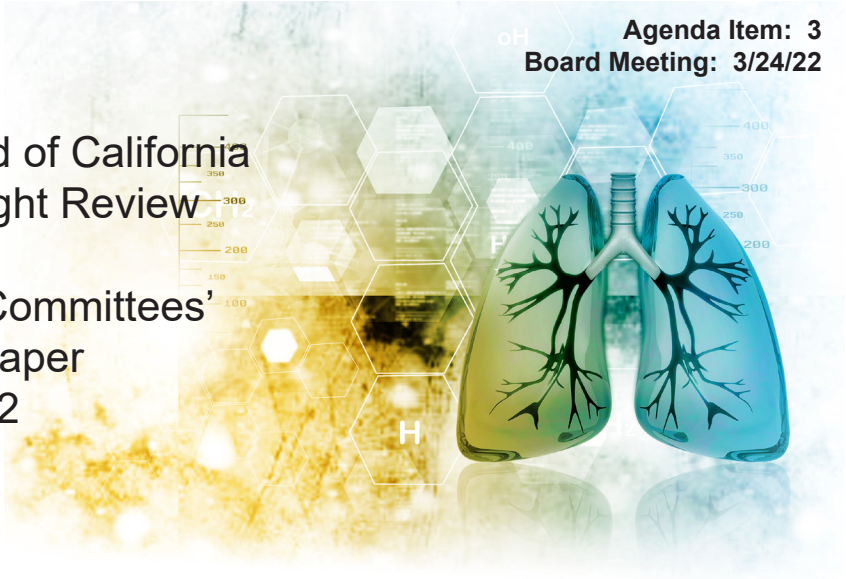

Respiratory Care Board of California
2022 Sunset Oversight Review

Board Response to Committees' Background Paper
March 2022

All text is duplicated from the "BACKGROUND PAPER FOR The Respiratory Care Board of California Joint Sunset Review Oversight Hearing, March 7, 2022 published by the Senate Committee on Business, Professions, and Economic Development and Assembly Committee on Business and Professions" except where noted as "Board Response."

CURRENT SUNSET REVIEW ISSUES

The following are unresolved issues pertaining to the Board and other 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 MBC needs to address. MBC and other interested parties have been provided with this Background Paper and MBC will respond to the issues presented and the recommendations of staff.

BOARD ADMINISTRATION ISSUES

ISSUE #1: (REGULATIONS.) What is the current timeframe for Board regulatory packages to be approved and finalized?

Background: Promulgating regulations is at the heart of the Board's work to implement the law and establish a framework for consumer protection. According to the Office of Administrative Law (OAL), a "regulation" is any rule, regulation, order or standard of general application or the amendment, supplement, or revision of any rule, regulation, order, or standard adopted by any state agency to implement, interpret, or make specific the law enforced or administered by it. When adopting regulations, every department, division, office, officer, bureau, board or commission in the executive branch of the California state government must follow the rulemaking procedures in the Administrative Procedure Act (APA) (Government Code section 11340 et seq.) and regulations adopted by OAL, unless expressly exempted by statute from some or all of these requirements. The APA requirements are designed to provide the public with a meaningful opportunity to participate in the adoption of regulations or rules that have the force of law by California state agencies and to ensure the creation of an adequate record for the OAL and judicial review.

The rulemaking process does provide some discretion to agencies. While each agency must comply with timeframe requirements and must produce the same uniform documents supporting rulemaking efforts to submit to OAL, there are not the same standards for how regulation packages are determined, written, and produced.

Prior to 2016, boards and bureaus like the Board that are organized within DCA filed rulemaking packages directly with OAL. Boards and bureaus were not required to submit rulemaking packages to DCA or the overseeing agency for review and approval prior to submission for publication in the Notice Register. OAL reported that this process was unusual within state government: most programs must submit regulations packages to their respective agency for approval. As a result, in September 2016, the Secretary of the Business, Consumer Services and Housing Agency (BCSH) changed the procedures: boards and bureaus were now required to submit rulemaking packages to the department and BCSH for review prior to filing with OAL. BCSH stated that the reason for the decision was an increase in the number of regulations disapproved by OAL for failing to meet their statutory requirements.

