

Respiratory Update

March 2003



Barry Winn, Ed.D., RCP

Farewell to Barry Winn, Ed.D., RCP After Longtime, Exemplary Service

Nearly 13 years ago, Barry Winn, Ed.D., RCP, was appointed to the Respiratory Care Examining Committee. Since his appointment, he has been instrumental in many of its achievements, including its name change to the Respiratory Care Board (Board) in 1994. During his tenure as a member, Dr. Winn has served in many capacities including Board Chair for 4 years, Board President for 7 years, and as Chair of various committees and task forces. Throughout his service, Dr. Winn has been credited with the achievement of many successes in part due to his ability to balance the interest of California RCPs while ensuring stellar consumer protection.

On many occasions Dr. Winn took time out of his busy schedule to testify on behalf of the Board and the respiratory care profession. The expertise he displayed during his testimony at each of the Board's Sunset Review Hearings was undoubtedly instrumental in its continued existence. Dr. Winn was also instrumental in protecting the professions' scope of practice with his testimony on the issue of performance of reporting electrolytes in conjunction with arterial blood gas analysis.

Dr. Winn has always upheld the belief that enhancement of the respiratory care profession takes the input

of many individuals. He has, on many occasions, reiterated this concept and expressed his commitment to fostering ongoing communications. Due to his unwavering belief in this concept, the Board's relationship with many of its stakeholders has greatly improved under his leadership. Never was this more evident than during the successful negotiation of the Board's current examination contract with the National Board for Respiratory Care or during the joint effort of the California Society for Respiratory Care and the Board to increase the minimum education standards.

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Scott J. Svonkin Elected President

The Respiratory Care Board of California (Board) elected Scott J. Svonkin to serve as President, effective January 1, 2003. Mr. Svonkin succeeds Barry Winn, Ed.D., RCP, of San Diego, whose term expires May 31, 2003.

Mr. Svonkin, was appointed as a member to the Board by Governor Gray Davis in November 2001. At the Board's November 2002 meeting in Los Angeles, Mr. Svonkin was elected by his fellow members to serve as President in 2003. While Mr. Svonkin is one of the newest members of the Board, he has brought a new energy and a clear vision from his first day of service.

Mr. Svonkin has shown an unyielding commitment to leading the Board and promoting the respiratory care profession. His unique experience as an asthmatic make him a great champion and spokesman for the life saving work RCPs do every day.

Mr. Svonkin has also demonstrated leadership with vision in his former positions as Chief of Staff to Assemblyman Paul Koretz, businessman with Prudential Insurance, member of Mayor Tom Bradley's staff, and an instructor at Los Angeles Valley College.

Mr. Svonkin, 36, of Sherman Oaks, is a longtime community activist with contributions spanning civic, political, cultural, educational, and religious activities. He has dedicated his life to public service through both traditional political work and grass-roots volunteerism. Some of Mr. Svonkin's work includes: serving as Chair for B'nai B'rith Southern California Public Policy Center, Immediate past Chair for the Valley Alliance of the Jewish Federation's Community Relations Committee, Chairman of the Los Angeles County Insurance Commission, and a board member of the Children's Hospital L.A. Huckleberry Fund.

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Board Recognizes Lon Lancaster

The Respiratory Care Board (Board) was honored to recognize Lon Lancaster for his significant contributions and dedication toward the practice of respiratory care at its November meeting.

Mr. Lancaster was nominated for recognition by the Board, by 24 RCPs who make up the entire Respiratory Care Department at Kern Medical Center where he has been employed since 1988. Mr. Lancaster has earned the respect and admiration of hospital staff with his vast contributions and endless hours of dedication to the education and training of respiratory therapists, nurses and resident physicians.

Mr. Lancaster also works closely with One Legacy, a transplant organ donation network, and San Joaquin Valley College's RCP educational program. One Legacy told the Board that Mr. Lancaster is an outstanding individual who proudly represents and contributes everyday to his profession. He is a true role model who teaches by example. One Legacy recounts an event demonstrating Mr. Lancaster's dedication to his profession and his generous, selfless actions, which resulted in preserving 5 life-saving organs for individuals who otherwise had no hope. San Joaquin Valley College also expressed to the Board that Mr. Lancaster assures that RCP students get the most out of their clinical rotation and that he goes beyond his regular duties to support the student, his department and the school of respiratory therapy.

Mr. Lancaster is a true role-model for the respiratory care profession and an asset to the consumers of California. Thank you Mr. Lancaster for your staunch work ethic and dedication to the practice of respiratory care!



Barry Winn, Ed.D., RCP Serves Last Term

(continued from page 1)

More recently, Dr. Winn has been an open supporter of the new enforcement procedures being implemented to promote cost effectiveness. These revisions include the expansion of the Board's cite and fine authority. This authority is crucial in reducing expenditures. At the same time, it allows the Board to meet its mandate to protect consumers by making this information available to the public and employers.

Dr. Winn has been acknowledged for his outstanding dedication and contributions including receipt of the American Lung Association's Leadership Award in recognition for his 30+ years of volunteer work in a variety of capacities. Dr. Winn helped found the San Diego Pulmonary Society and was specifically recognized for being one of the main medical advisors on the Lung Express, a 40-foot bus that visits schools and community events to teach kids and families about lung health. In addition to overseeing the clinical instruction component of the Respiratory Program at Grossmont College, Dr. Winn has been personally active in a myriad of respiratory-related volunteer organizations, and has also been instrumental in encouraging many of his students to become active volunteers.

Dr. Winn recently said, "I am delighted with the new direction the Board has taken." In response, it is important to understand that the Board would not be where it is today without the hard work and dedication of Dr. Winn, his loyalty to consumer protection and the advancement of the respiratory care profession.

**Thank you Dr. Winn for your immeasurable contributions
and many years of dedication!**

President's Message

It was a tremendous honor to have been appointed to the Respiratory Care Board (Board) in 2001 by Governor Davis. I was further honored to be elected by my fellow members to lead the Board as its 2003 president. Our Country, including this great State, faces a historic need for healthcare professionals. As a regulatory Board mandated to ensure quality respiratory care for consumers, it is our responsibility to do all we can to meet this challenge. I am committed to doing all I can to lead this Board during the healthcare crisis we are facing.

During my term as President, I will strive to guide the Board as it pursues the achievement of each goal and objective outlined in its Strategic Plan, including the following items which I will focus on throughout the upcoming year:

- ▶ Protecting California consumers by ensuring we have the most qualified respiratory care practitioners (RCPs) in the Nation;
- ▶ Increasing public awareness of the respiratory care profession and the important work performed by respiratory care practitioners;
- ▶ Expanding the number of RCPs necessary to meet the needs of all Californians who require the intervention of an RCP as part of their healthcare regimen, and
- ▶ Working together with professional organizations and societies, such as the California Society for Respiratory Care (CSRC) and the American Association for Respiratory Care, to increase opportunities for our licensees.

My initial step as President has been to establish regular communications with Bob Bence, President of the CSRC. I am hopeful that in working together, we can successfully obtain essential legislative changes needed by both consumers and therapists. We have already been successful in finding an author to carry legislation sponsored by the Board, and supported by the CSRC, that includes various initiatives to reduce enforcement expenditures while maintaining public protection.

I have been fortunate to have worked alongside many individuals willing to make changes resulting in a better California. With the dedication of many RCPs, and with the direct assistance of Virginia Ettinger of Los Angeles Valley College, I have been working to promote the profession by educating the Writers Guild of the important role a RCP often plays in the care of patients, with hopes they may write RCP roles into television programs.

"I am confident and willing to offer my experience and knowledge to benefit not only the consumers the Board is charged with protecting, but those licensees it is privileged to regulate."

I am confident and willing to offer my experience and knowledge to benefit not only the consumers the Board is charged with protecting, but those licensees it is privileged to regulate. I am optimistic that my years of positive working relationships with various members of congress will assist in bringing to fruition the recognition of RCPs under the Medicare home health services benefit. Additionally, along with the other members of the Board, I am committed to seeking mechanisms to ensure the balance of revenues and expenditures in hopes that, in the future, a fee reduction can be realized.

