BACKGROUND PAPER FOR
The Respiratory Care Board of California

Joint Sunset Review Oversight Hearing, March 7, 2022
Senate Committee on Business, Professions, and Economic Development
and Assembly Committee on Business and Professions

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

BRIEF OVERVIEW OF THE RESPIRATORY CARE BOARD OF CALIFORNIA

History and Function of the California Respiratory Care Board

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

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

The Board is comprised of nine members, including four public members, four RCP members, and one physician and surgeon member. Each appointing authority— the governor, the Senate Rules Committee, and the Speaker of the Assembly— appoints three members.

The Board's mandate is to protect the public from the unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care (Business and Professions Code (BPC) § 3701). The Board is further mandated to ensure that protection of the public shall be the highest priority in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount (BPC, § 3710.1).

The Board's current mission statement is as follows:

> ***To protect and serve consumers by licensing qualified respiratory care practitioners, enforcing the provisions of the Respiratory Care Practice Act, expanding the availability of respiratory care services, increasing public awareness of the profession, and supporting the development and education of respiratory care practitioners.***

The Respiratory Care Practice Act (Act) requires licensure for individuals performing respiratory care. According to the Board, to carry out its mandate, the Board reports that it takes the following steps:

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

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

RCPs provide services to patients ranging from premature infants to older adults. 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. Common RCP patients include individuals suffering from:

- Asthma Bronchitis
- Heart attack
- Cystic fibrosis
- Emphysema Stroke
- Lung cancer
- Premature infants and infants with birth defects
- High-risk influenza/COVID-19

Board Membership and Committees

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

The current board members are as follows:

Name	Appointing Authority	Appointment Type	Appointment Date	Reappointment Date	Expiration Date
Early, Mary Ellen	Governor	Public	4/13/2013	5/26/2020	6/1/2023
Goldstein, Mark	Governor	Professional	6/7/2012	5/26/2020	6/1/2023
Guzman, Ricardo	Senate	Professional	1/9/2019	N/A	6/1/2022
Hernandez, Raymond	Assembly	Professional	2/6/2020	N/A	6/1/2021
Kbushyan, Sam	Senate	Public	6/1/2017	N/A	6/1/2021
Lewis, Ronald	Senate	Physician	6/19/2013	1/30/2019	6/1/2022
Terry, Michael	Assembly	Professional	11/12/2020	N/A	6/1/2023
Williams, Cheryl	Governor	Public	4/27/2021	N/A	6/1/2024
Vacant	Assembly	Public		Vacant	

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

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

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

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

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

Fiscal, Fund and Fee Analysis

As a regulatory board within the DCA, the Board is entirely funded through regulatory fees and license renewal fees and does not receive funds from California's General Fund (GF).

The Board's FY 2021-22 projects budget authority of $3,878 million, with 5.3 months in budget reserve. Following several recent fee increases, the Board's fund is showing stable recovery with a projected 5.8 months in reserve in FY 2022–23 and balanced revenues and expenditures.

The Board's fund condition is included below:

Table 3a. Fund Condition (Dollars In Thousands)

	FY 16/17	**FY 17/18**	**FY 18/19**	**FY 19/20**	**FY 20/21**	**FY 21/22***	**FY 22/23***
Beginning Balance	$1,802	$1,335	$943	$793	$910	$1,405	$1,707
Adjusted Beginning Bal.	$56	$0	$41	($19)	$0	$0	$0
Revenues & Transfers	$2,725	$2,880	$3,153	$3,485	$3,785	$3,827	$3,870
Total Resources	$4,583	$4,215	$4,137	$4,259	$4,695	$5,232	$5,577
Budget Authority	$3,694	$3,715	$3,907	$3,868	$3,752	$3,878	$3,878
Expenditures	$3,218	$3,209	$3,323	$3,307	$3,210	$3,878	$3,878
Fi$Cal	$4	$4	N/A	N/A	N/A	N/A	N/A
Supplemental Pension	N/A	N/A	$36	$76	$76	$76	$76
General Fund Pro Rata (see footnote No. 1 below table)	$178	$242	$196	$136		$239	$239
Reimbursements	($152)	($183)	($211)	($170)	($161)	($160)	($160)
Fund Balance	$1,335	$943	$793	$910	$1,405	$1,707	$1,883
Months in Reserve	5.0	3.4	2.9	3.4	4.3	5.3	5.8

*Projected figures

According to the Board, enforcement activities account for 54 percent of expenditures, licensing accounts for 13.7 percent of expenditures. Administration represents12.7 percent of expenditures and DCA Pro Rata accounts for 19.6 percent of the Board's expenditures.