According to a 2019 DCA report to the Legislature, Internal Review of Regulation Procedures, "the resulting enhanced scrutiny from Agency and DCA's Legal Affairs Division successfully reduced the number of disapproved regulation packages, with the number of disapprovals falling from nine in 2016 to only one in 2018." The report also found that "while disapproval rates plummeted, a consequence was lengthened timelines to adopt regulations. Several boards and bureaus raised objections to the lengthened review time and reported difficulty obtaining timely updates about regulation packages under review." The "pre-review" process required regulations to go through DCA's entire review process prior to the package being submitted for public comment. DCA established a formal Regulations Unit to "minimize the length of time it currently takes to review regulatory packages; allow board and bureau attorneys to focus on the increased workload of non-regulatory work; respond to the demand of regulation packages under review and the increase of regulation packages from AB 2138 (Chiu and Low; Chapter 995, Statutes of 2018); avoid the habitual carry-over of regulation packages; and, enhance the level of regulation training provided to boards and bureaus to improve the quality of regulations and create efficiencies by having better quality packages submitted for review."

It would be helpful for the Committees to have a better understanding of the status of necessary Board regulations, the timeframe for regulations to be processed and complete and what efficiencies Board has realized since the creation of the Regulations Unit.

Staff Recommendation: The Board should provide the Committees with an update on pending regulations and the current timeframes for regulatory packages. In addition, the Board should inform the Committees of any achieved efficiencies in promulgating regulations in recent years.

Board Response: The Respiratory Care Board (RCB) has had a handful of regulatory packages that have been processed by DCA's new regulation unit in the last 4 years. There is one regulatory package pending at OAL that is expected to be approved in April that was inititated mid 2019 and we are in the process of finalizing language and the accompanying required documents to begin the rulemaking process for another package. While the Board has noticed an increase in processing times it has also seen a marked increase in quality.

Under the new framework, time to process a regulation package is not dependent solely upon the new DCA Legal Affairs-regulation unit, but also the board or bureau developing the product and DCA Executive Office and Agency in approving a package.

The RCB understands that DCA has had close oversight of this new unit and has witnessed process reengineering aimed at efficiency. From executive leadership down to practicing attorneys, there has been a sincere commitment to continual improvement.

The RCB is confident that in the coming years, processing times will improve while maintaining a quality product.

BOARD BUDGET ISSUES

ISSUE #2: (PRO RATA IMPACTS TO FUND CONDITION AND FEES.) Licensee renewal fees are at the statutory cap and have gone up $100 over the past four years. The Board pays almost 20 percent of its revenue to pro rata costs charged for various services

Background: The Department of Consumer Affairs (DCA) is almost entirely funded by a portion of the licensing fees paid by California's state-regulated professionals in the form of "pro rata." Pro rata funds DCA's two divisions, the Consumer and Client Services Division (CCSD) and the DOI. CCSD is the primary focus of this issue and contains the Administrative and Information Services Division (the Executive Office, Legislation, Budgets, Human Resources, Business Services Office, Fiscal Operations, Office of Information Services, Equal Employment Office, Legal, Internal Audits, and SOLID training services), the Communications Division (Public Affairs, Publications Design and Editing, and Digital Print Services), and the Division of Program and Policy Review (Policy Review Committee, Office of Professional Examination Services, and Consumer Information Center). Pro rata is apportioned primarily based on the number of authorized staff at each board, rather than based on the amount of DCA's services programs use. DCA does charge boards based on actual use for some services, such as the Office of Information Services, the Consumer Information Center, the Office of Professional Examination Services, and DOI. Based on DCA's own figures, actual pro rata costs for every board have increased of an average of over 100 percent since FY 2012-2013.

The Board pays pro rata from its fund, the majority of revenue for which comes from licensing and renewal fees. In turn, over the last four years, the Board has raised renewal fees from $230 to $330, primarily due to increased pro rata costs, after two decades of not raising the fee. According to the Board, "ongoing rates at 17% to 19% are excessive and threaten the stability of RCB's fund." Following fee increases, the fund condition has stabilized. The statutory cap for renewal fees is set at $330.

Staff Recommendation: The Board should report back to the Committees as soon as possible if there is a need to increase the statutory cap. The Board should also continue utilizing strategies to save costs where possible and report to the Committees if statutory changes needed to accomplish cost savings.

Board Response: At this time, the RCB does not foresee the need for a fee increase. The RCB's fund is stable through FY 22/23 and beyond and the RCB itself has no plans in the immediate future to increase any expenditures. However, as mentioned in the report, costs outside the RCB's control (e.g. personnel and benefits, Statewide pro rata and DCA pro rata) will eventually cause the RCB to seek a statutory fee increase.