While these are the principal goals and issues I plan to focus on, it will likely take the entire Board more than a year to achieve the major impacts we are seeking. However, if we work together I am confident that we can begin to achieve not only these goals, but other goals that will continually improve the respiratory profession and the quality of care for respiratory consumers.



Scott J. Svonkin
Board President

"We have already been successful in finding an author to carry legislation sponsored by the Board, and supported by the CSRC."

Board Re-Appointments

Richard L. Sheldon, M.D., Member

Richard L. Sheldon, M.D., a Redlands-based physician, graduated from Loma Linda University School of Medicine in 1968. He interned in Denver, CO, before being drafted into the United States Army, where he served six years, achieving the rank of Major. While in the Army he did his residency in internal medicine and fellowship in pulmonary medicine/critical care at Walter Reed Army Hospital in Washington, D.C. After leaving the Army he returned to Loma Linda and served on the full-time faculty, achieving the rank of professor of medicine.

During his years at Loma Linda, Dr. Sheldon has served as director of residency training for internal medicine, director of the medical intensive care unit, director of the hyperbaric medicine unit, and chief of pulmonary and critical medicine. He was elected president of Loma Linda University Medical Physicians, Inc. and served five years in that position. He joined Beaver Medical Group in 1993 as a staff pulmonologist and intensivist.

His involvement with the profession of respiratory care hails back to his early days at Loma Linda. "The first administrative issue I dealt with was becoming director of the ICU," he recalls. "In that capacity I had immediate involvement with RTs on a day-to-day basis. You couldn't survive as an intensivist in a large ICU without well trained, aggressive RTs." That close working relationship led Dr. Sheldon to volunteer his services on behalf of the American Association for Respiratory Care. He has served on the Association's Board of Medical Advisors every year since 1988, chairing the group twice, and has participated on numerous task forces and committees.

Dr. Sheldon has lectured throughout the United States, Asia, and Europe, and has coauthored seven books on respiratory care, along with many articles and editorials in professional journals. He was made an Honorary Member of the AARC in 1993 and is active in the American Thoracic Society and the American College of Chest Physicians. He is also a Fellow of the American College of Physicians and the American College of Chest Physicians, and is medical director of the school of respiratory care at Crafton Hills Community College.

Dr. Sheldon has served as a member of the Respiratory Care Board of California since 1999 and was recently reappointed for an additional 4 years.



Gary N. Stern, Esq., Member

Gary N. Stern has been practicing law in California since December 1980, following graduation from UCLA in 1977 and Southwestern University School of Law in 1980.

Mr. Stern was initially associated with Goodman and Hirschberg, a Los Angeles law firm founded in 1953. In 1986, with the retirement of Messrs. Goodman and Hirschberg, Mr. Stern "inherited" the firm and with probate and tax attorney Burton R. Popkoff, founded Popkoff & Stern, with offices in Los Angeles and Palm Springs. Mr. Stern limited his practice to general civil and tort litigation, with a focus on elder abuse and other types of health law litigation.

In 1999, Mr. Popkoff retired and after one year as a solo, Mr. Stern accepted a position with the prestigious Los Angeles firm Gordon, Edelstein, Krepack, Grant, Felton & Goldstein, where he continues to represent consumers in all areas of civil and tort litigation.

Mr. Stern is a member of the Consumer Attorneys of California, and the Consumer Attorneys Association of Los Angeles. He has published frequently in the area of tort and civil law and often participates as a panelist at continuing education seminars. Prior to his legal career, Mr. Stern was a Legislative Aide to a California Congressman and State Senator. He continues his involvement in the legislative arena as a member of the Los Angeles County Bar Association Legislation and Judiciary Committees.

In September 1997, Mr. Stern was appointed by the California State Senate to serve a 4-year term as a public member on the Respiratory Care Board of California (Board). In 2001, Mr. Stern was reappointed to a further 4-year term on the Board. Mr. Stern also serves on the Board of Directors for the Jewish Big Brothers Association of Los Angeles, and Volunteers Organized in Conserving the Environment, a non profit organization which seeks to preserve the Verdugo Mountains as open space territory.



NBRC Sole Examination Provider

On November 8, 2002, the Respiratory Care Board (Board) moved to adopt the Professional Licensing Committee's recommendation to utilize the National Board for Respiratory Care (NBRC) as its sole examination administration provider to streamline and simplify the examination process for applicants and program directors.

The Professional Licensing Committee's recommendation stemmed from the review of survey responses from program directors, applicants who took the licensing exam through Experior, and applicants who took the licensing exam through the NBRC. Responses from applicants indicated the exam processes through both agencies were fairly equal. However, the responses from program directors were overwhelmingly in support of using the NBRC.

Effective January 30, 2003, the examination process was changed so that all new examination applicants will file an application for licensure with the Board and schedule to take the licensing examination with the NBRC.

Since November, Board staff have been working with Experior and the NBRC to determine whether both of these agencies would be willing to make accommodations to facilitate the transition. The Board is pleased to report that Experior has agreed to terminate its contract with the Board without penalty and the NBRC has willingly made several accommodations to ensure the smoothest transition possible.

Effective January 30, 2003, the examination process was changed so that all new examination applicants will file an application for licensure with the Board and schedule to take the licensing examination with the NBRC.

Program directors and those

applicants affected by the transition were immediately advised of the new application process, and steps have been put into place to assist existing candidates throughout this transition. Board staff have also revised the application to be more user-friendly, reduce common deficiencies, and to accommodate the changes in the examination process.

Anyone with questions regarding the new application process is urged to contact the Board at: (916) 323-9983 or toll free at (866) 375-0386.

Board Meeting

Please note: LOCATION CHANGE

The next Respiratory Care Board of California (Board) meeting was previously scheduled to be held in San Francisco on Friday, May 16, 2003. In February, all State agencies were directed to reduce expenditures, especially those related to travel. As a result, the Board's meeting will continue to be held on Friday, May 16th, however it will be held in Sacramento.

The agenda for this meeting will be available after May 6th, at the Board's Web site: www.rcb.ca.gov.

All Board meetings are open to the public.

Board Authorized to Waive Education Requirements

The California Legislature has given the Respiratory Care Board (Board) authority to waive educational requirements for qualified individuals, via SB 1955 (statutes of 2002).

At the time the Board increased its education requirements from 1 to 2 years, it began to receive comments and inquiries from persons licensed as RCPs in other states and/or previously licensed in California, who had a wealth of experience and knowledge in the respiratory care profession. These professionals were not able to gain licensure in California after July 1, 2000, because they did not possess a minimum of an Associate Degree.

The Board found this situation to be alarming in light of the current shortage of RCPs and the Board's efforts to retain and recruit competent RCPs. In response, the Board sponsored legislation, which was authored by State Senator Liz Figueroa, to give the Board authority to waive education requirements "if evidence is presented and the board deems it as meeting the current educational requirements that will ensure the safe and competent practice of respiratory care. This evidence may include, but is not limited to:

- (1) Work experience.
- (2) Good standing of licensure in another state.
- (3) Previous good standing of licensure in the State of California."

[Previous or current good standing of licensure alone, is not sufficient to waive educational requirements. Applicants must also have acceptable work experience.]

The Board is in the process of developing regulatory language to clarify and define acceptable work experience and good standing.

For more information on this subject, please call the Board toll-free at (866) 375-0386.

Voice Your Ideas

So many times, respiratory care practitioners voice great ideas or valid concerns that do not make it to the right ears. Your opinion matters.

If you have issues, concerns or ideas you think would better serve the consumers of California or the respiratory care profession, we want to hear from you. You can either write us a letter or send us a quick e-mail (rcbinfo@dca.ca.gov). The Executive Officer will review suggestions on a routine basis to identify those issues within the purview of the Board. Please be an active participant in the regulation of your profession.

NEW!

Satisfaction Survey

If you've had the opportunity to visit our Web site recently, you've probably noticed the addition of our Satisfaction Survey. The survey was designed to gather input in an effort to continually improve our service to applicants, licensees and consumers.

