PUBLIC SESSION MINUTES

Thursday, October 24, 2023
PUBLIC WEBEX MEETING

Members Present:	Mary Ellen Early Mark Goldstein Ricardo Guzman Raymond Hernandez Sam Kbushyan Preeti Mehta Michael Terry Cheryl Williams
Staff Present:	Reza Pejuhesh, Legal Counsel Stephanie Nunez, Executive Officer Christine Molina, Staff Services Manager Kathryn Pitt, Associate Governmental Program Analyst

CALL TO ORDER

The Public Session was called to order at 9:01 a.m. by President Guzman.

Ms. Pitt called roll (present: Early, Goldstein, Guzman, Hernandez, Kbushyan, Mehta, Terry, Williams), and a quorum was established.

1. PRESIDENT'S OPENING REMARKS

President Guzman asked everyone to turn their cell phones to silent adding this is an official business meeting of the Respiratory Care Board. Board members may be accessing their laptops, phones, or other devices during the meeting. He explained, they are using the devices solely to access the Board meeting materials that are in electronic format. Public comment will be allowed on each agenda item, as each item is taken up by the Board, during the meeting. Under the Bagley-Keene Open Meetings Act, the Board may not take any action on items raised by public comment that are not on the agenda, other than to decide whether to schedule that item for a future meeting. If providing comments, it would be appreciated, though not required, if you would provide your name and the organization you represent if applicable, prior to speaking. To allow the Board sufficient time to conduct its scheduled business, public comments may be limited. The Board welcomes public comment on any item on the

agenda and it is the Board's intent to ask for public comment prior to the board taking action on any agenda item.

Request for public comment: No public comment was received.

President Guzman recognized respiratory care week and thanked all respiratory care licensees for the heroic work they do every day.

President Guzman then congratulated and thanked Ms. Nunez for her 30 years of outstanding service to the Board, and highlighted her numerous achievements. Ms. Nunez thanked the Board Members and stated she has been fortunate over the years to have wonderful Board Members and staff and added, her success would not have been possible without them.

2. APPROVAL OF JUNE 22, 2023, MEETING MINUTES

President Guzman asked if there were any additions or corrections to the June 22, 2023, minutes.

Vice President Goldstein moved to approve the June 22, 2023, Public Session Minutes as written. The motion was seconded by Dr. Mehta.

Request for public comment: No public comments were received.

M/Goldstein S/Mehta
In favor: Early, Goldstein, Guzman, Hernandez, Kbushyan, Mehta, Terry, Williams
MOTION PASSED

3. CONTINUING EDUCATION UPDATE

Strategic Plan Administration Goal 2.6: Complete continuing education (CE) regulations, develop and execute a plan to disseminate information to all interested parties to ensure awareness of updated changes.

Ms. Nunez stated the regulations were approved by the Office of Administrative Law in August 2023.

She summarized highlights of the changes which included:

- The number of CE hours required to be completed remains at 30 total hours. However, now, instead of 20 hours required for "directly related" respiratory courses and up to 10 hours of indirectly related courses, the new framework requires:

  15 hours directly related to the practice.
  10 hours directly related to respiratory care leadership.
  up to 5 hours indirectly related to the practice.
- 15 of the total 30 hours required must be from live interactive courses/meetings. Such courses may be delivered in person or through the Internet.
- Attendance at certain meetings may now be counted for up to 5 hours credit toward indirectly related CE hours.
- The new "leadership" category includes completion of the already required Law and Professional Ethics course and a new section to recognize qualified preceptor training and preceptorship for CE credit.
- Additional credentialing examinations and certifications are now recognized for CE credit toward direct care.

Regarding implementation, she shared the following:

- Regulations take legal effect: October 1, 2023
- RCB Two-Year Implementation: January 1, 2024 through December 31, 2025
- Dedicated CE Webpage Active: September 19, 2023
- E-Blast/Newsletter Sent to ALL Licensees: September 29, 2023
- E-Mail to Licensees: 10/2/24 (will be repeated each month for two years)
- CE Booklet to be distributed with all license renewal applications mailed beginning with 12/31/23 expiration dates, ending with 11/30/25 expiration dates (also available on the Board's website.

