BACKGROUND PAPER FOR
The Respiratory Care Board of California

(Oversight Hearing, March 6, 2017, Senate Committee on Business, Professions and Economic Development and the Assembly Committee on Business and Professions)

IDENTIFIED ISSUES, BACKGROUND AND RECOMMENDATIONS REGARDING THE RESPIRATORY CARE BOARD OF CALIFORNIA

BRIEF OVERVIEW OF THE RESPIRATORY CARE BOARD OF CALIFORNIA

History and Function of the Respiratory Care Board of California

The Respiratory Care Board (Board), originally established as the Respiratory Care Examining Committee, was created by the Legislature in 1982 to protect a vulnerable patient population from the unqualified practice of respiratory care. The Board is responsible for enforcing state laws pertaining to the practice of respiratory care and regulates a single category of health care workers – respiratory care practitioners (RCPs). RCPs are specialized health care workers, who work under the supervision of medical directors and are involved in the prevention, diagnosis, treatment, management, and rehabilitation of problems affecting the heart and lungs and other disorders, as well as providing diagnostic, educational, and rehabilitation services. 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. They are typically employed in hospitals, however, a growing number of RCPs work in alternative settings like skilled nursing facilities, physician's offices, hyperbaric oxygen therapy facilities and sleep laboratories, to name a few.

The law governing RCPs, the Respiratory Care Practice Act (Act) requires licensure for individuals performing respiratory care. In carrying out its mandate to ensure that protection of the public shall be highest priority in exercising its licensing, regulatory and disciplinary functions, the Board:

- Screens each application for licensure to ensure minimum education and competency standards are met and conducts a thorough criminal background check on each applicant.

- Investigates complaints against licensees, including those generated from updated criminal history reports and mandatory reporting of violations by licensees and employers.

- Aggressively monitors RCPs placed on probation.

- Exercises its authority to penalize or discipline applicants and licensees which may include issuing a citation and fine, issuing a public reprimand, placing the licensee on probation (which may include license suspension), denying an application for licensure or 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 practice of respiratory care is regulated through licensure in all states except for Alaska.

The current Board mission, which guides Board members and the Board's 18 employees, is as follows:

> ***The Respiratory Care Board of California's mission is to protect and serve consumers by licensing qualified respiratory care practitioners, enforcing the provisions of the Respiratory Care Practice Act, expanding the availability of respiratory care services, increasing public awareness of the profession, and supporting the development and education of respiratory care practitioners.***

The Board is comprised of nine members, four RCPs, four public members and one physician and surgeon member. Two public members and one RCP are appointed by the Governor. One public member and two RCPs are appointed by the Speaker of the Assembly. One public member, one RCP and one physician are appointed by the Senate Committee on Rules. Board members receive a $100-a-day per diem. All meetings are subject to the Bagley-Keene Open Meetings Act.

The following is a listing of the current Committee members and brief biographical information:

Name and Short Bio	Appointment Date	Term Expiration Date	Appointing Authority	Professional or Public
Alan Roth, MS MBA RRT-NPS FAARC, President Mr. Roth has worked in the field of Respiratory Care and Rehabilitation for more than 30 years. He has directed programs from community hospitals to academic medical facilities. He has published more than 30 articles in the field of Respiratory Care and a book chapter on Complex Humanitarian Emergencies. Mr. Roth is service-oriented, representing respiratory care in an international pediatric (congenital) heart team that goes to foreign countries and sets up training programs for the establishment of heart institutes in those countries. Mr. Roth is a member of a Federal Tier 1 Disaster Medical Assistance Team (DMAT CA-6) that was last deployed to Haiti after the 2010 earthquake. He has participated locally in community programs for asthma education and outreach, COPD awareness, and Community Transformational Grants for Smoking Cessation. Mr. Roth has also received several professional and humanitarian related honors.	09/12/2012	06/01/2015	Speaker of the Assembly	Professional
Thomas Wagner, BS, RRT, FAARC, Vice President Thomas Wagner, licensed respiratory care practitioner	06/04/2014	06/01/2018	Senate Committee	Professional