Beginning January 2003, inserts advising of the survey and inviting participation were added to all renewal notices. The survey takes less than five minutes to complete, and allows input in the areas of customer satisfaction, the Respiratory Update, on-line license verification, our Web site, promotion of the profession, and welcomes any other comments or suggestions you may have.

In a separate format, respiratory patients and their families are also invited to provide feedback on their experiences with RCPs and to assist with promoting the profession from a consumer perspective.

When you have an opportunity, please take a moment to visit our Web site at www.rcb.ca.gov and complete the Satisfaction Survey.

Address Change Notification

Remember, you must notify the Board in writing if you have changed your address of record within 14 days of such change. Your written request must include your RCP number, your previous address, your new address, and your signature.

The Board office will accept requests received by U.S. Mail, faxed notifications and changes made via Internet.

CDC Releases New Hand-Hygiene Guidelines

On October 25, 2002, the Centers for Disease Control and Prevention (CDC) released new guidelines that advise the use of alcohol-based handrubs to protect patients in healthcare settings.

"Clean hands are the single most important factor in preventing the spread of dangerous germs and antibiotic resistance in healthcare settings," said Dr. Julie Gerberding, director of the CDC. "More widespread use of these products that improve adherence to recommended hand hygiene practices will promote patient safety and prevent infections."

CDC estimates that each year nearly 2 million patients in the United States get an infection in hospitals, and about 90,000 of these patients die as a result of their infection. Infections are also a complication of care in other settings including long-term care facilities, clinics and dialysis centers. Improving hand hygiene helps prevent the spread of germs from one patient to another. Data show that healthcare personnel may be more inclined to use alcohol-based handrubs because they are more convenient to use. Recent studies show that these handrubs actually reduce the number of bacteria on the hands more effectively than washing hands with soap and water.

"Healthcare personnel are always on the go which sometimes makes handwashing with soap and water difficult," said Dr. Steve Solomon, acting director of CDC's healthcare quality promotion division. "These handrubs should help promote hand hygiene because they are much more accessible than sinks, take less time to use and cause less skin irritation and dryness than many soaps."

The new guidelines recommend additional steps that administrators can take to increase adherence to good hand hygiene practices. If, as expected, hand hygiene products improve hand hygiene practices, preventing even a few additional healthcare-associated infections per year will lead to savings that will exceed any extra costs for better hand hygiene products.

The hand hygiene guidelines are part of an overall CDC strategy to reduce infections in healthcare settings to promote patient safety. For more information about the hand hygiene campaign go to <http://www.cdc.gov/handhygiene>. For more information about CDC's seven healthcare safety challenges go to <http://www.cdc.gov/ncidod/hip/challenges.htm>.

Hand Hygiene Guidelines Facts

- Improved adherence to hand hygiene (i.e. hand washing or use of alcohol-based hand rubs) has been shown to terminate outbreaks in healthcare facilities, to reduce transmission of antimicrobial resistant organisms (e.g. methicillin resistant staphylococcus aureus) and reduce overall infection rates.
- CDC is releasing guidelines to improve adherence to hand hygiene in healthcare settings. In addition to traditional handwashing with soap and water, CDC is recommending the use of alcohol-based handrubs by healthcare personnel for patient care because they address some of the obstacles that healthcare professionals face when taking care of patients.
- Handwashing with soap and water remains a sensible strategy for hand hygiene in non-healthcare settings and is recommended by CDC and other experts.
- When healthcare personnel's hands are visibly soiled, they should wash with soap and water.
- The use of gloves does not eliminate the need for hand hygiene. Likewise, the use of hand hygiene does not eliminate the need for gloves. Gloves reduce hand contamination by 70 percent to 80 percent, prevent cross-contamination and protect patients and healthcare personnel from infection. Handrubs should be used before and after each patient just as gloves should be changed before and after each patient.
- When using an alcohol-based handrub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry. Note that the volume needed to reduce the number of bacteria on hands varies by product.
- Alcohol-based handrubs significantly reduce the number of microorganisms on skin, are fast acting and cause less skin irritation.
- Healthcare personnel should avoid wearing artificial nails and keep natural nails less than one quarter of an inch long if they care for patients at high risk of acquiring infections (e.g. Patients in intensive care units or in transplant units).
- When evaluating hand hygiene products for potential use in healthcare facilities, administrators or product selection committees should consider the relative efficacy of antiseptic agents against various pathogens and the acceptability of hand hygiene products by personnel. Characteristics of a product that can affect acceptance and therefore usage include its smell, consistency, color and the effect of dryness on hands.
- As part of these recommendations, CDC is asking healthcare facilities to develop and implement a system for measuring improvements in adherence to these hand hygiene recommendations. Some of the suggested performance indicators include: periodic monitoring of hand hygiene adherence and providing feedback to personnel regarding their performance, monitoring the volume of alcohol-based handrub used/1000 patient days, monitoring adherence to policies dealing with wearing artificial nails and focused assessment of the adequacy of healthcare personnel hand hygiene when outbreaks of infection occur.
- Allergic contact dermatitis due to alcohol hand rubs is very uncommon. However, with increasing use of such products by healthcare personnel, it is likely that true allergic reactions to such products will occasionally be encountered.
- Alcohol-based hand rubs take less time to use than traditional hand washing. In an eight-hour shift, an estimated one hour of an ICU nurse's time will be saved by using an alcohol-based handrub.
- These guidelines should not be construed to legalize product claims that are not allowed by an FDA product approval by FDA's Over-the-Counter Drug Review. The recommendations are not intended to apply to consumer use of the products discussed.

Continuing Education

Last year, the Education Committee (Committee) began holding roundtable meetings to gather input for strengthening continuing education (CE) course requirements. Initially the idea was to require all CE providers to register with the Respiratory Care Board (Board), but after much thought and discussion, it was found that requiring providers to register with the Board would prove to be an expensive endeavor. In light of the State's fiscal restraints and the Board's own efforts to minimize costs, this pathway was not an option.

Instead, the Committee made a recommendation to the Board last November, to amend CE requirements so that courses would have to be provided by or approved by recognized organizations as follows:

- 1) Any post-secondary institution accredited by a regional accreditation agency or association recognized by the United States Department of Education;
- 2) A hospital or healthcare facility licensed by the California Department of Health Services;
- 3) The American Association for Respiratory Care;
- 4) The California Society for Respiratory Care (and all other state societies directly affiliated with the American Association for Respiratory Care);
- 5) The American Medical Association;
- 6) The California Medical Association;
- 7) The California Thoracic Society;
- 8) The American College of Surgeons;
- 9) The American College of Chest Physicians, or
- 10) Any entity approved or accredited by the California Board of Registered Nursing or the Accreditation Council for Continuing Medical Education.

Licensees are still required to maintain proof of completion for CE courses completed for a period of 4 years. Once these regulations are in effect, proof of completion includes identification that each course was provided by or approved by one of the above organizations.

Changes were also made to the maximum allowable credit that can be granted for various certifications and types of courses (i.e. ACLS, NRP, PALS, ATLS, review courses, etc.).

And to dispel a very popular rumor.....It was brought to the Board's attention there is/was a rumor that the Board is raising the number of CE hours required. The truth is that the Committee received a suggestion to double the number of CE hours required by a meeting participant, but the suggestion was rejected by the Committee. While it is clear that education in general, is paramount in gaining respect for and raising awareness of the profession, it was not the purpose of this exercise. The Committee believed such an action would place a hardship on RCPs at this time and would show special interest to the meeting attendees, who in large part were CE providers. It is clear that many dedicated RCPs strongly support the increase in the number of CE hours. Likewise, there are just as many dedicated RCPs that believe on-the-job education is most valuable. In the future, if the Board decides to explore the option of increasing the number CE hours, the matter will be open for public comment. It is important for all interested parties to participate.

The regulation process will be initiated this month and is expected to take anywhere from 6 to 12 months to complete, at which time the requirements will go into effect. To view the actual language, please log on to our Web site at: www.rcb.ca.gov and click on "Laws/Regulations" on the left side of the page.



