Item: 2021-2022 SUNSET REPORT REVIEW/APPROVAL

Item Summary: Every four-five years, the Assembly Business and Professions Committee and the Senate Business, Professions, and Economic Development Committee hold joint sunset review oversight hearings to review the Board. The sunset review process provides an opportunity for the DCA, the Legislature, the Board, and interested parties and stakeholders to discuss the performance of the Board, and make recommendations for improvements.

Attached is a draft portion of the Board's 2021-2022 Sunset Review Report for your review and consideration. The Executive Officer will request that final approval of the complete report will be granted to the Executive Committee. The final revised questionnaire was received September 13, 2021 from legislative staff. The due date was also pushed back from December 1, 2021 to January 5, 2022.

Board Action:

1. President calls the agenda item and it is presented by or as directed by the President.
2. If the Board is willing, make a motion to:

   Grant authority to the Executive Committee to provide final approval of the Board 2021-22 Sunset Report.

   [Alternately, the Board may suggest to hold an additional meeting in December solely for the purpose of approving the Sunset Report.]
3. President may request if there is a second to the motion, if not already made.
4. Board member discussion/edits (if applicable).
5. Inquire for public comment / further Board discussion as applicable.
6. Repeat motion and vote: 1) aye, in favor, 2) no, not in favor, or 3) abstain

Attachment: 3

Meeting Date: 10/20/21

2022
Sunset Oversight Review

Submitted January 5, 2022

Respiratory Care Board of California

Est. 1982

Respiratory Care Board of California
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Acronyms and Abbreviations

AARC	American Association for Respiratory Care
ADA	Americans with Disabilities Act
ALJ	Administrative Law Judge
APA	Administrative Procedure Act
Board	Respiratory Care Board of California
B&P	Business and Professions Code
CCR	California Code of Regulations
CDPH	California Department of Public Health (formerly DHS)
CE	Continuing Education
C&F	Cite and Fine
CoARC	Committee on Accreditation for Respiratory Care
CPEI	Consumer Protection Enforcement Initiative
CRT	Certified Respiratory Therapist
CSRC	California Society for Respiratory Care
DAG	Deputy Attorney General
DCA	Department of Consumer Affairs
DOJ	Department of Justice
DMV	Department of Motor Vehicles
NBRC	National Board for Respiratory Care
OAG	Office of the Attorney General
OAH	Office of Administrative Hearings
RCP	Respiratory Care Practitioner
RCPA	Respiratory Care Practice Act
RRT	Registered Respiratory Therapist
SOI	Statement of Issues

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

BACKGROUND AND DESCRIPTION OF THE RESPIRATORY CARE BOARD

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

The Board was the eighth “allied health” profession created “within” the jurisdiction of the Medical Board of California (MBC). Although created within the jurisdiction of the MBC, the Board had sole responsibility for the enforcement and administration of the Respiratory Care Practice Act (RCPA). At the time the Board was established, the MBC had a Division of Allied Health Professions (DAHP) designated to oversee several allied health committees. It was believed that this additional layer of oversight (in addition to the Department of Consumer Affairs (DCA)) was unnecessary and ineffective. Therefore, the DAHP subsequently dissolved on July 1, 1994.

The Board is comprised of a total of nine members, including four public members, four RCP members and one physician and surgeon member. Each appointing authority, the Governor, the Senate Rules Committee and the Speaker of the Assembly, appoints three members. This current framework helps prevent quorum issues and provides a balanced representation needed to effectuate the Board’s mandate to protect the public from the unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care (B&P, § 3701).

The Board is further mandated to ensure that protection of the public shall be the highest priority in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount (B&P, § 3710.1).

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

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

In carrying out its mandate, the Board:

- Screens each application for licensure to ensure minimum education and competency standards are met and conducts a thorough background check on each applicant.
- Investigates complaints against licensees primarily as a result of updated criminal history reports (subsequent rap sheets) and mandatory reporting (licensees and employers are required to report violations).
- Aggressively monitors RCPs placed on probation.
- Exercises its authority to penalize or discipline applicants and licensees which may include: 1) issuing a citation and fine; 2) issuing a public reprimand; 3) placing the license on probation (which may include suspension); 4) denying an application for licensure, or 5) revoking a license.
- Addresses current issues related to the unlicensed and/or unqualified practice of respiratory care.
- Promotes public awareness of its mandate and function, as well as current issues affecting patient care.

The Board continually strives to enforce its mandate and mission in the most efficient manner, by exploring new and/or revising existing policies, programs, and processes. The Board also strives to increase the quality or availability of services, as well as regularly provide courteous and competent service to its stakeholders.

The Board regulates and issues licenses solely for RCPs. The RCPA is comprised of Business and Professions Code Section 3700, et. seq. and California Code of Regulations, Title 16, Division 13.6, Article 1, et. seq..

BACKGROUND AND DESCRIPTION OF RESPIRATORY CARE PRACTITIONERS

RCPs are one of three licensed healthcare professionals who work at patients' bedsides, the other two being physicians and nurses. RCPs work under the direction of a medical director and specialize in providing evaluation of, and treatment to, patients with breathing difficulties, as a result of heart, lung, and other disorders, as well as providing diagnostic, educational, and rehabilitation services. RCPs are needed in virtually all healthcare settings.

On a daily basis, RCPs provide services to patients ranging from premature infants to the elderly. RCPs provide treatments for patients who have breathing difficulties and care for those who are dependent upon life support and cannot breathe on their own. RCPs treat patients with acute and chronic diseases including Chronic Obstructive Pulmonary Disease (COPD), trauma victims, and surgery patients. Most familiar are patients or victims of the following conditions or traumas:

Asthma	Bronchitis Stroke
Cystic Fibrosis	Emphysema
Near Drowning Heart Attack	Lung Cancer
Premature Infants	Infants with Birth Defects
High-risk Influenza	High-risk COVID-19

RCPs are the key healthcare professionals that will provide the needed treatments and services to these types of patients, as well as patients suffering from other ailments. RCPs are educated and trained in this very specialized area of medicine. RCPs perform a number of diagnostic, treatment, and life support procedures, including, but not limited to:

- Employing life support mechanical ventilation for patients who cannot breathe adequately on their own.
- Administering medical gases and pharmacological agents for the purpose of inducing conscious or deep sedation.
- Administering all forms of extracorporeal life support (ECMO).
- Inserting and maintaining arterial lines.
- Administering medications to help alleviate breathing problems and to help prevent respiratory infections.
- Monitoring equipment and assessing patient responses to therapy.
- Operating and maintaining various types of highly sophisticated equipment to administer oxygen or to assist with breathing.
- Obtaining blood specimens and analyzing them to determine levels of oxygen, carbon dioxide, and other gases.
- Maintaining a patient's artificial airway (i.e. tracheostomy or endotracheal tube).

- Performing diagnostic testing to determine the disease state of a patient's lungs and heart.
- Obtaining and analyzing sputum specimens and chest X-rays.
- Interpreting data obtained from tests.
- Assessing vital signs and other indicators of respiratory dysfunction.
- Performing stress tests and other studies of the cardiopulmonary system.
- Studying disorders of people with disruptive sleep patterns.
- Conducting rehabilitation activities.
- Conducting asthma education and smoking cessation programs.

Hospitals employ the majority of RCPs. However, there is a growing number of RCPs being employed in alternative facilities and locations. RCPs may be employed in any of the following settings:

- Hospitals.
- Emergency care departments.
- Adult, pediatric, and neonatal intensive care units.
- Critical care units.
- Neonatal (Infant) units.
- Pediatric units.
- Home care.
- Sub acute facilities.
- Fixed wing and helicopter critical care transport.
- Critical ground transportation.
- Physicians' offices.
- Hyperbaric oxygen therapy facilities.
- Pulmonary function, rehabilitation, cardiopulmonary, blood gas, and sleep laboratories.