The DCA provides centralized administrative services to all boards, committees, commission and bureaus which are funded through a pro rata calculation that appears to be based on the number of authorized staff positions for an entity rather than actual number of employees. The Board paid DCA $558,000 in Pro Rata for FY 2020/21, an average of 19.6 percent of its expenditures compared to the 15% average reported during the 2016-2017 sunset review. Pro Rata is discussed in Current Issues below.

	FY 2016–17		FY 2017–18		FY 2018–19		FY 2019–20		FY 2020–21*	
	Personnel Services	**OE&E**	**Personnel Services**	**OE&E**	**Personnel Services**	**OE&E**	**Personnel Services**	**OE&E**	**Personnel Services**	**OE&E**
Enforcement	$997	$760	$1,038	$646	$1,025	$741	$1,096	$686	$1,046	$763
Licensing/ Exam	$398	$79	$348	$79	$358	$74	$380	$78	$342	$85
Administration	$298	$60	$358	$59	$370	$56	$383	$58	$353	$63
DCA Pro Rata	N/A	$626	N/A	$681	N/A	$699	N/A	$626	N/A	$558
Totals	$1,693	$1,525	$1,744	$1,464	$1,753	$1,570	$1,859	$1,448	$1,741	$1,470
Budget Expenditure	$3,218		$3,209		$3,323		$3,307		$3,210	

**Statewide pay reduction reduced expenses for personnel services affecting all program areas listed*

The Board notes a growing concern of costs outside of their control such as pro rata and personnel costs. The RCB was forced to increase renewal and renewal-related fees to account for increased operating costs. The last fee increase was in 2002. The following are the increases since the 2016-17 sunset review:

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

The Board also notes they do not anticipate a need to increase renewal fees based on current business practices unless there are costs outside of their control (i.e. Pro Rata).

Current law authorizes the Board to request fee recovery from any licensee found guilty of violation of the licensing act to pay for the reasonable costs of the investigation and enforcement of their case. Cost recovery is a standard term and condition specified in the Board's disciplinary guidelines for all proposed decisions and stipulations.

There is no specific amount of cost recovery ordered for revocations, surrenders, and probationers, as each discipline case has its own amount of cost recovery ordered depending on the investigation and prosecution costs incurred. Most cost recovery is due within 12 months of the order's effective date. If cost recovery is determined to be unrecoverable, the Board uses the Franchise Tax Board's Offset intercept program to collect the amount due. Generally, there is not a problem recovering costs from licensees because cost recovery is a term of probation, and failure to pay could result in license revocation. A fiscal overview of the Board's cost recovery program is available below:

Fiscal Overview of Cost Recovery				(list dollars in thousands)
	FY 2017–18	**FY 2018–19**	**FY 2019–20**	**FY 2020–21**
Total Enforcement Expenditures	$449,451	$554,121	$491,261	$550,879
Potential Cases for Recovery *	47	35	25	33
Cases Recovery Ordered***	47	35	24	33
Amount of Cost Recovery Ordered	$215,805	$237,486	$187,908	$234,234
Amount Collected	$84,386	$135,019	$119,867	$106,721

* "Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on violation of the License Practice Act.
** Total based on preliminary yearly expenditures provided by DCA
***Cost recovery ordered may be from other accusations in different fiscal years

Staffing Levels

The Board is currently authorized in the Governor's 2021/22 budget for 17.4 positions; the Board's current 16 staff were all employed at the Board during its last review.

The Board has statutory authority to appoint its own Executive Officer (EO), who is tasked with performing duties as delegated by the Board. The current EO has served in the position since 2001.

Over the last five FYs the Board has spent approximately $4,500 on staff training and education. Costs are associated with courses taken outside of DCA such as the Certified Professional Collector Program, a course the Board's staff probation monitors take to maintain certification in collecting specimens for drug testing.