Ms. Nunez stated the Board received several phone calls (an estimated 50 inquiries) when staff sent the initial email notice to all licensed RCPs on September 29, 2023. That has since tapered off. Most of the feedback from the inquiries were in these areas:

- Misunderstanding of "Leadership" courses, misunderstanding of the "Live" requirement and inquiries from CE providers.
- Leadership: Once callers were made aware that "leadership" did not just include management-type courses, their concerns were alleviated.
- "Live" requirement: Once they understood that the live requirement did not mean "in-person" but rather live interaction, even online, their concerns were alleviated.
- A few CE providers commented that they are modifying their courses to meet both leadership and live course requirements, indicating the industry is adapting and taking advantage of the new opportunities.
- One caller expressed her excitement that preceptors are being recognizing for CE credit.

Public Comments:

Craig Giangregorio, owner of "The CE Place.com" voiced some concerns providing continuing education for respiratory therapists with the new regulations. He shared there will be an impact to his and other small minority owned businesses which will cause a complete adjustment to stay in business. Another concern of his is regarding the management leadership courses. He stated, only 38% of RTs aspire to go into leadership roles which means 62% are basically removing clinical education and replacing it with management and leadership related courses. While he agrees with the objective of increasing preceptors and management, it should be optional not mandated. Secondly, everyone has a different learning style so when half of the CE hours are shifted to "live," it excludes those who have predominantly different learning styles. He believes both should be optional and not mandated.

Irene inquired how many hours will be credited for BLS, ACLS, PALS and ethics, and expressed concern that some of these seminars are out-of-state. She is concerned about the costs of travel as well as the cost of the seminars.

Carol Haft stated she also had some concerns about the expense, but understands that CEs may be accessed in an online format. She added she does not have a problem with the educational direction the Board is moving toward with management and leadership courses as respiratory therapists are often looked to for direction by nurses and some of the younger physicians, so learning some of these leadership skills will help toward working with and unifying different care teams.

Commenter (Sioux) stated she is certified at her hospital as a preceptor and added that it seems the preceptor CE credits would benefit only a small group of RT instructors. Using the breakdown of hours required to earn CEUs, for her to earn CEUs from preceptor work she would have to work most of her hours as a preceptor, which would not be possible considering the number of hours that they have students and new hires at her facility. She added, it remains to be seen how many live online courses will be available. She also questioned whether "live" courses meant they would have to participate live, the moment they are given, or if a recorded course would be acceptable.

President Guzman thanked everyone for attending and engaging with the Board, adding this feedback is important.

President Guzman clarified that a “live” course does not have to be attended in person. Participation can be online or virtual as well. He gave an example of UCSF hosting a 1-day seminar available both in person and through Zoom and that would be acceptable. He added, as a practicing respiratory therapist, he has not taken an online CE course in about 10 years and has also never left the State to do so. He also clarified that clinical instructors from RT programs are not eligible for the preceptor CE credits, only preceptors at the bedside are eligible to earn those credits.

Ms. Nunez added if anyone has questions about the CE requirements, she encouraged them to go to the RCB’s website where it is well laid out. Of course, if someone still has questions or concerns, they are welcome to contact the RCB office.

4. FINANACIAL ANALYSIS/REVIEW

Strategic Plan Administration Goal 1.2 Regularly monitor the budget and fund condition in connection with cost saving measures and new expenses to determine if a statutory fee adjustment is necessary.

Ms. Molina reviewed the current financial analysis based on final expenditure and revenues for the fiscal year ending on June 30, 2023. The Board's fund is projected to remain solid in the coming years. A new bargaining unit contract was recently approved which includes a 9 to 10% salary increase over the next 3 fiscal years retroactive to July 1 of this year. Salary increases not only result in increases to the RCB staff salary and benefits budget but will also increase costs in areas, such as pro rata (the amount that the Board pays to DCA and the state for providing administrative services).

Ms. Molina pointed out that application numbers have shown a gradual increase and monthly license statuses have remained steady. Both are being closely monitored. She also highlighted the one-time $139,000 transferred to the general fund that was required by AB 84, a budget trailer bill from the legislative year 2000/2001, which required the State Department to reimburse the general fund for their share of $2.5 billion used to lower State, employer, and retirement contributions. DCA’s overall share of the $2.5 billion was $21.8 million and the Board’s allocated share was the $139,000 that is reflected on the Fund Condition.

Public Comments:
Carol Haft stated her understanding is this is not the first time the RCB transferred money to the State’s General Fund. She recalled it happening back in the 1980’s or 1990’s and inquired if that money was returned. She also asked for a link to the UCSF class mentioned by President Guzman.

Ms. Molina replied, there was a $785,000 general fund loan back in the 1990’s but the Board received repayment for this loan and a subsequent lawsuit ensured Board funds could not be taken again during a fiscal crisis without agreement. Ms. Molina pointed out that the $139k was different in that it wasn’t a loan. It was included as part of legislation and as such was not optional.