Sam Giordano, Executive Director American Association for Respiratory Care (AARC)

It was an honor to have Sam Giordano, Executive Director of the AARC, address the Respiratory Care Board (Board) at its Nov. 8th meeting, on a number of issues facing the respiratory care profession. Throughout the entire meeting, Mr. Giordano provided a wealth of information and expertise in many areas. Mr. Giordano specifically addressed the Board on the areas of continuing education and continuing competency as they relate to strengthened consumer protection.

Mr. Giordano has had a major influence on the direction the respiratory care profession has taken throughout the years. For his dedication and tireless efforts, Mr. Giordano was awarded the Jimmy A. Young Medal by the AARC in October 2002. Many of the Board's members expressed what a great honor it was to have had the opportunity to meet such an influential and distinguished member of the respiratory profession.

RCP Recruitment

A principal outreach goal of the Respiratory Care Board (Board) remains to, "increase the number of qualified and competent respiratory care practitioners in the State of California, to address the RCP shortage."

During 2002, Board staff, with the assistance of many program directors and members of the profession, attended over 10 career fairs and conferences and coordinated the attendance of respiratory care program volunteers at 15 high school career days.

In January 2003, the Board distributed postcards to all California high schools seeking information on upcoming career days; a follow-up to the distribution of pamphlets and brochures regarding the profession last May. As many as 30 high school representatives had contacted the Board by mid-February, requesting Board staff to participate in booth exhibitions and/or RCP speakers to provide presentations on the field.

Where an RCP is requested for speaking engagements, the Board acts as a liaison in uniting the high school with an RCP in the same area. This has proven to be an exceptional recruitment opportunity for the programs and has been successful, in large part, due to the willingness of program directors to take time out of their busy schedules to visit and make presentations.

There have been a number of people to thank for the success in promoting the respiratory care profession. The Board recognizes the following RCPs and sincerely appreciates their assistance and support in this endeavor:

Steven Boyd, MS, RRT
Fresno City College

Michael Carr, BA, RRT
East Los Angeles College

Robert Chudnofsky, BS, RRT, RCP
Napa Valley College

Virginia Ettinger, MPH, RRT, RCP
Los Angeles Valley College

Christine Kingston, BS, RRT
Simi Valley Adult School

Terrance Krider, BS, RRT
Mt. San Antonio College

Terry Lyle, MS, RRT, RCP
Modesto Junior College

Lorenda Seibold-Phalan, MA, RCP, RRT
Grossmont College

Louis Sinopoli, EdD, RRT
El Camino College

Heidi Story, RRT, RCP
Ohlone College

James Warman, PhD, RRT
American River College

Barry Westling, MS, RRT, RPFT
San Joaquin Valley College, Bakersfield

Julius Autry, RRT, BVE, RCP
East Los Angeles College

The Board would also like to give a very special thanks to Mr. Julius Autry who has been extremely generous with his time and expertise. Mr. Autry has graciously attended various career fairs and high school events to bring awareness to and promote the respiratory care profession. His willingness to assist the Board has been a clear demonstration of his dedication to the licensees and consumers of California. Thank you again Mr. Autry for your support!

Jennifer Mercado and Christine Molina
Board Staff

We'd be amiss to not mention Christine Molina, Staff Services Manager, and Jennifer Mercado, Staff Services Analyst, for their contributions to this goal. Christine Molina is responsible for overseeing and coordinating fairs and presentations and has gone above and beyond in negotiating contracts and working with school representatives. Jennifer Mercado is responsible for attending numerous fairs and high school exhibitions. This in itself takes a well organized person able to tackle mishaps at the last minute. Ms. Mercado has gone the extra mile on many occasions (i.e. traveling odd hours and unusual terrain, rising at 3 a.m. to visit and personally assist the mail courier to find a misplaced shipment needed that day, taking advantage of opportunities while in route to personally stop by career centers in high schools, etc...).

If anyone you know is interested in learning more about a career in the respiratory care field, please have them visit our Web site or contact the Board office for a free brochure.

Web site: www.rcb.ca.gov

E-Mail: rcbinfo@dca.ca.gov

Toll-free Telephone No.: (866) 375-0386

Recognition of Illness Associated with the Intentional Release of a Biologic Agent

Original release 10/19/01 by the
Centers for Disease Control and Prevention

After the September 11th attacks in New York City and Washington, D.C., the Centers for Disease Control and Prevention (CDC) recommended heightened surveillance for any unusual disease occurrence or increased numbers of illnesses that might be associated with the terrorist attacks. The CDC issued the following report which provides guidance for healthcare providers and public health personnel about recognizing illnesses or patterns of illness that might be associated with intentional release of biologic agents.

Healthcare Providers

Healthcare providers should be alert to illness patterns and diagnostic clues that might indicate an unusual infectious disease outbreak associated with intentional release of a biologic agent and should report any clusters or findings to their local or state health department. The covert release of a biologic agent may not have an immediate impact because of the delay between exposure and illness onset, and outbreaks associated with intentional releases might closely resemble naturally occurring outbreaks.

Indications of intentional release of a biologic agent include:

1) an unusual temporal or geographic clustering of illness (e.g., persons who attended the same public event or gathering) or patients presenting with clinical signs and symptoms that suggest an infectious disease outbreak (e.g., >2 patients presenting with an unexplained febrile illness associated with sepsis, pneumonia, respiratory failure, or rash or a botulism-like syndrome with flaccid muscle paralysis, especially if occurring in otherwise healthy persons);

2) an unusual age distribution for common diseases (e.g., an increase in what appears to be a chickenpox-like illness among adult patients, but which might be smallpox); and

3) a large number of cases of acute flaccid paralysis with prominent bulbar palsies, suggestive of a release of botulinum toxin.

CDC defines three categories of biologic agents with potential to be used as weapons, based on ease of dissemination or transmission, potential for major public health impact (e.g., high mortality), potential for public panic and social disruption, and requirements for public health preparedness. Agents of highest concern are *Bacillus anthracis* (anthrax), *Yersinia pestis* (plague), *variola major* (smallpox), *Clostridium botulinum* toxin (botulism), *Francisella tularensis* (tularemia), filoviruses (Ebola hemorrhagic fever, Marburg hemorrhagic fever); and arenaviruses (Lassa [Lassa fever], Junin [Argentine hemorrhagic fever], and related viruses). The following summarizes the clinical features of these agents.

Anthrax.

A nonspecific prodrome (i.e., fever, dyspnea, cough, and chest discomfort) follows inhalation of infectious spores.

Approximately 2-4 days after initial symptoms, sometimes after a brief period of improvement, respiratory failure and hemodynamic collapse ensue. Inhalational anthrax also might include thoracic edema and a widened mediastinum on chest radiograph. Gram-positive bacilli can grow on blood culture, usually 2-3 days after onset of illness.

Cutaneous anthrax follows deposition of the organism onto the skin, occurring particularly on exposed areas of the hands, arms, or face. An area of local edema becomes a pruritic macule or papule, which enlarges and ulcerates after 1-2 days. Small, 1-3 mm vesicles may surround the ulcer. A painless, depressed, black eschar usually with surrounding local edema subsequently develops. The syndrome also may include lymphangitis and painful lymphadenopathy.

Plague.

Clinical features of pneumonic plague include fever, cough with muco-purulent sputum (gram-negative rods may be seen on gram stain), hemoptysis, and chest pain. A chest radiograph will show evidence of bronchopneumonia.

Botulism.

Clinical features include symmetric cranial neuropathies (i.e., drooping eyelids, weakened jaw clench, and difficulty swallowing or speaking), blurred vision or diplopia, symmetric descending weakness in a proximal to distal pattern, and respiratory dysfunction from respiratory muscle paralysis or upper airway obstruction without sensory deficits. Inhalational botulism would have a similar clinical presentation as food-borne botulism; however, the gastrointestinal symptoms that accompany food-borne botulism may be absent.

Smallpox (variola).