It would be beneficial for the RCB to raise its statutory fee authority for its renewal fee, just as a means to have a safety net. Given that the RCB had not raised fees for nearly 20 years, exemplifies its commitment to reducing unnecessary expenditures and the effectiveness of it reengineering its processes. However, there are a number of reasons the RCB has taken pause: 1) The RCB is currently looking at operations to see where additional reductions and process reengineering can be effective. 2) It is our understanding that currently to raise a fee statutorily requires a fee study, which would likely require contracting for services at an estimated cost of $100,000. This cost itself is counterproductive consuming approximately 3% of the RCB's average annual expenditures. Moreover, it would reveal similar data -- including how expenses were reduced--that has been reported via sunset review over the years. 3) The chief complaint among licensed stakeholders are fees. Given that the RCB just increased their renewal fee by $100, a statutory fee increase will not be supported and possibly opposed by the profession at this time.

The RCB's fund currently has room to withstand some increases that are outside its control-even considering the current rate of inflation (approximately 7-10%). This coupled with the RCB's efforts to reduce expenditures is expected to keep the RCB's fund solvent for several years. The RCB believes it can maintain its fiscal solvency for a minimum of ten years and hopes it can reach near the 20-year mark again.

BOARD LICENSING AND WORKFORCE ISSUES

ISSUE #3: (WORKFORCE LANDSCAPE.) After a workforce study highlighting needs for the profession, there has been growing concern from the Board about the appropriate level of training to prepare the workforce. Since the sunrise of the Board, an Associates degree is the minimum education standard. Is an Associates degree still appropriate? If the minimum education level is raised, will it exacerbate the workforce shortage? Are there alternatives to preparing the workforce for changing needs than a Bachelor's degree? Should Respiratory Care Therapists have a Bachelor's degree to practice?

Background: The Board conducted a workforce study in 2007 citing the need for 19,000 RCPs by 2025 and 21,000 RCPs by 2030. From FY 2016-17 until FY 2021, there has been a 25% decline in licensees including new licensees and licensee that left the field. The need for RCPs has been highlighted by the COVID-19 pandemic as well as the increase in long term care needs. However the 2017 Workforce Study suggests there is also a need for more advanced RCPs. The study found the need to develop and strengthen critical thinking and critical reasoning among entry-level therapists, as well as the need for additional time to cover the entire breadth of respiratory therapy. The Board is currently working on amending regulations to adjust CE to better address workforce needs; however, the Board is also taking a review to determine how best to incorporate a Bachelor's degree into the Respiratory Care Practice Act. No determination has been made whether the Bachelor's degree would replace the Associate degree requirement, be used as a ladder for advanced practice, or another possible outcome. Of the 35 education programs in California, three currently offer a Respiratory Care Bachelor's degree. Is a Bachelor's degree the only or most appropriate way to train RCPs?

Staff Recommendation: The Board should report back to the Committees on their findings and understanding of the best way to incorporate a Bachelor's degree without creating further barriers to entry to the profession.

Board Response: The 2007 workforce study predicted the need for 19,000 RCPs by 2025 and 21,000 RCPs by 2030. The RCB had 20,248 active licensees as of July 1, 2021; 1,248 more RCPs than the expected need in 2025.

Licensing Data					
	FY 16/17	FY 17/18	FY 18/19	FY 19/20	FY 20/21
Active & Current	19,668	19,588	19,676	20,052	20,248
Delinquent	3,028	2,968	2,956	2,649	2,657
Inactive & Current	777	891	858	887	827
Retired	684	775	865	940	1,017
New Licenses Issued	1,106	1,061	1,124	1,137	1,175

At the Board's sunset hearing on March 7, 2022, there was some confusion regarding the statement above regarding a 25% decline in licensees. We could not identify a 25% reduction in the data provided (taken from pages 23 and 24 of the report). Active licensees have increased from 19,668 in FY 16/17 to 20,248 in FY 20/21 (3% increase) and new licenses issued have increased from 1,106 to 1.175 (6.2% increase) in that same timeframe.

However, the Board is aware that since the implementation of fee increases in 2017, the growth in active licensure has not been steady from year to year. In FY 17/18 there was even a (.04%) drop of 80 active licensees from the previous fiscal year.

In 2016, the Board advised licensees that renewal fee increases would be taking place beginning with licenses that expired July 1, 2017. The renewal fee was increased from $230 to $330 with the last fee increase effective with licenses expiring on or after July 1, 2020. (B&P §3775(d) required step increases). The 2007 Workforce Study noted that approximately 10% of active licenses were outside of the workforce. Half of those had jobs outside respiratory care and 12% were retired but maintained licensure. It is surmised that the fluctuation in active license numbers over the last four years may be a direct result of the fee increases and licensees who were not active in the field deciding to allow their license to become delinquent and ultimately cancel. A small percentage also take advantage of the option to place their license in a retirement status since a provision was established in 2004 (B&P § 3775.6).