5. LICENSING AND ENFORCEMENT ACTIVITY ANNUAL REPORT

Ms. Nunez stated there has been a slight uptick in complaints and investigations, but staff continue to meet our timeline goals for processing complaints, investigations, and prosecutions. The goal to process a case from the date a complaint is received, through investigation and final adjudication through the Office of the Attorney General is 540 days and we are currently at an average of 465 days.

Board Comments:
Mr. Hernandez acknowledged the report stating after conversations about the workforce pipeline, he is happy to see the Board is up almost 500 active licenses.

Dr. Mehta noticed the increase in the number of complaints received and inquired, when these complaints initially come to the Board, if there is any questioning or other processes followed to discipline the person that was complained against within their system or do we investigate every complaint? Does every complaint require legal action?

Ms. Nunez responded, when the Board receives a complaint, it first determines if it is relevant. There are many ways the Board can take action ranging from Citation & Fine (where fine amounts depend on the violation), education letters that carry no fine, probation, suspension, or revocation, and if it is a heinous act, the Board may pursue criminal charges through the District Attorney. How the Board moves forward depends on the type of complaint. The Board can only issue a strong warning letter without a legal process.

Ms. Molina added when there is a mandatory reporting complaint received, because someone has been terminated or suspended for specific causes, enforcement staff reaches out to the facility, and in many instances, information regarding any internal investigation is obtained via subpoena. Many times, some of the investigative work has already been completed by the facility and can be utilized. When appropriate, staff works collaboratively with facilities that have filed mandatory reports.

Public comment: No public comments received.

6. SB 1436 IMPLEMENTATION: PROPOSED LEGISLATION

Strategic Plan Licensing Goal 2.2: Develop and promulgate regulations identifying basic respiratory tasks and services and disseminate information to pertinent state agencies and licensed facilities in response to the implementation of Senate Bill 1436

a. Proposed Legislation: Additional Exemptions for LVNs Practicing

Ms. Nunez stated last year SB 1436 was signed by the Governor which allowed the Board to codify and name basic respiratory tasks in an effort to reduce the unlicensed or unauthorized practice of respiratory care. In that bill, it laid out an exemption for home health agencies licensed by the California Department of Public Health to use trained LVN's to provide respiratory care to patients in the home as it is unfeasible to require an RCP to provide that care.

In October 2022, the Board approved language identifying basic respiratory tasks via regulation. Staff publicly noticed the proposed regulations and in December, numerous comments were received in opposition. While it remains the Board's position that unauthorized persons practicing respiratory care beyond these basic tasks is illegal and has a myriad of liability issues, the perception to these facilities is that the regulations are the catalyst to making unauthorized practice illegal.

At the last meeting, the Board agreed to withdraw the proposed regulations that laid out basic respiratory tasks LVNs are authorized to perform, to have time to provide additional legislative exemptions for LVNs to practice respiratory care beyond basic tasks in certain home and community-based settings. She added, while the RCB attempts to secure an author and support from home and community-based stakeholders, it is important to note that next year, whether any legislative bill fails or succeeds, the Board must pursue the regulations to identify the basic tasks LVNs may perform.

She presented a background paper and proposed legislation as a means to secure an exemption for some of the home and community-based organizations to allow the practice of respiratory care by trained LVNs to prevent the re-institutionalization of patients who prioritize their choice of their patient care setting over the expertise of their health care provider.

The legislative proposal provides exemptions in the spirit of the exemption provided to home health agencies in SB 1436 last year with the following three qualifiers:

1. Facilities and homes that have a small home-like setting, with six beds or less, with one or so few respiratory care patients it makes it unfeasible to hire an RCP to provide all respiratory care,
2. Facilities and homes that are not currently using RCPs or RNs to deliver respiratory care, and
3. Facilities that are not explicitly required to use RCPs to deliver respiratory care.

Ms. Nunez read the proposed legislation.