The acute clinical symptoms of smallpox resemble other acute viral illnesses, such as influenza, beginning with a 2-4 day nonspecific prodrome of fever and myalgias before rash onset. Several clinical features can help clinicians differentiate varicella (chickenpox) from smallpox. The rash of varicella is most prominent on the trunk and develops in successive groups of lesions over several days, resulting in lesions in various stages of development and resolution. In comparison, the vesicular/pustular rash of smallpox is typically most prominent on the face and extremities, and lesions develop at the same time.

Inhalational tularemia.

Inhalation of *F. tularensis* causes an abrupt onset of an acute, nonspecific febrile illness beginning 3-5 days after exposure, with pleuropneumonitis developing in a substantial proportion of cases during subsequent days. Hemorrhagic fever (such as would be caused by Ebola or Marburg viruses). After an incubation period of usually 5-10 days (range: 2-19 days), illness is characterized by abrupt onset of fever, myalgia, and headache. Other signs and

symptoms include nausea and vomiting, abdominal pain, diarrhea, chest pain, cough, and pharyngitis. A maculopapular rash, prominent on the trunk, develops in most patients approximately 5 days after onset of illness. Bleeding manifestations, such as petechiae, ecchymoses, and hemorrhages, occur as the disease progresses.

Clinical Laboratory Personnel

Although unidentified gram-positive bacilli growing on agar may be considered as contaminants and discarded, CDC recommends that these bacilli be treated as a "finding" when they occur in a suspicious clinical setting (e.g., febrile illness in a previously healthy person). The laboratory should attempt to characterize the organism, such as motility testing, inhibition by penicillin, absence of hemolysis on sheep blood agar, and further biochemical testing or species determination.

An unusually high number of samples, particularly from the same biologic medium (e.g., blood and stool cultures), may alert laboratory personnel to an outbreak. In addition, central laboratories that receive clinical specimens from several sources should be alert to increases in demand or unusual requests for culturing (e.g., uncommon biologic specimens such as cerebrospinal fluid or pulmonary aspirates).

When collecting or handling clinical specimens, laboratory personnel should

- 1) use Biological Safety Level II (BSL-2) or Level III (BSL-3) facilities and practices when working with clinical samples considered potentially infectious;

- 2) handle all specimens in a BSL-2 laminar flow hood with protective eyewear (e.g., safety glasses or eye shields), use closed-front laboratory coats with cuffed sleeves, and stretch the gloves over the cuffed sleeves;

- 3) avoid any activity that places persons at risk for infectious exposure, especially activities that might create aerosols or droplet dispersal;

- 4) decontaminate laboratory benches after each use and dispose of supplies and equipment in proper receptacles;

- 5) avoid touching mucosal surfaces with their hands (gloved or ungloved), and never eat or drink in the laboratory; and

- 6) remove and reverse their gloves before leaving the laboratory and dispose of them in a biohazard container, and wash their hands and remove their laboratory coat.

When a laboratory is unable to identify an organism in a clinical specimen, it should be sent to a laboratory where the agent can be characterized, such as the state public health laboratory or, in some large metropolitan areas, the local health department laboratory. Any clinical specimens suspected to contain variola (smallpox) should be reported to local and state health authorities and then transported to CDC. All variola diagnostics should be conducted at CDC laboratories. Clinical laboratories should report any clusters or findings that could indicate intentional release of a biologic agent to their state and local health departments.

Heightened awareness by infection-control professionals (ICPs) facilitates recognition of the release of a biologic agent. ICPs are involved with many aspects of hospital operations and several departments and with counterparts in other hospitals. As a result, ICPs may recognize changing patterns or clusters in a hospital or in a community that might otherwise go unrecognized.

ICPs should ensure that hospitals have current telephone numbers for notification of both internal (ICPs, epidemiologists, infectious diseases specialists, administrators, and public affairs officials) and external (state and local health departments, Federal Bureau of Investigation field office, and CDC Emergency Response office) contacts and that they are distributed to the appropriate personnel. ICPs should work with clinical microbiology laboratories, on- or off-site, that receive specimens for testing from their facility to ensure that cultures from suspicious cases are evaluated appropriately.

If you believe that you have been exposed to a biological or chemical agent, or if you believe an intentional biological threat will occur or is occurring, please contact your local health department and/or your local police or other law enforcement agency.

Healthcare professionals may also contact:

**CDC's
Emergency Response Hotline
(24 hours) at (770) 488-7100.**

If you have general program questions, please call (404) 639-0385.

You can find more information on this subject and biological agents at the Centers for Disease Control and Prevention's Web site: www.cdc.gov or <http://www.bt.cdc.gov>.

Other resources include: the U.S. Army Medical Research Institute of Infectious Diseases at <http://www.usamriid.army.mil/education/bluebook.html>; the Association for Infection Control Practitioners at <http://www.apic.org>; and the Johns Hopkins Center for Civilian Biodefense at <http://www.hopkins-biodefense.org>.

Smallpox Vaccine Distributed

The Centers for Disease Control and Prevention (CDC) announced January 22, 2003 that it began distributing the smallpox vaccine to state and local governments that will coordinate the vaccination of smallpox response teams. The teams are part of the nation's voluntary vaccination program to protect Americans from the potential threat of a terrorist attack involving the release of the smallpox virus.

"Our highest priority is to vaccinate members of smallpox response teams in the states," said Dr. Julie Gerberding, director, CDC. "Several months of detailed planning and training, and the development of scientifically sound and informative educational materials have prepared us for the safe and rapid implementation of the plan to vaccinate those healthcare professionals who would be on the front lines in the event of a smallpox attack."

At the time of this announcement, CDC delivered kits with enough vaccine and needles for 21,600 public health and healthcare workers to Connecticut, Nebraska, Vermont and Los Angeles County. And 20 states (including 1 county) have requested nearly 100,000 doses of the vaccine.

This was the first shipment of vaccine to state and local governments under the President's plan to protect the American people from an intentional release of the smallpox virus. Under the program, smallpox vaccine is being offered to those most likely to respond to a potential outbreak of the disease. By preparing these smallpox response teams, the government will be able to protect the American people in the event of a smallpox release.

In all states, smallpox vaccination is voluntary. Each state notifies CDC when it is ready to receive its shipment of smallpox vaccine to begin pre-event vaccination of public health and healthcare workers.

Once CDC receives a request for smallpox vaccine from a state, the order is forwarded to the National Pharmaceutical Stockpile for processing and shipment.

Smallpox vaccine is not given with a hypodermic needle. The vaccine is administered using a bifurcated (two-pronged) needle that is dipped into the vaccine solution. The needle is used to prick the skin, usually the upper arm, several times in a few seconds. Each shipment of vaccine includes bifurcated needles.

For more information about smallpox, visit www.smallpox.gov or www.cdc.gov/smallpox. Spanish-language materials are available at www.cdc.gov/smallpox.

CDC has a public information hotline for questions about smallpox and smallpox vaccine at 888-246-2675; Spanish 888-246-2857; TTY 866-874-2646.

American Lung Association's COPD Lung Profiler™

The American Lung Association announced in November, the introduction of a new free Internet-based lung health decision-support tool for patients suffering from COPD (Chronic Obstructive Pulmonary Disease), a smoking-related illness commonly known as chronic bronchitis, emphysema or "smoker's lung."

The COPD Lung Profiler™ is a user-friendly interactive Web-based tool that confidentially matches an individual's clinical information to a carefully selected group of peer-reviewed clinical studies. As a result, patients receive personalized information about treatment options and side effects relevant to their condition, along with helpful questions to discuss with their doctors. The site can be easily accessed by going to www.lungusa.org and clicking on the COPD Profiler icon.

COPD is the nation's fourth leading cause of death with approximately 119,000 Americans dying each year as a result of this respiratory disease. COPD is the only one of the top ten illnesses on the rise and more than 726,000 COPD patients are hospitalized each year due to exacerbations – a severe COPD attack when patients struggle to breathe. According to a recent study from the Centers for Disease Control, the number of women diagnosed with the disease has surpassed men.