The Board's Professional Qualifications Committee charged with the review to incorporate a bachelor's degree into the Practice Act has explicitly stated its intention to have stakeholder involvement and that the review would take a minimum of two years, likely four-five years, to complete in order to ensure every aspect is considered.

At the Board's sunset hearing on March 7, 2022, legislators provided feedback in response to increasing education levels in any manner including:

- A suggestion to exercise caution in increasing education levels from an associate to a bachelor's degree (creating a barrier to licensure), unless significant consumer protection issues exist.

- A request to identify with some degree of specificity the differences between the "clinical experiences" for an associate program vs. bachelor's program (e.g.. Is clinical work done most entirely at the associate level and does the baccalaureate degree simply add liberal arts).

- A request to identify potential impact of having a bachelor's program working alongside or against an associate program specific to the clinical training and the availability of clinical training slots.

- A request to identify the potential impact on preference of hiring; Would increasing education to a bachelor's degree make associate programs irrelevant? Would the bachelor's degree be the gold standard or minimum requirement and if not how would it be implemented and received by the industry?

- A request to explain how additional education will benefit daily practice? Will the additional education be used and needed for the expected number of licensees earning a bachelor's degree or is it additional education that will not be required for all respiratory positions? [Example cited was additional training is necessary to performing ECMO, but it is rarely required. We would not need all licensees formally educated to perform ECMO].

- A request to identify the potential impact of a workforce shortage.

- A request to consider whether current and possibly future licensees with an associate degree be pushed out of the profession?

The Legislature is a key RCB stakeholder and the RCB will ensure that every comment, request and suggestion is part of the education review. Further, as part of examining the workforce supply, the Professional Qualifications Committee will conduct in-depth analyses of its license population to identify trends and projections in concert with other outside data as one segment of its education review. The Board genuinely appreciates the words of caution and concern expressed at the hearing that will help shape the education review that is still in its infancy.

CE ISSUE RAISED AT MARCH 7 HEARING

At the March 7 hearing, there was also an inquiry regarding the Board's CE audit program and the percentage of licensees who fail a CE audit. Following up on that inquiry the Board's data is as follows:

Table 4h. CE Audits Performed/Failed

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

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

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

An average of 3% of licensees failed renewal audits over this five-year period. Licensees who fail a CE audit subject their license to being placed in an inactive status. If immediate compliance is not met, these matters are then referred to enforcement where cases are investigated to determine if unlicensed practice has also taken place. Once a matter is investigated, if the licensee has still not produced records verifying completion of required CE, a citation and fine will be issued. The citation and fine may be based upon the CE violation itself or may also include other violations, such as perjury or unlicensed practice. Below are the guidelines RCB staff rely upon when issuing fine amounts for licensees with no discipline history:

Table 4i. CE Violations/Citation and Fine Guidelines

	Fine Amount
Non-Compliance/No Response to 30-day and 10-day initial requests (and subsequently cleared)	$250
Each CE unit deficient	$15
Perjury on renewal form	$300
Unlicensed practice (per day worked) up to 30 days	$50
Unlicensed practice (per day worked) beyond 30 days	$100

Cases in which certificates of completion are believed to be forged are referred to the Enforcement Unit for investigation. If evidence of forgery is found, the case will be referred for formal disciplinary action.

ISSUE #4: (STRATEGIC PLAN IMPLEMENTATION RELATED TO WORKFORCE.) The California Respiratory Care Workforce Study was completed and integrated into the Board's strategic plan. Is the Board's current implementation strategy reflective of the findings of the Workforce Study?

Background: During the 2017 Sunset Review, the Committees requested an update on the 2015 study from Institute for Health Policy Studies at the University of California, San Francisco. The study was set 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.

The California Respiratory Care Workforce Study was completed and integrated into the Boards strategic plan. The two goals taken from the study are as follows:

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

The study revealed two significant training shortcomings for RCPs: 1) consistent quality preceptor training, and 2) clinical internship availability. The Board was concerned that requiring additional preceptor training would limit access, so as an alternative RCPs are encouraged and able to do the training as CE, pending regulation approval. Additionally, the Commission on Accreditation for Respiratory Care (CoARC) is currently working on new standards for clinical training.

In response to the study, the Board drafted regulations to revamp the CE requirements. The regulations are currently pending. The proposed language adds CE incentives to participate in preceptor training and as a preceptor for clinical education students. It also provides an incentive for hospitals to provide the training in the interest of developing leaders and improve the quality of training for future prospective employees.

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

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

Staff Recommendation: The Board should report back to the Committees on the effectiveness of on the implementation of their strategic plan as it pertains to the workforce.