RESPIRATORY CARE BOARD COMMITTEES

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

Executive Committee

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

President: Ricardo Guzman, MA, RRT, RCP
Vice-President: Mark Goldstein, MBA, BS, RRT

Enforcement Committee

Members of the Enforcement Committee are responsible for the development and review of Board-adopted policies, positions, and disciplinary guidelines. Although members of the Enforcement Committee do not typically review individual enforcement cases (if they do they recuse themselves from any further proceedings), they are responsible for policy development of the enforcement program, pursuant to the provisions of the Administrative Procedure Act.

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

Outreach Committee

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

Chair: Mark Goldstein, MBA, BS, RRT
Member: Sam Kbushyan, MBA

Professional Qualifications Committee

Members of the Professional Qualifications Committee are responsible for the review and development of regulations regarding educational and professional ethics course requirements for initial licensure and continuing education (CE) programs. Essentially, they monitor various education criteria and requirements for licensure, taking into consideration new developments in technology, managed care, and current activity in the healthcare industry.

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

RESPIRATORY CARE BOARD MEETINGS AND MEMBER ATTENDANCE

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

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

Table 1a. Respiratory Care Board Meetings and Member Attendance

		Date Appointed	MD-Physician; P-Public; RCP-Professional	Appointing Authority Governor; Senate;	10/7/16 - Sacramento	3/10/17 - San Diego	6/30/17 - Sacramento	10/13/17 - Sacramento	2/2/2018 - Garden Grove	5/14/2018 - Monterey	10/26/2018 - Fresno	3/1/2019 - Orange	6/7/2019 - Teleconference	11/1/2019 - Sacramento	4/3/2020 - Southern CA	10/23/2020 - WebEx TC	3/3/2021 - WebEx TC	6/30/2021 -WebEx TC
CURRENT MEMBERS																		
Early	Mary Ellen	Apr-13	P	G	X	X	X	X	X	X	X	X	X	X	Meeting cancelled due to COVID-19	X	X	X
Goldstein	Mark	Jun-12	RCP	G	X	X	P	X	X	X	X	A	X	X		X	X	X
Kbushyan	Sam	Jun-17	P	S			X	X	X	X	X	X	A	X		X	A	X
Lewis	Ronald	Jun-13	MD	S	X	X	X	A	X	X	A	X	A	A		X	X	X
Hernandez	Raymond	Feb-20	RCP	A												X	X	X
Guzman	Ricardo	Jan-19	RCP	S								X	X	X		X	X	X
Terry	Michael	Aug-20	RCP	A													X	X
Williams	Cheryl	Apr-21	P	G														X
PAST MEMBERS																		
Romero	Laura	May-13	P	S	X	X												
Wagner	Thomas	Jun-14	RCP	S	X	X	X	X	X	X								
Roth	Alan	Sep-12	RCP	A	X	X	X	X	X	X	X	A						
McKeever	Judy	Feb-14	RCP	A	X	X	X	X	X	X	X	A	X					
Bose	Sherleen	Apr-19	RCP	A									X	X				
Hardeman	Michael	Jun-13	P	A	A	X	X	X	X	X	X	X	X	X		X	X	
Franzoia	Rebecca	Jun-12	P	G	X	X	X	X	X	X	X	X	A	X		X	X	

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

Table 1b. Current Board Member Roster

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

INTERNAL STRUCTURE AND OTHER SIGNIFICANT EVENTS/CHANGES

Staffing

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

Strategic Planning

The Board conducted an extensive strategic planning effort and developed a four-year Strategic Plan in 2017. The plan includes four areas of focus: Enforcement, Education, Practice Standards, and Organizational Effectiveness. The Board's next plan will be developed following the conclusion of its FY 21/22 Sunset Review to consider legislative recommendations as well.

Administrative Procedure Manual (attached)

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

Baccalaureate Review and Integration

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

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

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

LEGISLATIVE CHANGES AFFECTING THE BOARD SINCE 2017

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

SB 796 (Hill) Chapter 600, Statutes of 2017

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

SB 1003 (Roth) Chapter 180, Statutes of 2018

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

SB 1491 (Hill) Chapter 703, Statutes of 2018

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

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

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

REGULATORY CHANGES AFFECTING THE BOARD SINCE 2017

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

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

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

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

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

NATIONAL ASSOCIATION PARTICIPATION

Currently, the Board is a member of the American Association for Respiratory Care (AARC), the Council on Licensure, Enforcement, and Regulation (CLEAR), and the Federation of Associations of Regulatory Boards (FARB). The Board's membership in each of these associations does not include voting privileges. However, they all provide valuable resources in connection with enforcement, licensure, exams, or issues specific to respiratory care.

In addition, most RCP Board members are also members of the AARC. Several members attend (on their own) the AARC's Annual Conferences or Summer Forums.

NATIONAL EXAM PARTICIPATION

The Board uses the National Board for Respiratory Care's (NBRC's) "Registered Respiratory Therapist (RRT)" examinations which includes both the Therapist Multiple-Choice (TMC) Examination and the Clinical Simulation Examination for licensure. They are developed, scored, and analyzed by the NBRC. Annually, the Board verifies that the NBRC meets the requirements set forth in §139 of the B&P for occupational analyses and ongoing item analyses.

The examinations associated with the RRT were developed to objectively measure essential knowledge, skills, and abilities required of advanced respiratory therapists, and to set uniform standards for measuring such knowledge. The TMC Examination is designed to objectively measure essential knowledge, skills, and abilities required of entry-level respiratory therapists, as well as determine eligibility for the Clinical Simulation Examination (CSE). Individuals who attempt and pass both the Therapist Multiple-Choice Examination and the Clinical Simulation Examination will also be awarded the Registered Respiratory Therapist (RRT) credential.

Section 2
Performance Measures and Customer Satisfaction Surveys

CUSTOMER SERVICE FEATURES AND CORE PHILOSOPHIES

The Board has the following features and has maintained core philosophies in its effort to continually improve service to all of its stakeholders:

- Toll-Free Number: In April 2002, the Board acquired a toll-free number for statewide use. The Board continues to actively publicize and promote the use of the toll-free number (866-375-0386).
- E-mail Address: In 2002, the Board also established an e-mail address (rcbinfo@dca.ca.gov) for consumers and applicants to contact the Board with any questions. The Board makes it a point to respond to each e-mail within 24 to 72 hours.
- Human Contact: Since the inception of the Board, it has rejected automated systems that pick up calls (from the main telephone number) with a recorded phone tree. The Board believes immediate human contact is the optimal choice in providing outstanding customer service.
- Online Satisfaction Survey: In 2002, a “Satisfaction Survey” was added to the Board’s website for consumers, licensees, and applicants to complete online.
- Enforcement Performance Measures: In 2010, the Board, in concert with DCA, began compiling and reporting “average days” to complete various aspects of the enforcement process.
- Licensing Performance Measures: In 2015, the Board, together with the DCA, established target times to process initial applications for licensure.
- Consumer Satisfaction Survey: In 2012, the Board revised its survey sent to complainants and updated its “letter-style” format to the following postage-paid postcard (actual size larger than shown below).

CONSUMER SATISFACTION SURVEY (COMPLAINT HANDLING/RESOLUTION)

As part of the Board's procedures to close enforcement cases, staff provide Consumer Satisfaction Surveys to each complainant (primarily those complaints received from patients, family members, and employers). Complaints initiated by rap sheets or similar entities are excluded.

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

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

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

ONLINE SATISFACTION SURVEY

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

Overall satisfaction for each year and category ranged from:

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

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

Section 3
Fiscal Issues and Staffing

FUND CONDITION

Following several recent fee increases, the Board's fund is showing stable recovery with a projected 5.8 months in reserve in FY 22/23 and balanced revenues and expenditures. The Board has not made any loans to the General Fund in the last 20 years. Loans made prior to that date were repaid in FY 2000–01.

