BACKGROUND PAPER FOR THE RESPIRATORY CARE BOARD

(Oversight Hearing, March 19, 2013, Senate Committee on Business, Professions and Economic Development and Assembly Committee on Business, Professions and Consumer Protection)

IDENTIFIED ISSUES, BACKGROUND AND RECOMMENDATIONS REGARDING THE RESPIRATORY CARE BOARD

BRIEF OVERVIEW OF THE RESPIRATORY CARE BOARD

The Respiratory Care Board (Board), originally established as the Respiratory Care Examining Committee, was created by the Legislature in 1982 to protect a vulnerable patient population from the unqualified practice of respiratory care. The nine-member board is responsible for enforcing state laws pertaining to the practice of respiratory care. The board regulates a single category of health care workers – respiratory care practitioners (RCPs). RCPs are specialized health care workers, who work under the supervision of medical directors and are involved in the prevention, diagnosis, treatment, management, and rehabilitation of problems affecting the heart and lungs and other disorders, as well as providing diagnostic, educational, and rehabilitation services. RCPs provide treatments for patients who have breathing difficulties and care for those who are dependent upon life support and cannot breathe on their own. RCPs treat patients with acute and chronic diseases, including Chronic Obstructive Pulmonary Disease (COPD), trauma victims, and surgery patients. They are typically employed in hospitals, however, a growing number of RCPs work in alternative settings like skilled nursing facilities, physician's offices, hyperbaric oxygen therapy facilities and sleep laboratories, to name a few.

The law governing RCPs is a practice act that requires licensure for individuals performing respiratory care. The practice of respiratory care is regulated through licensure in all states except for Alaska.

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

> ***The Respiratory Care Board of California's mission is to protect and serve the consumer by enforcing the Respiratory Care Practice Act and its regulations, expanding the delivery and availability of services, increasing public awareness of respiratory care as a profession and supporting the development and education of all respiratory care practitioners.***

The Board's mandates include:

- Screening applicants for licensure to ensure minimum education and competency standards are met and conducting a thorough criminal background check on each applicant.
- Investigating complaints against licensees as a result of updated criminal history reports and mandatory reporting of violations by licensees and employers.
- Monitoring RCPs placed on probation.
- Taking enforcement actions to penalize or discipline applicants and licensees such as issuing a citation and fine, issuing a public reprimand, placing a licensee on probation (which may include suspension), denying an application for licensure, revoking a license.
- Addressing current issues related to the unlicensed and/or unqualified practice of respiratory care.
- Promoting public awareness of the Board's mandate and function, as well as current issues affecting patient care.

The Board is comprised of nine members; 4 RCPs, 4 public members and one physician. Two public members and one RCP are appointed by the Governor. One public member and two RCPs are appointed by the Speaker of the Assembly. One public member, one RCP and one physician are appointed by the Senate Committee on Rules. Board members receive a $100-a-day per diem. The Board meets about three times per year. All Board meetings are subject to the Bagley-Keene Open Meetings Act. There are currently two vacancies on the Board.

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

Name and Short Bio	Appointment Date	Term Expiration Date	Appointing Authority	Professional or Public
Charles B. Spearman, MSEd, RCP, RRT **President** Mr. Spearman has served on the Board since 2006. He is an Assistant Professor of Respiratory Care Programs at Loma Linda University. Mr. Spearman is also active in a number of professional organizations including the American Association for Respiratory Care (AARC) and the California Society for Respiratory Care. Mr. Spearman has developed and authored numerous respiratory related video presentations and publications and, as acknowledgment of his extensive expertise, has been asked to present on a myriad of specialized respiratory care topics. Mr. Spearman has been the recipient of a number of prestigious scholarships and awards, including his bestowment as a Fellow by the AARC.	06/23/2010	06/01/2014	Senate Committee on Rules	Professional
Mark Goldstein, RRT, RCP **Vice President** Mr. Goldstein has been a senior manager for respiratory and clinical services at Sutter Care at Home, Timberlake Division since 2002. He was a per diem respiratory	06/07/2012	06/01/2015	Governor	Professional

therapist II at University of California, Davis, Sacramento Medical Center from 1994 to 2002, special projects and regional cardiopulmonary quality assurance coordinator at Mercy San Juan Medical Center from 1989 to 2002 and a respiratory therapist for Kaiser Sacramento from 1983 to 1989.				
Murray Olson, RCP, RRT-NPS, RPFT Mr. Olson has been a respiratory therapist since 1988. In addition to his vast experience, Mr. Olson also possesses five years of vocational teaching experience, and currently employs his advanced-level skills in his role as a bedside therapist in the Neonatal Intensive Care Unit at Children's Hospital, in San Diego. Mr. Olson has established respiratory care patient driven protocols and has participated on a host of committees relating to quality assurance and disaster preparedness. He currently participates in Heart Care International, a health care community built entirely of volunteers, whose mission is to aid developing nations in establishing up and running pediatric heart surgery units in host countries.	12/14/2009	06/01/2013	Speaker of the Assembly	Professional
Lupe V. Aguilera Ms. Aguilera worked for the California Department of Corrections and Rehabilitation for 21 years before retiring from her position as senior youth correctional counselor in 2006. She enjoys performing volunteer work within her community and frequently volunteers with the Oakdale Police Department's Senior Outreach Program which is designed to assist the elderly with issues such as health, safety and resources. Ms. Aguilera has served as a board member for the Oakdale Women's Club which hosts fundraisers to benefit other non-profit organizations in the community. She has been a commissioner for the Oakdale Parks and Recreation Department since 2002, and the treasurer for the California Correctional Peace Officers Retired Chapter Board.	12/15/2008	06/01/2012	Governor	Public
Sandra Magaña Cuellar Ms. Magaña earned her Baccalaureate Degree in Communications from UC Berkeley, and a Masters of Arts Degree in Communications Management from the University of Southern California. Ms. Magaña is active in a variety of professional organizations and societies including Women in Cable and Telecommunications, Hispanas Organized for Political Equality, and the UC Berkeley Scholarship Fundraising Committee. Ms. Magaña has lived with asthma for most of her life and was drawn to serving on the RCB in response to her experience with this condition.	07/08/2009	06/01/2013	Senate Committee on Rules	Public
Rebecca Franzoia Mrs. Franzoia served as capitol director for Lieutenant Governor John Garamendi from 2007 to 2009. She worked in a number of positions for the California Department of Insurance from 1991 to 2007, including deputy commissioner of executive operations, chief deputy commissioner, manager of the selections and training unit, training officer and assistant to the	06/07/2012	06/01/2016	Governor	Public

commissioner. Franzoia served on the California Senate Revenue and Taxation Committee as a committee secretary from 1988 to 1990 and a consultant from 1981 to 1986. She was an elementary school teacher at the Tuolumne County School District from 1977 to 1981 and at the Modoc Unified School District from 1974 to 1977.				
Alan Roth, MS MBA RRT-NPS FAARC Mr. Roth has worked in the field of Respiratory Care and Rehabilitation for more than 30 years. He has directed programs from community hospitals to academic medical facilities. He has published more than 30 articles in the field of Respiratory Care and a book chapter on Complex Humanitarian Emergencies. Mr. Roth is service-oriented, representing respiratory care in an international pediatric (congenital) heart team that goes to foreign countries and sets up training programs for the establishment of heart institutes in those countries. Mr. Roth is a member of a Federal Tier 1 Disaster Medical Assistance Team (DMAT CA-6) that was last deployed to Haiti after the 2010 earthquake. He has participated locally in community programs for asthma education and outreach, COPD awareness, and Community Transformational Grants for Smoking Cessation. Mr. Roth has also received several professional and humanitarian related honors.	09/12/2012	06/01/2015	Speaker of the Assembly	Professional
Vacant			Senate Committee on Rules	Physician
Vacant			Speaker of the Assembly	Public

The Board is a special fund agency, with funding from the licensing of RCPs and biennial renewal fees of RCP licenses. The Board currently has 18,869 active and current licensees.

The Board's fees have remained fairly steady. In May 2004, the Board made changes to its fee schedule, including: modifying the $200 Initial License Fee and creating a "prorated" fee based on the number of months an initial license was issued as opposed to a flat amount; increasing the Renewal Fee from $200 to $230; decreasing the Duplicate License Fee from $75 to $25; increasing the Endorsement Fee (which is charged to prepare an official verification of licensure) from $50 to $75 and; eliminating the $100 Transcript Review Fee.

In June 2012, the Board's fee schedule was again modified, including: eliminating the Initial License Fee; increasing the Application Fee from $200 to $300; eliminating the $250 Application Fee for out-of-state and foreign applicants and; decreasing the previously raised Endorsement Fee of $75 to $25. The Board states that these modifications have not significantly impacted revenues but any noted revenue increases are directly related to increases in the number of new applications received combined with a greater number of licensees maintaining their license and renewing, as well as the expansion of the Board's citation and fine program.