This act does not prohibit any of the following activities:

(j) The performance, by a vocational nurse licensed by the Board of Vocational Nursing and Psychiatric Technicians of the State of California who meets the additional qualifications under paragraph (1) of this subdivision, to perform respiratory care services identified by the board and within the scope of the patient-specific training and the certification(s) required under paragraph (1) of this subdivision, while practicing in the settings listed under paragraph (2) of this subdivision:

> (1) In order to perform respiratory care services in accordance with subdivision (j) of this section, on or after January 1, 2028, the licensed vocational nurse shall have completed patient-specific training satisfactory to the employer, and shall maintain current and valid certifications of competency for respiratory tasks performed, from the California Association of Medical Product Suppliers or the California Society for Respiratory Care or another organization identified by the board.
>
> (2) Licensed vocational nurses may perform respiratory care services pursuant to this subdivision exclusively in the following settings:
>
> > (A) At congregate living health facilities licensed by the California Department of Public Health that are designated as six beds or less
> >
> > (B) At intermediate care facilities licensed by the California Department of Public Health that are designated as six beds or less.
> >
> > (C) At adult day health care facilities licensed by the California Department of Public Health.
> >
> > (D) As an employee of a home health agency licensed by the California Department of Public Health.

(E) At pediatric day health and respite care facilities licensed by the California Department of Public Health.

(F) At small family homes licensed by the Department of Social Services designated as six beds or less.

(G) As a private duty nurse as part of daily transportation and activities outside a patient's residence or family respite for home and community-based patients.

Ms. Nunez added that since the distribution of the agenda materials, she received feedback that independent nurse providers in residential homes were not included, so she recommended one change to subdivision (j)(2)(D) which currently reads "as an employee of a home health agency licensed by the California Department of Public Health." It should be amended to read "as an employee of a home health agency licensed by the California Department of Public Health or an individual nurse provider, working in a residential home."

Motion:
Mr. Kbushyan moved to approve this legislative proposal as presented, including the amendment by the Executive Officer, and directed staff to work with our Executive Committee to secure an author and make amendments as appropriate and in line with this proposal. If any substantive amendments are made to the language members shall be notified prior to the next scheduled meeting. In addition, this matter shall be on the next agenda for updates and discussion as appropriate.

M/Kbushyan S/Goldstein

Public Comment

Jennifer McLelland, parent of a 12-year-old child who is tracheostomy and ventilator dependent, made the following statement:

"My son spent most of the first year of his life in institutional care, in a pediatric subacute facility more than 200 miles from our home. I know what kind of care institutions deliver – that's why I'm so passionate about the systems that make it possible for tracheostomy and ventilator dependent children to live at home with their families where they belong. Home care in California is messy. It's chronically underfunded, families struggle to get any help at all. Home care isn't just care at home – it's care that makes it possible for disabled people to live normal lives. I'm grateful that the RCB is working out a home care exemption so that LVNs can continue to provide the respiratory care services they have historically provided, but with better and more standardized training. I want to make sure that a specific group of LVNs are included in the home care exemption – Individual Nurse Providers (AKA INPs). INPs are currently locked out of the home care exemption because it applies only to nurses who work for licensed home health agencies. INPs do exactly the same work, they just work through a special state program that allows them to bill directly for services. INPs are LVNs who specialize in home care for medically fragile patients. If they lose the ability to provide the care they're currently providing, these children are at risk of losing stable placement. Many INPs work in rural areas where home nursing agencies don't exist, because there isn't enough population to make a profit. Home nursing agencies pay LVNs a small fraction of what they get paid by the state in order to make a profit – by working as INPs, LVNs can make a living wage, which means they can stay with the same family long term.

I've been in communication with Stephanie Nunez about this issue and it has been awesome to work with her. She has assured me that there wasn't an intent to exclude INPs from the home care exemption, we just need a small tweak in the wording. It's been great to work with her about all the complicated acronyms that are considered "home and community-based settings" under CMS rules.

I agree Business and Professions Code [BPC] section 3765 should add a phrase to include LVNs working as INPs as being allowed to perform respiratory care services and participate in the approved education and training program when it is finalized. I'm also glad for the changes in BPC 3765 that will ensure that LVNs working as private duty nurses in school settings will be included in the exemption and for the inclusion of PDHCs, CLHFs, ICFs, and all of the other home and community-based settings. Homecare isn't just the care that home nursing agencies provide in homes. It's care that makes it possible for disabled kids and adults to go to school, work and interact with the world. I'm grateful to the RCB for working to improve the care that disabled kids get at home. If these exemptions aren't codified into law, children who are currently living at home will lose access to care. Families will either have to institutionalize their children (or more likely) figure out how to have ventilator dependent kids at home with no help at all. That puts these kids at substantial risk of death. Home care can barely staff LVNs. There's no way we can staff these cases with RNs, and there is no billing structure that would make it possible to staff these cases with RTs. I'm grateful for everyone's time and thankful that the RCB is working to improve the quality of care that these fragile kids get at home."