Table 3a. Fund Condition

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

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

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

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

§ 3775. Amount of fees.

"The amount of fees provided in connection with licenses or approvals for the practice of respiratory care shall be as follows:

...(d) For any license term beginning on or after January 1, 1999, the renewal fee shall be established at two hundred thirty dollars ($230). The board may increase the renewal fee, by regulation, to an amount not to exceed three hundred thirty dollars ($330). The board shall fix the renewal fee so that, together with the estimated amount from revenue, the reserve balance in the board's contingent fund shall be equal to approximately six months of annual authorized expenditures. If the estimated reserve balance in the board's contingent fund will be greater than six months, the board shall reduce the renewal fee. In no case shall the fee in any year be more than 10 percent greater than the amount of the fee in the preceding year..."

EXPENDITURES BY PROGRAM COMPONENT

Examining expenditures by program you will find that the majority of expenditures are attributed to the Board's Enforcement Program followed by DCA ProRata, and then followed by Licensing/Examination and Administration.

Of interest is the "Average %" for DCA Pro Rata. Looking back to the Board's 2016/17 Sunset Review the average percentage of total expenditures spent on DCA Pro Rata was at 12% in FY 12/13 and increased to 17% in FY 15/16. Breaking down the average percentage of the budget spent each fiscal year during this reporting period you find:

DCA ProRata- Average Percentage/Dollars of Total Budget by Fiscal Year

FY 16/17	19% or $626,000
FY 17/18	21% or $681,000
FY 18/19	21% or $699,000
FY 19/20	19% or $626,000
FY 20/21	17% or $558,000

It is presumed the increases to 19% and 21% were largely in part due to BreEZe costs:

BreEZe Expenditures by Fiscal Year

12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23
$28	$96	$105	$223	$217	$213	$199	$127	$113	$103	$75

However, it is refreshing to see these expenditures falling. Without these reductions, the Board's fund condition would not be recovering and would have shown the need for additional fee increases.

Table 3b. Expenditures by Program Component

PROGRAM AREA	FY 16/17		FY 17/18		FY 18/19		FY 19/20		FY 20/21*		Average %
	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E	
Enforcement	$997	$760	$1,038	$646	$1,025	$741	$1,096	$686	$1,046	$763	54%
Licensing/Exam	$398	$79	$348	$79	$358	$74	$380	$78	$342	$85	13.7%
Administration	$298	$60	$358	$59	$370	$56	$383	$58	$353	$63	12.7%
DCA Pro Rata	n/a	$626	n/a	$681	n/a	$699	n/a	$626	n/a	$558	19.6%
TOTALS	$1,693	$1,525	$1,744	$1,464	$1,753	$1,570	$1,859	$1,448	$1,741	$1,470	
Budget	$3,218		$3,209		$3,323		$3,307		$3,210		

- Dollars listed in thousands.

* FY 20/21 Statewide pay reduction reduced expenses for personnel services affecting all program areas listed.

HISTORY OF FEE CHANGES

The authority for the Board's fees is found in §3775 of the B&P and provides either a ceiling for the fee amount or an actual amount. This section also provides the Board some flexibility by authorizing it to reduce the amount of any fee at its discretion. All fees are current in the Board's regulations §1399.395 (CCR, Title 16, Division 13.6).

Over the last ten years, the Board has had several changes in fees. As reported in the Board's 2016-17 Sunset Report the changes in the Board's fee structure since 2006 included the following changes made in 2012:

- Eliminating the Initial License Fee (to reduce application processing times).
- Increasing the Application Fee from $200 to $300 (as part of the effort to reduce application processing times at near neutral cost impact).
- Reducing the Endorsement Fee from $75 to $25.

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

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

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

Table 3c. Fee Schedule and Revenue

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

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

BUDGET CHANGE PROPOSALS

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

STAFFING AND TRAINING

The Board has been fortunate in retaining a highly-skilled and experienced workforce over the last twenty years. Turnover is extremely rare, with only a handful of employees leaving to pursue other promotional opportunities. At the time of the Board's last Sunset Review in 2016-17, the Board had 18 staff members. Since that time two have retired; one is expected to return as a retired annuitant in the near future. Currently the Board has 16 staff members, all of which were employed during the Board's last Sunset Review. Organizational charts for the last four fiscal years can be found on pages 88–91.XXXX

Board Staff Receive "Team Superior Accomplishment Award"

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

Workforce and Succession Plan 2021-2024

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

The Board's ability to deliver services effectively in the future is at risk due to the projected retirement of 9 or 56% of the Board's workforce over the next two to five years. With the departure of experienced employees, who possess a wealth of institutional knowledge and perform vital roles, it is important for the Board to outline opportunities where it can enhance its infrastructure and be proactive in developing workforce planning guidance.

Staff Training

Over the last five fiscal years, the Board has spent approximately $4,500 on training and education. Costs are associated with courses taken outside of DCA such as the Certified Professional Collector Program, a course our probation monitors take to maintain certification in collecting specimens for drug testing. However, staff have also participated in numerous courses, free of (direct) charge, offered through DCA. A list of training completed since 2016/17 is provided in Table 3d.

Table 3d. Staff Training

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

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

Section 4
Licensing Program

LICENSEE POPULATION

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

4a. Licensee Population

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

APPLICATION PROCESSING TIMES

The Board strives to process applications for licensure as quickly as possible. As of June 30, 2021, the average cycle time to process a complete application from date of receipt to date of licensure was 7 days. The average cycle time for incomplete applications was 68 days.

4b. Licensing Performance Targets

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

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

INITIAL LICENSURE AND RENEWALS

The Board currently issues over 1,100 new licenses and renews over 9,500 licenses each year. As discussed in greater detail in Section 11, the Board increased the level of its competency examination required for licensure effective January 1, 2015. At that time the Board anticipated the number of initial applications to drop for a period of time. The table below demonstrates that the number of initial applications received has increased from 1215 to 1538 from FY 18/19 to FY 20/21 reaching its former level of applications received (prior to the implementation of the new exam) of 1,560 in FY 13/14.

Table 4c. Licensing Data by Type

	Application Type	Received (opened)	Approved	Closed *	Initial and Renewed Licenses Issued	Pending Apps at Close of FY	Cycle Times (in days)	
							Complete Apps	Incomplete Apps
FY 18/19	License/Exam	1215	1124	112	1124	387	7	66
	Renewal	9517	9594	1082	9594	n/a	-	-
FY 19/20	License/Exam	1424	1137	152	1137	492	9	59
	Renewal	9606	9761	1018	9761	n/a	-	-
FY 20/21	License/Exam	1538	1175	237	1175	375	7	68
	Renewal	9718	9841	974	9841	n/a	-	-

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

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

The Board denied a total of 7 applications for initial licensure between FY 18/19 and FY 20/21 regardless of whether a hearing was requested and all 7 denials were based on a criminal history as follows:

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

Application for a respiratory care practitioner license is denied under B&PC sections 3750 subsection (d), 3750.5 subsection (b), 3752.5, and CCR section 1399.370 (a), (c), and (h). The circumstances are as follows:

On June 23, 2013, applicant was arrested for violating Vehicle Code (VC) section 23153(a), driving under the influence of alcohol causing bodily injury. On August 21, 2014, applicant was convicted of violating VC section 23153(b), driving with a blood alcohol content of .08% or higher causing bodily injury, upon plea of guilty.

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

Lastly, on June 4, 2016, applicant was arrested for violating VC sections 23152(a), driving under the influence of alcohol and 23152(b), driving with a blood alcohol content of .08% or higher. On August 9, 2016, applicant was convicted of violating VC sections 23152(a) and 23152(b), upon plea of nolo contendere.