Fee Schedule and Revenue										
FEE	Current Fee Amount	Statutory Limit	FY 08/09 Revenue	%	FY 09/10 Revenue	%	FY 10/11 Revenue	%	FY 11/12 Revenue	%
Duplicate License	$25	$75	$2,500	0.1%	$2,475	0.1%	$2,400	0.1%	$2,075	0.1%
Endorsement Fee[1]	$75/($25)	$100	$26,390	1.1%	$23,100	0.9%	$24,975	1.0%	$24,470	0.9%
Initial License Fee[2]	varies/($0)	$300	$117,009	5.1%	$119,328	4.8%	$127,488	5.0%	$115,068	4.3%
Examination Fee	$190	actual cost	$190	0.0%	$0	0.0%	$0	0.0%	$760	0.0%
Re-Examination Fee	$150	actual cost	$0	0.0%	$0	0.0%	$0	0.0%	$0	0.0%
Application Fee[3]	$200/ ($300)	$300	$233,800	10.1%	$256,600	10.4%	$241,800	9.5%	$284,900	10.7%
Application Fee (OOS)	$200/ ($300)	$300	$37,800	1.6%	$31,800	1.3%	$29,400	1.2%	$33,800	1.3%
Application Fee (Foreign)	$250/ ($300)	$350	$400	0.0%	$200	0.0%	$200	0.0%	$0	0.0%
Biennial Renewal Fee	$230	$330	$1,797,985	77.9%	$1,915,310	77.5%	$1,987,767	78.4%	$2,095,565	78.8%
Delinquent Fee (<2 yrs)	$230	$330	$35,881	1.6%	$34,500	1.4%	$30,590	1.2%	$37,030	1.4%
Delinquent Fee (>2 yrs)	$460	$660	$5,060	0.2%	$8,980	0.4%	$9,660	0.4%	$6,900	0.3%
Citation and Fine	varies	$15,000	$30,121	1.3%	$41,863	1.7%	$41,378	1.6%	$28,646	1.1%
Enf. Review Fee	varies	actual cost	$20,193	0.9%	$21,420	0.9%	$22,093	0.9%	$20,291	0.8%
Reinstatement Fee	$200	$300	$800	0.0%	$400	0.0%	$400	0.0%	$800	0.0%
Miscellaneous*	N/A	N/A	$1,181	0.1%	$15,801	0.6%	$15,956	0.6%	$8,509	0.3%
			$2,309,310		$2,471,777		$2,534,107		$2,658,814	

The total revenues anticipated by the Board for Fiscal Year (FY) 2012/13, is $5,052,834 and for FY 2013/14, $4,615,889. The total expenditures anticipated for the Board for FY 2012/13, is $3,153,000, and for FY 2013/14, $3,216,000. The Board anticipates it would have approximately 7.09 months in reserve for FY 2012/13, and 5.22 months in reserve for FY 2013/14.

The Board spends approximately 67 percent of its budget on its enforcement program, 16 percent on its licensing program, 4 to 5 percent on its administration and 12 percent on costs for services provided by the Department of Consumer Affairs (DCA) known as “Pro Rata.” According to the DCA, the Consumer and Client Services Division and the Division of Investigations at the department provide centralized services to all boards and bureaus, including: investigation complaints against licensees; developing valid examinations for applicants for licensure; monitoring and advocating for legislation; providing consumer education and outreach; providing legal and audit services and; and providing general administrative support involving personnel, budgeting, accounting, purchasing, and office space management.

Fund Condition						
(DOLLARS IN THOUSANDS)	FY 08/09 ACTUAL	FY 09/10 ACTUAL	FY 10/11 ACTUAL	FY 11/12 ACTUAL	FY 12/13 PROJECTED	FY 13/14 PROJECTED
Beginning Balance	$1,487,080	$1,789,093	$2,017,407	$2,176,982	$2,363,124	$1,899,834
Adjusted Beginning Balance	$150,258	$58,000	($48,593)	-	-	-
Revenues and Transfers	$2,309,310	$2,471,777	$2,534,107	$2,658,814	$2,689,710	$2,716,055
Total Revenue	$3,946,648	$4,318,870	$4,502,921	$4,835,796	$5,052,834	$4,615,889
Budget Authority	$2,924,844	$2,849,279	$3,040,196	$3,108,981	$3,153,000	$3,216,000
Expenditures	$2,315,867	$2,481,992	$2,507,500	$2,680,172	$3,153,000	$3,216,000
Disbursements[1]	$2,000	$9,000	$7,000	$12,000	-	-
Reimbursements	($160,312)	($189,529)	($188,561)	($219,500)	-	-
Fund Balance	$1,789,093	$2,017,407	$2,176,982	$2,363,124	$1,899,834	$1,399,889
Months in Reserve	7.53	7.96	8.40	8.99	7.09	5.22

Toward the end of FY 2007/08, the Board observed that its estimated reserve balance was near exceeding the six month reserve level. However, it also recognized that its actual expenditures (including reimbursements) and revenues were fairly balanced. In March 2008, at the Board's Strategic Planning session, there was discussion about reducing the license renewal fee. According to the Board, in light of the fact that any reduction to the renewal fee would be a one-time reduction, and would have amounted to no more than $20 per licensee, and the fact that the Board was also planning a large outreach movement which was tied to significant expenditures, it opted to not reduce its renewal fee. Subsequent to that decision, the Board's anticipated large outreach movement, its marketing plan, was interrupted by the Governor's Executive Order to halt all outreach that is not deemed "mission critical," thus the anticipated increased expenditures were never realized.

Additionally, the DCA launch of the Consumer Protection Enforcement Initiative (CPEI) to overhaul the enforcement process of healing arts boards led to an attempted redirection of Board resources. The CPEI is a systematic approach designed to address three specific areas: Legislative Changes, Staffing and Information Technology Resources, and Administrative Improvements. The DCA expects the healing arts boards to reduce the average enforcement completion timeline to between 12 -18 months.

The DCA requested an increase of 106.8 authorized positions and $12,690,000 (special funds) in FY 2010-11 and 138.5 positions and $14,103,000 in FY 2011-12 and ongoing to specified healing arts boards for purposes of funding the CPEI. As part of CPEI, the Board requested, through the Budget Change Proposal Process (BCP) to augment its enforcement staff by three PYs, totaling approximately $283,000 in an attempt to develop processes allowing the Board to assume many of the responsibilities of the Office of the Attorney General for routine pleadings and stipulated decisions. The Board's BCP was denied.

The Board is currently analyzing its fund condition to determine if a fee reduction is warranted due to unscheduled reimbursements and salary reductions that are not reflected in the projections provided to this Committee in the Sunset Report provided by the Board.

The Board has five standing committees.

- **Executive Committee –** Makes interim (between Board meetings) decisions as necessary, including recommendations about legislation and guidance to staff on pending legislation and budgetary guidance to staff in order to fulfill recommendations of legislative oversight committees.

- **Enforcement Committee**: Develops and reviews Board-adopted policies, positions and disciplinary guidelines. Develops policy for the enforcement program.

- **Outreach Committee:** Develops consumer outreach projects, including the Board's newsletter, website, e-government initiatives and outside organization presentations. Members also represent the Board at the invitation of outside organizations and programs.

- **Professional Qualifications Committee**: Reviews and develops regulations regarding educational and professional ethics course requirements for initial licensure and continuing education programs. Monitors various education criteria and requirements for licensure, taking into consideration new developments in technology, managed care, and current activity in the healthcare industry.

- **Disaster Preparedness Committee**: Keeps the Board abreast of issues regarding disaster preparedness and facilitates communication between the Board, respiratory therapists, and public and private agencies on disaster-related matters.

The Board is a member of the American Association for Respiratory Care (AARC), the Council on Licensure, Enforcement, and Regulation (CLEAR), and the Federation of Associations of Regulatory Boards (FARB). The Board's membership in each of these associations does not include voting privileges; however, according to the Board, they all provide valuable resources in connection with enforcement, licensure, exams, or issues specific to respiratory care. The Board has actively participated in the AARC project to identify likely new roles and responsibilities of respiratory therapists in the year 2015 and beyond through attendance and input at conferences.

The Board does not administer its own examination but utilizes National Board for Respiratory Care's (NBRC) "Certified Respiratory Therapist" examination for licensure which is developed, scored, analyzed and administered by the NBRC and its subsidiary, Applied Measurement Professionals, Inc. (AMP). The Board annually verifies that the NBRC meets the requirements for occupational analyses.

Licensing

Since the Board's inception in 1985, it has issued over 33,000 licenses. As of June 30, 2012, the Board had 18,869 active and current licensees and an additional 1,521 delinquent licensees. The Board does not track the number of licensees currently residing out-of-state or out-of-country but determined that as of August 8, 2012, the number of active licensees using an out-of-state address of record is 875 and an out-of-country address of record is 21. The Board has seen an increase over the past 9 years in the

number of applications received, with an average of 700 applications per year in FY 2002/03 to now 1,593 applications received in FY 2011/12. Similarly, in FY 2002-03 approximately 620 licenses were issued and 7,200 licenses were renewed each year, while the Board now issues approximately 1,300 new licenses and about 9,000 already licensed are renewed each year.

