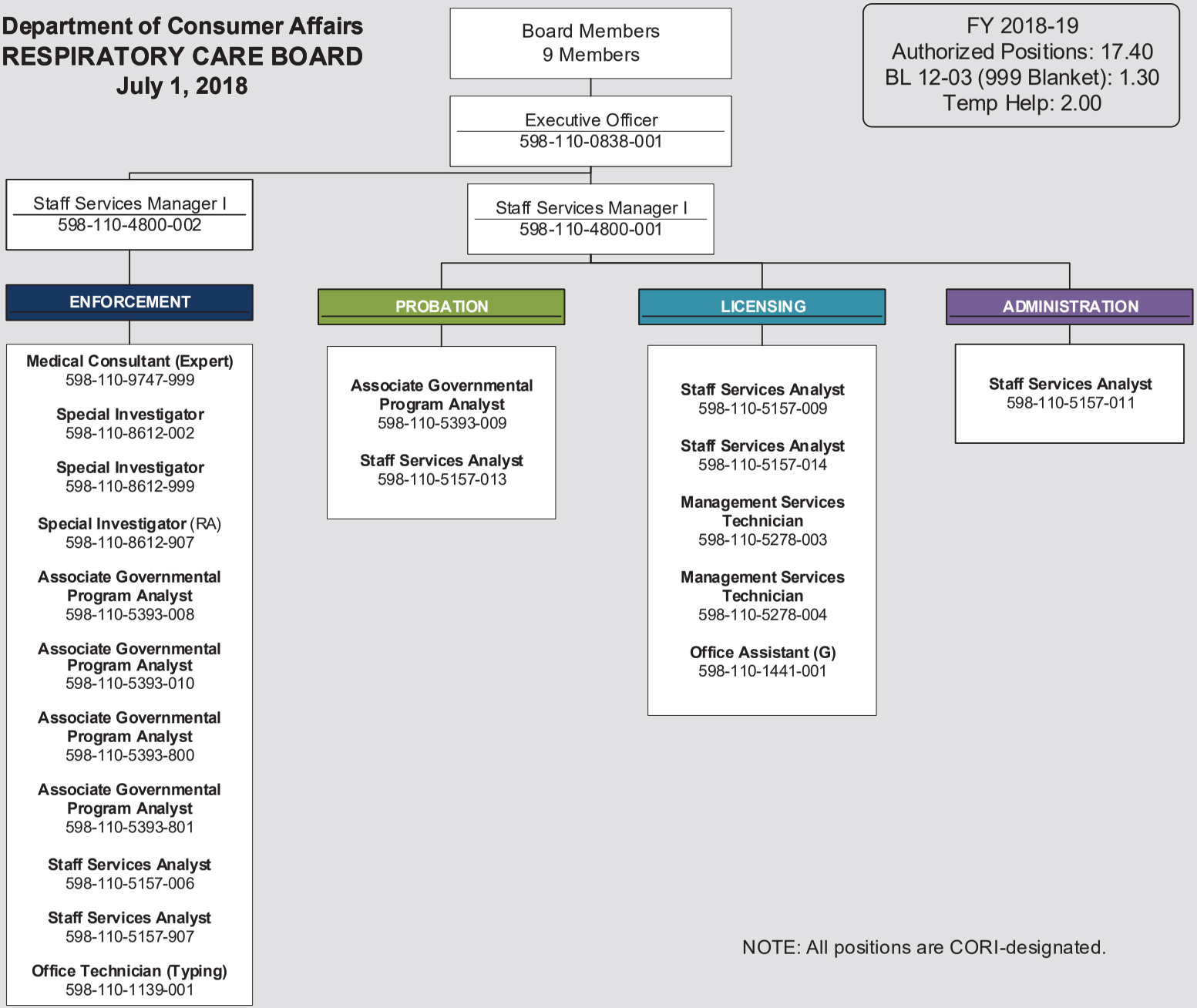
Fiscal Year 2020–21 Organizational Chart