"Smoking is a physical addiction which makes quitting very difficult," said Dr. Edelman, who recommends smoking cessation as the first step for COPD patients. "The information offered to patients through the COPD Lung Profiler may provide an additional motivator to help them quit smoking and seek treatment from their physician, which is the best thing they can do for themselves." COPD is a slowly progressive disease, not presenting any obvious signs or symptoms until many patients have reached middle age - 40s. And many of those who do experience symptoms - like shortness of breath during a walk or climbing stairs - will reduce the level of their activities, so those symptoms disappear. The problem is the disease is still there. To combat this, the American Lung Association recommends that anyone who has ever smoked should visit their doctor and ask for a lung function test, known as a spirometry test.

"Anyone with a smoking history, who notices a constant nagging cough, excess mucus production or shortness of breath after mild exertion may have COPD and should see their doctor," said Dr. Edelman.

The American Lung Association introduced the COPD Lung Profiler in November, which was COPD Awareness Month. The designation, which was supported by President George W. Bush, was made to raise awareness across the United States for this devastating disease.

JCAHO's 2003 National Patient Safety Goals

In July 2002, the Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) Board of Commissioners approved the 2003 National Patient Safety Goals, the first to be issued by JCAHO. JCAHO established these goals to help accredited organizations address specific areas of concern in regards to patient safety.

Each year, the goals and associated recommendations are re-evaluated; some may continue while others will be replaced because of emerging new priorities. New goals and recommendations are announced in July and become effective on Jan. 1 of the following year.

Beginning Jan. 1, 2003, all JCAHO accredited healthcare organizations will be surveyed for implementation of the following recommendations, or acceptable alternatives, as appropriate to the services the organization provides. Alternatives must be at least as effective as the published recommendations in achieving the goals.

1. Improve the accuracy of patient identification.

Use at least two patient identifiers (neither to be the patient's room number) whenever taking blood samples or administering medications or blood products.

Prior to the start of any surgical or invasive procedure, conduct a final verification process, such as a "time out," to confirm the correct patient, procedure and site, using active—not passive—communication techniques.

2. Improve the effectiveness of communication among caregivers.

Implement a process for taking verbal or telephone orders that require a verification "read-back" of the complete order by the person receiving the order.

Standardize the abbreviations, acronyms and symbols used throughout the organization, including a list of abbreviations, acronyms and symbols not to use.

3. Improve the safety of using high-alert medications.

Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride >0.9%) from patient care units.

Standardize and limit the number of drug concentrations available in the organization.

4. Eliminate wrong-site, wrong-patient, wrong-procedure surgery.

Create and use a preoperative verification process, such as a checklist, to confirm that appropriate documents (e.g., medical records, imaging studies) are available.

Implement a process to mark the surgical site and involve the patient in the marking process.

5. Improve the safety of using infusion pumps.

Ensure free-flow protection on all general-use and PCA (patient controlled analgesia) intravenous infusion pumps used in the organization.

6. Improve the effectiveness of clinical alarm systems.

Implement regular preventive maintenance and testing of alarm systems.

Assure that alarms are activated with appropriate settings and are sufficiently audible with respect to distances and competing noise within the unit.

Medicare Home Health Services Benefit

Continuing to follow the American Association for Respiratory Care's lead, the Respiratory Care Board (Board) issued another letter to all California congressional members in January urging for legislation that will recognize respiratory therapists under the Medicare home health services benefit. It has been shown that the use of RCPs to treat respiratory diseases results in controlled costs and higher quality of care. The Board is optimistic that its efforts will not go unheeded and that, ultimately, California's consumers with respiratory ailments will greatly benefit.

Scope of Practice Inquiries

Inquiry: I am faxing you this letter to inquire about CPAP, Auto CPAP and BiPAP set ups. I realize respiratory therapy programs educate their students on how to do CPAP set-up, but so do polysomnography programs. I have made inquiries with the Department of Health Services in regards to this and I am now seeking your guidance. I need a copy of the law or laws that state if you are not a licensed Respiratory Therapist you can not do a set up or titration. I am very well aware that it is in the Respiratory Care Board's scope of practice but where does it say that only a Respiratory Therapist can perform this procedure.

Response: Section 3702 of the practice act specifically defines what the practice act means and includes. It defines the practice of respiratory care as caring for patients with deficiencies and abnormalities, which affect the pulmonary system, and associated aspects of cardiopulmonary and other system functions. Based upon the current practice act it does require that a licensed respiratory care practitioner administer or educate patients on CPAP, Auto CPAP and BiPAP utilizing a physician's order. Because of the potential risk to patient safety, unlicensed personnel cannot perform these practices.

Inquiry: Our Imaging Department has two MRI suites. To meet the needs of ventilator patients, the Anesthesia/Surgery Department purchased an MRI-safe anesthesia system. The anesthesia system is manufactured by Datex-Ohmeda. The Anesthesiology Department claims inadequate manpower and are pushing our Respiratory Care Practitioners to provide ventilation and monitoring of the respiratory status for their intubated patients undergoing MRI. These patients would not be given anesthetic agents through the MRI system. They would instead be pre-medicated in the critical care arena prior to transport to the MRI suite and then be placed on the anesthesia system during the imaging process. If further sedation were required, it would be delivered via an intravenous route as conscious sedation. The Medical Center currently has a policy regarding RCPs and the use of conscious sedation for the purpose of intubation by a select group of high functioning intubation certified RCPs.

From my viewpoint, this request for our staff's services could create licensure problems due to the use of a ventilator that is licensed and approved for use by physicians in the delivery of anesthetic agents. The anesthesia system is radically different than the fleet of mechanical ventilators used in our department and therefore competency in the use of a different (and rarely used machine) is also a concern. In point of fact, some RCPs have heard one anesthesiologist complain of his discomfort in using the machine due to his own unfamiliarity with this particular machine. All of the anesthesia systems in the medical center are made by Datex-Ohmeda.

I would appreciate a prompt response clarifying whether the RCP scope of practice would cover their use of an anesthesia machine being used "off label" as a ventilator.

Response: Under the Practice Act, this equipment is neither permissible nor forbidden from use by Respiratory Therapists. A licensed Respiratory Care Practitioner can practice under the direct supervision of a physician. If the Anesthesiologist trains, certifies and supervises this "select group of high functioning RCPs" to operate this equipment, the RCPs are functioning within the boundaries of their clinical practice act.

RCP Recognition Nominations

The Respiratory Care Board (Board) is honored to recognize respiratory care practitioners (RCPs) for contributing and strengthening consumer health, safety and welfare.

There are a number of ways RCPs make this impact, whether they are staff practitioners that perform routine equipment maintenance or procedures or managers who may have years of experience and education. Each RCP's dedication to the respiratory care field to better himself and better serve patients is the cornerstone for Board recognition.

Nominations may include extraordinary actions taken by an RCP that indirectly or directly affected one or more patients' health, safety and welfare. Extraordinary actions that **indirectly** affect consumers health, safety and welfare include, *but are not limited to*, an RCP who: overcame obstacles to further her education; regularly attends continuing education conferences and courses and shares new information, or continually improves or makes viable recommendations to respiratory care processes and procedures. Extraordinary actions that **directly** affect consumers include, but are not limited to, an RCP: who makes contributions and efforts above and beyond the call of duty that result or resulted in better patient-health outcomes; who continually and regularly sees to the comfort of patients, or whose quick thinking and/or actions saved a patient's life or quality of life.

The Board tries to recognize one individual at each of its meetings, followed by recognition in its newsletter. Nominations should be received five weeks prior to each scheduled Board meeting. Nominations for recognition at the Board's next meeting, tentatively scheduled for May 16, should be received by April 11th.

To nominate an RCP for recognition, draft a letter or e-mail that includes:

- the name of the RCP nominated;
- the RCP's employment address and telephone number;
- your name, address and telephone no.;
- a description of why you believe your nominee is deserving of recognition.

Mail your letter to:

Respiratory Care Board
444 North 3rd Street, Suite 270
Sacramento, CA 95814

Attn: Stephanie Nunez, Executive Officer
or E-Mail:

rcbinfo@dca.ca.gov
Attn: Stephanie Nunez, Executive Officer

Fees and Expenditures

The Respiratory Care Board (Board) continues to strive toward reducing expenditures and increasing applicant and licensee-retention levels. It is optimistic that renewal fees will be reduced in the future, especially with significant increases in new applicants realized.