Denise Ordonez, Aveanna Healthcare, stated she appreciates that the RCB is excluding home health agencies and recognizes the importance of the services they provide to their patients. She asked for clarification with regards to subdivision 1, specifically, the requirements for maintaining current and valid certifications and competencies with either the California Association of Medical Product Suppliers or the California Society for Respiratory Care or another organization identified by the Board. She asked if this will include any home health agencies and whatever current program that they have or do? She added, LVNs have to go through either one of those avenues.

Ms. Nunez responded the home health agencies will have an additional option because of the legislation that was passed last year. This is an additional option. .

Ms. Nunez thanked Ms. McLelland stating she has been fabulous and has helped her tremendously in breaking this issue down.

Heidi Gibson: LVN since 1999. She stated since about 2013, she has been caring for medically fragile foster kids in her home. This is a wonderful program because children get to be in a home with the family versus staying in an institution. They live with one main caregiving family and become part of that family. She has cared for several children, four have had trachs and vents. She has used INP nurses to help in the home as these kids truly need 24-hour care. She has seen babies that need ventilators 24 hours a day go to being able to sprint for large portions of a day. Her own son came off a vent at 3 years old, despite being told he would most likely require it forever.

She understands that LVNs can use more training in vent and trach care, but with the INPs that she has used, along with the foster parents, she has seen some great progress in these children. She wants to make sure that INPs are included in the home care exemption so they can continue to provide the quality care they're currently providing and have access to the training program when it is finalized.

Kathryn Severson, a nurse consultant working with Intermediate Care Facilities and the California Department of Developmental Services, thanked the Board for looking at all the homes and different types of settings. She added she echoes the previous speakers' comments. She inquired about the exemption qualifiers and if the home needed to meet all of those for a residential setting, either an ICF or one of the other types of settings mentioned and how they would work moving forward. She added, do those qualifiers only apply to the facilities listed under the CDPH and DSS and where do the adult residential facilities for people with special healthcare needs fall? They are staffed by RNs and have respiratory therapists available.

Ms. Severson also had a question about subdivision (2)(B), the “intermediate care facilities licensed by the California Department of Public Health”. She inquired if that was intended to include all the different ICF facilities. There are several different license levels.

Ms. Nunez responded that subdivision (2)(B) does include all the intermediate care facilities licensed as intermediate care facilities that have 6 beds or less. She added the qualifiers pointed out were just the criteria used to develop the exemptions. What is in the legislation is actually who is being exempted. That was just the criteria to determine that. The AARCF mentioned is currently staffed by respiratory therapists and RNs and would not be exempt.

Ms. Severson also inquired if the basic respiratory tasks will be decided in the future by the RCB.

Ms. Nunez indicated the Board will pursue the regulation to codify what have already been established as basic tasks. As of today, no LVN should be performing respiratory care beyond those tasks. It is creating a legal liability for some people doing those tasks and that is why the RCB is trying to make it very clear what is okay and what is not and give exemptions wherever possible. She added feel free to contact her with additional questions.

DCA Moderator, David Bouilly stated he will respond to a question in the Q & A box with a link to the earlier request for information on the UCSF training.

Jerry Hammersley questioned the distinction between 6 beds or less versus those greater than 6. For example, congregate living facilities may have 6 ventilated patients and not have a respiratory therapist. Would an 18 or 15 bed congregate facility with less than 6 ventilator patients be included in this exemption and why the distinction between 6 beds or less versus greater than 6 beds?

Ms. Nunez replied, the qualifiers were established in the spirit of providing the home care exemption where there was only one patient in the home, and it was not feasible for a respiratory therapist to be staffed there all day. It is a 6-bed designation, not a 6-patient designation because facilities are licensed by their bed designation. An 18-bed designation facility could have one respiratory care patient or 18. The point of the exemption was for very few people. Generally, an RCP may be staffed at a ratio of 1 RCP for 4 to 6 patients depending on the acuity level of the patients. For purposes of enforcing this and to stay in line with the spirit of the exemption of one RCP patient, the Board acknowledged the 6-bed designation. In addition, 70%-80% of the congregate living facilities are 6 beds or less.

Mr. Hammersley added, it seems like there is an implication that if they have greater than 6 beds, they could afford to hire an RT, which may not be accurate.

Ms. Nunez replied it is not about affordability, it is about needed care. So, if you have more than 3 patients and you can employ a full-time respiratory therapist, that is what should be done. Whereas it is not feasible when you have one patient in a home to employ a full time RCP to give a couple of treatments throughout the day.

Ms. Nunez stated the amendment concerning the individual nurse provider that several people voiced concern with, was added to the motion.