was appointed by the Senate Rules Committee on June 5, 2014. Throughout his career, Mr. Wagner has served as Respiratory Director at most of the East Bay hospitals. Mr. Wagner has also served as Past President of the California Society for Respiratory Care (CSRC), and is an active member of the American Association for Respiratory Care's (House of Delegates). Most recently, Mr. Wagner has served as a respiratory instructor with Ohlone college, and is a Commissioner of Parks & Recreation in San Leandro, California.			on Rules	
Mary Ellen Early Ms. Early held several positions at Valley Presbyterian Hospital from 1972 to 2013, including information technology security analyst, analyst for patient care systems, management information systems specialist and nursing computer liaison. Ms. Early was a ward clerk at Riveredge Hospital in 1972 and a nurse aide at Loretto Hospital from 1969 to 1972.	06/2/2015	6/1/2019	Governor	Professional
Rebecca Franzoia Ms. Franzoia served as capitol director for Lieutenant Governor John Garamendi from 2007 to 2009. She worked in a number of positions for the California Department of Insurance from 1991 to 2007, including deputy commissioner of executive operations, chief deputy commissioner, manager of the selections and training unit, training officer and assistant to the commissioner. Ms. Franzoia served on the California Senate Revenue and Taxation Committee as a committee secretary from 1988 to 1990 and a consultant from 1981 to 1986. She was an elementary school teacher at the Tuolumne County School District from 1977 to 1981 and at the Modoc Unified School District from 1974 to 1977.	06/03/2016	06/01/2020	Governor	Public
Mark Goldstein, RRT, RCP Mr. Goldstein has been a senior manager for respiratory and clinical services at Sutter Care at Home, Timberlake Division since 2002. He was a per diem respiratory therapist II at University of California, Davis, Sacramento Medical Center from 1994 to 2002, special projects and regional cardiopulmonary quality assurance coordinator at Mercy San Juan Medical Center from 1989 to 2002 and a respiratory therapist for Kaiser Sacramento from 1983 to 1989.	06/09/2015	6/1/2019	Governor	Professional
Michael Hardeman Michael Hardeman was appointed to the Respiratory Care Board in July of 2013 by the Speaker of the Assembly. Mr. Hardeman was born, raised, and educated in San Francisco. He and his wife Marina have three children and two grandchildren. Prior to retiring in July of 2011 as business manager of the Sign Display Local Union 510, Mr. Hardeman was a sign painter and pictorial artist. He has served on dozens of notable boards and commissions including more than 15 years on the San Francisco Port Commission, and 30 years on the San Francisco Labor Council Executive Committee. Currently, Mr. Hardeman is the president of the San Francisco Fire Department Commission, and	06/29/2016	06/01/2020	Speaker of the Assembly	Public