Licensee Population					
		FY 08/09	FY 09/10	FY 10/11	FY 11/12
Respiratory Care Practitioner	Active	16,608	17,274	18,177	18,869
	Out-of-State	Not Tracked	Not Tracked	Not Tracked	Not Tracked
	Out-of-Country	Not Tracked	Not Tracked	Not Tracked	Not Tracked
	Delinquent	1,469	1,529	1,481	1,521

The average time to process a complete application from date of receipt to date of licensure is 67 days. A complete application includes all required materials, with the exception of official transcripts and verification of successful completion of the licensing exam. Because the Board allows applicants to apply for licensure 90 days in advance of their graduation, this 67 day time frame includes a waiting period for the majority of applicants to graduate and have their official transcripts submitted, as well as submit proof of exam passage. In most instances, applications and required documentation are reviewed and action is taken by the Board within one to two days of receipt. After reviewing its application process and timelines to determine if greater efficiencies could be achieved, the Board found that significant delays were associated with the waiting periods to receive the licensing fee and for the DCA to cashier the monies before the license could be issued, thus the Board eliminated the initial licensing fee altogether. Now, once an applicant is approved for licensure, the license is issued immediately and as such, the Board states that it expects its average application processing time to be reduced significantly in the coming year.

Total Licensing Data			
	FY 09/10	FY 10/11	FY 11/12
Initial Licensing Data			
Initial License/Initial Exam Applications Received	1,443	1,357	1,593
Initial License/Initial Exam Applications Approved	1,272	1,391	1,313
Initial License/Initial Exam Applications Closed	107	101	88
License Issued	1,272	1,391	1,313
Initial License/Initial Exam Pending Application Date			
Pending Applications (total at close of FY)	602	560	687
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE)			
Average Days to License Issued (All - Complete/Incomplete)	119	83	87

Average Days to License Issued (Incomplete applications)	155	101	106
Average Days to License Issued (Complete applications)	82	65	67
License Renewal Data			
License Renewed	8,327	8,642	9,111

The Board requires certification of application materials to prevent falsification of documents. To ensure authenticity, all required information other than Department of Motor Vehicles (DMV) history must be sent directly to the Board from the respective agency rather than from the applicant. As part of the licensing process, all applicants are required to submit fingerprint cards or utilize the "Live Scan" electronic fingerprinting process in order to obtain prior criminal history criminal record clearance from the California Department of Justice (DOJ) and Federal Bureau of Investigation (FBI). Licenses are not issued until clearance is obtained from both DOJ and FBI background checks. Applicants who have been licensed in other states as RCPs or who have other health care licenses must request that the respective agencies submit verification of license status and any disciplinary actions directly to the Board for verification. The Board also queries the National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank to determine prior disciplinary actions taken against licenses in other states or other health care-related licenses the applicant may possess.

In addition to the above requirements, the Board requires primary source documentation as part of the licensure process, which includes verification that the applicant has successfully completed the licensing examination and verification that the applicant has successfully completed the Board-approved Law and Professional Ethics Course.

An applicant for licensure as a RCP must successfully pass the National Board for Respirator Care's (NBRC) "Certified Respiratory Therapist (CRT)" examination. This test is designed to objectively measure essential knowledge, skills, and abilities required of entry-level respiratory therapists, consisting of 160 multiple-choice questions (140 scored items and 20 pretest items) in the areas of clinical data, equipment, and therapeutic procedures. The NBRC administers up to six different, equivalent versions of the CRT examination on a daily basis and ensures that no candidate is permitted to consecutively repeat an examination form he or she has previously taken. Applicants may apply to take the examination online or via paper application. Upon verification of education requirements, applicants may schedule themselves to sit for the examination at one of 16 locations throughout California. Applicants are given three hours to complete the entry-level examination via computer-based testing, with exceptions made in accordance with the ADA. Once applicants have completed the examination, they will be notified immediately of the results. Those results are then shared with the Board on a weekly basis.

Over the last four years, the pass rates for first time takers of the CRT examination has hovered around 80 percent and is between 24 percent to 32 percent for repeat takers.

There are 36 respiratory care programs in California that are approved by the Board by virtue of their accreditation status. The Board requires applicants to have completed an education program for respiratory care that is accredited by the Committee on Accreditation for Respiratory Care (CoARC). Applicants must also possess 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). Board staff verifies the status of each respiratory care program

one to two times annually to ensure 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 36 programs in the state are accredited by CoARC, 24 are accredited by the Western Association of Schools and Colleges (WASC) and the remaining 12 are accredited by an agency recognized by the USDOE and are approved by BPPE. The CoARC reviews schools annually and performs full-level reviews and site visits once every ten years. The Board regularly communicates with the CoARC and provides input into their review process. In 2007 and 2008, a member of the Board's Education Committee participated as an observer in six of these school site visits/reviews.

The Board does not have any legal requirements regarding approval of international schools. With the exception of Canadian students, all other foreign-educated students can obtain "advanced standing" at most of the respiratory care educational programs in California, where their education and experience is evaluated and they are placed in the program accordingly. Canadian students, who provide evidence of a degree equivalent to that required for all other students and completion of a respiratory care program approved by the Canadian Board of Respiratory Care, qualify for licensure by the Board.

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

In addition, during every other renewal cycle, each active RCP must also complete a Board-approved Law and Professional Ethics Course which may be claimed as three hours of non-clinical CE credit. This course is currently offered by the AARC and the CSRC and is aimed at informing RCPs of the expectations placed upon them as professional practitioners in California. 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.

Enforcement

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 violating the RCPA.

The Board has established performance targets for its enforcement program of: 7 days to complete complaint intake; 210 days from the time the complaint is received until the investigation is completed and; 540 days from the time a complaint is received and the disciplinary decision is ordered. On average, the Board is meeting these targets, however the Board still experiences delays in the average time it takes to complete the process with formal discipline, largely the result of lags in processing times by AG and Office of Administrative Hearings (OAH). Specifically, over the past three years, it has taken the Board an average of 3 days to complete complaint intake, 102 days to complete investigations and 609 days to complete a disciplinary case.

Two-thirds of the Board's formal disciplinary cases result in a stipulated decision. Board staff roughly estimate the time for most of these cases from intake to ordering the final decision, is between one and

one and one-half years to complete. The remaining cases that go to hearing and result in an Administrative Law Judge (ALJ) or Board decision generally take anywhere from 2 to 4-plus years to complete. There are a significant amount of cases (24, nearly one-third of the cases closed in FY 2011-12) that took 2 or more years to adjudicate.

Enforcement					
	FY 09/10	FY 10/11	FY 11/12	Cases Closed	Average %
Attorney General Cases (Average %)					
CLOSED WITHIN:					
0-1 Year	9	11	23	43	20%
1-2 Years	50	35	28	113	53%
2-3 Years	11	16	18	45	21%
3-4 Years	3	2	4	9	4%
Over 4 Years	1	0	2	3	1%
Total Cases Closed	**74**	**64**	**75**	**213**	**100%**
Investigations (Average %)					
CLOSED WITHIN:					
90 Days	368	521	558	1,447	57%
180 Days	242	162	135	539	21%
1 Year	163	95	78	336	13%
2 Years	92	75	41	208	8%
3 Years	11	2	6	19	1%
Over 3 Years	2	1	0	3	0%
Total Cases Closed	**878**	**856**	**818**	**2,552**	**100%**

The overall statistics indicate that the number of disciplinary actions taken since the Board's last review is consistent with the previous Sunset period. However, the Board has noticed significant changes in the numbers of accusations filed, with the average number around 50 per year now as opposed to around 95 per year prior to FY 2004-05, a direct correlation to the Board's implementation of a citation and fine program.

The Board did experience an increase in the number of cases closed in less than a year, from only 9 cases in FY 2009-10 to 23 in FY 2011-12. In FY 2009-10, the Board saw a reduction in time for Accusations to be filed by the OAG, with most being filed within 90 days. In the last three fiscal years, the number of cases closed within 90 days rose from 42 percent to 68 percent and overall, investigations were closed in an average of 170 days in FY 2009-10, down to an average of 102 days in FY 2011-12.

The Board uses a series of guidelines which are intended to help staff determine the priority for handling complaints, guidelines that are in line with the DCA's Complaint Prioritization Guidelines for Health Care Agencies which were established in August 2009. The Board notes that special consideration is given to complaints involving a child, dependent adult or even an animal who was affected or could have been affected by the willful or negligent behavior or incompetence of the

licensee at or away from work, information about which that is typically contained in an arrest or initial report. Within each level, some complaints take higher priority. In addition, at any time during an investigation, if it is found the complaint poses a greater risk or will require additional analytical or investigative work, the complaint is elevated. Media attention may also warrant the expedient handling of a particular complaint.

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

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

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

In 2003, the Board expanded its citation and fine (C&F) program authorizing it to cite and fine for any violation of the RCPA, as opposed to the previous ability for only one violation, practicing with an expired license. The Board's C&F program allows the Board to penalize licensees rather than pursue formal discipline for less serious offenses, or offenses where probation or license revocation are not appropriate. Prior to the expansion of the Board's C&F program, the Board pursued formal disciplinary action for lesser convictions like petty theft, receiving stolen property, trespassing, driving under the influence of alcohol, public intoxication, and some practice related complaints. The Board justified its formal action as necessary to create a public record for possibly use in future disciplinary actions in the event that subsequent convictions occurred, potentially showing a pattern of behavior. Now, as long as there is not a clear pattern of behavior and no child, dependent adult or animal was neglected or involved in any crime, the Board will generally issue a C&F.