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

Application for a respiratory care practitioner license is denied under B&PC section 3750 subsection (d), 3750.5 subsection (b), and CCR section 1399.370 subsections (a) and (c). The circumstances are as follows:

On October 26, 1997, applicant was arrested for driving under the influence of alcohol. On March 30, 1998, applicant was convicted upon plea of no contest to violating Vehicle Code (VC) section 23152(a), driving under the influence of alcohol with admission to two prior convictions for VC section 23152(b), driving with a .08% or more blood alcohol content on July 29, 1994, and October 25, 1995.

On October 29, 2016, applicant was arrested for VC sections 23152(a), 23152(b), and 20002(a), hit and run causing property damage. On February 22, 2017, applicant was convicted upon plea of nolo contendere to violating VC sections 23152(b) and 20002(a).

WISE
Initial Denial Letter Dated: 5/8/19
No Hearing Requested

Application for a respiratory care practitioner license is denied under B&PC section 3750 subsection (d), 3750.5 subsection (b), and CCR section 1399.370 subsections (a) and (c). The circumstances are as follows:

On April 10, 2008, applicant was arrested for a violation of Florida Statute (FS) section 316.193(1), driving under the influence of alcohol. On May 1, 2009, applicant was convicted upon plea of nolo contendere to violating FS section 316.193(1).

On October 10, 2011, applicant was convicted upon plea of nolo contendere to violating FS section 322.34(2)(a), driving on a suspended license.

On October 17, 2013, applicant was arrested for a violation of FS sections 322.34(2), knowingly driving on a suspended license. On May 12, 2014, applicant was convicted upon plea of nolo contendere to violating FS section 322.34(b)(2), driving on a suspended license with a prior conviction.

On September 8, 2014, applicant was arrested for a violation of FS section 322.34(6), driving on a suspended license, habitual offender. On March 16, 2016, applicant was convicted upon plea of nolo contendere to violating FS section 322.34(5), a felony.

On May 11, 2017, applicant was arrested for Vehicle Code sections 23152(a), driving under the influence of alcohol and 23152(b), driving with a .08% or

more blood alcohol content. On January 17, 2018, applicant was convicted upon plea of nolo contendere to violating VC sections 23162(a) and 23152(b).

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

CLEMENTS
Initial Denial Letter Dated: 8/23/19
No Hearing Requested

Application for a respiratory care practitioner license is denied under B&PC sections 3750 subsection (d), 3750.5 subsection (b), and CCR section 1399.370 subsection (c). The circumstances are as follows:

On March 7, 2012, applicant was arrested for violating VC sections 23152(a), driving under the influence of alcohol and 23152(b), driving with a blood alcohol content of .08% or higher. On December 28, 2012, applicant was convicted upon plea of guilty to violating VC section 23152(b) with an admission to having a blood alcohol content of .15% or more.

On December 24, 2017, applicant was arrested for violating VC sections 23152(a) and 23152(b). On August 5, 2019, applicant was convicted upon plea of guilty to violating VC section 23152(b) with an admission to a prior violation of VC 23152(b) on March 7, 2012.

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

Application for a respiratory care practitioner license is denied under B&PC sections 3750 subsections (d), (j), and (q), 3750.5 subsection (a), 3752, 3752.5, and CCR section 1399.370 subsections (a), (b), (h), and (i). The circumstances are as follows:

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

On December 14, 2006, applicant was convicted upon plea of no contest to violating PC section 273.5(a), inflicting corporal injury on a spouse.

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

2006, applicant was convicted upon plea of guilty to violating Health and Safety Code section 11359, possession of marijuana for sale.

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

On December 15, 2014, applicant was convicted upon plea of guilty to violating PC section 29805, convicted person possessing a firearm.

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

CABRILLOS
Initial Denial Letter Dated: 6/30/2020
No Hearing Requested

Application for a respiratory care practitioner license is denied under B&PC sections 3750 subsections (d), 3750.5 subsection (a) and (b), 3752, and CCR section 1399.370 subsections (a) and (c). The circumstances are as follows:

On February 22, 2019, applicant was arrested for violating Vehicle Code (VC) section 23152(f), driving under the influence of drugs. On July 19, 2019, applicant was convicted upon plea of guilty to violating VC section 23103/23103.5, reckless driving involving ingestion or administration of a drug; to wit methamphetamine.

REED
Initial Denial Letter Dated: 7/20/20
SOI Withdrawn/License Denied

Application for a respiratory care practitioner license is denied under B&PC sections 3760 subsections (d) and (m), 3760.6 subsection (a) and (b), 3762, and CCR section 1399.370 subsections (a) and (c). The circumstances are as follows:

On June 6, 2014, applicant was arrested on an outstanding warrant and cited for violating Arizona Revised Statute (ARS) sections 13-3416(A), possession of drug paraphernalia. On November 18, 2014, applicant was convicted upon plea of guilty to violating ARS sections 13-3416(A).

On July 11, 2014, applicant was arrested for violating ARS sections 28-1381A1, driving under the Influence of alcohol, drugs or a toxic vapor and 28-1381A2, driving with a blood alcohol content of .08% or higher. On April 8, 2016, applicant was convicted upon plea of guilty to violating ARS section 28-1381A1.

On February 21, 2013, applicant was issued Respiratory Care Practitioner License no. 01082 by the Arizona Board of Respiratory Care Examiners

(ABRCE), On applicant's 2014 renewal application with the ABRCE, applicant disclosed he had a substance abuse problem. As a result, effective April 2016, applicant entered into a consent agreement for non-disciplinary rehabilitative probation for three (3) years' which required compliance with certain terms related to standard rehabilitation agreement. In May 2016, the ABRCE received information that applicant had consumed alcohol in violation of the order, took prescription medications that were not disclosed to ABRCE, and failed to comply with a request for a mandatory drug test within a reasonable amount of time. In August 2016, the ABRCE reinstated the terms of the original probation under an amended consent agreement for a non-disciplinary rehabilitative program.

On January 4, 2017 applicant provided a bodily fluid sample that was not observed, was not within temperature perimeters, and was not consistent with natural urine. On January 10, 2017, the ABRCE issued an Interim Order of Summary Suspension against his Arizona respiratory care practitioner license (pending an administrative hearing) in order to protect the public health, welfare, or safety. On February 16, 2017, applicant entered into a consent agreement and order with the ABRCE whereby his license was suspended until the Board received a substance abuse evaluation to determine if he could safely practice respiratory care. Upon affirmative approval from the ABRCE permitting him to return to the practice of respiratory care, his license would be placed on probation for three (3) years with terms and conditions, including complete Individual counseling, attend AA/NA meetings, submit to drug testing, abstain from drugs and alcohol, and comply with standard terms and conditions.

On November 20, 2017, applicant was arrested for violating ARS sections 28-1381A 1, driving under the influence of alcohol, drugs or a toxic vapor and 28-1381A3, driving under the influence of drugs, 4- 251 A 1, consuming alcohol while operating a vehicle, 4-251A2, possession of an open container, 13-3406A1, possession of prescription drug, and 13-3415A, possession of drug paraphernalia. On July 18, 2018, applicant was convicted upon plea of guilty to violating ARS section 28-1381 A 1.

On December 6, 2018, applicant was arrested for violating ARS sections 28-1383A1, aggravated driving under the influence and 28-3473A, driving with a suspended license, 28-1383A4, aggravated interlock and 28-1383A2, driving under the influence with priors. On April 23, 2019, a criminal complaint was filed charging him with violating the December 6, 2018 arresting codes stated above and was pending at the time of the denial.

On March 26, 2020, applicant applied to the ABRCE for a new license to practice respiratory care disclosing his criminal history and all actions by the ABRCE, including the 2018 arrest for DUI. At that time, he provided the ABRCE with evidence of rehabilitation since his suspension and expressed a desire to fulfill the conditions of probation.