serves on the Angel Island Immigration Station Board and Serenity House of San Francisco. He is also chair of the OPE Local 3 Pension Trust Fund, and co-chair of the Health and Welfare Fund, and also serves on the Consumer Federation of California Policy Board. Mr. Hardeman has coached youth baseball and basketball, and is a season ticket holder for both the San Francisco 49ers and the San Francisco Giants.				
Ronald H. Lewis, M.D. Dr. Lewis has been a physician and surgeon with the California Department of Corrections at Ironwood State Prison since 2008. He also has been an assistant clinical professor at the University of California, San Diego Department of Medicine since 2000. Prior to that, Dr. Lewis was an urgent care physician at Eisenhower Immediate Care from 2003 to 2008, and Sharp Rees-Stealy Medical Group from 2001 to 2004. Lewis was the director of medical affairs at Agouron Pharmaceuticals, Inc. from 1997 to 2001 and at Sequus Pharmaceuticals, Inc. from 1995 to 1997. He was a clinical assistant professor at Stanford University School of Medicine from 1993 to 1999, and held multiple positions at Syntex Laboratories, Inc. from 1987 to 1995, including associate director of medical services, senior associate director of medical services, and senior associate director, clinical investigation. Dr. Lewis was an emergency department physician at St. Mary's Hospital and Medical Center in San Francisco from 1985 to 1995. Dr. Lewis earned his Doctor of Medicine degree at The George Washington University in Washington D.C., and is a Fellow of the American College of Physicians. Dr. Lewis also serves as a member of the Medical Board of California.	07/19/2013	7/18/2017	Senate Committee on Rules	Physician
Judy McKeever, RCP Judy McKeever, a licensed respiratory therapist at the University of California San Francisco Medical Center was appointed to the Respiratory Care Board on February 19, 2014 by former Assembly Speaker John A. Perez. Ms. McKeever's career as a respiratory therapist has spanned over twenty years. Prior to her current position at UCSF, she spent ten years at Kaiser Permanente. Also an American Federation of State, County & Municipal Employees (AFSCME) 3299 Executive Board Member, Judy has been a relentless leader who has devoted countless hours to ensure UC patients have the care environment they deserve.	02/19/2014	06/01/2017	Speaker of the Assembly	Public
Laura C. Romero Laura C. Romero, Ph.D., currently serves as a President and Chief Executive Officer of Brillante Strategies, a public affairs and professional development consulting firm. Prior to this position, she worked at Los Angeles Universal Preschool for over two years focusing on corporate relations. Dr. Romero also worked at UCLA for 10 years in various capacities. She taught a UCLA Fiat Lux seminar titled, "Civic Engagement in Los Angeles," and worked as assistant director at the UCLA Higher Education Research Institute and assistant	05/29/2013	06/01/2017	Senate Committee on Rules	Public

director of Local Government and Community Relations at UCLA for over eight years. At the Office of Government and Community Relations (GCR), she successfully promoted UCLA's tripartite mission of research, teaching, and public service by diplomatically working with diverse constituencies including elected officials, community and corporate leaders, faculty, staff, students, alumni, and volunteers. Prior to assuming her GCR role, Dr. Romero worked within the private and public sectors as acting director of Public Affairs at KMEX-TV Channel 34/Univision and National Mentoring Coordinator of the award winning Communities In Schools, Inc./Univision Mentoring Initiative. Dr. Romero received her bachelor's, master's, and doctoral degrees from UCLA, and said she is honored to have been appointed to the Respiratory Care Board in May 2013, by the Senate Rules Committee.				

The Board performs certain work in committees and currently has five standing committees. According to the Board, committees enhance the efficacy, efficiency and allow for prompt attention to certain issues and Board functions. The following is a list of Board committees:

- *Executive Committee.* The Executive Committee provides recommendations to the Board on pending legislation that may impact the Board's mandate and operations. The Executive Committee also provides guidance to administrative staff for the budgeting and organizational components of the Board and is responsible for directing the fulfillment of recommendations made by legislative oversight committees.

- *Enforcement Committee.* The Enforcement Committee is responsible for developing and reviewing Board-adopted policies, positions and disciplinary guidelines. Members of the Enforcement Committee do not typically review individual enforcement cases but rather help develop the overarching policy of the Board's enforcement program.

- *Outreach Committee.* The Outreach Committee develops consumer outreach projects, including the Board's newsletter, website, e-government initiatives and outside organization presentations. Committee members act as goodwill ambassadors and represent the Board at the invitation of outside organizations and programs.

- *Professional Qualifications Committee.* The Professional Qualifications Committee reviews and develops regulations regarding educational and professional ethics course requirements for initial licensure and continuing education (CE) programs. Committee members monitor various education criteria and requirements for licensure, taking into consideration new developments in technology, managed care and current activity in the healthcare industry.

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

The Board is a member of the American Association for Respiratory Care (AARC), the Council on Licensure, Enforcement, and Regulation (CLEAR) and the Federation of Associations of Regulatory Boards (FARB). The Board's membership in each of these associations does not include voting privileges.