Board Response: The RCB appreciates this issue being highlighted. We believe offering CE incentives for licensees to voluntarily take approved preceptor training and provide clinical oversight will have a noticeable impact on the quality of clinical education. The RCB looks forward to reporting back to the Committees on the impact and effectiveness of this strategy.

BOARD ENFORCEMENT ISSUES

ISSUE #5: (VENTILATOR CARE) Licensed Vocational Nurses (LVNs) have been providing ventilator support to patients based on a guidance issued from the Board of Vocational Nursing and Psychiatric Technicians (BVNPT). Is patient care in jeopardy by allowing LVNs to perform ventilator services? Is there any circumstance LVNs can safely assist in ventilator services?

Background: Dating back to May 1, 1996, LVNs and RCPs have struggled to determine the appropriate scope of practice for administering respiratory services such as managing patients. The Board contends LVNs should not be administering any ventilator services. The BVNPT guidance to licensees permitting LVNs to adjust ventilator settings. The Board has maintained this policy was an underground regulation without any authority to allow this practice. The Board has made numerous requests throughout the last 25 years to rescind the policy, but BVNPT has failed to revoke any policy regarding respiratory services and continues to take the position that LVNs should be able to adjust ventilators. The Board provided five examples adverse incident reports in the past 25 years resulting in death or serious harm from LVNs performing ventilator services.

The two boards began to work collaboratively in 2019 and issued a joint statement clarifying RCP and LVN roles relating to patient care on mechanical ventilators. After feedback from various types of facilities and organizations, there was expressed desire to further clarify its respective regulations regarding patient care. The boards hosted a stakeholder meeting to further discuss the joint statement and concerns grew about expanding places LVNs can conduct ventilator services to home based settings as well. According to the Board, BVNPT backed out of the agreement and began exploring CE to train LVNs to perform ventilator services in more setting. The Board has offered legislative options to clarify scopes of practice, but has not come to an agreement with BVNPT on a solution moving forward.

Staff Recommendation: The Board should advise the Committees on an agreed upon solutions from both boards and stakeholder including statutory changes. The Board may also wish to provide further case studies or additional adverse outcomes from LVNs performing respiratory services.

Board Response: The RCB appreciates the Committees highlighting this issue that has indeed been resolved only to resurface later on multiple occasions.

In 2005, the BVNPT accepted its legal counsel's office recommendations at its September board meeting and agreed to no longer dispense advice stating LVNs were permitted to manage ventilators. Less than one year later, in June 2006, the RCB was provided documentation that the BVNPT was again advising LVNs they could perform ventilator care.

In 2007, the RCB received and shared with BVNPT, an informal legal opinion from the Office of the Attorney General that provided in part:

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

Upon receiving several complaints in or around 2015, the RCB attempted again, to find data to show harm done as a result of LVNs practicing respiratory care. The RCB had attempted to find this data previously through various reporting systems, but found that such reporting systems only provide the underlying cause of death and pay no attention to the health care providers' competence. For example, a patient could be admitted to a sub acute facility with a chronic lung disorder. If that patient later dies because an LVN or for that matter

an RCP did not provide proper care, the death is attributed to the lung condition for which the patient was initially admitted or other complications that may have arisen due to lack of qualified care. Outside of malicious and witnessed intent to kill, there are no records, and rarely even an investigation into the competency of providers. Rather the public and inspectors expect healthcare providers to be qualified through their licensure based on education and competency exams. The reason the RCB found the five examples in 2015 was simply because families of the patients witnessed the LVN providers behavior. In addition, after the discovery of these five cases back in 2015, the BVNPT updated their website so that the public could no longer search for such records. It should be noted that during the RCB's investigations, many LVNs have expressed their concern and insecurities in performing respiratory tasks. They acknowledge the tasks are outside their education and training and are uncomfortable performing these duties, but feel obliged to follow their employers' direction.

Also in 2015 and 2016 board members, staff, and legal counsel met with Agency to try and correct the problem. At that time, there were several specific tasks noted as outside the LVN scope of practice. The BVNPT members, staff and experts flip-flopped several times on which tasks they believed LVNs could perform.

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

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

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

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

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

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

Administration
- DCA assistant deputy director.

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

The goal for the RCB was to have an agreed-upon interpretation of existing law concerning which services LVNs are authorized to perform. Specifically, RCB had noticed increases in complaints, primarily in Southern California, of subacute facilities using LVNs to perform respiratory care. Incidents which included failure to respond timely or appropriately, to emergencies to failing to plug in a ventilator, all leading to the deterioration of patients. It was also found that employers were asking the one or two licensed RCPs on staff to co-sign or sign for work that was not performed by them.