In May 2012, the Board approved regulations adjusting fine amounts to the maximum of $5,000. The Board issues an average of 80 citations per year. Seventy-five percent of the fines issued are for $250 and few exceed $1,000. Most of the citations exceeding $1,000 are for acts of unlicensed practice or misrepresentation. According to the Board, there has only been one Administrative Procedures Act appeal since the inception of the C&F program stemming from a record-high fine issued in the amount of $75,000 in FY 2009-10 against a subacute facility for using LVNs to practice respiratory care.

The five most common violations for which citations are issued include:

- Driving under the influence (with no priors)
- "Wet Reckless" driving violation (with no priors)
- Unlicensed practice
- Petty theft
- CE violations

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. Currently, any interested person may either review a summary of all disciplinary action taken since January 2006, with links to actual documents or utilize the Online License Verification component to look up an individual and, if applicable, will be advised of disciplinary action taken with links directly to the documents.

For more detailed information regarding the responsibilities, operation and functions of the Respiratory Care Board, please refer to the Board's "2012-2013 Sunset Oversight Review." This report is available on its Website at http://www.rcb.ca.gov/media_outreach/rcb_sunset_report_12-13.pdf .

PRIOR SUNSET REVIEWS: CHANGES AND IMPROVEMENTS

The Board was last reviewed in 2002 by the Joint Legislative Sunset Review Committee (JLSRC). During the previous sunset review, the JLSRC raised 5 issues. The final recommendations from JLSRC contained a set of recommendations to address those issues. Below are actions which the Board and the Legislature took over the past 10 years to address many of the issues and recommendations made, as well as significant changes to the Board's functions. For those which were not addressed and which may still be of concern to this Committee, they are addressed and more fully discussed under "Current Sunset Review Issues."

In October 2012, the Board submitted its required sunset report to this Committee. In this report, the Board described actions it has taken since its prior review to address the recommendations of JLSRC. According to the Board, the following are some of the more important programmatic and operational changes, enhancements and other important policy decisions or regulatory changes made:

- **Ensuring Consumer Protection Through Licensing and Regulation**. JLSRC was concerned about consumers who receive health care services in their homes and providing assurances that these more vulnerable patients are cared for by quality, safe, skilled providers. With increasing reliance on home health care providers working in the homes of patients without supervision unqualified personnel could be providing respiratory care services. The Committee recommended that the Board study whether regulation was needed for three categories of professionals: home medical device providers; pulmonary function technicians and; polysomnography technicians. The Board reviewed each of these areas and disseminated issue papers on each.

    - *Home Medical Device Retail Facility Providers*: With input from the community and the California Department of Public Health (CDPH), the Board gained authority and promulgated regulations that clearly delineate the services unlicensed personnel may and may not perform.

    - *Pulmonary Function Technicians*: The Board found that simple pulmonary function tests (PFTs) are being performed by unlicensed personnel such as medical assistants in physician offices and some Health Maintenance Organizations (HMOs). The Board attempted to seek legislation to exempt certain tests from being regulated if certain education requirements

were met but was not successful in this effort. The Board is further exploring PFTs in its 2013 strategic plan.

- *Polysomnography Technicians*: Following the completion of the Board's issue paper, it prepared proposed legislation to regulate individuals working in sleep laboratories. In 2007, an unlicensed person practicing polysomnography was arrested for sexual misconduct with several patients, a case that mirrored concerns raised by the Board in its issue paper on this profession. After this incident, the Board began citing and fining persons practicing polysomnography for unlicensed practice, while continuing to seek an Author for its proposed legislation to regulate these individuals. The passage of Senate Bill 132 (Denham, Chapter 635, Statutes of 2009) required unlicensed personnel performing polysomnography to be registered with the Medical Board of California and also required these individuals to meet certain education requirements, successfully pass a competency exam and undergo criminal background checks. RCPs are exempt from having to meet any additional requirements to perform polysomnography.

- **Enforcement Program Improvements**. JLSRC noted that the Board may be too vigorous in its enforcement efforts. In response, the Board promulgated regulations that took effect in May 2003 to revise its Disciplinary Guidelines along with developing a comprehensive Citation and Fine Program. The Board also gained authority through Senate Bill 1955 (Figueroa, Chapter 1150, Statutes of 2002) to allow licensees currently serving on probation to petition for early termination of probation, if the cause for discipline would be addressed differently based on new Board policies and guidelines.

- **Providing Assistance To International Medical Graduates**. JLSRC was concerned that international medical graduates may be qualified for careers as RCPs but may not understand the steps necessary for licensure. The Committee recommended that the Board designate a staff liaison to work with these individuals to more easily facilitate licensure and entry into the profession. The Board designated a liaison who worked with DCA to publicize the Board's plans to accommodate international medical graduates through modifications to the RCPA, specifically allowing educational programs in California to evaluate international graduate applicants and help those people with an advanced standing gain the additional education and/or work experience necessary to successfully perform as an RCP in California.

- **Forward Thinking Emergency and Disaster Response Efforts**. In July 2006, Board staff began meeting with the Office of Emergency Services and the then Department of Health Services (DHS) to assist in the development of the State's response plan. The Board arranged a meeting with seven licensed RCPs and the DHS to assist the DHS in identifying a ventilator for mass purchase in the event of an epidemic. In July 2007, Board staff began meeting with the Emergency Medical Services Authority (EMSA) and providing assistance in getting the word out for various projects aimed at seeking medical volunteers. The Board also established its own Disaster Response Webpage with information about medical volunteer recruitment opportunities, and links to the EMSA and training materials for the stockpiled ventilators that were selected and purchased by the State for use in the event of a pandemic or disaster. In 2008, the Board sponsored legislation to include RCPs in an existing law to provide protection from liability for services rendered during a state of war, state of emergency, or local emergency, that was subsequently enacted in 2009. The Board believes this provision is

extremely important given the need for respiratory therapists to sustain life in emergency situations and stay in keeping with the Board's efforts toward emergency planning.

The Board also recognizes the potential need to expeditiously respond to applications for licensure or licensure verifications for either displaced therapists or volunteers as a result of any catastrophe. In 2005, after the destruction of Hurricane Katrina, Board staff responded expeditiously (issued license verifications immediately, followed up with calls to verify that information was received) to those affected and took additional efforts to assist displaced victims in becoming eligible to work with a work permit immediately.

- **Hospital Tour Awareness Efforts**. In 2006, Board staff began coordinating hospital tours for staff and staff with the Office of the Attorney General (OAG) to enhance familiarization with the respiratory care practice, patients and providers, and offer an in-depth perspective of the day-to-day activities and responsibilities of licensed RCPs. Staff continue to coordinate tours for new public members and other interested parties involved in Board matters.

- **Taking Action Against Unqualified Practice by Licensed Vocational Nurses in Subacute Facilities**. Since 1997, administrators and licensed vocational nurses (LVNs), most predominantly those in subacute facilities, have attempted to have LVNs perform advanced respiratory care. The Board has met with the Board of Vocational Nursing and Psychiatric Technicians (BVNPT) on several occasions to continue expressing its opposition to and concern about LVNs managing patients on a ventilator in any manner due to their lack of training and qualifications. The Board has received complaints related to this unqualified practice and in 2009, the Board cited a facility $75,000 for the use of more than 10 LVNs to perform respiratory care. The citation and fine was appealed and upheld.

- **Approval of Continuing Education Courses**. Since the Board was last reviewed, the regulations surrounding CE have been amended to identify approved providers, identify advanced credentialing examinations that qualify for credit, clarify definitions, and strengthen audit and sanctions for noncompliance.

- **Cost Recovery Expansions**. The Board has employed several mechanisms that have improved collections of costs. Prior to FY 2002-03, the Board collected approximately 33 percent of costs ordered. Since then, the Board now collects approximately 42 percent of costs ordered. The Board began using the Franchise Tax Board Intercept Program in 1996. Beginning in 2002, procedures were in place that ensured costs were tracked and that every case was pursued through this means. Collections from the Intercept Program account for $8,000 to $20,000 collected each year. The Board also has the authority to withhold a renewal for a licensee's failure to pay probation monitoring costs, once they are off probation, an effort that the Board states is quite effective in collecting costs from individuals that continue to hold a license. In 2003, the Board developed its own Cost Recovery Database to track all fines, cost recovery, and probation monitoring costs ordered. This system generates regular invoices that are printed weekly. The Board noticed a sharp increase in payments, especially more timely payments, as a result of this more frequent invoicing. Also in 2003, the Board entered into a contract with a collection agency to assist in collecting outstanding costs. The Board remains careful to only use this option when all other avenues have been exhausted due to the percentage from a collection the agency received, but since FY 2003-04, using the collection agency has allowed the Board to collect nearly $200,000.

- **Meeting Outreach Goals Despite Limitations**. Certain expenditures for the Board marketing and outreach are prohibited due to Executive Orders issued by the Governor. However, since it was last reviewed, the Board was able to launch some of its key strategies surrounding public information about RCP opportunities and a potential workforce shortage through other means, absent the ability to formally expend resources for outreach. Specifically, the Board has worked to bring awareness of the profession and career opportunities in the field to prospective students and the public through its Inspire Campaign using cost effective, informal mediums such as: Facebook and You Tube; providing practicing RCPs brochures to share with prospective students (the Board believes that referral by or relationship to a licensed RCP accounts for about one-third of new applications); providing a DVD and brochures to counseling centers at public high schools, health-related vocational schools, public community colleges and four-year colleges in California; notifying professional societies about the Board's efforts and working to encourage scholarship development and; making a separate page on the Board's Website for careers in the field with supporting materials.