The Board uses its website home page and the e-mail subscription services found on its website to inform interested parties of new requirements, news, and Board activities. The Board posts meeting dates and location information, meetings agendas and related materials/attachments, meeting minutes, proposed language for regulation updates/changes, topics of interest, a list of outreach events, newsletters and the Board's Strategic Plan, among other information points designed to assist licensees and the public.

The Board has posted meeting information since 2011. Public notice for Board meetings and committee meetings is provided at least ten days prior to a meeting and the website includes agendas and meeting materials. The Board also uses an e-mail subscription feature to distribute updates, notices and special bulletins.

The Board notes that it webcasts meetings and has since February 2011.

Periodically, the Board publishes and distributes a hard copy newsletter with pertinent information to all licensees. The Board also distributes information impacting licensees, like new license renewal requirements through materials sent via U.S. mail to respiratory care department managers in health facilities and through emails to respiratory care education program directors.

Fiscal, Fund and Fee Analysis

The Board is a special fund agency whose activities are funded through regulatory fees and license renewal fees. At the end of FY 2015/16, the Board reports that it had a reserve balance of 5.8 months which is almost $2 million and projects to have a fund reserve of 3.8 months at the end of FY 2016/17 but only 1.2 months at the end of FY 2017/18. In response, the Board exercised its authority to promulgate regulations for a renewal fee increase that is set to become effective July 1, 2017. The Board's fees have not changed in five years. The Board's primary source of revenue is RCP license renewal fees.

The following is the past, current and projected fund condition for the Board:

Fund Condition						
(DOLLARS IN THOUSANDS)	FY 2012/13 ACTUAL	FY 2013/14 ACTUAL	FY 2014/15 ACTUAL	FY 2015/16 ACTUAL	FY 2016/17 PROJECTED	FY 2017/18 PROJECTED
Beginning Balance	$2,401	$2,596	$2,612	$2,432	$1,795	$1,243
Adjusted Beginning Balance	$2,412	$2,672	$2,660	$2,497	-	-
Revenues and Transfers	$2,688	$2,711	$2,709	$2,710	$2,724	$2,807
Total Revenue	$5,100	$5,383	$5,369	$5,208	$4,519	$4,050
Budget Authority	$3,189	$3,315	$3,566	$3,844	$3,799	$3,799

Expenditures	$2,691	$2,922	$3,074	$3,552	$3,420	$3,799
Disbursements[1]	$17	$14	$3	$5	-	-
Reimbursements	($206)	($166)	($140)	($144)	($144)	($144)
Fund Balance	$2,596	$2,612	$2,432	$1,795	$1,243	$395
Months in Reserve	9.7	9.2	7.8	5.8	3.8	1.2

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

According to the Board, enforcement activities account for 63 percent of expenditures, licensing accounts for 15 percent of the Board's budget and Administration represents 7 percent of expenditures.

The Board is one of 40 entities within the DCA. Through its divisions, the DCA provides centralized administrative services to all boards, committees, commission and bureaus which are funded through a pro rata calculation that appears to be based on the number of authorized staff positions for an entity rather than actual number of employees. The Board paid DCA over $620,000 in Pro Rata for FY 2015/16, an average of 15 percent of its expenditures.

Staffing Levels

The Board is currently authorized in the Governor's 2017/18 budget for a total of 18 positions; 16 of the Board's current 18 staff were employed at the Board during its last review.

Licensing

Since the Board's inception in 1985, it has issued over 38,000 licenses. As of June 30, 2016, the Board had 20,337 active and current licensees and an additional 2,878 delinquent licensees, a 14% percent increase since the prior sunset review. Over the past four years, the Board received over 5,882 new applications, issued over 5,422 licenses, and renewed over 36,827 licenses.