Licensing

The Board currently issues approximately 1,100 new licenses and renews approximately 9,500 licenses each year. As of June 30, 2021, the Board had 20,248 active licensees, 2,657 delinquent licensees, and 827 current but inactive licensees. Of these licensees, 1,718 live out of the state or country. An additional 1,017 licenses have been placed in retirement status as of June 30, 2021.

The Board's licensee population is outlined below:

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

As of June 30, 2021, the average cycle time to process a complete application from date of receipt to date of licensure was seven days. The average cycle time for incomplete applications was 68 days.

Licensing Data by Type								
	Application Type	Received (opened)	Approved	Closed	Initial and Renewed Licenses Issued	Pending Apps at Close of FY	Cycle Times (in days)	
							Complete Apps	Incomplete Apps
FY 18/19	License/Exam	1,215	1,124	112	1,124	387	7	66
	Renewal	9,517	9,594	1,082	9,594	N/A	-	-
FY 19/20	License/Exam	1,424	1,137	152	1,137	492	9	59
	Renewal	9,606	9,761	1,018	9,761	N/A	-	-
FY 20/21	License/Exam	1,538	1,175	237	1,175	375	7	68
	Renewal	9,718	9,841	974	9,841	N/A	-	-

As part of the application for licensure process, the Board requires the following documentation directly from the source:

- Department of Justice background check.
- Federal Bureau of Investigation background check.
- Official education transcript(s).
- Licensing examination verification
- Board-approved Law and Professional Ethics Course verification
- Out-of-state licensure history
- National Practitioner Databank (NPDB) query for applicants whose residence or education may be outside of California.

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

As a result of AB 1972 (Author, Chapter, Statutes of 2014), the Board began using the advanced respiratory credentialing examination as its licensing examination in January 1, 2015. An applicant must successfully pass both the National Board for Respiratory Care's (NBRC) Therapist Multiple-Choice Examination and the Clinical Simulation Examination. The NBRC prepares and administers all examinations pursuant to a contractual agreement.

The Therapist Multiple-Choice Examination is designed to objectively measure essential knowledge, skills, and abilities required of entry-level respiratory therapists. The Clinical Simulation Examination is designed to objectively measure essential knowledge, skills, and abilities required of advanced respiratory therapists.

The NBRC also offers voluntary credentials upon passage of each exam, the Certified Respiratory Therapist for passage of the Therapist Multiple-Choice Examination and the Registered Respiratory

Therapist for passage of the Clinical Simulation Examination. While passage of the RRT examination is required for licensure, holding the actual credential is not, though the RRT credential is required for various reimbursements and is recognized by the medical community.

The NBRC exams are administered in English on a daily basis. Applicants may apply to take the examination online or via paper application. Upon verification of meeting entry requirements, applicants may schedule themselves to sit for either examination at one of 42 locations throughout California. Applicants are given three hours to complete the Therapist Multiple Choice Exam and four hours to complete the Clinical Simulation Exam (exceptions are made in accordance with the Americans with Disabilities Act). Once applicants have completed either examination, they are notified immediately of the results. Those results are then shared with the Board on a weekly basis. Applicants may take the exam up to three times. After the third attempt, applicants must wait 120 days to retake each failed examination.

From fiscal year 2016–17 through fiscal year 2020–21, the pass rates for first-time takers averaged near 80 percent for the written exam and 64 percent for the clinical exam.

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

There are 35 respiratory care education programs in California that are approved by the Board by virtue of their accreditation status. Each program must be accredited by the Committee on Accreditation for Respiratory Care as well as an accrediting body recognized by the US Department of Education. Twenty-six of the 35 programs are accredited by WASC and the remaining 9 are accredited by other agencies recognized by the USDE and are approved by the Bureau for Private Postsecondary Education (BPPE). Pursuant to B&P §3740, the Board requires two components of education for licensure:

1) Completion of an education program for respiratory care that is accredited by the Committee on Accreditation for Respiratory Care and
2) Possession of a minimum of an associate degree from an institution or university accredited by a regional accreditation agency or association recognized by the United States Department of Education.

Most often, these components are one in the same, but in some instances, they may be distinct. A degree will be issued by a different institution usually when the respiratory care program was completed prior to 2001 (when education requirements were changed) or if the respiratory care education was received outside of California. Otherwise, 34 schools in California offer an associate degree in respiratory care and three schools—Loma Linda University, Skyline College and Modesto Jr. College—offer a baccalaureate degree in respiratory care.