M/Kbushyan S/Goldstein
In favor: Early, Goldstein, Guzman, Hernandez, Kbushyan, Mehta, Terry, Williams
MOTION PASSED

7. PROFESSIONAL QUALIFICATION COMMITTEE UPDATE & DISCUSSION

Strategic plan Licensing Goal 2.3: Evaluate current respiratory care educational requirements and revise, as necessary, to support practice standards and patient safety.

Strategic plan Licensing Goal 2.4: Collaborate with professional organizations and schools to perform a needs assessment for the advanced respiratory practitioner role in California to address the projected shortage of physicians and the evolving role of being a physician extender.

Mr. Hernandez stated that for over two years, the Professional Qualifications Committee (PQC) has been gathering and exploring data to share at Board Meetings and continues to do that in relation to Strategic Plan Goals 2.3 and 2.4. At the last meeting in June, the PQC presented the findings from focus group sessions and formulated some recommendations, had some conversations, and received some feedback. The Board supported moving forward with those recommendations. The PQC met and prioritized two of those recommendations. The first was to advocate for more capacity for higher education for respiratory therapists. As such, a letter was created and sent to all programs in the State of California advocating for building capacity for higher education in particular bachelor's degrees. The second recommendation was to gather more information. At the last meeting, the Board heard from the SEIU representative who forwarded 5 letters from their constituents. Of those five, one was not in support of a bachelor's degree as the minimum licensure qualification. The others were looking at the impact of the workforce and the grandfathering of current licensed practitioners and if they would need to meet future requirements. After reviewing the letters, the PQC thanked the SEIU for the feedback and added the Board continues to state that any changes would apply to future licenses, not current licensees. For the next steps, the PQC is currently in the process of creating a survey aligned with the data that has been shared with the Board in study sessions thus far, along with the focus group questions. Once that survey is ready, practitioners across the State would be alerted. That survey would also be linked to the Board's website so any stakeholder can participate in the survey. The PQC will analyze the survey data and present it at a future meeting.

Mr. Terry added he would like the Board to take the survey at its next meeting to get feedback before the survey is shared with the general population.

Public Comments:

Denise Tugade, SEIU United Healthcare Workers, representing 100,000 healthcare workers in California, including respiratory therapists, thanked the Board for their continued partnership and for keeping them a part of the conversation.

a. CSRC Legislative Proposal – Advanced Practice Respiratory Therapist

Mr. Terry asked CSRC to update the Board on their legislative proposal.

Krystal Craddock stated that, on August 15th, the CSRC met with members of the California Legislature, including members of the health committee to introduce the Advanced Practice Respiratory Therapist (APRT) and get some feedback from legislators regarding the direction to take when proposing licensure for an APRT. CSRC received great feedback. Currently, the CSRC's Governmental Affairs (GA) Committee and Professional Advancement Committee are working together on a proposal for legislation for APRT licensure in California. This is going to be a long project, but the CSRC is currently gathering information and looking at data specific to Californians with chronic pulmonary diseases, looking at how many pulmonologists are practicing within California and in what areas, and trying to figure out what the need is prior to coming up with a proposal.

At the June 2023 RCB meeting, Abdullah Alismail from Loma Linda presented survey results with details regarding the perception of the APRT in California from respiratory care practitioners. He is also gathering more data from physicians, specifically pulmonologists, regarding their perception of the APRT and the need. They also met with Bill Croft, the North Carolina RCB president who met with their Governmental Affairs and Professional Advancement committees and Jennifer Tannehill, who works for Aaron Read and Associates as their lobbyist. They gave the CSRC some feedback on where North Carolina is in passing the APRT in that state and to help with the information that will be needed when advancing this proposal.

Ms. Craddock added the AARC had a work group come together to provide resources to various states who are looking at the proposal of the APRT licensure and looks forward to hearing from them next month. They should be getting some information out to all the states, including the CSRC who is looking at 2025 to propose this legislative action.

Mr. Terry thanked Ms. Craddock for her and all of CSRC's efforts in making this happen, and asked if they have defined a scope of practice for the proposal.

Ms. Craddock replied, not yet but they have received a lot of feedback and are currently working out the details. The NBRC and CoARC have talked about the credentialing. It must be a master's degree minimum in respiratory science. In looking at the scope of practice, the one detail they are trying to piece out is the prescriptive rights of this practitioner. North Carolina has proposed prescriptive rights and then had to go back on that and are now going forward with ordering rights. They have learned a lot from their counterparts, nurse practitioners and physician assistants who have gone through the same process and started out with ordering rights versus prescriptive rights.