The Board recognized military experience for license eligibility via regulation in 2004 and states that it 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. According to the Board, in several cases, Board staff took it upon themselves (instead of the applicant) to contact other state licensing agencies or the national examination provider to obtain necessary verifications to assist military personnel and their spouses in obtaining licensure. The Board has had 30 applicants that qualified for the expedited license available to military spouses and domestic partners of a military member who is on active duty in California pursuant to BPC Section 115.5. In August 2014, the Board began asking applicants for initial licensure if he/she is serving or has ever served in the military. In FY 2014/15, the Board received 33 affirmative responses and in FY 2015/16, the Board received 68 affirmative responses. All of these applicants have been approved for licensure. In August 2015, the Board began asking licensees on their renewal forms, if he/she serves or has served in the military. Since then, a total of 1,021 applicants and licensees have been identified as having current or prior military service. Since July 1, 2014, the Board has received 22 applications that included military education, experience, and training. All 22 were approved for licensure. The Board has no record of ever denying an applicant who requested an education waiver based on military education and experience.

There are 38 respiratory care programs in California that are approved by the Board by virtue of their accreditation status. Pursuant to BPC Section 3740, the Board requires two components of education: completion of an education program for respiratory care that is accredited by the Committee on Accreditation for Respiratory Care (CoARC) and 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 (USDE). CoARC accredits programs in respiratory care that have undergone a rigorous process of voluntary peer review and have met or exceeded the minimum accreditation standards. The CoARC reviews schools annually and performs full-level reviews and site visits once every ten years. The Board notes that most often, these components are one in the same, but in some instances, they may be distinct. There are 37 schools in California that offer an associate degree in respiratory care and three schools offer a baccalaureate degree in respiratory care. The Board staff review each respiratory care program and school one to two times annually to verify that the programs and schools continue to hold valid accreditation. In addition, the Board also confers with the Bureau for Private Postsecondary Education (BPPE) to ensure private institutions continue to hold their approval. In May 2014, the Board and the BPPE entered into a Memorandum of Understanding to actively share information about schools with respiratory care programs as well as share resources for investigations or compliance inspections, as appropriate.

Applicants with education from Canada must complete an education program recognized by the Canadian Board of Respiratory Care. 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.

The Board uses the advanced respiratory credentialing examination as its licensing examination. Applicants must successfully pass both the National Board for Respiratory Care's (NBRC's) "Therapist Multiple-Choice Examination" and the "Clinical Simulation Examination" to qualify for licensure as an RCP. The Therapist Multiple-Choice Examination is designed to objectively measure essential knowledge, skills, and abilities required of entry-level respiratory therapists. The examination consists of 160 multiple-choice questions (140 scored items and 20 pretest items) distributed among three major content areas: 1) patient data evaluation and recommendations, 2) troubleshooting and quality control of equipment and infection control, and 3) initiation and modification of interventions. The Clinical Simulation Examination is designed to objectively measure essential knowledge, skills, and abilities required of advanced respiratory therapists. The Clinical Simulation Examination consists of 22 problems (20 scored items and 2 pretest items). The clinical setting and patient situation for each problem are designed to simulate reality and be relevant to the clinical practice of respiratory care, clinical data, equipment, and therapeutic procedures.

The NBRC also offers voluntary credentials upon passage of each exam, the Certified Respiratory Therapist for passage of the Therapist Multiple-Choice Examination and the Registered Respiratory Therapist (RRT) exam for passage of the Clinical Simulation Examination. While passage of the RRT examination is required for licensure, holding the actual credential is not, though the RRT credential is required for various reimbursements and is recognized by the medical community. The NBRC exams are administered in English on a daily basis and candidates are not permitted to consecutively repeat an examination form previously taken. Applicants may apply to take the examination online or via paper application. Upon verification of meeting entry requirements, applicants may schedule themselves to sit for either examination at one of 15 locations throughout California. Since the implementation of

the higher level RRT examination on January 1, 2015, the pass rates for first-time takers averages around 76 percent for the written exam and 58 percent for the clinical exam.

The Board requires documents supporting an application to be sent directly from: schools (for transcripts), NBRC (for exam results), Board-approved Law and Professional Ethics course providers (for verification that these courses have been completed) and other state respiratory care or licensing board (for out-of-state licensure verification and other evidence that is necessary to consider for licensure.