On June 1, 2020, applicant entered into another consent agreement with the ABRCE granting license no. 0043590 and placing said license on three years' probation with terms and conditions.

APPLICATION BACKGROUND VERIFICATION/FINGERPRINTS

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

- Department of Justice Background Check.
- Federal Bureau of Investigation Background Check.
- Official Education Transcript(s).
- Licensing Examination Verification (successful completion).
- Board-approved Law and Professional Ethics Course Verification (successful completion).
- Out-of-State Licensure History (as applicable).
- National Practitioner Databank History for Applicants Where Residence or Education May be Outside of California.

All of the above documentation must come directly from the source. Documentation submitted by the applicant will not be accepted.

Since the inception of the Board, all applicants have been fingerprinted to ascertain any criminal history. The Board notifies the Department of Justice (DOJ) that it is no longer interested in receiving this follow-up information once a license is cancelled, deceased, retired, surrendered or revoked or an application is denied or abandoned. The Board is current and up-to-date in notifying DOJ of all records the Board no longer has jurisdiction over.

The Board's application also includes very specific background questions for the rare occasion in which an event is not captured by other means. The Board takes a tough stance against any type of perjury, and discourages applicants from concealing any historical criminal/disciplinary information. An incident that may result in a strong warning letter if revealed will nearly always result in the denial of a license if perjury is committed.

In addition to fingerprinting, the Board will also run a check with the National Practitioner Databank if it appears that an applicant may have resided or obtained his or her education outside of California (this check is not performed on existing licensees during the renewal process). The Board also requires applicants who reveal they have been licensed out-of-state to have those states where licensure was held, submit a license verification directly to the Board's office, indicating if there is any history of disciplinary action.

Applicants with education from Canada must complete an education program recognized by the Canadian Board of Respiratory Care (§3740 (d) of the B&P). Applicants with foreign education (with the exception of Canada) must have their education evaluated by an approved respiratory program to determine if their education is equivalent to requirements for all other applicants. Applicants may receive full equivalency or may be required to take some additional education to achieve equivalency (Reference, §3740 (c) of the B&P).

MILITARY APPLICATIONS

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

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

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

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

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

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

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

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

The Board has promulgated regulations to recognize military service and experience. The following sections can be found in the California Code of Regulations, Title 16, Division 13.6:

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

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

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

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

The rulemaking package with this amendment is currently at the Office of Administrative Law for final review and approval. You may check the current status of this package on the Board's website here (scroll to the bottom of this page).

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

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

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

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

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

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

Table 4e. Military Applications for Initial Licensure

	FY 16/17	FY 17/18	FY 18/19	FY 19/20	FY 20/21
Aps Received - Military	77	74	82	97	105
Aps Received - Military Spouse	24	20	24	18	24
Aps Approved - Military	82	71	68	74	72
Aps Approved - Military Spouse	19	12	21	16	17
Military Education Waivers Requested	0	0	0	0	1
Military Education Waivers Approved	0	0	0	0	1

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

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

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

EXAMINATION

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

The Therapist Multiple-Choice Examination is designed to objectively measure essential knowledge, skills, and abilities required of entry-level respiratory therapists. The examination consists of 160 multiple-choice questions (140 scored items and 20 pretest items) distributed among three major content areas: 1) patient data evaluation and recommendations, 2) troubleshooting and quality control of equipment and infection control, and 3) initiation and modification of interventions.

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

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

The NBRC exams are administered in English on a daily basis and candidates are not permitted to consecutively repeat an examination form previously taken. Applicants may apply to take the examination online or via paper application. Upon verification of meeting entry requirements, applicants may schedule themselves to sit for either examination at one of 42 locations throughout California. Applicants are given three hours to complete the Therapist Multiple Choice Exam and 4 hours to complete the Clinical Simulation Exam (exceptions are made in accordance with the ADA). Once applicants have completed either examination, they are notified immediately of the results. Those results are then shared with the Board on a weekly basis.

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

From FY 16/17 through FY 20/21, the pass rates for first-time takers averaged near 80% for the written exam and 64% for the clinical exam.

The NBRC is sponsored by the American College of Chest Physicians, the AARC, the American Society of Anesthesiologists, and the American Thoracic Society. It is a voluntary health certifying board that was created in 1960 to evaluate the professional competence of respiratory therapists. Its executive office has been located in the metropolitan Kansas City area since 1974. The NBRC is a member of the Institute for Credentialing Excellence (ICE), and both the Therapist Multiple Choice Exam and the Clinical Simulation Exam (as well as several others) are accredited by the National Commission for Certifying Agencies (NCCA). Accreditation by the NCCA signifies unconditional compliance with stringent testing and measurement standards among national health testing organizations.

SCHOOL APPROVALS

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

1) Completion of an education program for respiratory care that is accredited by the Committee on Accreditation for Respiratory Care (CoARC); AND

2) Possession of a minimum of an associate degree from an institution or university accredited by a regional accreditation agency or association recognized by the United States Department of Education (USDOE).

Most often, these components are one in the same, but in some instances, they may be distinct. A degree will be issued by a different institution usually when the respiratory care program was completed prior to 2001 (when education requirements were changed) or if the respiratory care education was received outside of California. Otherwise, 34 schools in California offer an associate degree in respiratory care and three schools, Loma Linda University, Skyline College and Modesto Jr. College, offer a baccalaureate degree in respiratory care. The two community colleges were approved for a pilot program to issue baccalaureate degrees pursuant to SB 850 (statutes of 2014). AB 927 (statutes of 2021) established the community college baccalaureate degree program statewide.

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

All 35 programs are accredited by CoARC; 26 are accredited by the Western Association of Schools and Colleges (WASC), and the remaining 9 are accredited by an agency recognized by the USDOE and are approved by the BPPE. Other respiratory care programs' and schools' accreditation statuses are verified as they are presented. The Board does not have any legal requirements regarding approval of international schools.

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

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

CONTINUING EDUCATION

As of July 2017, an active RCP must complete 30 hours of approved CE every two years (previously 15 hours). Two-thirds of the continuing education must be directly related to clinical practice. In addition, during every other renewal cycle, each active RCP must also complete a Board-approved Law and Professional Ethics Course which may be claimed as three hours of non-clinical CE credit (reference CCR §1399.350).

After completion of the Respiratory Care Workforce study in 2017, the Board developed several goals in its Strategic Plan 2017-2021 to improve its CE program, student clinical education and education outcomes. The Board drafted and disseminated proposed regulatory language in 2020 and discussed it at several meetings gaining a tremendous amount of public input. The Board edited the original proposal several times and has since approved regulatory language that is currently pending the onset of the rulemaking process and further legal review.

The framework of the Board's CE program would be drastically changed from a general requirement that 2/3 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 5 hours in courses or meetings indirectly related to the practice.

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

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

Leadership

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

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

Several current and past members of the Board have also been educators and are aware of difficulties in finding placement for students at facilities. Many facilities are reluctant to take students. The Board believes mandating a facility meet preceptor requirements would

result in a sharp decline of participation. After review of the Board's Workforce Study and other underlying documents, the Board determined providing incentives through its CE program is the best way to effectuate the goals listed in its strategic plan. Rather than mandating required training for preceptors, which was feared to halt facility participation, the Board instead is offering incentives to its licensees to participate in a preceptor training program.

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

Live Format

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

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

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

The Board does not approve courses, but requires courses to be provided by approved providers as outlined in subdivision (b) of §1399.352 of the CCR:

Since 2006, each licensee is required to successfully complete a Board-approved Law and Professional Ethics Course. The course is currently offered by the AARC and the CSRC and is aimed at informing RCPs of the expectations placed upon them as professional practitioners in the State of California. Two-thirds of the course is comprised of scenarios based on workplace ethics and one-third is specific to acts that jeopardize licensure based on the laws and regulations that govern their licenses (reference §1399.350.5 and §1399.352.7).