In the last two years, the Board has reduced its total budget amount by \$322,000. The Board's request to reduce its budgetary line item for Attorney General expenditures by \$132,000 was approved by the Department of Finance in November 2002 (and is pending Legislative approval). In addition to the 3 enforcement staffing positions the Board relinquished last year, it also lost 2 additional positions as a result of budget reductions made across the board affecting all State agencies, late last year. The abolishment of these 5 positions has resulted in a \$190,000 reduction to the Board's budget.

In the last newsletter, the Board reported an increase in the number of new applications it had received. Though it is too early to tell, preliminary numbers suggest this is a continuing trend. The number of applications received through Dec. 31, 2002 shows an increase of 31% compared to the number of applications received at the same time the previous year. Since most applications are received in May and June of each year (coinciding with the end of most respiratory programs), it is probable that the Board will see a significant increase in the total number of applications for this fiscal year (July 1, 2002 through June 30, 2003).

	97/98	98/99	99/00	00/01	01/02	02/03
Total No. of Applications Received in Fiscal Year (July 1st - June 30th):	722	849	614	397	638	670 (projected)
Total No. of Applications Received as of December 31st (1/2 point) of each fiscal year:	177	265	242	157	240	315

Printed below are the Board's current and projected revenues and expenditures, as well as the outlook of expenditures by program component for this fiscal year (July 1, 2002 through June 30, 2003). The Board is projecting revenue based on 670 applicants for this fiscal year according to the assumptions above.

REVENUE

Revenue Category	ACTUAL 2001/02	Scheduled 2002/03	Actual Rev. thru 12/31/02	Projected thru 2002/03
Exam/Re-Exam	\$53,530	\$119,500	\$16,350	\$35,010
Application Fees	\$135,250	\$155,250	\$67,950	\$140,250
Initial License	\$71,264	\$71,050	\$31,820	\$55,860
Renewal	\$1,383,824	\$1,472,000	\$912,127	\$1,529,500
Endorsement	\$50,450	\$22,500	\$11,550	\$20,625
Cite and Fine	\$18,729	\$25,000	\$4,885	\$7,500
Miscellaneous	\$118,660	\$59,000	\$52,624	\$126,515
<i>Unscheduled Reimbursements</i>			\$103,139	\$190,000
Total Revenue	\$1,831,707	\$1,924,300	\$1,200,445	\$2,105,260

Miscellaneous revenue includes: dishonored check fees, statute/reg exam fees, transcript review fees, delinquent renewal fees, duplicate license fees, interest, franchise tax intercept, fingerprints, etc.

The gap between revenues and expenditures is closing. Last fiscal year revenues fell short of actual expenditures by approximately \$815,000. While this year, projections indicate the gap will be narrowed to approximately \$133,000.

Generally Board projections are within 5%, give or take, of actual total revenue and expenditures. Therefore, it is possible that revenues may actually exceed expenditures. Actual figures are available in September when the annual budget is closed out. As done in November 2002, the Board will again review its budget and fee schedule in detail at its next meeting held in November 2003.

EXPENDITURES

Expenditure Items	ACTUAL 2001/02	Budgeted 2002/03	Actual Exp. thru 12/31/02	Projected thru 2002/03*
Salary & Benefits	\$1,046,975	\$1,080,577	\$536,076	\$1,101,932
Training / Travel	\$37,888	\$52,901	\$11,926	\$26,500
Printing / Postage	\$91,142	\$64,893	\$24,361	\$90,000
Fixed Expenses ¹	\$548,752	\$432,158	\$111,487	\$271,400
ProRata ²	\$382,161	\$397,767	\$210,741	\$397,767
Enforcement ³	\$539,706	\$639,091	\$161,754	\$351,000
Total Expenditure	\$2,646,624	\$2,667,387	\$1,056,345	\$2,238,599

¹ Fixed Expenses include general expenses, communications, facility operations, data processing maintenance, consultant and professional services, Teale Data Center, Examination and Equipment expenses.

² ProRata includes departmental and central administrative services.

³ Enforcement includes: Fingerprints, Investigations, Attorney General, Office of Administrative Hearings, Evidence and Witness and Vehicle Operations expenses.

EXPENDITURES BY COMPONENT

July 1, 2002 - June 30, 2003 (Projected)

Expenditures	Enforcement	Licensing	Admin	Projected thru 2002/03*
Salary & Benefits	\$561,985	\$187,328	\$352,618	\$1,101,932
Training / Travel	\$13,000	\$500	\$13,000	\$26,500
Printing / Postage	\$22,500	\$22,500	\$45,000	\$90,000
Fixed Expenses	\$118,014	\$89,338	\$74,048	\$271,400
ProRata	\$202,861	\$67,620	\$127,285	\$397,767
Enforcement	\$351,000	\$0	\$0	\$351,000
Total Expend.	\$1,269,360	\$367,287	\$611,952	\$2,238,599
	57%	16%	27%	

Disciplinary

Actions

Taken

July 1, 2002 through
December 31, 2002

FINAL DECISIONS REVOKED OR SURRENDERED

Amisola, Jude M., RCP 21381
Los Angeles, CA
Anderson, Ursula, RCP 12936
Los Angeles, CA
Bailes, William, RCP 20387
Fresno, CA
Duffey, Ervin Wayne, RCP 3840
San Bernardino, CA
Galpin, Kenneth Scott, RCP 2181
El Dorado, CA
Hoover, Melissa Marie, RCP 15958
Tulare, CA
Howell (Sardar), Zenith Z., RCP 1312
San Bernardino, CA
Mendoza, Serafin Perez, RCP 6292
Alameda, CA
Miller, Larry R., RCP 7159
San Diego, CA
Smoot Sr., Terrance B., RCP 10676
Siskiyou, CA
Taylor, Kenneth Edward, RCP 6998
Los Angeles, CA
Townsend, John Lawrence, RCP 7145
Lake, CA
Yates, Roy L., RCP 12727
Los Angeles, CA
Yu, Bonito Chua, RCP 11946
San Mateo, CA

OTHER DECISIONS

Gonzales, Raymond Martin – Denial
Riverside, CA

PLACED ON PROBATION / ISSUE CONDITIONAL LICENSE

Anderson, Darrell Scott, RCP 15691
Battle-Montoya, Susan, RCP 16238
Breazeale, Wally W., RCP 18938
Butler, Beth Lorene, RCP 9848
Chamberlain, Keith Allen, RCP 11622
Chan, Dennis William, RCP 12160
Conley, Darby Morgan, RCP 18617
De Jesus, Mario M., RCP 15450
Enyeart, Mark Leroy, RCP 11238
Figgins-Johnson, Karen D., RCP 5157
Gilles, Cesar H., RCP 18653
Green, Don, RCP 9685
Greenwood, Thomas W., RCP 12066
Horrell, Crystal Ann, RCP 22654
Johnston, James Edward, RCP 22601

Koen, Shaun Eric, RCP 22734
Lim, Steve Michael, RCP 1663
Pickett, Michele Eileen, RCP 17206
Ratter, Tamara, RCP 12224
Resurreccion, Jamie J., RCP 22742
Roscoe, James Timothy, RCP 13526
Santini, Mark A., RCP 21080
Silverio, Maria Alexandra, RCP 19600
Trujillo, David, RCP 7497
Van Hull, Barbara Patricia, RCP 2832
White, John David, RCP 11059
White, Katherine Renae, RCP 21905