All applicants must obtain fingerprint criminal record checks from both the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI) prior to the issuance of a RCP license. Applicants must provide a 10-year driving history from the Department of Motor Vehicles (or other state department of motor vehicles). The Board also queries the National Practitioner Databank, a confidential information clearinghouse created by Congress to improve health care quality, protect the public, and reduce health care fraud and abuse in the U.S., for applicants who may have resided or obtained education outside of California.

As of June 30, 2012, the average cycle time to process a complete application from date of receipt to date of licensure was 67 days. As of June 30, 2016, the average cycle time is 4 days as a result of changes in the process so that now, when an applicant fulfills all the requirements for licensure, he or she is licensed in an average of four days which in turn allows applicants to enter the workforce sooner.

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

Continuing Education

Every two years, an active RCP must complete 15 hours of approved Continuing Education (CE). The required hours will increase to 30 in July. Ten of the current 15 hours must be directly related to clinical practice. Licensees may also count up to 5 hours of CE in courses not directly related to clinical practice, if the content of the course or program relates to other aspects of respiratory care. The Board also accepts the passage of various credentialing exams as credit towards CE.

In addition, during every other renewal cycle, each active RCP must also complete a Board-approved Law and Professional Ethics Course which may be claimed as three hours of non-clinical CE credit. This 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 California.

The Board targets five to eight percent of its renewals for a random CE audit. In FY 2014/15, the Board audited 615 (6.5%) of renewals and in FY 2015/16, the Board audited 496 (5.2%) of renewals. Of those, 12 (2%) failed the audit in FY 2014/15 and 11 (2%) failed in FY 2015/16. CE is discussed further in Issue #4 below.

Enforcement

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

The Board has established performance targets for its enforcement program of: 7 days to complete complaint intake; 210 days from the time the complaint is received until the investigation is completed and; 540 days from the time a complaint is received and the disciplinary decision is ordered. The Board is meeting these targets.

The enforcement process begins with a complaint. Complaints are received from the public, generated internally by the Board or based on information the Board receives from various entities through mandatory reports, as outlined below. On average, the Board receives about 800 complaints per fiscal year (55% of these complaints are a result of new criminal activity identified). The Board uses a series of guidelines which are intended to help staff determine the priority for handling complaints, guidelines that are in line with the DCA's Complaint Prioritization Guidelines. The Board notes that special consideration is given to complaints involving a child, dependent adult or even an animal who was affected or could have been affected by the willful or negligent behavior or incompetence of the licensee at or away from work, information about which is typically contained in an arrest or initial report. Within each level, some complaints take higher priority. In addition, at any time during an investigation, if it is found the complaint poses a greater risk or will require additional analytical or investigative work, the complaint is elevated.

- "Urgent Complaints" are categorized as those in which the RCP has allegedly engaged in conduct that poses an *imminent* risk of serious harm to the public health, safety, and welfare and where the time that has lapsed since the act occurred may be weighted in the risk factor.

- "High Priority Complaints" are those in which the RCP has allegedly engaged in conduct that poses a risk of harm to the public health, safety, and welfare.

- "Routine Complaints" are strictly paper cases where no patient harm is alleged, expert or additional investigation is not anticipated and may require routine personnel or employment records but not medical records.

The Board receives mandatory reports about licensees as follows:

BPC Section 3758. RCP employers must report the suspension or termination for cause of any RCP related to: the use of controlled substances or alcohol to such an extent that it impairs the ability to safely practice respiratory care; the unlawful sale of controlled substances or other prescription items; patient neglect, physical harm to a patient, or sexual contact with a patient; falsification of medical records; gross incompetence or negligence; or theft from patients, other employees, or the employer. An employer is subject to a fine not to exceed $10,000 per violation for failure to report to the Board.

BPC 3758.5. RCPs must report violations by other RCP licensees to the Board.

BPC 3758.6. RCP employers must report the name, professional licensure type and number and title of the person supervising a RCP who has been suspended or terminated for cause. An employer is subject to a fine not to exceed $10,000 per violation for failure to report to the Board.