According to the Board, staff review each respiratory care program and school one to two times annually to verify 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. The Board reports that it posts annual exam pass/fail rates for all

California programs on its website.

Continuing Education

As of July 2017, an active RCP must complete 30 hours of approved continuing education (CE) every two years (previously 15 hours). Two-thirds of the required CE must be directly related to clinical practice. In addition, during every other renewal cycle, each active RCP must also complete a Board-approved Law and Professional Ethics Course which may be claimed as three hours of non-clinical CE credit (Title 16, California Code of Regulations §1399.350).

After completion of the Respiratory Care Workforce study in 2017, the Board developed several goals in its Strategic Plan 2017–2021 to improve its CE program, student clinical education, and education outcomes. The anticipated gaps in management in the respiratory care field were brought to light by the workforce study. The study revealed the expected retirement of 35 percent of people in management in the near future, and the need for leadership development among existing licensees to fill that void. In addition, the study revealed the need to improve clinical education and outcomes.

In response to the study, the Board drafted regulations to revamp the CE requirements. The regulations are currently pending. The proposed regulations drastically change from a general requirement that two-thirds or 20 hours of the required 30 hours of CE be directly related to clinical practice in any format. The new framework would require:

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

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

Until these amended regulations are in effect, RCPs are required to, every two years, complete 30 hours of approved CE. Twenty of the current 30 hours must be directly related to clinical practice. Licensees may also count up to 10 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 response to the Board's 2016-17 Sunset Review, the Board reports that is has worked to increase CE audits to 10 percent. In FY 2018–19, the Board reports that it audited nearly 8 percent of renewals for compliance with CE requirements. But in the following two fiscal years, the number of renewals audited dropped to 3.5 percent. In FYs 2019–20 and 2020–21, the Board reports that CE audits were impacted as a result of the issuance of CE waivers and the Board's efforts to mitigate the additional stress of undergoing a CE audit during a pandemic. The Board also cites a staffing problem for the decrease in audits.

Enforcement

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

In 2010, the Board established performance targets for measures developed by DCA, as a result of the Consumer Protection Enforcement Initiative. The Board's overall goal for all cases to be completed, from the date the complaint is received to final adjudication, is 540 days (18 months). Since FY 2017-18, the Board has met this target goal. In FY 2020-21 each quarter's average completion rate was under 500 days.

The Board has noted that since the onset of the pandemic through the end 2020, there was a decrease in arrest records received. In the Board's prior sunset review, it averaged 533 convictions received each year. During this period, the Board received an average of 434 convictions, with only 380 of those received in FY 2020–21. The Board reports that it will continue to study the data in the coming years to determine cause of the downward trend.

Complaints are received from the public, generated internally by the Board or based on information the Board receives from various entities through mandatory reports, as outlined below. On average, the Board receives about 800 complaints per FY (55% of these complaints are a result of new criminal activity identified). The Board utilizes guidelines that are in line with the DCA's Complaint Prioritization Guidelines which are intended to help staff determine the priority for handling complaints, The Board notes that special consideration is given to complaints involving a child, dependent adult or even an animal.

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

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

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

The Board receives on average 25 mandatory complaints per year. The mandatory reports about licensees are in compliance with the following:

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

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

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

The Board's Cite and Fine program allows the Board to "penalize" licensees rather than pursue formal

discipline for less serious offenses or offenses where probation or revocation are not appropriate. The Board amended its regulations in 2012, to increase fine amounts to the maximum of $5,000 pursuant to BPC § 125.9. To be eligible under the Board's cite and fine program, no patterned behavior may exist and no child, dependent adult or animal may be neglected or involved in a crime as a victim or otherwise.