Dr. Mehta inquired what things are being considered regarding prescriptive rights? Procedures or medications?

Ms. Craddock responded that in North Carolina, the APRT will not have prescriptive rights, but they will have ordering rights within a facility. For example, within a hospital, they can order medications, ventilator changes, and different diagnostic procedures, but in the clinic setting, a patient cannot leave with a prescription written by the APRT. The APRT could prepare the prescription, the physician would sign it, approving it, similar to what a physician's assistant currently does.

Bridgette LaMere inquired how to get information to help with the APRT on any of the committees.

Ms. Craddock replied, Ms. LaMere can email her directly and she will respond. Her email address is on the CSRC's website as the Chair of the Professional Advancement Committee.

8. LEGISLATION OF INTEREST

President Guzman stated, they are at the closing of the first year of a two-year legislative cycle and asked Ms. Molina to give the Board an update.

Ms. Molina stated only a few bills made it through the legislative process, and many may become active next year. She highlighted a few of the bills:

AB 996 (Low) - Board Position: WATCH Title: Department of Consumer Affairs: continuing education: conflict-of-interest policy. Status: 8/17/2023: Ordered to Inactive File. May become a 2-year bill. Existing law provides for the licensure and regulation of professions and vocations by entities within the Department of Consumer Affairs. Under existing law, several of these entities may require licensees to satisfy continuing education course requirements, including, among others, licensed

physicians and surgeons licensed by the Medical Board of California and certified public accountants and public accountants licensed by the California Board of Accountancy. This bill would require those entities to develop and maintain a conflict-of-interest policy that, at minimum, discourages the qualification of any continuing education course if the provider of that course has an economic interest in a commercial product or enterprise directly or indirectly promoted in that course and requires conflicts to be disclosed at the beginning of each continuing education course. Ms. Molina added, when this bill was discussed last March, the Board took a watch position, but requested that a letter be sent to the author providing feedback expressing concerns. The letter was sent in April of this year, essentially indicating that the Members felt it sends an unfair message that a provider with a financial interest in a particular project is somehow less ethical. So far, the bill has been ordered to an inactive file. It may be one of those bills that becomes a 2-year bill. The RCB will continue to monitor it.

AB 1028 (McKinnor) - Board Position: OPPOSE Title: Reporting of crimes: mandated reporters. Status: 9/1/2023: Held under submission. May become a 2-year bill. Existing law requires a health practitioner, as defined, to make a report to law enforcement when they suspect a patient has suffered physical injury that is either self-inflicted, caused by a firearm, or caused by assaultive or abusive conduct, including elder abuse, sexual assault, or torture. A violation of these provisions is punishable as a misdemeanor. This bill would, on and after January 1, 2025, remove the requirement that a health practitioner make a report to law enforcement when they suspect a patient has suffered physical injury caused by assaultive or abusive conduct, and instead require a health practitioner who suspects that a patient has suffered physical injury that is caused by domestic violence, as defined, to provide brief counseling, education, or other support, and a warm handoff, as defined, or referral to local and national domestic violence or sexual violence advocacy services, as specified. The bill would, on and after January 1, 2025, specify that a health practitioner is not civilly or criminally liable for any report that is made in good faith and in compliance with these provisions. The RCB did send a letter expressing its opposition that it would diminish the protection currently afforded some of California's most vulnerable patients.

SB 372 (Menjivar) - Board Position: WATCH Title: Department of Consumer Affairs: licensee and registrant records: name and gender changes. Status: 9/23/2023: Approved by the Governor [Chapter 225, Statutes of 2023] This bill would require a board within the Department of Consumer Affairs to update a licensee's or registrant's license or registration by replacing references to the former name or gender on the license or registration, as specified, if the board receives documentation, as described, from the licensee or registrant demonstrating that the licensee or registrant's legal name or gender has been changed. If the board operates an online license verification system, the bill would require the board to replace references to the licensee's or registrant's former name or gender with the individual's current name or gender, as applicable, on the publicly viewable information displayed on the internet. The bill would prohibit a board from publishing the licensee's or registrant's former name or gender online. Instead, the bill would require the board to post an online statement directing the public to contact the board for more information. For specified licensees or registrants, the board would be prohibited from posting enforcement records online but would be required to post an online statement stating that the individual was previously subject to an enforcement action and directing the public to contact the board, as prescribed. This bill would provide that all records related to a request to update an individual's license or registration under these provisions are confidential and not subject to public inspection or disclosure. The bill would require the board, if requested by a licensee or registrant, to reissue any license created by the board and conferred upon the licensee or registrant. The bill would prohibit a board from charging a higher fee for reissuing a license with an updated legal name or gender than the fee it charges for reissuing a license with other updated information. This bill was signed by the Governor and DCA has begun communicating with the boards and bureaus to implement the requirements imposed by the bill while also continuing to provide information to the consumers.