For complaints that are subsequently referred for investigation by sworn officer investigators in the DCA's Division of Investigation and when the evidence gathered through an investigation meets the necessary legal prerequisites, a Deputy Attorney General (DAG) within the Office of the Attorney General drafts formal charges, known as an "Accusation". A hearing before an Administrative Law Judge (ALJ) is subsequently scheduled, at which point settlement negotiations take place between the DAG, RCP and Board staff. Often times these result in a stipulated settlement, similar to a plea bargain in criminal court, where a licensee admits to have violated charges set forth in the accusation and accepts penalties for those violations. If a licensee contests charges the case is heard before an ALJ who subsequently drafts a proposed decision. This decision is reviewed by the Board which either adopts the decision as proposed, adopts the decision with a reduced penalty or adopts the decision with an increased penalty.

The Board uses its Disciplinary Guidelines and the Uniform Standards for Substance-Abusing Licensees as the framework for determining the appropriate penalty for charges filed against a RCP.

Over the last three years, the Board:

- Investigated and closed approximately 2,400 investigations
- Referred 210 cases to OAG for action
- Filed 164 accusations and/or petitions to revoke probation
- Obtained 106 suspension/restriction orders (83 of these are Cease Practice Orders issued in response to probation violations; 23 are Interim Suspension Orders and PC 23/Criminal Court Orders)
- Revoked or accepted the surrender of 78 licenses
- Placed 71 licensees on probation

The Board's Cite and Fine (C&F) program allows the Board to "penalize" licensees rather than pursue formal discipline for less serious offenses or offenses where probation or revocation are not appropriate. The Board amended its regulations, effective July 1, 2012, to increase fine amounts to the maximum of $5,000 pursuant to BPC Section 125.9. 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. 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 Board issued an average of 79 citations and fines over the last three years. The five most common violations for which citations are issued include:

- Driving under the influence of alcohol (with no priors)
- Unlicensed practice
- CE violations
- Perjury
- Petty theft

Over half of the fines issued are for $250 and only a handful exceed $1,000. Most of the citations exceeding $1,000 are for acts of unlicensed practice or misrepresentation where fines are assessed on a sliding scale on the number of facilities or shifts an individual practiced without a license.

(For more detailed information regarding the responsibilities, operation and functions of the Board please refer to the Board's "2016-2017 Sunset Oversight Review Report." This report is available on its website at http://www.rcb.ca.gov/about_us/forms/sunset2016.pdf)

PRIOR SUNSET REVIEWS: CHANGES AND IMPROVEMENTS

The Board was last reviewed by the Legislature through sunset review in 2012-13. During the previous sunset review, 11 issues were raised. In December 2016, the Board submitted its required sunset report to the Senate Committee on Business, Professions and Economic Development and Assembly Committee on Business and Professions (Committees). In this report, the Board described actions it has taken since its prior review to address the recommendations made. The following are some of the more important programmatic and operational changes, enhancements and other important policy decisions or regulatory changes made. For those which were not addressed and which may still be of concern to the Committees, they are addressed and more fully discussed under "Current Sunset Review Issues."

- **Licensing Processing Times Have Improved**. The Board redesigned the application for licensure and made changes to the process in order to decrease the cumbersome nature of the process, increase efficiencies more efficient, and more transparent to applicants and educators. The Board anticipates additional improvements to licensing when its online application system becomes available in 2017.

- **The Board Successfully Implemented BreEZe.** Unlike most of the other DCA entities in the first phase of rollout for the new BreEZe system who faced significant challenges, the Board implemented BreEZe with few issues. Even for the minimal potential problems facing the Board through the transition to BreEZe, Board staff took initiative and created alternate procedures to ensure its work was not delayed as it implemented BreEZe. Board staff worked to explore BreEZe concepts and the system contractor's methodology for applying changes in order to adapt to the new system and worked from the outset to ensure that the necessary components of the Board's prior databases were integrated into the new BreEZe. In 2014, six of the Board's employees were recognized and awarded the "Sustained Superior Accomplishment Award" designed "to recognize superior job performance by an individual employee or a team of employees resulting in an exceptional contribution to improving the DCA and California." The Board reports that approximately 75 percent of licensees use the system to renew their licenses and feedback provided to the Board indicates licensees are extremely pleased with the service. The Board also notes that the system has added significant value to the way that staff can produce reports and cull data from BreEZe that they did not have

in previous Legacy systems, allowing continuous review of operations and identification of where process improvements can be made.