In the last four FYs, the Board reports between 25 and 47 cases annually that had potential for cost recovery. The Board initially sought full cost recovery in all 140 of these cases. Ultimately, costs were ordered in all cases except one. The most common reasons the Board would not continue to pursue full cost recovery is either 1) evidence supporting *Zuckerman vs. Board of Chiropractic Examiners* which states a Board may not increase or impose costs on a person claiming they have a financial hardship and/or 2) the costs and time to non-adopt the decision do not outweigh the benefit (e.g., revocation) for those cases where the Board believes consumer protection is at imminent risk. The Board may non-adopt a case when the case is heard by an Administrative Law Judge (ALJ) and the Board disagrees with the ALJ decision. The board may non-adopt an ALJ decision to add terms and conditions of probation, lengthen or shorten the probation period, or increase cost recovered. If the board non-adopts an ALJ decision, it will immediately thereafter draft its own decision with any changes the Board finds appropriate.

Cost Recovery				
	FY 2017–18	**FY 2018–19**	**FY 2019–20**	**FY 2020–21**
Total Enforcement Expenditures	$449,451	$554,121	$491,261	$550,879
Potential Cases for Recovery	47	35	25	33
Cases Recovery Ordered	47	35	24	33
Amount of Costs Ordered	$215,805	$237,486	$187,908	$234,234
Amount Collected	$84,386	$135,019	$119,867	$106,721

The Board collected 51 percent of the costs ordered during the last four FYs. The Board notes that it is most successful in collecting costs in those cases that result in probation or a public reprimand, because licensees are more vested in retaining licensure. According to the Board, in nearly all cases, in which formal discipline results in a surrendered license, the board will agree to forego cost recovery as a means to expedite stipulated decisions and not accrue additional unrecoverable hearing costs. However, if and when the surrendered license holder petitions to reinstate their license, those costs must be paid in full before a petition for reinstatement will be considered). The most difficult cases from which to collect costs are those resulting in revocation. As noted by the Board, cost recovery ordered averages $6,253 per case and is due within one year from the date ordered (although the Board reports that it is very flexible with payment schedules/extensions).

PRIOR SUNSET REVIEW: CHANGES AND IMPROVEMENTS

The Board was last reviewed by the Legislature through sunset review in 2016-2017. During the previous sunset review, six issues were raised. In January 2022, the Board submitted its required sunset report to the Senate Committee on Business, Professions, and Economic Development and Assembly Committee on Business and Professions (Committees). In this report, the Board described actions it has taken since its prior review to address the recommendations made. The following are some of the more important programmatic and operational changes, enhancements and other important policy decisions or regulatory changes made. For those which were not addressed and which may still be of concern to the Committees, they are addressed and more fully discussed under "Current Sunset Review Issues."

- **Website enhancements have been made.** At the time of the last Sunset Review, the Board had just launched a new website in February 2017. The new website include enhance features, layout, and accessibility. The website revamped disciplinary postings by redirecting to breeze making it more difficult to find was not consumer friendly. Committee staff raised concerns about the lack of public disclosure of disciplinary actions. Since this discussion, the Board has updated the disciplinary actions posting to reflect prior conversations and increase transparency. Disciplinary actions now are displayed back to October 2016 and are updated quarterly.

- **Continuing education audits are taking place.** In 2017, the Board reported that the Board has audited about 5% of licensees at the time of renewal to ensure CE hours were actually completed. The Committees asked the Board to increase audits by implementing a more innovated way the audits. The Board set out to increase the audit to 10%. The Board was hopeful to accomplish this by using the BreEZe system to randomly select licensees. The BreEZe system does not have the capabilities to conduct the audits for the Board. The Board is now using a DCA-Developed system that allows applicants to upload CE certificates which the Board believes is more efficient. The Board cites staffing issues as the reason for not hitting the 10% target. In FY 2020 – 21, the Board was only able to audit about 3%; however, the Board reports they are now on target to hit the 10% goal for FY 2021-22.

- **Nonessential DMV history is no longer evaluated.** The Committees raised concern about the necessity and importance for an applicant to safely practice RCP duties. The Board agreed this requirement was not essential and stopped requiring driving history as of October 2017. The Board will finalize the new approach by removing the requirement from the application process through regulation, but retain the ability to access driving records. Since the change in requirement, the Board has requested driving histories for eight applicants where circumstances warranted further investigation.