SB 544 (Laird) - Board Position: WATCH Title: Bagley-Keene Open Meeting Act: teleconferencing. Status: 9/22/2023: Approved by the Governor [Chapter 216, Statutes of 2023] This bill would, among other things, remove existing teleconference requirements within the Bagley-Keene Open Meeting Act (Act) and instead require a state body to provide a means for the public to remotely hear audio of the meeting, remotely observe the meeting, or attend the meeting by providing on the posted agenda: a teleconference phone number, an internet website or other online platform, and a physical address for at least one site, including, if available, access equivalent to the access for a member of the state body participating remotely. This bill would also revise the Act to no longer require members of the public to have the opportunity to address the state body directly at each teleconference location and instead require the specific means of access to the meeting to be included in the meeting notice. DCA boards and bureaus may conduct entirely remote public meetings without noticed locations accessible to the public through December 31, 2023, so long as the public is able to participate in the meeting remotely. This bill was approved by the Governor. Commencing on January 1, 2024, these meeting options will be available under Bagley-Keene:

(1) Traditional single-location option
- Majority of members gathered at one publicly noticed and accessible location.
- No members participating remotely.
- No requirement to allow remote public participation.

(2) Traditional teleconference option
- Members at different publicly noticed and accessible locations connected via phone or Webex.
- No requirement to allow remote public participation.

(3) New teleconference option
- Majority of members gathered at one publicly noticed and accessible location.
- Extra members above a majority can participate remotely from private, non-public sites.
- Must allow remote public participation.

Board Member Comments: No comments received.

Public Comments: No public comments received.

9. ELECTION OF OFFICERS FOR 2024

Vice President:

President Guzman nominated Mark Goldstein for Vice President. Mr. Goldstein thanked President Guzman but declined the nomination.

Mr. Terry nominated Ray Hernandez for Vice President. Mr. Kbushyan seconded the nomination. The nomination was accepted by Mr. Hernandez.

President Guzman asked if there were any other nominations for vice president. None were presented.

Public Comments: No public comments were received.

M/Terry S/Kbushyan
In favor: Early, Goldstein, Guzman, Hernandez, Kbushyan, Mehta, Terry, Williams
MOTION PASSED

President:

Mr. Terry nominated Ricardo Guzman for President. Mr. Kbushyan seconded the nomination.

President Guzman asked if there were any other nominations for president. None were presented.

The nomination was accepted by President Guzman.

Public Comments: No public comments were received.

M/Terry S/Kbushyan
In favor: Early, Goldstein, Guzman, Hernandez, Kbushyan, Mehta, Terry, Williams
MOTION PASSED

10. SCHEDULE 2024 BOARD MEETING DATES AND LOGISTICS

March 21, 2024 (in alignment with the CSRC Annual Conference) President Guzman stated he will not be able to attend an in-person meeting on this date as he will be out-of-state. He offered to possibly participate via Webex. Reza Pejuhesh, Legal Counsel, stated he will research whether President Guzman is able to participate from out-of-state. Ms. Williams stated she will not be able to attend a meeting on March 21 either.

Thursday, March 28, in San Diego. The Board selected this date as a second choice.

June 10, 2024, in Sacramento, tentatively scheduled if Board business requires a meeting.

October 14, 2024, in Sacramento.

Public Comment:

Mary Adorno, California Association for Health Services representing home health agencies, hospices, and home care requested the Board continue to have virtual means available to give public comment as it is difficult to travel to comment on one agenda item.

11. PUBLIC COMMENT ON ITEMS NOT ON THE AGENDA

No public comments received.

12. FUTURE AGENDA ITEMS

President Guzman asked if Board members had any specific items they would like to see on the next agenda.

Mr. Terry stated they will continue the Professional Qualification Committee survey update and would like the proposed survey to be sent out to be opened back up for feedback from the Board.

Public comment: No public comments received.

13. CLOSED SESSION

No Closed Session items discussed.

ADJOURNMENT

The Public Session Meeting was adjourned by President Guzman at 10:54 a.m.

RICARDO GUZMAN
President

STEPHANIE A. NUNEZ
Executive Officer