- **The Board implemented the Uniform Standards for Substance Abusing Healing Arts Licensees.** In addition to implementing and utilizing the Uniform Standards, the Board has been proactive in reviewing whether the testing frequencies outlined in the Uniform Standards benefit consumers and the public and continues to collect and analyze data to determine long-term trends.

- **The Board is now authorized to receive certified records from a local or state agency of all arrests and convictions, certified records regarding probation, and any and all other related documentation needed to complete an applicant or licensee investigation.** The local or state agency is now authorized to provide those records to the Board upon receipt of such a request.

- **The Board is monitoring workforce trends**. The Committees asked the Board to explain what additional efforts it can take or models it can follow to increase the RCP workforce and ensure participation of its licensees in the state's health care delivery system. A prior workforce study prepared for the Board suggested the need for 19,000 active RCPs by 2020; California currently has about 20,000 licensed RCPs. The Board continues to monitor workforce trend and access to care issues and notes that there does not appear to be a shortage of RCPs currently.

CURRENT SUNSET REVIEW ISSUES

The following are unresolved issues pertaining to the Respiratory Care Board of California or areas of concern that should be considered, along with background information for each issue. There are also recommendations Committee staff have made regarding particular issues or problem areas the Board needs to address. The Board and other interested parties have been provided with this Background Paper and the Board will respond to the issues presented and the recommendations of staff.

BOARD ADMINISTRATION ISSUES

ISSUE #1: (UCSF Study.) The Board 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 Board believe statutory changes may be necessary following release of the study?

Background: In 2015, the Board contracted with the Institute for Health Policy Studies at the University of California, San Francisco, to conduct a study to determine 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 Board should provide the Committees with an update on the study, including when it will be released and finalized and what steps the Board plans to take following the study's release.***

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 Board 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 Board. What features have changed since the implementation of BreEZe? What Board 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 Board 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 Board 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 Board began posting a running list of these records with links directly to accusations, statements of issues, and decisions available in a pdf format. In 2007, the Board was the first 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 Board 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 Board'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 Board'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 Board'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 Board 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 Board, about licensees and Board activity.***

BOARD LICENSING ISSUES

ISSUE #3: (NEW EXAM.) The Board 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 Board's inception in 1985, the National Board for Respiratory Care, Inc. (NBRC) has offered two credentials specific to respiratory care that are both nationally recognized: The Certified Respiratory Therapist (CRT) - entry level credential and the Registered Respiratory Therapist (RRT) credential - advanced level credential.

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

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

Staff Recommendation: ***The Board 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.***

ISSUE #4: (CE.) The Board 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 challenges for many boards. Are there more effective means by which the Board 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 Board 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 Board has audited about five percent 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 Board 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, Board 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 Board staff), a citation and fine will be issued. The citation and fine may be based upon the CE violation itself or may also include other violations, primarily, unlicensed practice**.**

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 Board may consider whether there are more efficient ways to ensure CE completion such as proof of completion provided directly to the Board through the DCA cloud. The Board 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 Board should explore innovative methods to confirm CE completion and update the Committees on steps it is taking to streamline processes.***

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 Board 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 Board 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 Board 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 Board 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 Board 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 Board 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 Board. The Committees may wish to amend the Act to remove this requirement.***

CONTINUED REGULATION OF RESPIRATORY CARE PRACTITIONERS BY THE RESPIRATORY CARE BOARD OF CALIFORNIA

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 Board membership?

Background: Patients and the public are best protected by strong regulatory boards with oversight of licensed professions. The Board has shown a strong commitment efficiency and effectiveness, responding to practice and operational issues in a proactive, forward-thinking manner. The Board 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 Board should be reviewed again in four years.***