Respiratory Care Board Administrative Manual

Under separate cover

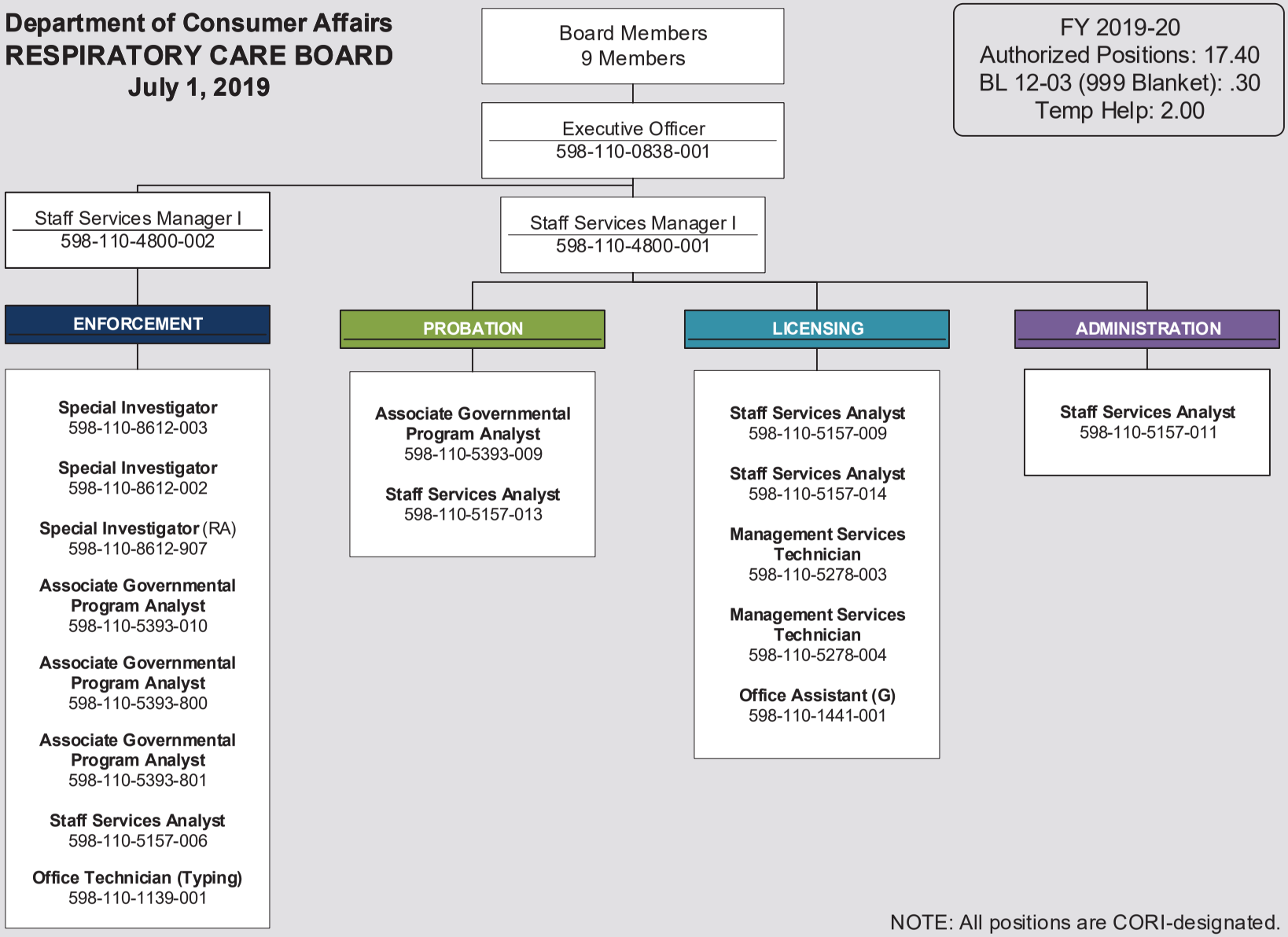

Department of Consumer Affairs
RESPIRATORY CARE BOARD
July 1, 2017
Board Members
9 Members
FY 2017-18
Authorized Positions: 17.40
BL 12-03 (999 Blanket): 1.30
Temp Help: 2.00
Executive Officer
598-110-0838-001
Staff Services Manager I
598-110-4800-002
Staff Services Manager I
598-110-4800-001
ENFORCEMENT
PROBATION
LICENSING
ADMINISTRATION
Medical Consultant (Expert)
598-110-9747-999
Special Investigator
598-110-8612-002
Special Investigator
598-110-8612-999
Associate Governmental Program Analyst
598-110-5393-008
Associate Governmental Program Analyst
598-110-5393-010
Associate Governmental Program Analyst
598-110-5393-800
Associate Governmental Program Analyst
598-110-5393-801
Associate Governmental Program Analyst (RA)
598-110-5393-907
Staff Services Analyst
598-110-5157-006
Staff Services Analyst
598-110-5157-907
Office Technician (Typing)
598-110-1139-001
Associate Governmental Program Analyst
598-110-5393-009
Staff Services Analyst
598-110-5157-013
Staff Services Analyst
598-110-5157-009
Staff Services Analyst
598-110-5157-014
Management Services Technician
598-110-5278-003
Management Services Technician
598-110-5278-004
Office Assistant (G)
598-110-1441-001
Staff Services Analyst
598-110-5157-011
NOTE: All positions are CORI-designated.