Employers had given new titles to LVNs, calling them "respiratory nurses." Employers were caught telling their employees to lie to our investigators about LVNs performing respiratory care. All of these acts violate the Business and Professions Code. Respiratory tasks require comprehensive assessment, formal education and training, and competency testing. Both boards agreed and repeated on numerous occasions that consumer protection was the utmost priority in developing the joint statement.

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

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

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

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

The RCB minutes from its June 2019 meeting reflect:

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

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

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

The update in the July 2019 revision included this language:

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

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

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

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

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

Sample regulations are provided in the Sunset Report should this legislation move forward and the BVNPT would be invited and encouraged to help shape these regulations. The overarching goal is to make sure consumers continue to have access to respiratory care in all settings, while minimizing the risks in the quality of respiratory care to meet consumer demands for their and their loved ones quality of life. Either of the following legislative proposals, combined with regulations formulated by stakeholders, will accomplish this goal.

ALTERNATIVE RESOLUTION #1

Amend B&P § 2860 (LVN Practice Act)

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

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

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

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

ALTERNATIVE RESOLUTION #2

Amend B&P § 2860 (LVN Practice Act)

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

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

Amend B&P § 3765 (Respiratory Practice Act) 3765.

This act does not prohibit any of the following activities:
(a) The performance of respiratory care that is an integral part of the program of study by students enrolled in approved respiratory therapy training programs.
(b) Self-care by the patient or the gratuitous care by a friend or member of the family who does not represent or hold himself or herself out to be a respiratory care practitioner licensed under the provisions of this chapter.
(c) The respiratory care practitioner from performing advances in the art and techniques of respiratory care learned through formal or specialized training.
(d) The performance of respiratory care in an emergency situation by paramedical personnel who have been formally trained in these modalities and are duly licensed under the provisions of an act pertaining to their specialty.
(e) Respiratory care services in case of an emergency. “Emergency,” as used in this subdivision, includes an epidemic or public disaster.

(f) Persons from engaging in cardiopulmonary research.
(g) Formally trained licensees and staff of child day care facilities from administering to a child inhaled medication as defined in Section 1596.798 of the Health and Safety Code.
(h) The performance by a person employed by a home medical device retail facility or by a home health agency licensed by the State Department of Public Health of specific, limited, and basic respiratory care or respiratory care related services that have been authorized by the board.
(i) The performance by a vocational nurse licensed by the Board of Vocational Nursing and Psychiatric Technicians, employed by a home health agency licensed by the California Department of Public Health, with patient-specific training as identified by the board, of respiratory tasks and services identified by the board.
(j) The performance of pulmonary function testing by persons who are currently employed by Los Angeles County hospitals and have performed pulmonary function testing for at least
15 years.

ISSUE #6: (REGISTRY REPORTING) Currently, RCPs are not being reported to the Board in cases involving registries. This results in RCPs continuing to work without discipline and without public disclosure of harm potentially caused. Should mandatory reporting be expanded?

Background: Respiratory care practitioners are not reported by facilities in instances where they were advised to resign instead of face termination. Facilities rightfully claim they do not have to report RCPs who were employed by registries. Instead, facilities using registry employees notify the registry that they do not want the employee assigned to their facility ever again. And while in most instances the registry is made aware of the reason the facility refuses assignments by certain RCPs, the registry (nor the facility) is obligated to inform the Board, even in those cases of serious violations as outlined in BPC Section 3758. As a result of this gap within mandatory reporting, RCPs are able to continue to work without discipline.

Staff Recommendation: The Committees may wish to amend the reporting requirements in the Act to ensure all violations are reported to the Board.

Board Response: The language as introduced in SB 1436 on February 18, 2022, authored by Senator Roth addresses this concern with precision. The RCB appreciates Senator Roth's and the Committees' assistance in resolving this issue.

TECHNICAL CHANGES

ISSUE #7: (TECHNICAL CHANGES MAY IMPROVE EFFECTIVENESS OF THE ACT AND BOARD OPERATIONS.) There are amendments to the Respiratory Care Practice Act that are technical in nature but may improve Board operations and the enforcement of the Act.

Background: There are instances in the Respiratory Care Practice Act where technical clarifications may improve Board operations and application of the statutes governing MBC's work.

Staff Recommendation: The Committees may wish to amend the Act to include technical clarifications.

Board Response: The RCB is unaware of any technical changes proposed, but is pleased to work with the Committees' in this endeavor.

COVID-19

ISSUE #8: (SUPPORT FOR COVID-19 PROVIDERS.) Under ordinary circumstances, frontline healthcare providers and first responders often face difficult situations that are mentally and emotionally challenging. Are there new issues arising from, or ongoing issues being worsened by, the extreme conditions of the COVID-19 pandemic?