A copy of the Board's 2022 Sunset Review Report is available at https://www.rcb.ca.gov/about_us/forms/sunset2022.pdf

CURRENT SUNSET REVIEW ISSUES

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

BOARD ADMINISTRATION ISSUES

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

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

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

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

According to a 2019 DCA report to the Legislature, Internal Review of Regulation Procedures, "the resulting enhanced scrutiny from Agency and DCA's Legal Affairs Division successfully reduced the number of disapproved regulation packages, with the number of disapprovals falling from nine in 2016 to only one in 2018." The report also found that "while disapproval rates plummeted, a consequence was lengthened timelines to adopt regulations. Several boards and bureaus raised objections to the lengthened review time and reported difficulty obtaining timely updates about regulation packages under review." The "pre-review" process required regulations to go through DCA's entire review

process prior to the package being submitted for public comment. DCA established a formal Regulations Unit to "minimize the length of time it currently takes to review regulatory packages; allow board and bureau attorneys to focus on the increased workload of non-regulatory work; respond to the demand of regulation packages under review and the increase of regulation packages from AB 2138 (Chiu and Low; Chapter 995, Statutes of 2018); avoid the habitual carry-over of regulation packages; and, enhance the level of regulation training provided to boards and bureaus to improve the quality of regulations and create efficiencies by having better quality packages submitted for review."

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

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

BOARD BUDGET ISSUES

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

Background: The Department of Consumer Affairs (DCA) is almost entirely funded by a portion of the licensing fees paid by California's state-regulated professionals in the form of "pro rata." Pro rata funds DCA's two divisions, the Consumer and Client Services Division (CCSD) and the DOI. CCSD is the primary focus of this issue and contains the Administrative and Information Services Division (the Executive Office, Legislation, Budgets, Human Resources, Business Services Office, Fiscal Operations, Office of Information Services, Equal Employment Office, Legal, Internal Audits, and SOLID training services), the Communications Division (Public Affairs, Publications Design and Editing, and Digital Print Services), and the Division of Program and Policy Review (Policy Review Committee, Office of Professional Examination Services, and Consumer Information Center).

Pro rata is apportioned primarily based on the number of authorized staff at each board, rather than based on the amount of DCA's services programs use. DCA does charge boards based on actual use for some services, such as the Office of Information Services, the Consumer Information Center, the Office of Professional Examination Services, and DOI. Based on DCA's own figures, actual pro rata costs for every board have increased of an average of over 100 percent since FY 2012-2013.

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

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

BOARD LICENSING AND WORKFORCE ISSUES

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

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

Of the 35 education programs in California, three currently offer a Respiratory Care Bachelor's degree. Is a Bachelor's degree the only or most appropriate way to train RCPs?

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

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

Background: During the 2017 Sunset Review, the Committees requested an update on the 2015 study from Institute for Health Policy Studies at the University of California, San Francisco. The study was set to determine the feasibility and impact of requiring new applicants to obtain a baccalaureate degree; the need to modify current requirements regarding clinical supervision of RCP Students; the effectiveness of the current requirement to take a Professional Ethics and Law continuing education course, and the benefit or need to increase the number of continuing education hours and/ or its curricular requirements. The California Respiratory Care Workforce Study was completed and integrated into the Boards strategic plan. The two goals taken from the study are as follows:

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

field.

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

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

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

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

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

BOARD ENFORCEMENT ISSUES

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

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

The two boards began to work collaboratively in 2019 and issued a joint statement clarifying RCP and LVN roles relating to patient care on mechanical ventilators. After feedback from various types of facilities and organizations, there was expressed desire to further clarify its respective regulations regarding patient care. The boards hosted a stakeholder meeting to further discuss the joint statement and concerns grew about expanding places LVNs can conduct ventilator services to home based

settings as well. According to the Board, BVNPT backed out of the agreement and began exploring CE to train LVNs to perform ventilator services in more setting. The Board has offered legislative options to clarify scopes of practice, but has not come to an agreement with BVNPT on a solution moving forward.

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

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

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

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

TECHNICAL CHANGES

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

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

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

COVID-19

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

Background: Throughout the COVID-19 pandemic, frontline healthcare workers and first responders,

such as physicians, nurses, respiratory care therapists, paramedics, and more, have been caring for COVID-19 patients through multiple deadly surges, including a record-shattering death toll surge in December of 2020.

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

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

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

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

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

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

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

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

ISSUE # 10: (CONTINUED REGULATION BY RESPIRATORY CARE BOARD OF CALIFORNIA.) Should the licensing and regulation of RCPs be continued and be regulated by the current Board membership?

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

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