PUBLIC REPRIMAND

Aguiar, Raul Grimaldi, RCP 21438
Allen, Sean C., RCP 19935
Allison, William M., RCP 8652
Anderson, Paul David, RCP 17217
Buck, Warren K., RCP 8789
Capdeville, Matthew James, RCP 17958
Cervantes, Jose Gabriel, RCP 22624
Frandsen, Charles W., RCP 7904
Hernandez-Castillo, Reuben, RCP 19356
Johnston, Victoria, RCP 12289
Jones, Viola Maria, RCP 19621
Jozwick, Julia Marie, RCP 22745
Kauble, James B., RCP 8225
Knoepfel, Susan Lee, RCP 8625
Leask, Dave B., RCP 20272
Lee, Brian Po-Lin, RCP 22621
Manister, Dawn Helane, RCP 16116
Marcu, Florin, RCP 21173
Mensonides, Dennis James, RCP 22681
Powell, Stewart Gary, RCP 20470
Richardson, Andre Joey, RCP 19890
Shaw, Randolph Todd, RCP 15152
Smith, David James, RCP 22501
Thornton, Douglas Graham, RCP 17978
Valenzuela, Ruel Santos, RCP 19666
Vogt, Christopher Matthew, RCP 9560
Wolf, Frank John, RCP 11708

CITED & FINED

Baier, Christopher David, RCP 20234
Galvan, Alejandro Marcos, RCP 18641
Gary, Christopher Scott, RCP 17631
Jimenez, Katherine R., RCP 17790

STATEMENT OF ISSUES

Bergmann, Jason M.
Dimacali, Erica Joy
Diwa, Jonathan Taylor
Georgeon, Mathew L.
Ivery, Lamont Otis
Munoz, Estelle

ACCUSATIONS FILED

Acosta, Alfieri T., RCP 12869
Bell, Dwayne Allen, RCP 10145
Bryd, Don Michael, RCP 13958
Burries III, Solomon Lee, RCP 11961
Carlson, Kimberly Grace, RCP 855
Caruthers, Jeffery Lynn, RCP 9919
Conklin, John J., RCP 13897
Connors, Francine L., RCP 21471
Correa, Fermin, RCP 19401
Diwa, Elmer G., RCP 12948
Felomino, Jennie L., RCP 6534

Ferrante, Robert Charles, RCP 12827
Foley, Edwin David, RCP 12993
Garza, Robert, RCP 2580
Howard II, Colin C., RCP 1034
Huch, Steven, RCP 4904
Kaplan, Harris, RCP 8118
Karim, Patricia Ann, RCP 12453
Mack, Kim Dion, RCP 12961
Miller, Joe V., RCP 4286
Moore, Emery E., RCP 5938
Oehmen, Judith Immen, RCP 18516
Owens, Chuck, RCP 13384
Pena, Steven Fernando, RCP 15392
Pulos, George Thomas, RCP 16081
Steed, Reginald Decarlo, RCP 10870
Tager, Robert, RCP 3058
Tam, Steven Tom, RCP 53
Tana, Alejo M., RCP 13225
Temple, Evelyn, RCP 20522
Templeton, Stephanie Y., RCP 18775
Thompson, Howard Joseph, RCP 21883
Wilson, Reginald H., RCP 17198

ACCUSATION AND/OR PETITION TO REVOKE PROBATION FILED

Cudney, Cindy Marie, RCP 21840
Demouchet, Kerry Donald, RCP 617
Gwilliam, Alfred Hans, RCP 17521
Jordan, Richard Carl, RCP 2238
Nicola, Clarissa Denise, RCP 9290
Pierson, Melinda Nicole, RCP 21964
Releford, Steven Wayne, RCP 21481
Sturtz, Stephanie J., RCP 12085
Tuliau, Christopher Daniel, RCP 21890
Weseloh, Donald N., RCP 12576
Wooley II, Johnny, RCP 14957

DEFINITIONS

Final Decisions. Decisions become operative on the effective date, except in situations where a stay is ordered. This may occur after the publication of this newsletter.

Accusations Filed. An Accusation is the legal document wherein the charge(s) and allegation(s) against a licensee are formally pled.

Statements of Issues Filed. A Statement of Issues is the legal document wherein the charge(s) and allegation(s) against an applicant are formally pled.

Accusation and/or Petition to Revoke Probation. An Accusation and/or Petition to Revoke Probation is filed when a licensee is charged with violating the terms or conditions of his or her probation and/or with additional violations of the Respiratory Care Practice Act.

-
- To order copies of legal pleadings, •
- please send a written request, including •
- the name and license number (if appli- •
- cable), to the Board's Sacramento office •
- or e-mail address. •
-

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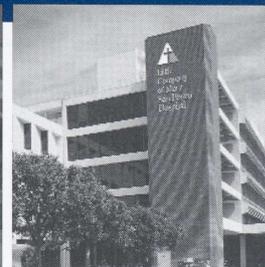
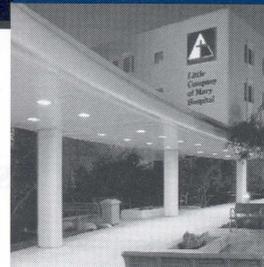
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Recently voted one of the two best medical facilities by Consumer's Guide to Hospitals and Doctors in the San Fernando and Santa Clarita Valleys, we are a 251-bed acute care facility offering the full continuum of health services. Submit resume to: Providence Holy Cross Medical Center, Human Resources Dept., 15031 Rinaldi St., P.O. Box 9600, Mission Hills, CA 91346, FAX (818) 898-4629.

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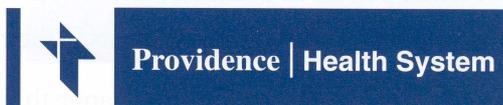
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Hoag Hospital, Attn: Human Resources
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Newport Beach, CA 92658-6100



Patients Need Access to Respiratory Therapists in the Home

Should California's Medicare beneficiaries have access to respiratory therapists in their homes? The American Association for Respiratory Care (AARC) believes that access to these experts would benefit patient care.

Unfortunately, current Medicare policy does not recognize a respiratory therapist's visit to a homebound Medicare patient as a skilled visit. Under Medicare regulations, only nurses and physical therapists provide skilled visits to respiratory therapy patients in their homes.

The AARC is trying to change this policy. The AARC, a national professional association for respiratory therapists located in Dallas, Texas, is working with the federal government to allow home health agencies (HHAs) the option of using respiratory therapists to deliver home respiratory therapy services.

The AARC worked with the Centers for Medicare and Medicaid Services (CMS), the agency that administers the Medicare program, to develop legislative language that would accomplish this goal in a budget neutral manner. This legislative language would not mandate the use of respiratory therapists, but would give HHAs another provider option. Aside from giving patients access to respiratory therapists, this proposal would help alleviate workforce shortage problems, especially in rural areas.

Under this proposal, respiratory therapists would not provide nursing or physical therapy services to homebound patients. Acting only within their scope of practice, respiratory therapists would deliver respiratory therapy to Medicare's pulmonary patients such as those with chronic obstructive pulmonary disease or who are on ventilators.

All California respiratory therapists can help give patients access to their services by writing your Members of Congress in the U.S. Senate and House of Representatives. Ask your congressional members to amend the Medicare home health services benefit to recognize respiratory therapists. This can be done in a cost neutral way in which everyone wins: patients gain access to care from respiratory therapists; home health agencies can meet patient needs and control costs through greater flexibility in resource utilization; physicians can tailor treatment regimens based on patient needs, and the Medicare program can offer choices to home health agencies, physicians, and patients without additional expense.

Fax a letter or e-mail your congressional offices today. Include a copy of this article. Interested patients should write their congressional members. After all, they have access to respiratory therapists in hospitals and skilled nursing facilities, why not their homes?

PLACE AN AD!

The *Respiratory Update* newsletter features current information on the business of the Respiratory Care Board of California (Board) and other matters affecting the profession.

The *Respiratory Update* is a two-color newsletter published two times each year and distributed to nearly 16,000 active respiratory care practitioners licensed in the State of California and to as many as 600 applicants for licensure.

If you are interested in placing an advertisement in the *Respiratory Update* or would like more information, please contact Jennifer Mercado at (916) 323-9983 or send her an e-mail at: rcbinfo@dca.ca.gov.



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**Mission
Statement**

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, and promoting the profession by increasing public awareness of respiratory care as a profession and supporting the development and education of all respiratory care practitioners.