- **Increased Utilization of the Internet and Computer Technology to Provide Services**. In 2001, the Board began using its Website as a tool to provide an array of information and forms to its stakeholders. Since that time the number of visits on the Website has climbed from 27,000 to over 204,000 hits per year. The Board posts meeting dates and locations, agendas and related materials, meeting minutes, language for proposed regulations, topics of interest to current and potential licensees, outreach events (when possible, although currently this feature is inactive due to previously mentioned executive prohibitions), newsletters and also strategic plans. In 2004, the Board established an option for people to subscribe to interested party emails.

  The Board's Website also features summary information on all accusations, statements of issues, and decisions that have been filed against licensees with the following documents available once they are final or a judge has issued an order:

  - Citations, fines, and orders of abatement
  - Interim Suspension Orders (ISOs)
  - Suspensions and Restrictions

  In 2007, the Board was the first at the DCA to link the actual pdf records directly to individual records through the Online License Verification (OLV)component for any person who had disciplinary action as of January 1, 2006. Currently, citations, fines and orders of abatement are reflected via the Board's OLV system; however, actual links to those records are not yet available. In 2009, the Board added respiratory programs' CRT exam pass and fail rates to the Board's Website to assist prospective students with making an informed decision when selecting a respiratory care program.

CURRENT SUNSET REVIEW ISSUES

The following are unresolved issues pertaining to the Board, or those which were not previously addressed by the Committee, and other areas of concern for this Committee to consider along with background information concerning the particular issue. There are also recommendations by the Senate Business, Professions and Economic Development Committee staff which have been made regarding particular issues or problem areas which need to be addressed. The Board and other interested parties, including the professions, have been provided with this Background Paper and can respond to the issues presented and the recommendations of staff.

BOARD ADMINISTRATION ISSUES

ISSUE #1 : (IMPLEMENTATION OF BreEZe.) The Board states that all of the features and tracking mechanisms in its current multiple databases and spreadsheets are expected to be included in the new BreEZe system. The Board is included in the first phase of the rollout which was set to take place in early 2013. What is the status of The BreEZe Project?

Background: The DCA is in the process of establishing a new integrated licensing and enforcement system, BreEZe, which would also allow for licensure and renewal via the internet. BreEZe will replace the existing outdated legacy systems and multiple "work around" systems with an integrated solution based on updated technology. The goal is for BreEZe to provide all the DCA organizations with a solution for all applicant tracking, licensing, renewal, enforcement, monitoring, cashiering, and data management capabilities. In addition to meeting these core DCA business requirements, BreEZe will improve the DCA's service to the public and connect all license types for an individual licensee. BreEZe will be web-enabled, allowing licensees to complete applications, renewals, and process payments through the Internet. The public will also be able to file complaints, access complaint status, and check licensee information. The BreEZe solution will be maintained at a three-tier State Data Center in alignment with current State IT policy.

In November of 2009, the DCA received approval of the BreEZe Feasibility Study Report (FSR), which thoroughly documented the existing technical shortcomings at the DCA, and how the BreEZe solution would support the achievement of the DCA's various business objectives. The January 2010 Governor's Budget and subsequent Budget Act included funding to support the BreEZe Project based on the project cost estimates presented in the FSR.

Currently, the Board uses a separate Cost Recovery Database, Probation Monitoring Database and complex spreadsheets to track caseloads. The Cost Recovery database also provides for automated invoicing of outstanding cost recovery, monthly probation monitoring fees, and fines as a result of citations issued. The Board is unique as one of the few at DCA with an online license renewal application option. According to the Board, almost 30 percent of licensees currently use this option to renew their license and it is believed that the implementation of BreEZe will further increase the number of licensees who do this; however, it is unclear when BreEZe will ultimately become operational and it remains to be seen if the Board's current needs will be met by the system's design and functions which were crafted a number of years ago.

Staff Recommendation: ***The Board should provide an update of anticipated timelines, existing impediments and the current status of BreEZe.***

LICENSING AND ENFORCEMENT ISSUES

ISSUE #2 : (SCHOOL APPROVALS.) What is the Board's role in approving schools and RCP programs in the state? How does the Board work with the Bureau for Private Postsecondary Education to ensure student protections?

Background: The Board plays an important role in ensuring the educational quality of RCP programs in California. There are currently 36 respiratory care programs in California that are approved by the Board by virtue of their accreditation status. Pursuant to the BPC §3740, the Board requires prospective licensees to complete an education program for respiratory care that is accredited by the Committee on Accreditation for Respiratory Care (CoARC) and requires that prospective licensees possess at least 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). According to the Board, CoARC accredits degree-granting programs in respiratory care that have undergone a rigorous process of voluntary peer review and have met or exceeded the minimum accreditation standards as set by the professional association in cooperation with CoARC. The CoARC reviews schools annually and performs full-level reviews and site visits once every ten years. The Board regularly communicates with the CoARC and provides input into their review process.

The Board reports that staff verify the accreditation status of each respiratory care program one to two times annually as a means of ensuring that programs hold valid accreditation. Over the years, the Board has performed detailed audits of all education programs' transcripts and catalogs and has received a handful of complaints from students. According to the Board, the overwhelming majority of student complaints were from those attending programs at an institution that is not accredited by the Western Association of Schools and Colleges (WASC); one of six *regional* accrediting agencies recognized by USDOE.

The issue of what appropriate role the Board should play in school and program approval was also raised by JLSRC during the last Sunset Review of the Board. At the time, the Board was concerned with significant inconsistencies in the transcripts of many licensees that could impact the individual's ability to safely interact with patients as a RCP so the Board promulgated regulations to alter educational requirements of licensees. JLSRC noted that the Board may not have had the statutory authority for such clarifications and recommended that a number of changes be made through legislation, the result of which was Senate Bill 1955 (Figueroa, Chapter 1150, Statutes of 2002) which: created the current requirements for licensees to possess an associate degree; gave the Board certain authorities to waive educational requirements deemed as roadblocks to reciprocity; provided a pathway to license foreign-educated applicants, and repealed the Board's authority to approve schools.

There have been serious problems in the past with the approval and oversight of private degree granting and non-degree granting (career and vocational) schools by the state agencies charged with regulation. After numerous legislative attempts to remedy the laws and structure governing regulation of private postsecondary institutions, AB 48 (Portantino, Chapter 310, Statutes of 2009) took effect on January 1, 2010, to make many substantive changes that both created a new, solid foundation for oversight and responded to the major problems with prior law. The California Private Postsecondary

Education Act (The Act) requires all *unaccredited* colleges in California to be approved by the new Bureau for Private Postsecondary Education (Bureau), and all *nationally accredited* colleges to comply with numerous student protections. It also establishes prohibitions on false advertising and inappropriate recruiting. The Act requires disclosure of critical information to students such as program outlines, graduation and job placement rates, and license examination information, and ensures colleges justify those figures. The Act also guarantees students can complete their educational objectives if their institution closes its doors, and, most importantly, it gives the Bureau an array of enforcement tools to ensure colleges comply with the law.

Prior to the enactment of AB 48, California was without a regulatory body for private postsecondary institutions after the previous Bureau for Private Postsecondary Vocational Education (BPPVE) ceased to exist as of July 2008, leaving approximately 1,500 private postsecondary institutions to operate in California without state oversight. During the sunset of the former BPPVE, many Boards, including the Respiratory Care Board, took on a more direct role in institutional approval. The Board reports that it began reviewing school transcripts in more detail in attempt to reconcile records from licensees indicating completion of certain courses that did not necessarily match course listings in the institutions' course catalogs. This resulted in the delay of licensing for several applicants, as the Board was concerned about the quality of those licensees' training and needed to ensure that they had in fact taken the proper courses to effectively, safely work as a licensed RCP. The Board forwarded its findings to CoARC which acknowledged that it would take the Board's findings into consideration during one specific institution's next review. The Board did not, however, have either the staff capacity nor statutory authority to further investigate institutions to determine if greater deficiencies existed.

A number of boards within the DCA also have a role in overseeing educational *programs* attended by licensees but do not have express authority to approve *institutions* offering these programs. While some boards are required to review the curriculum and sometimes even the institutions offering programs, others require Bureau approval in order to meet educational requirements for licensure, certification or registration. The Board of Barbering and Cosmetology (BBC) for example, approves curriculum, facilities, equipment and textbooks for schools offering training programs for eventual licensees. The Board of Vocational Nursing and Psychiatric Technicians (BVNPT) staff grants approval Vocational Nursing and Psychiatric Technician *programs* but does not have oversight of *institutions* offering these programs. The Board of Registered Nursing (BRN) approves all nursing school *programs* in the state.

Given the expertise of the Board staff in the educational and training requirements for an RCP to safely interact with patients, it may be appropriate for the Board to have approval over RCP programs offered in California. Similarly, it may be appropriate for the Board to have the ability to remove its approval of programs that do not meet the educational quality standards necessary for an individual to learn how to be a safe, effective RCP. It may also be appropriate for the Board to enter into an MOU with the Bureau to ensure coordinated oversight of RCP programs, without resulting in unnecessary duplication or dual oversight.