All CE course content must be relevant to the scope of practice of respiratory care. As previously mentioned, a minimum of two-thirds of the required hours must be directly related to clinical practice. Licensees may also count up to one-third of the CE hours required, from courses not directly related to clinical practice if the content of the course or program relates to any of the following:

(1) Those activities relevant to specialized aspects of respiratory care, which activities include education, supervision, and management.
(2) Healthcare cost containment or cost management.
(3) Preventative health services and health promotion.
(4) Required abuse reporting.
(5) Other subject matter which is directed by legislation to be included in CE for licensed healing arts practitioners.
(6) Re-certification for ACLS, NRP, PALS, and ATLS.
(7) Review and/or preparation courses for credentialing examinations provided by the NBRC, excluding those courses for entry-level or advance level respiratory therapy certification.
(8) The Law and Professional Ethics Course required every other renewal cycle.

The Board also accepts the passage of any of the following credentialing exams as credit towards CE:

(1) Adult Critical Care Specialty Exam (ACCS).
(2) Certified Pulmonary Function Technologist (CPFT).
(3) Registered Pulmonary Function Technologist (RPFT).
(4) Neonatal/Pediatric Respiratory Care Specialist (NPS).
(5) Advanced Cardiac Life Support (ACLS).
(6) Neonatal Resuscitation Program (NRP).
(7) Pediatrics Advanced Life Support (PALS).
(8) Advanced Trauma Life Support (ATLS)
(9) Sleep Disorders Testing and Therapeutic Intervention Respiratory Care Specialist (SDS).

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

Audits

Following the Board 2016-17 Sunset Review, the Board considered recommendations made by the committees and included the following goals in its 2017-2021 Strategic Plan:

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

In FY 18/19, the Board 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 Board was on target and meeting the 10% mark as of October 2017, the Board was forced to ease up on audits due to a staff person's extended medical absence. In FY 19/20 and FY 20/21, audits were heavily impacted as a result of the issuance of CE waivers and the Board'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 3/31/20 through 10/31/21 to complete CE by 1/26/22 (and 3/28/22 for those licenses expiring 10/31/21).

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

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 3/31/2020 and 9/30/21 to complete CE by 1/26/22 and licenses expiring on 10/31/2021 to complete CE by 3/28/2022.

The Board's auditing process is very thorough and demands sufficient and qualified resources. Records submitted by the licensee are reviewed to determine if all required information is present and required "clinical" hours of CE have been obtained. The Board's auditor will also verify many of the records received with the actual provider to verify authenticity. There are significant written and oral communications that are exchanged.

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

Table 4i. CE Violations/Citation and Fine Guidelines	
	Fine Amount
Non-Compliance / No Response to 30-day and 10-day initial requests (and subsequently cleared)	$250
Each CE unit deficient	$15
Perjury on renewal form	$300
Unlicensed practice (per day worked) up to 30 days	$50
Unlicensed practice (per day worked) beyond 30 days	$100

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

Section 5
Enforcement Program

The Board's enforcement program is charged with investigating complaints, issuing penalties and warnings, and overseeing the administrative prosecution against licensed RCPs and unlicensed personnel for violations of the Respiratory Care Practice Act (RCPA). The enforcement program is key to the Board's success in meeting its mandate and highest priority of consumer protection.

PERFORMANCE MEASURES

In 2010, the Board established performance targets for measures developed by DCA, as a result of the CPEI. The DCA also developed the criteria and program to calculate these days, according to their measures.

The Board's overall goal for all cases to be completed, from the date the complaint is received to final adjudication, is 540 days (18 months). From FY 12/13 through FY 15/16, the Board averaged 572 days to complete the entire process. Prior to that the Board had a high of 692 days in the final quarter of FY 11/12.

By FY 12/13, the Board fell way under its target processing times for every category within its control. The only exception was the category that includes prosecution, as the Board has little to no control over the time spent on cases once they are referred to the Office of the Attorney General (OAG).

On the following page you will see that since FY 17/18, all of the Board's averages now fall well below the Board's maximum targets. A more detailed description of each column is as follows:

PM1 reflects the number complaints and rap sheets received.

PM2 reflects the average cycle time from complaint receipt to the date it is assigned to an investigator.

PM3 marks the average cycle time from complaint receipt to closure of the investigation process. PM3 does not include cases sent to the Office of the Attorney General.

PM4 represent the average number of days to complete the entire enforcement process for cases resulting in formal discipline (includes intake and investigation by the Board, and dispensation by the Office of the Attorney General.

PM7 reflects the average number of days from monitor assignment to the date the monitor makes first contact with the probationer.

PM8 marks the average number of days from the date a violation is reported to the date an assigned monitor initiates appropriate action.

The OAG has made incredible strides to reduce processing times and it is wholly responsible for the marked improvement over the last four years and the Board meeting its "Intake, Investigation and AG" target (PM4). Since FY 17/18, every quarter has fallen under the Board's target of 540 days (18 months) and in half of these quarters the processing time fell at or under one year. Under the leadership of Gloria L. Castro, Senior Assistant Attorney General, the Board has enjoyed open dialogue and appreciates her efforts to tackle these processing times.

Table 5a. Enforcement Performance Measures	Volume PM1	Intake (in days) PM2	Intake & Inv. PM3	Intake, Inv. & AG (in days) PM4	Probation Intake (in days) PM7	Probation Violation Response (in days) PM8
TARGETS (in days)	**-**	**7**	**210**	**540**	**6**	**10**
FY 16/17						
Quarter 1: July - Sept. 2016	254	2	65	592	3	1
Quarter 2: Oct. - Dec. 2016	161	2	66	521	3	2
Quarter 3: Jan. - March 2017	169	2	69	596	2	1
Quarter 4: Apr. - June 2017	159	2	59	537	3	2
FY 17/18						
Quarter 1: July - Sept. 2017	207	2	57	396	4	1
Quarter 2: Oct. - Dec. 2017	186	2	63	421	2	1
Quarter 3: Jan. - March 2018	195	2	53	344	3	2
Quarter 4: Apr. - June 2018	215	2	58	336	3	1
FY 18/19						
Quarter 1: July - Sept. 2018	220	1	51	326	3	1
Quarter 2: Oct. - Dec. 2018	171	1	46	324	2	2
Quarter 3: Jan. - March 2019	204	1	46	429	2	1
Quarter 4: Apr. - June 2019	198	2	63	365	4	1
FY 19/20						
Quarter 1: July - Sept. 2019	217	2	69	363	3	2
Quarter 2: Oct. - Dec. 2019	204	1	58	463	3	1
Quarter 3: Jan. - March 2020	191	1	69	516	2	1
Quarter 4: Apr. - June 2020	130	1	60	305	3	1
FY 20/21						
Quarter 1: July - Sept. 2020	164	1	59	348	4	1
Quarter 2: Oct. - Dec. 2020	160	1	61	416	3	1
Quarter 3: Jan. - March 2021	182	1	46	496	2	1
Quarter 4: Apr. - June 2021	193	1	49	452	2	1