Background: Throughout the COVID-19 pandemic, frontline healthcare workers and first responders, such as physicians, nurses, respiratory care therapists, paramedics, and more, have been caring for COVID-19 patients through multiple deadly surges, including a record-shattering death toll surge in December of 2020.

The Centers for Disease Control notes that "[p]roviding care to others during the COVID-19 pandemic can lead to stress, anxiety, fear, and other strong emotions…. Experiencing or witnessing life-threatening or traumatic events impacts everyone differently. In some circumstances, the distress can be managed successfully to reduce associated negative health and behavioral outcomes. In other cases, some people may experience clinically significant distress or impairment, such as acute stress disorder, post-traumatic stress disorder (PTSD), or secondary traumatic stress (also known as vicarious traumatization). Compassion fatigue and burnout may also result from chronic workplace stress and exposure to traumatic events during the COVID-19 pandemic."

Frontline healthcare workers are essential to the state of California. Given the length and the unique conditions of the COVID-19 pandemic, it may be beneficial to track trends and identify potential challenges and solutions in delivering mental health care and support for frontline healthcare workers who have been under extreme physical and mental pressure since the start of the coronavirus pandemic.

Staff Recommendation: The Board should discuss any findings related to the mental and behavioral healthcare needs of frontline healthcare providers arising from the COVID-19 pandemic.

Board Response: The RCB offers the following article written by the RCB president, Ricardo Guzman for the RCB's 2021 annual newsletter. His sentiment was expressed by those RCPs who contacted the RCB over the course of the pandemic.

> "We must recognize that 2021 was a difficult year for everyone, but even more so for those on the front line fighting the COVID-19 pandemic. Respiratory care practitioners, along with other health care workers, have reported stress, anxiety, and depressive symptoms because of the challenges associated with taking care of those afflicted with COVID-19. As a bedside practitioner of 38 years, I can attest that this has been unlike anything we have ever experienced.
>
> Those of us in critical care had grown accustomed to enjoying moderate to high success in preventing patients from having to go on life-support and/or in liberating them when they required it. Over the past two years, we have had to adjust our expectations in the realization that so many of our patients would not be going home to their loved ones. Week after week, our patients got sicker faster and for longer than before, despite our knowledge, our sophisticated equipment, and the evolving recommendations from the health care community. All of this, while having to manage our own health and that of our families and friends during lock downs, travel restrictions, and while having to wear a mask everywhere we went, even in our break rooms.
>
> Yet, the courage and determination I see every day is nothing short of amazing. Although at the end of our shifts we are exhausted and sometimes discouraged, we remain committed to do it again on

our next shift and to offer greater compassion to not only our patients and their families, but also to each other as we recognize that we are in this together. As an educator for two decades, I have been a great proponent of the important role we play in the lives of our patients. Today, I am more proud to be a respiratory therapist than ever before. May we not lose heart as we head into a new year for brighter days are ahead. We will win this fight and emerge stronger, and at the same time gentler than we used to be."

ISSUE #9: (IMPACTS OF THE COVID-19 PANDEMIC.) Since March 2020, there have been a number of waivers issued through Executive Orders that impact Board operations, Board licensees, providers, and patients throughout the state. Do any of these waivers warrant an extension or statutory changes? How has the Board addressed issues resulting from the pandemic?

Background: In response to the COVID-19 pandemic, a number of actions were taken by the Governor, including the issuance of numerous executive orders in order to address the immediate crisis. Many executive orders directly impact the state's healthcare workforce. On March 4, 2020, the Governor issued a State of Emergency declaration which immediately authorized the Director of the Emergency Medical Services Authority (EMSA) to allow licensed healthcare professionals from outside of California to practice in California without a California license. Under BPC Section 900, licensed professionals are authorized to practice in California during a state of emergency declaration as long as they are licensed and have been deployed by the Director of EMSA. Following that executive order, on March 30, 2020, the Governor issued Executive Order N-39-20 authorizing the Director of DCA to waive any statutory or regulatory professional licensing relating to healing arts during the duration of the COVID-19 pandemic – including rules relating to examination, education, experience, and training.

Many of the waivers impact the Board's work and RCPs. The Board states in their sunset report that they were immediately concerned about an insufficient number of RCPs. The Board identified the need to allow for other health professionals, students or groups to perform respiratory services during an emergency which includes an endemic or public disaster.

Staff Recommendation: The Board should update the Committees on the impact to licensees and patients stemming from the pandemic and potential challenges for future RCPs. The Board should discuss the impact of waivers on patient safety and note any statutory changes that are warranted as a result of the pandemic.