Staff Recommendation: ***The Board should comment on its ability to approve RCP programs with its current resources and staff that have RCP subject matter expertise. The Board should comment on its satisfaction with CoARC approval. The Board should advise the Committee on whether it would be appropriate to provide the Board with additional authority to oversee schools. The Board should provide the Committee with an update on its current working relationship with the Bureau.***

ISSUE #3 : (AUDIT OF CONTINUING EDUCATION UNITS.) Is the Board effectively determining that licensees complete mandatory continuing education (CE)?

Background: Upon renewing an RCP license, active RCPs must attest, under penalty of perjury, that they have completed 15 hours of the required CE. In 2004, the Board targeted five to eight percent of its renewals to audit and determine appropriate completion of reported CE. Records submitted by the licensee are reviewed to determine if all the required information is present. The Board's auditor will also verify many of the records received with the actual provider to verify authenticity. 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 (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. Cases where 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.

In 2009, the Board halted its CE audit program in order to redirect resources needed to respond to numerous drills presented by the Administration at that time, as well as the CPEI. The Board states that in 2011, it resumed performing CE audits and is on track to audit 5 percent of its licensees in FY 2012-13.

CE Audits Performed/Failed					
	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12
Renewals Audited	598	315	0	0	213
Failed	54	18	0	0	7

Staff Recommendation: ***The Board should report on any consequences arising from a lack of CE audits during a two year period. The Board should report on whether it has the staffing necessary for these important evaluations.***

ISSUE #4 : (SUBSTANCE ABUSE RECOVERY.) Have Uniform Standards been adopted?

Background: In an attempt to provide health care boards with consistent standards in dealing with substance-abusing licensees, the DCA was mandated by legislation (SB 1441 (Ridley-Thomas) Chapter 548, Statutes of 2008) to put forth "Uniform Standards Regarding Substance-Abusing Healing Arts Licensees" (Uniform Standards). The Board reports that its Uniform Standards were adopted in April 2011.

According to the Board, one of the caveats in developing the standard for drug testing frequency of licensees who have been placed on probation was to require data collection as a means of better determining if the higher frequency and standards were effective. A computer generated model identifying the mean average days to a positive urine test considering the frequency of drug use versus

the frequency of urine testing was referenced when developing this standard. As stated in the Board's rationale for its regulation:

> "In principal, testing a licensee an average of two times per week sounds like a sound practice to detect alcohol/drug use. However, the number of days substance use is detected in the more chronic user (and therefore, in most scenarios, the greater the risk) varies much less, regardless of the frequency of testing. One could make the argument that this is evidence for more frequent testing. However, given consideration to the risk factor of a person who uses once a month or less, the importance of "randomness" in testing, and the need to find a reasonable and pragmatic approach, this solution would appear to be implausible."

The adoption of these standards resulted in an increase in the number of times probationers were tested for banned substances.

Random Testing Schedule	Random Tests Per Year per Probationer
Prior to 2009	6-8
2009 - February 2011	12-16
March 2011 - June 2011	24
July 2011 - Present (First Year of Probation)	52-104
July 2011 - Present (Second Year-plus of Probation)	36-104

Extended Probation Data			
	FY 09/10	FY 10/11	FY 11/12
New Probationers	41	30	39
Probations Successfully Completed	30	23	22
Probationers (close of FY)	105	92	98
Petitions to Revoke Probation	21	9	10
Probations Revoked	15	7	6
Probations Surrendered in Lieu of Disc Action	6	6	1
Probations Voluntary Surrendered	**0**	**2**	**4**
Probations Extended	1	1	2
Probationers Subject to Drug Testing (entire FY)	115	97	96
OVERALL DRUG TESTS ORDERED/POSITIVE TESTS			
Drug Tests Ordered	1,153	1,325	2,368
Positive Drug Tests	115	101	216
Number of Probationers Testing Positive	30	26	30
POSITIVE DRUG TESTS FOR BANNED SUBSTANCES			
Positive Drug Tests	5	5	4
Number of Probationers w/Positive Drug Tests	5	3	4

According to the Board, the number of tests ordered has more than doubled and positive test results have nearly doubled. However, closer examination of this data reveals that the number of probationers who tested positive remained unchanged from FY 2009-10 to FY 2011-12. Since the Board implemented more frequent testing, it reports that six probationers have voluntarily surrendered their license. Four of these surrenders were a direct result of the increase in testing with probationers stating to the Board they could not afford all the costs associated with probation (for example, Cost Recovery, Monthly Probation Monitoring Costs and Drug Testing Costs), specifically citing the costs for drug testing that could be as much as $3,500 to $7,000 the first year of probation.

Effective July 1, 2012, the Board gained authority to issue cease practice notices to probationers for major violations of probation. New data collected in connection with these notices, coupled with additional drug testing data, may allow the Board to evaluate its program more effectively.

Staff Recommendation: ***The Board should update the Committee on the implementation of the "Uniform Substance Abuse Standards" and whether more frequent testing is an appropriate mechanism for monitoring probationers who abuse substances. The Board should also address whether it believes the Uniform Standards are providing the intended consumer protections, for example is increased testing resulting in desired outcomes.***

ISSUE #5: (DIFFICULTY OBTAINING RECORDS FROM LOCAL LAW ENFORCEMENT.) The Board, as well as other boards at DCA, is having problems obtaining important records from local government agencies pertaining to its licensees. What type of information is the Board having difficulty accessing? How does this potential inability to access records, such as arrest documents, impede the Board's enforcement efforts?

Background: It is customary for most boards and bureaus to obtain complete arrest, conviction and other related documentation as part of an applicant' or licensee investigation. As such, boards rely on various authorities and local law enforcement agencies to provide documentation. Lately the Board, as well as others at the DCA, have been refused access to records, with local government agencies justifying this refusal based on the Board's perceived lack of authorization to obtain records without approval by the individual in question. This situation causes delays in investigations and can even potentially prevent the Board from taking appropriate disciplinary action.

The Board states that it is crucial to its consumer safety mission to be able to access all arrest, court and other related documentation through the course of an applicant or licensee investigation. The Board believes that requiring an authorization to release such information impedes the ability of licensing entities to efficiently take appropriate disciplinary action or thoroughly investigate applicants.

The Board cites a recent example where a local agency required Board staff to obtain authorization from the licensee for the Board to access the information. In that case, the Board ended up getting the records from the district attorney. The Board also states that it has had issues with some local agencies requiring a fee from the Board prior to their releasing of records which also slows down the process. In one situation, a local government agency provided the following language to the Board when it refused to produce records:

> **The arrest record(s) cannot be released pursuant to Section 432.7(g)(1) of the Labor Code which reads that** "no peace officer or employee of a law enforcement agency with access to

criminal offender record information maintained by a local law enforcement criminal justice agency shall knowingly disclose, with intent to ***affect a person's employment, any information contained therein pertaining to an arrest or detention or proceeding that did not result in a conviction***, including information pertaining to a referral to, and participation in, any pretrial or post trial diversion program, to any person not authorized by law to receive that information."

Staff Recommendation: ***Section 144.5. should be added to the Business and Professions Code as follows:***

Notwithstanding any other provision of law, a board described in Section 144 is authorized to receive certified records from a local or state agency of all arrests and convictions, certified records regarding probation, and any and all other related documentation needed to complete an applicant or licensee investigation. The local or state agency is authorized to provide those records to the board upon receipt of such a request.

ISSUE #6: (CURRENT STAFFING LEVELS CAN BE INCREASED TO BETTER MEET GOALS.) The Board's fund condition shows a healthy reserve, the monies of which may need to be spent to prevent the Board from having to pursue a fee decrease or fee suspension. Boards like the Respiratory Care Board have been discouraged from submitting budget change proposals (BCPs) and those that are submitted have typically been denied. What are the Board's current staffing needs to effectively serve consumers and maintain a robust, timely licensing and enforcement program?

Background: While the Board reports continuity in its staff (14 of the current 18 staff members were employed at the Board during its last Sunset Review), it reports that the past few years have been challenging related to staffing. Board efforts to increase staffing, particularly staff hiring for its enforcement program to meet timelines and efficiency goals, have been denied due to budget cuts and staff reduction mandates. The most recent administrative requirement to reduce staff resulted in the loss of one of the two special investigator positions the Board was able to gain, as well as a number of other positions. While that special investigator position was vacant, the Board believes it was necessary to retain the position within the Board staff structure in the event that the Board ever lost a highly experienced staff member working as a retired annuitant. The Board states that if the retired annuitant leaves, the Board will be severely understaffed until a Budget Change Proposal (BCP) is approved allowing for the creation of new positions. The Board reports that it was also advised that if the individual currently working full-time in an Office Assistant position were to leave, the Board could only replace such a vacancy on a part-time basis. Coupled with additional budget reductions, the Board believes that its effective operations would be crippled, particularly considering the lengthy process it takes to acquire new positions and hire to fill those.

As previously stated, in keeping with DCA CPEI efforts, the Board requested, through the BCP, to augment its enforcement staff by three PYs, totaling approximately $283,000 in attempt to develop processes allowing the Board to assume many of the responsibilities of the Office of the Attorney General for routine pleadings and stipulated decisions. The Board's BCP was denied.