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

ENFORCEMENT STATISTICS

XXXXX

Table 5b. Enforcement Statistics

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

Table 5b. Enforcement Statistics (continued)			
	FY 18/19	FY 19/20	FY 20/21
INVESTIGATION			
Desk Investigations			
Closed	669	665	604
Average Days to Close	47	61	44
Pending (close of FY)	154	119	113
Non-Sworn Investigation			
Closed	62	52	54
Average Days to Close (from Desk Inv to Expert Review to Inv)	156	163	189
Pending (close of FY)	25	25	23
Sworn Investigation			
Closed	1	1	0
Average Days to Close (from Desk Inv to Inv Closed)	47	126	0
Pending (close of FY)	0	0	0
All Investigations			
Opened (First Assigned)	739	688	648
Closed	732	718	658
Average Days for all Inv Outcomes (from start inv to inv closure or referral for prosecution)	56	69	56
Average Days for Inv Closures (from start inv to inv closure - not including prosecution referrals)	51	64	49
Average Days for Inv when Referring for Prosecution (from start inv to referral for prosecution)	133	141	212
Average Days from Receipt of Complaint to Inv Closure	56	70	57
Pending (close of FY)	179	144	136
CITATION AND FINE			
Citations Issued	71	77	36
Average Days to Complete (from complaint receipt to citation issued)	65	74	81
Amount of Fines Assessed	$53,058	$47,563	$16,760
Reduced, Withdrawn, Dismissed	$3,350	$7,475	$110
Amount Collected	$41,413	$44,795	$12,885
CRIMINAL ACTION			
Referred for Criminal Prosecution	1	0	0

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

Table 5b. Enforcement Statistics (continued)			
	FY 18/19	FY 19/20	FY 20/21
PROBATION			
Probations Successfully Completed	13	14	10
Probations Voluntary Surrendered	3	4	1
New Probationers	15	18	20
Probationers Tolling (close of FY)	5	6	7
Active Probationers (close of FY)	51	45	51
Cease Practice Orders			
Cease Practice Orders Issued	9	4	12
Orders Upheld	4	1	4
Orders Dissolved	5	3	8
Subsequent Discipline			
Accusation and/or Petition to Revoke Probation	9	3	2
Probations Revoked	2	4	0
Probations Surrendered in Lieu of Disciplinary Action	3	1	2
Probations Extended	1	0	1
Substance Abusing Licensees			
Probationers Subject to Drug Testing (entire FY)	42	38	30
Drug Tests Ordered	930	895	703
Positive Drug Tests	127	71	52
Number of Probationers Testing Positive	12	8	8
Positive Drug Tests for Banned Substances			
Positive Drug Tests	4	1	6
Number of Probationers w/ Positive Drug Tests	4	1	4

Table 5b. Enforcement Statistics (continued)			
	FY 18/19	FY 19/20	FY 20/21
PETITIONS			
Petitions to Modify Probation			
Granted	0	0	0
Denied	1	0	0
Petitions to Terminate Probation			
Granted	5	5	3
Denied	0	0	0
Petitions for Reinstatement of License			
Granted	0	0	0
Granted with Probation	3	1	1
Denied	1	2	0

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

ISSUE #1: UCSF Workforce Study

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

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

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

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

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

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

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

Clinical Education Standards

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

The 2017 California Respiratory Workforce Study, revealed the following challenges of clinical training:

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

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

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

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

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

Standard 1.03: Requires programs to "ensure" students have access to clinical sites (standard strengthened)

Standard 2.07: The Director of Clinical Education would now be responsible for providing "evolving practice skills" as part of clinical education for "all students." (standard strengthened)

Standard 2.10: Proposed change would include "frequent" visits by the Director of Clinical Education with students, clinical faculty and clinical affiliates at all program locations. The interpretive guideline demonstrates that the clinical director must be accessible to all parties.

Standard 3.06: "Employer and graduate" surveys must be completed as part of the program's annual assessment of program outcomes. Deficiencies identified must be resolved by the program. Beginning 7 /1 /20, accreditation decision will again be based on survey results that cover the prior three years. CoARC's "outcomes threshold grid" provides the threshold as "at least 80% of returned employer surveys rating overall satisfaction 3 or higher on a 5-point Likert scale."

Standard 3.10: Evidence of compliance for "Clinical Site Evaluation" now includes "Clinical evaluation mechanisms that document the progressive independence of the student in the clinical setting" and "detailing required student competencies."

Standard 4.01: "Clinical evaluation mechanisms that document the progressive independence of the student in the clinical setting" will be added as "evidence of compliance" for minimum course content. The interpretative guideline for this standard is also beefed up heavily providing that "Each clinical experience should be of sufficient quality and duration to meet the objectives/competencies identified in the clinical syllabi for that rotation. The program must document that each clinical site provides student access to the physical facilities, patient populations, and supervision necessary to fulfill program expectations for the clinical experience at that site. The number of hours per semester devoted to clinical practice should increase as students progress in the program. Programs must ensure that students are exposed to all the categories of patient encounters necessary to prepare them for entry into practice as Registered Respiratory Therapists. At a minimum these should include preventive, emergent, acute and chronic patient encounters.

Standard 4.03: Curriculum must be based on competencies performed by RRTs as established by the NBRC and must be updated anytime the NBRC's TMC matrix is updated. This standard broadly defines the scope of practice.

Standard 4.04: Provides that "Graduates must be competent to perform all respiratory care diagnostic and therapeutic procedures required of a Registered Respiratory Therapist entering the profession." Evidence of Compliance includes "Evaluations that document the student's ability to perform all required diagnostic and therapeutic procedures safely and effectively in patient care settings"

Standard 4.08: Provides all learning experiences for each program's students must be equivalent.

Standard 4.09: Provides that "The program must be solely responsible for the selection and coordination of clinical sites as well as ensuring that the type, length, and variety of clinical experiences are sufficient for students to acquire all required competencies." The Evidence of Compliance includes "Detailed clinical schedules" and "current, formal clinical affiliation agreements or memoranda of understanding with all sites." The interpretative guideline also states in part, "The coordination of clinical experiences involves identifying, contacting and evaluating clinical sites for suitability as a required or elective rotation experience, which is a responsibility usually assigned to the Director of Clinical Education (DCE). When program clinical faculty will not be involved at a given site, the DCE should work with employer representatives on the Advisory Committee (when applicable) and/or with department supervisors at the clinical sites, to identify suitable preceptors to supervise students when they are on site.

Standard 5.09: Provides that students must be appropriately supervised at all times during clinical education. Students must not be used to substitute for clinical, instructional, or administrative staff. Students are not to be paid, however they may be paid interns in states where this is allowed. The standard provides that interns shall not receive educational credits for this experience.

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

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

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

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

Baccalaureate Degree Provision

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

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

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

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

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

The Board invited both baccalaureate degree pilot programs below, to its February 2018 meeting.

Skyline College: Raymond Hernandez, MPH, RRT, NPS, Dean-Science, Math, Technology [Board Member 2020-present and Professional Qualifications Committee Chair]

Modesto Jr. College: Alan Roth, MS, MBA, RRT-NPS, FAARC, FCCP
[Member and Board President 2012-2018]

Skyline College: Raymond Hernandez, MPH, RRT, NPS, Dean-Science, Math, Technology noted the pilot program is really helping the profession move forward setting the stage across the nation in terms of how we can build more capacity for further education. Presentation highlights included:

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

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

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

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

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

Modesto Jr. College: Alan Roth, MS, MBA, RRT-NPS, FAARC, FCCP stated one of the goals was to increase the diversity of the program to reflect the community at large and to advance the profession to reflect that same diversity. Mr. Roth also noted it was important to emphasize other program elements including research, management and education.

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

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

June 2021 Board Meeting
At the Board's June 2021 meeting, the new Professional Qualifications Committee provided the Board with a 2-hour presentation briefly recapping the history of the profession and the multiple factors supporting the need for further education. It was the first of a series of study sessions focused on educational preparation and requirements to support RCP competency. All those in attendance were actively engaged and provided valuable, thought-provoking feedback. Numerous reference materials were presented.