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

The first and most profound challenge the RCB identified in response to the State of Emergency was the possibility of an insufficient number of RCPs available to respond to a virus that was known to attack the lungs in serious cases. Respiratory therapists are the experts in diagnosing and treating respiratory ailments across the medical spectrum. Severe cases of COVID-19 lead to low oxygen saturation levels, and extreme cases almost always result in the need for mechanical ventilation: both of which are areas of RCP specialty. Knowing that the lives of patients would be dependent upon having enough respiratory therapists available to respond made finding legal pathways to supplement the workforce the RCB's top priority. The RCB immediately began working with Legal Counsel to determine the RCB's authority to allow various waivers and allow students, retirees, and out-of-state licensees to fill anticipated gaps. The daily calls and emails requesting guidance and action were mounting in intensity as each day passed. At this same time, the Administration wanted to have a unified response, so the RCB turned our attention to working with DCA for waiver approvals.

On March 31, 2020, the first waiver (DCA 20-02) to allow retired, cancelled and inactive licensees to return to temporary practice was issued. The RCB has not received any complaints for the 148 people allowed to practice under this waiver.

In addition the Emergency Medical Services Agency (EMSA) adopted policies and procedures governing the use of out-of-state medical personnel to respond to the COVID-19 outbreak. The EMSA authorized 900 people, licensed as RCPs in respiratory care in other states to practice during the State of Emergency. To date, we have been notified that two of these individuals had their authorization rescinded, but we are unaware of any detail that led to the rescission.

Students were another resource the RCB turned to, to relieve expected staffing pressure. A waiver was not necessary to permit students to assist during the pandemic, but they were still subject to direct supervision. Nonetheless, respiratory care students that had completed their education and part of their clinical training could be beneficial in performing tasks where they had shown competency and other manual respiratory tasks (e.g. moving equipment). The greatest concern for students was the issue of financial compensation. While the RCB has no prohibitions to this, the education accrediting agency does. The RCB reached out to the accrediting agency to express concerns, and the agency subsequently temporarily lifted the prohibition, allowing students to be financially compensated with the understanding that such activity would not count toward the required clinical practice hours. In addition, those students that were within three months of graduation were encouraged to apply early, so that upon graduation they would either have a work permit or licensed in hand.

Following the messaging of these efforts through April 2020, the phone calls to the RCB noticeably dropped. The RCB has received maybe one or two calls a month thereafter. The Department of Health Care Services reached out to the RCB a few times for assistance in 2020 to find RCPs for placement in subacute facilities, to which the RCB's president, Ricardo Guzman responded and resolved.

Overall, no concerns for patient safety were raised for licensees or students under its jurisdiction. However, the RCB did identify areas where statutes could be improved from its perspective.

BUSINESS AND PROFESSIONS CODE, SECTION 3765

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

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

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

NEWLY PROPOSED BUSINESS AND PROFESSIONS CODE, SECTION 3723

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

B&P §3723.
a) In the event a state of emergency is declared, the Board may, for a period of up to 60 days from the date of the declaration, temporarily waive any requirement in the Respiratory Care Practice Act it deems necessary and as commensurate in response to the circumstances known surrounding the cause of the state of emergency, provided there are no gubernatorial objections.

b) For purposes of this section, the Board may hold an "Emergency Meeting" as provided in section 11125.5 of the Government Code. The Board may hold the meeting, open to the public, through the means of information technology, however the Board shall not be subject to the provisions in sections 11123 or 11123.5 of the Government Code requiring a physical location be made available to the public.

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

ISSUE # 10: (CONTINUED REGULATION BY RESPIRATORY CARE BOARD OF CALIFORNIA.) Should the licensing and regulation of RCPs 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 toward efficiency and effectiveness, responding to practice and operational issues in a proactive, forward-thinking manner.

Staff Recommendation: The licensing and regulation of respiratory care practitioners by the Respiratory Care Board of California should be, to be reviewed again on a future date to be determined.

Board Response: The RCB's highest priority is consumer protection and it aims to provide this through effective application review and investigative services and meaningful application of the law. Moreover, the RCB strives to provide excellent customer service and efficiency in state government. The RCB would like to thank members of both the Senate Business, Professions and Economic Development Committee and the Assembly Business and Professions Committee for the many comments of appreciation for the respiratory care profession, especially during the pandemic, at the March 7 hearing. The Board would also like to acknowledge and sincerely thank the Committees and their staffs' for their thorough review of the RCB and bringing to light several recommendations that lead to greater efficiency and/or consumer protection.