Currently, it takes an average of 3 to 4 months (90 to 120 days) from the time of the Board's request, to the time the OAG files an Accusation. Board staff estimate that most stipulations take 6 to 8 months (180 to 240 days) to produce (from the date after the Accusation is filed to the date the stipulation is

ready for mail vote by the Board). The Board reports that over the last 2 years, Default Decisions are taking months, rather than weeks, to produce.

The Board is not alone in its problems related to its lengthy disciplinary process; all other health boards under the DCA are affected as well. Complaints often take a circuitous route through several clogged bureaucracies; from the health care boards for initial assessment to the DOI of the DCA for investigation, to the AG's Office for filing of an accusation and prosecution, to the State Office of Administrative Hearings (OAH) for a disciplinary hearing. Lastly, the case goes back to the Board for a final decision. On August 17, 2009, this Committee held an informational hearing entitled, *"Creating a Seamless Enforcement Program for Consumer Boards."* The hearing revealed that the biggest bottleneck occurs at the investigation and prosecution stages of the process, as the DOI investigators and the AG's Office prosecutors struggle to handle complaints against a variety of health care practitioners, as well as those against cosmetologists, accountants, engineers, shorthand reporters, funeral directors, private investigators and others. Some of the reasons given for delays of almost three years in the investigation and prosecution of cases by boards are as follows:

- The DOI has high caseloads and lacks adequate staffing.
- Lack of management and prioritization of cases by DOI and training and specialization of investigators.
- Inability to obtain important medical records and other documents in a timely manner
- Delay in obtaining needed outside expert or consultant evaluations of complaints
- Lack of communication and coordination with the client board by the DOI and the AG in its handling of cases.
- Lack of accountability, such as reporting of performance measures both for the DOI and the AG's Office
- Complicated budgeting mechanism for use of the DOI and the AG's Office services.
- The Deputy AGs within its Licensing Section handle both licensing and health care cases in a similar fashion without any expertise devoted to the prosecution of those cases involving serious health care quality issues.

The most significant delay in the Board's enforcement process is associated with those cases that must go to hearing. Many of these cases are the most complex, requiring witnesses, expert testimony and mounds of evidence. According to the Board, hearings take anywhere from six to 12 months to even get scheduled with the OAH. Once the hearing is scheduled, there are several variables that may delay the hearing further such as the respondent's request or scheduling witnesses. The Board acknowledges that it does not have control over this piece of the process but Board staff does expend a great deal of resources to coordinate witnesses, demonstrations and evidence to ensure that any delays are not caused by the Board.

Given additional resources, the Board believes that it could assume some of the responsibilities currently held by the OAG. The Board believes it could assist the OAG in producing routine Accusations and Stipulations in half the time. The Board is clearly frustrated by its lack of ability to obtain additional staff.

Recommendation: ***The Board should state its current staffing needs and how additional positions could help the Board reduce licensing and enforcement timelines.***

ISSUE #7: (PROTRACTED PROCESS TO SUSPEND LICENSE OF RCP.) The Board must go through a cumbersome process to suspend the license of a RCP who may pose an immediate threat to patients or who have committed a serious crime and may even be incarcerated. What are the Board's proposed efforts to reduce ISO timelines?

Background: Currently in California, even if a health care provider is thought to be a serious risk to the public, the boards must go through a cumbersome legal process to get permission to stop the provider from practicing, even temporarily. As pointed out by an article in the *Los Angeles Times* about nurses and disciplinary action, the Board of Registered Nursing was found to have only obtained immediate suspension of nurses 29 times within a 5 year time period, while Florida, which oversees 40 percent fewer nurses, was able to takes suspension action more than 70 times per year. Under existing law, the Interim Suspension Order (ISO) process (BPC §494) provides boards with an avenue for expedited suspension of a license when action must be taken swiftly to protect public health, safety, or welfare. However, the ISO process currently takes weeks to months to achieve, allowing licensees who pose a serious risk to the public to continue to practice for an unacceptable amount of time.

For several years, the Board has pursued avenues that would allow it to immediately suspend a license upon learning of an arrest related to sexual misconduct or serious bodily harm. The existing pathways to achieve suspension have a number of caveats that can allow a licensee to continue to practice for weeks, months, sometimes years, placing the public at serious risk. Given that many respiratory care patients are vulnerable, including children, dependent adults, and the elderly, the Board states that it is committed to finding a means to better protect this population and adhere to its consumer protection mandate.

Obtaining an ISO through OAH can occur in as little as 24 hours to three weeks, from the date the OAG requests the exparte or standard hearing. In accordance with the Board's ISO Policy, it aggressively pursues an immediate suspension and grounds to provide public notice for any of the following scenarios involving a licensed RCP:

- Under the influence of drugs or alcohol while at work.
- Charged with Driving Under the Influence on the way directly to a work shift.
- Allegations of engaging in a lewd act, sexual misconduct, or sexual assault involving a child, patient or unconsenting adult.
- Allegations of engaging in or attempting to engage in murder, rape, or other violent assault.

The Board currently follows a process when a RCP has been arrested for an egregious crime which the Board believes poses an immediate threat to the public. Initially, the Board receives a complaint, typically notification from a rap sheet or media report within one to five days of the arrest in these situations. Staff then verifies the arrest by contacting the arresting agency for verbal verification of the arrest and also requests certified copies of the arrest. The Board states that it typically receives an uncertified copy of the arrest report within 24 hours and a certified copy within two to ten days. The Board then contacts the appropriate supervising deputy attorney general (DAG) to begin steps to pursue a suspension, either through the Administrative Procedures Act (the ISO) or through the criminal justice system (Penal Code 23). The DAG assists in obtaining certified copies of the arrest report if necessary and also makes contact with the local district attorney who will prosecute the case criminally. The Board typically pursues a suspension through the criminal justice system (Penal Code

23) which usually obtained in six weeks to three months; however some cases can take as long as two years. Once a suspension is ordered, public notification is made.

The Board states that it prefers to obtain a PC 23 suspension because these can be ordered more quickly than the above process to obtain an ISO but that barriers have arisen to this type of suspension as well. Prior to "*Gray v. Superior Court of Napa County/Medical Board of California*," filed on January 5, 2005, the Board's counsel could appear at an arraignment (with or without notice to the defendant) and request the suspension based on the charges. The Board notes that this case changed the process by now requiring "reasonable notice" to the defendant as well as an evidentiary showing that failure to take such action would result in serious injury to the public. The case cited that the mere fact that charges were filed was not sufficient to show serious injury to the public.

The delay in obtaining suspensions can mean that licensed RCPs who are arrested or convicted for malicious and egregious crimes such as lewd and lascivious acts against a child under 14, possession of child pornography, and attempted murder, to name a few, are permitted to continue practicing while waiting for their case to be adjudicated. In most cases, the Board has found that those RCPs who have been arrested for malicious and egregious crimes can continue to work for weeks, months, even years, all the while with no public notice, placing the public health, welfare, and safety at immediate and significant risk. The Board is concerned that the current processes to obtain a suspension prevents early public disclosure and includes several barriers to secure a suspension swiftly.

The Board is also concerned that it lacks authority to make public disclosure of any arrests until such time as a formal legal pleading such as an accusation or a suspension (either an ISO or PC 23 suspension) order is filed wherein those details are provided. According to the Board, unless the subject is arrested at work or the media provides coverage, the public and employers do not have any knowledge of an arrest. As part of its investigation, the Board requests employer documentation (usually within two days from learning of the arrest). However, it is not authorized to divulge the basis for the request, based on legal advice and concerns for allegations of harassment that could ultimately thwart efforts for discipline.

The Board has seen examples of swift action such as a DAG visiting the licensee and obtaining a stipulation to suspend that person's license on the same day the Board learned of the arrest. However, the Board has also been frustrated by scenarios like one in which a licensee was alleged to have engaged in lewd conduct with a child under 14 and it took two years to make a public record through the filing of an Accusation. The Board is concerned that the same RCP continues to practice today because the victim would not come forward after the initial arrest was made and charges were reduced, resulting in a potential inability for the Board to obtain a conviction against the licensee. Criminal prosecution of licensees can take months or even years, to adjudicate, which in turn affects the Board's ability to discipline the license. The barriers present in securing an order of suspension, directly correlate, to delays in making public notice.

The Board states that it has given consideration to due process rights weighted against the potential severity for grossly negligent or malicious and potential harm to patients and believes that it should have the authority to do all of the following:

- Swiftly secure an order containing suspension.
- Provide public notice and ensure employers are informed of allegations within 24 hours.

- Substantially relate "acts" (not just convictions) for all egregious crimes and sexual misconduct violations.
- Substantially relate any crime against a child, dependent adult, or the elderly.
- Expand the definition of "unprofessional conduct" to include inappropriate behavior in a care setting

Staff Recommendation: ***The Board should seek to extend the timeframe placed on the AG to file an accusation. This will allow the AG to utilize the ISO process without being subject to the currently limited timeframe.***

ISSUE #8 : (LACK OF CLARITY IN DEFINITION OF UNPROFESSIONAL CONDUCT MAY DELAY ENFORCEMENT.) The Board is concerned that a lack of definition for unprofessional conduct in the RCPA may be impacting its ability to take necessary action against RCPs.