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

ISSUE #2: Website Enhancements

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

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

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

website also used to feature summary information on all accusations, statements of issues, and decisions that have been filed against licensees with documents available once they were final or a judge has issued an order, including citations, fines and orders of abatement, Interim Suspension Orders (ISOs) and suspensions and restrictions.
The Board's website now directs users to the BreEZe system rather than listing information directly on the site. While it is true that important information is available on the website and through BreEZe, a key issue for the Committees remains how easily available it is for California patients to access understandable information about practitioners, particularly those who have been the subject of disciplinary action. Users have to start at the Board's website and are redirected and navigated to BreEZe – looking up a RCP requires a few additional clicks to get to the actual disciplinary action and findings, information that may be easier to understand in summary form similar to the way it is presented in newsletters.
Staff Recommendation: Given that public disclosure of disciplinary action for health professionals has been a Legislative priority for many years, the Board should provide an update to the Committees on efforts to ensure patients and the public are able to easily access information, particularly information about enforcement actions taken by the Board, about licensees and Board activity.

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

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

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

ISSUE #3: New Exam

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

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

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

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

Evidence of competency at what was once considered the advanced level provides greater consumer protection, improved job performance as a whole and the ability to measure school outcomes as a part of program accreditation. The Board's most commonly expressed concern from RCPs was the lack of full competency and clinical preparedness of RCP students.

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

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

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

The new requirement to pass the advanced level RRT exam, is an effort seen as aligning the minimum examination requirements for licensure with the natural progression of the respiratory care field. Employers have responded favorably to the new requirement. Evidence of competency at what was once considered the advanced level, provides greater consumer protection, improved job performance as a whole and the ability to measure school outcomes as a part of program accreditation.

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

Below you will see the number of applications received each fiscal year. The average for FYs 16-17, 17-18 and 18-19 is 1,129 applications per year. The high influx of applications received in FY 19-20 and FY 20-21 is partly attributed to the COVID pandemic, though the Board also noticed an uptick of out-of-state applications prior to the pandemic, as well as in-state graduates. It is too early to tell whether the Board will maintain 1,100-1,200 new applications a year or if an increased baseline will be established.

	FY 16-17	FY 17-18	FY 18-19	FY 19-20	FY 20-21
Aps Received	1,158	1,015	1,215	1,424	1,538

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

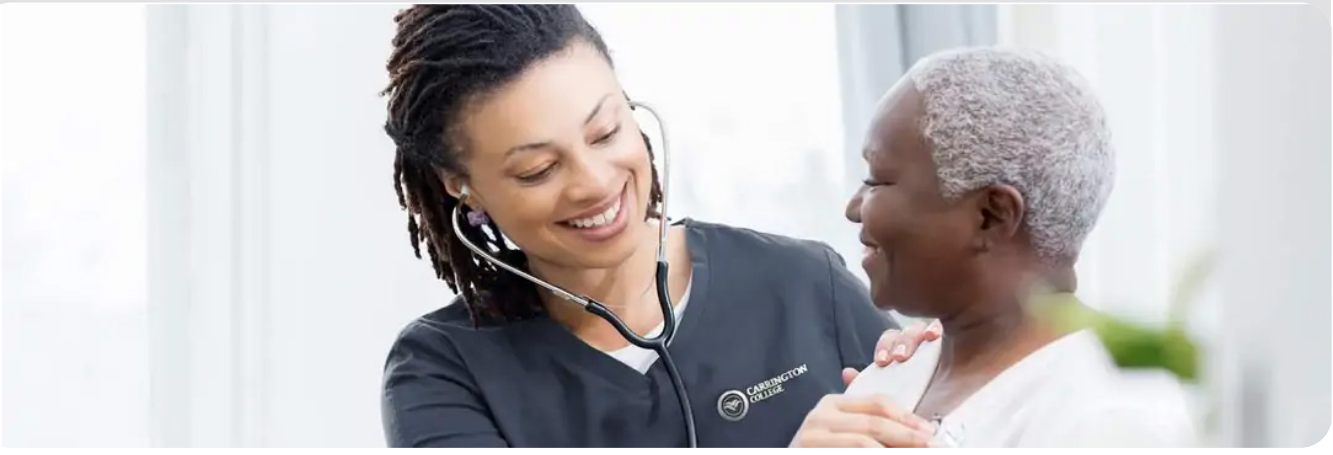
Previous minimum requirements included passing the lower-level written exam. After January 2015, applicants were required to pass the advanced exam consisting of two parts: written and clinical simulation. In order to sit for Clinical Simulation Exam, a test taker must first pass the written examination.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

In Spring 2017, as noted above, the Board reported the following pass rates:

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

Reviewing data below you will find:

- Since this reporting in 2017, the passage rate for first-time test takers continued to climb each year from 58% topping out at 67% in FY 19-20.
- The repeat test taker passage rate also continued to climb from 41% in Spring 2017 to as high as 54.3% in FY 19-20 and then dropping to 47.6% in FY 20-21.



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

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

ISSUE #4: Continuing Education:

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

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

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

Since July 2014, the Board has audited about five percent of licensees at the time of renewal to ensure CE hours were actually completed.

CE Audits Performed

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

The Board notes that its auditing process is very thorough and demands sufficient and qualified resources. Records submitted by the licensee are reviewed to determine if all required information is present and required clinical hours of CE have been obtained. In a CE audit, Board staff verifies whether a RCP actually completed courses with the actual course provider directly. This is a lengthy and time consuming process, resulting in only a fraction of renewals being subject to audit to verify that CE units were actually earned. Licensees who fail a CE audit are initially subject to their license being placed in an inactive status. These matters are then referred to enforcement where cases are investigated to determine if unlicensed practice has also taken place. Once a matter is investigated, if the licensee has still not produced records verifying completion of required CE, records that are also verified by Board staff), a citation and fine will be issued. The citation and fine may be based upon the CE violation itself or may also include other violations, primarily, unlicensed practice.

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

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

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

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

This equates to roughly 500 licensees audited each year.

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

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

In our initial response, we offer the following:

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

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

2021 Board Update: The Board's 2017-2021 Strategic Plan provides the following goals:

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

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

In addition, the Board inquired about the suggestion made by the then-Executive Officer of the Board of Registered Nursing to have all providers upload proof of completion. It is our understanding that an interface would have to be developed for each provider making this a cost prohibitive alternative with no guarantee of the intended outcome.

However, the Board does manually run reports to select RCPs for random audit and manually tracks those audits in BreEZe. In October 2017, the Board was hitting its mark of auditing 10% of renewals (approximately 1,000/ year or 83/month). Immediately following this success, the Board was forced to ease up on audits due to a staff person's extended medical absence. In FY 19/20 and FY 20/21, audits were heavily impacted as a result of the issuance of CE waivers and the Board's efforts to mitigate the additional stress of undergoing an audit during a pandemic.

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

Currently the Board, is again on target to hit its goal of auditing 10% of renewals for CE compliance in FY 21/22.

ISSUE #5: DMV History

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

Background: The Board requires applicants for licensure to provide a 10-year driving history during the application process, a requirement that seems onerous and potentially not providing important information to the Board about an applicant's background or ability to safely practice as an RCP.

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

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

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

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

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

2021 Board Update: In 2017, the Board included the following goal in its 2017-2021 Strategic Plan:

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

The DMV history submission was no longer required as part of the standard application process effective 10/15/17. However, the Board still maintains the authority to require a driving history for an applicant as part of its investigation prior to licensure as deemed necessary. Proposed regulatory amendments were noticed in January 2021 which include the following amendment:

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

Since 10/15/17, the Board has requested driving histories for 8 applicants where circumstances warranted further investigation.

The Board appreciates the Committees' insight on this requirement.

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

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

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

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

2017 Board Response: The Board'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 Board strives to provide excellent customer service and efficiency in state government. The Board would like to acknowledge and sincerely thank both the Senate Business, Professions and Economic Development Committee and the Assembly Business and Professions Committee, as well as your staff for your thorough review of the Respiratory Care Board and bringing to light several recommendations that lead to greater efficiency and/or consumer protection.

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