Department of Consumer Affairs
RESPIRATORY CARE BOARD
July 1, 2018

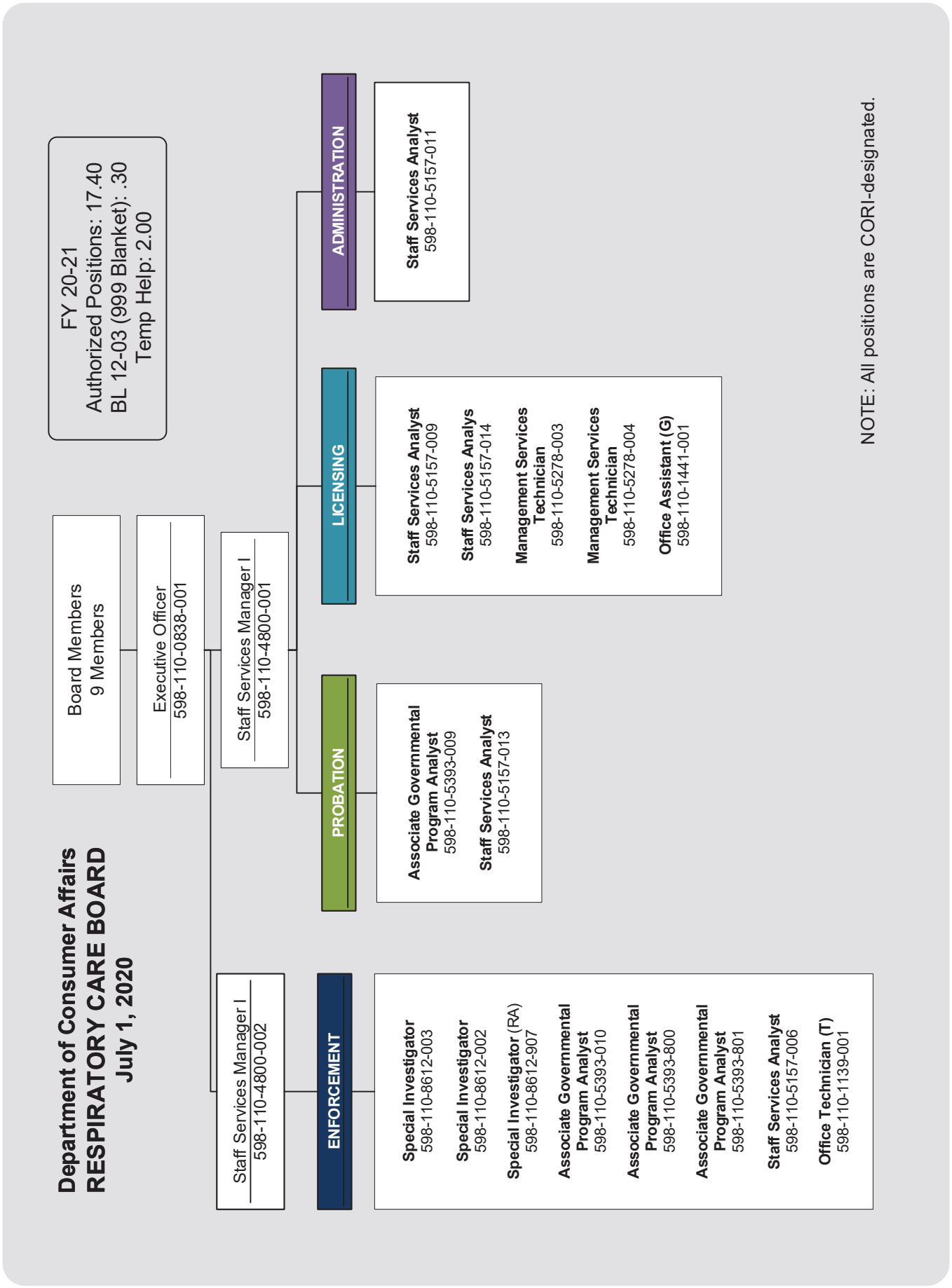


NOTE: All positions are CORI-designated.

Department of Consumer Affairs
RESPIRATORY CARE BOARD
July 1, 2019



NOTE: All positions are CORI-designated.


Department of Consumer Affairs
RESPIRATORY CARE BOARD
July 1, 2020
Board Members
9 Members
Executive Officer
598-110-0838-001
FY 20-21
Authorized Positions: 17.40
BL 12-03 (999 Blanket): .30
Temp Help: 2.00
Staff Services Manager I
598-110-4800-001
Staff Services Manager I
598-110-4800-002
ENFORCEMENT
Special Investigator
598-110-8612-003
Special Investigator
598-110-8612-002
Special Investigator (RA)
598-110-8612-907
Associate Governmental Program Analyst
598-110-5393-010
Associate Governmental Program Analyst
598-110-5393-800
Associate Governmental Program Analyst
598-110-5393-801
Staff Services Analyst
598-110-5157-006
Office Technician (T)
598-110-1139-001
PROBATION
Associate Governmental Program Analyst
598-110-5393-009
Staff Services Analyst
598-110-5157-013
LICENSING
Staff Services Analyst
598-110-5157-009
Staff Services Analys
598-110-5157-014
Management Services Technician
598-110-5278-003
Management Services Technician
598-110-5278-004
Office Assistant (G)
598-110-1441-001
ADMINISTRATION
Staff Services Analyst
598-110-5157-011
NOTE: All positions are CORI-designated.