Background: According to the Board, there are potential roadblocks within the RCPA that prevent administrative suspension or discipline for egregious criminal offenses committed by RCPs. The Board states that many DAGs believe the Board's existing law does not allow it to pursue administrative suspension or discipline for some sexually related crimes, or even in a case where the RCP was arrested for attempted murder, unless there is a conviction. In these cases, the DAG would only pursue administrative discipline such as an ISO upon a conviction. BPC §§ 3752.5 and 3752.6 delineate sexual misconduct and attempted bodily injury as substantially related to the practice but the Board can only take action for: conviction of a crime (BPC §3750(d)); a corrupt act (BPC §3750(j)) or; unprofessional conduct (BPC §3755). The Board has found that DAGs are often reluctant to take action solely based on "a corrupt act;" for example, because the language is too broad.

The Board believes that it is necessary to amend the RCPA to allow for timely enforcement. Specifically, the Board proposes:

- Amending the BPC §3750 to add that "Commission of any crime substantially related to the qualifications, functions, duties or practice of an RCP or the respiratory care practice" and "Commission of any act in violation of any provision of Division 2" are grounds to deny, suspend, revoke or impose probationary terms and conditions upon a license.
- Add the BPC §3752.3 to make the commission of a crime involving a minor, any person under 18 years of age, substantially related to the qualifications, functions or duties of an RCP.
- Add the BPC §3752.4 to make the commission of a crime involving an elder, any person 65 years of age or older, or dependent adult, as described in Section 368 of the Penal Code, substantially related to the qualifications, functions, or duties of an RCP.
- Amend the BPC §3752.7 to provide clarity of sexually related crimes that are grounds for revocation.
- Amend the BPC §3755 to include inappropriate behavior, including but not limited to, verbally or physically abusive behavior, sexual harassment, or any other behavior that is inappropriate for any care setting, as unprofessional conduct
- Add the BPC §3769.7 to authorize the Board to publicly disclose any criminal arrest for a period of up to 60 days after the matter has been adjudicated and all appeals have been exhausted or the time to appeal has elapsed.

Staff Recommendation: ***The Board should consider pursuing legislation that will help clarify the definition of unprofessional conduct and specify the Board's ability to follow through with administrative suspension and discipline.***

RESPIRATORY CARE PRACTITIONER WORKFORCE ISSUES

ISSUE #9: (INCREASED DEMAND FOR RCPs WITH AFFORDABLE CARE ACT IMPLEMENTATION AND AGING CALIFORNIANS NEEDING RESPIRATORY SERVICES.) How will the Board meet increased demand for RCPs? What trends has the Board noticed in its licensing numbers? Is the Board prepared for an increase in the potential number of applicants and licensees?

Background: According to numerous recent studies and media reports, statewide shortages of health care providers currently exist in several major health professions. Additionally, health care workforce needs are projected to increase dramatically due to population aging, growth, and diversity. Compounding this issue is the implementation of the federal Affordable Care Act (ACA) in 2014 which is projected to make about 4.7 million new Californians eligible for health insurance, thus bringing many new patients into the healthcare system. At the heart of an increased need for health care services are "allied health professions" which include clinical laboratory scientists, radiological technologists, pharmacy technicians, and respiratory therapists, among others. Respiratory therapy services are specifically mentioned by the U.S. Bureau of Labor Statistics as being in greater demand due to growths in the middle-aged and elderly populations. Older Americans suffer most from respiratory ailments and cardiopulmonary diseases such as pneumonia, chronic bronchitis, emphysema, and heart disease. As the numbers of older Americans increase, the need for respiratory therapists will also increase. The Board also notes that advances in treating victims of heart attacks, accident victims, and premature infants, many of whom are dependent on a ventilator during part of their treatment will increase the demand for advanced respiratory care services.

In 2006, the Board contracted with the Institute for Social Research at the California State University, Sacramento to conduct a study to determine the current dynamics of the respiratory care profession. The study documented current workforce trends, future workforce needs and demographic and economic data. The notes in this study are a key resource to the Board and has been instrumental in assisting the Board in decisions related to the RCP workforce, consumer needs, as well as assisting the Office of Statewide Health Planning and Development in establishing its own data collection systems for all health care workers.

The Board's study found "the potential for a 'perfect storm' scenario driven by a constellation of factors that [would] create serious shortages of RCPs available to meet the needs of the California population in the coming decades." Specifically, the age distribution of the current RCP workforce suggested a large group about to leave the workforce through retirement. The study also indicated that a significant portion of individuals in education programs and close to entering the RCP profession is comprised of older individuals returning to school and may result in shorter career spans for these new licensees.

Following the release of the Workforce Study in 2007, the Board developed its own Marketing Plan aimed primarily at increasing the number of licensed RCPs and bringing awareness to the value of

professional, licensed RCPs. The plan included a background, goals, target audiences, key messages, strategies and tactics, performance measures, and budgetary requirements.

Staff Recommendation: ***The Board should explain what additional efforts it can take or models it can follow to increase the RCP workforce and ensure participation of its licensees in the state's health care delivery system.***

RESPIRATORY CARE RELATED STATUTORY IMPLEMENTATION EFFORTS

ISSUE #10: (REGULATION OF POLYSOMNOGRAPHY TECHNICIANS.) The Board took efforts over a number of years to license technicians working in sleep laboratories. What is the Board's impression of regulation by the Medical Board of California of polysomnography technicians? Does the Board still get complaints about these individuals? How do the two boards interact to promote consumer protection for individuals receiving services at sleep labs?

Background: Polysomnography involves monitoring and recording physiological data, generally while an individual is asleep, to assess and help treat sleep disorders**.** Also known as sleep medicine, this discipline is practiced by licensed physicians who specialize in sleep medicine, with the aid of trained technicians. Sleep medicine has been practiced by licensed physicians for some time and was recognized by the American Medical Association as a specialty in 1996. Physician sleep specialists are board certified, and the American Board of Sleep Medicine is one of the specialty boards officially recognized and approved by the California Medical Board.

In 2001, the Board noted its concern with the unlicensed practice of respiratory care as it related to polysomnography in its report to the then JLSRC. As previously discussed, JLSRC included in its 2002 recommendations to support the Board's effort to review the function and skill of currently unlicensed technicians and further study to determine the need for regulation. Over the ensuing years, the Board reviewed the issues in detail, considering a number of factors including: 1) the level of harm of unlicensed practice by various credentialed and non-credentialed technicians, 2) existing industry standards, and 3) the demand for sleep studies. The Board estimates, based on the review and study after it was last considered for Sunset Review, indicated the existence of over 175 sleep laboratories in California with 65% of personnel working with no license. The Board noted that sleep testing was being performed in homes, hotel rooms, independent and unregulated facilities, as well as in hospitals. The Board was concerned that the numbers of unlicensed personnel performing polysomnography would continue to rise exponentially, due to a growing demand for sleep testing, and that the field would be even more lucrative because it lacked regulation. Specifically, the Board was concerned about large numbers of unlicensed technicians working with patients in vulnerable circumstances, where most had not undergone a criminal background check or met competency standards.

The Board determined that the most effective alternative to protect the public from the unlicensed and unqualified practices of respiratory care and polysomnography was to establish a new licensure category for polysomnographic technologists under the Board; however, the Board sponsored legislation did not make it through the legislative process. The Board then passed a motion at a 2007 Board meeting to begin issuing citations against entities engaged in the practice of sleep medicine.

While the RCB is aware of two specific incidents involving unlicensed sleep technicians and criminal activity, the Board surmises there are many more similar cases. The Board also initiated investigations into sleep care physicians for employment of technicians who were not licensed respiratory therapists. Finally in 2009, legislation was passed (SB 132, Denham, Chapter 635) to require those who engage in the practice of polysomnography or use the title "certified polysomnographic technologist" to be registered with the MBC and meet certain education, examination and certification requirements, work under the supervision and direction of a licensed physician and surgeon, and undergo a criminal record clearance.

Subsequent to the passage of SB 132, the California Department of Health (CDPH) issued a directive requiring registered nurses (RNs) to oversee polysomnography technicians, creating a major shift in the current practice. CDPH issued an All Facilities Letter that provided that an RN must provide patient assessments and be responsible for the nursing service in outpatient facilities but the directive only applied to those sleep centers associated with a licensed acute care hospital (under the jurisdiction of CDPH) and did not include so-called "free standing clinics" which typically were more concerning to regulators. Many RCPs are employed in sleep laboratories and the Board worked with CDPH and RCP stakeholders to seek important modifications in the CDPH All Facilities Letter reflecting input from these professionals.

Staff Recommendation: ***The Board should outline its view on the current registration and regulation of those who engage in the practice of polysomnography, including any continuing problems and ideas for more robust consumer protections if applicable.***

CONTINUED REGULATION OF THE PROFESSION BY THE CURRENT RESPIRATORY CARE BOARD

ISSUE #11. (CONTINUED REGULATION BY RESPIRATORY CARE BOARD.) Should the licensing and regulation of respiratory care therapists be continued and be regulated by the current Board membership?

Background: The Respiratory Care Board has shown over the years a strong commitment to improve its overall efficiency and effectiveness and has worked cooperatively with the Legislature and this Committee to bring about necessary changes. 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: ***Recommend that the respiratory care professional profession continue to be regulated by the current Board members in order to protect the interests of the public and be reviewed once again in four years.***