



# Breathing Matters



FALL 2008

A BIENNIAL NEWSLETTER FROM THE RESPIRATORY CARE BOARD

## Governor Vetoes Bill to Establish Scope of Practice for Sleep Techs, Board Enforcement



In September 27, 2008, Senate Bill (SB) 1526 was unexpectedly vetoed by Governor Arnold Schwarzenegger, redirecting the course of events for the Respiratory Care Board. SB 1526 proposed to establish a system requiring all sleep testing personnel to be registered with the State. Consistent with the Governor's veto, the Board is expanding its enforcement activities to uphold its mandate to prevent the unqualified and/or unlicensed practice of respiratory care.

Governor Schwarzenegger vetoed SB 1526 (Perata) following the longest budget stalemate in history. The Governor stated the following in his veto message: "The historic delay in passing the 2008-2009 State Budget has forced me to prioritize the bills sent to my desk at the end of the year's legislative session. Given the delay, I am only signing bills that are the highest priority for California. This bill does not meet that standard and I cannot sign it at this time."

SB 1526 had proposed to further consumer protection by establishing a registration system for Polysomnography Technicians and included provisions for competency testing, education requirements, and supervision. It also would

... continued on page 5



The American Association for Respiratory Care's International Respiratory Congress is coming to sunny California, "Where Respiratory Therapists Shine!" We'll be there to capture it all, and we hope you are too! Please see page 3 for all the exciting details.

## Professionals Achieving Consumer Trust Summit

The Respiratory Care Board encourages you to attend the Professionals Achieving Consumer Trust Summit, presented by the California Department of Consumer Affairs (DCA) and the California Consumer Affairs Association. The Summit will take place from Tuesday, November 18, 2008, to Friday, November 21, 2008, at the Westin Los Angeles Airport Hotel, 5400 West Century Boulevard, Los Angeles, CA 90045.

The Summit will include DCA regulatory meetings, training sessions designed especially for board members, consumer advocates and law enforcement, panel discussions on important issues that affect DCA's consumer protection mission, and the Small Claims Court Advisors Training Session.

We invite you to attend the Respiratory Care Board's regulatory public meeting on Thursday, November 20, 2008, being held in conjunction with the Summit. This is an opportunity for stakeholders to gather and share information and to address common issues like workforce shortage and the value of a California professional license.

For more information, including specific workshops and registration information, please visit <http://www.dca.ca.gov/summit>.

### Inside this issue...

President's Message	2
Board Welcomes Lupe V. Aguilera, Public Member	3
AARC International Respiratory Conference Comes to California	3
Concurrent Therapy, What is Proper Protocol?	4
RCPs in the News	4
Board Appreciation	4
EMSA Recruiting Licensed RCPs	4
Board Recruiting Experts to Review Quality of Care Complaints	4
Enforcement Actions	11

DEPARTMENT OF CONSUMER AFFAIRS | [www.dca.ca.gov](http://www.dca.ca.gov)



RESPIRATORY CARE BOARD OF CALIFORNIA, 444 NORTH 3RD STREET, SUITE 270, SACRAMENTO CA 95811  
T: (916) 323-9983 TF: (866) 375-0386 F: (916) 323-9999 E: [rcbinfo@dca.ca.gov](mailto:rcbinfo@dca.ca.gov) [www.rcb.ca.gov](http://www.rcb.ca.gov)



## President's Message

As our weather begins to cool and we approach the end of 2008, we need to realize that the time to refocus our attention toward the fall election is just around the corner. So, how have you prepared yourself for the election? Have you taken the time to research the candidates and the issues? Are you clear on what propositions and candidates will improve this profession's ability to render efficient and safe healthcare? Have you e-mailed your local, state, and national candidates to gain understanding of their position(s)? If not, the time to get busy is now. Make the effort and reach out to the candidates. Get yourself informed and up-to-date on the issues, candidates and the outcomes you can expect when you vote. Take time to identify your top concerns, and get the candidates' action plans to determine if they will make them a reality. For me, I want to understand their ability and vision to improve the current economy, eliminate our dependence on foreign oil, and to hear their plan to accelerate and deliver cleaner, renewable, and energy efficient power and transportation for our nation. We all have the ability to make a significant difference this election. What will your choice be? Active participation or complacency? Decide to weigh in on this important election.



Larry L. Renner, BS, RRT, RPFT, RCP  
President

## Respiratory Care Board of California

Larry L. Renner, BS, RRT,  
RPFT, RCP  
President

Barbara M. Stenson, RCP, RRT  
Vice President

Lupe V. Aguilera  
Member

Gopal D. Chaturvedi  
Member

Sandra Magaña, MA  
Member

Murray Olson, RCP, RRT  
Member

Richard L. Sheldon, MD  
Member

Charles B. Spearman, MSED,  
RCP, RRT  
Member

Stephanie Nunez  
Executive Officer

This past year, the Board has continued its efforts to eliminate the unlicensed practice of respiratory care across the State. In fact, the Board is now issuing citations and fines to companies that are providing this type of care within their organizations or facilities. It is not a decision we arrived at haphazardly. It required much discussion and reflection before embarking down this road. However, it was a course that became necessary to protect the safety of the State's consumers. In fact, we re-affirmed our commitment to this effort at our recent strategic planning session held in March 2008. The Board feels strongly that the strong technology applied, and the diversity of the care warrants the use of an authorized and qualified licensed professional—professionals whose scope of practice is inclusive of data gathering, analysis, assessment and intervention based upon treatment protocols and interpreted results.

For many years, the Board has been asked for its opinion and comment regarding the providing of concurrent therapy by licensed practitioners. Since my appointment to the Board roughly eight years ago, it has been my practice and contention that concurrent therapy has no value when the objective of practitioners is to deliver exceptional quality patient care. As both a manager and an assistant director of various respiratory care departments, I have always supported the case that patients deserve our full attention during therapy provided in the acute care or critical care environments. From my perspective, there is no quality, safety, or coaching that can come from performing any concurrent therapy to patients. It is simply impossible. However, that is my position and practice. Included in this newsletter are the White Paper and Position Statement offered by the American Association for Respiratory Care and the California Society for Respiratory Care. As you are aware, these are our professional organizations. Take a moment to review these papers so that you can understand the positions they support on the topic of concurrent therapy.

In closing, the Board recently welcomed a new member, Ms. Lupe Aguilera. She is a public member appointed by Governor Schwarzenegger. We welcome her and know that her input and participation will benefit the Board's mission and strategic objectives.

## *Board Welcomes Lupe V. Aguilera, Public Member*

The Board welcomed new member Lupe Aguilera at its June 13 meeting in Sacramento. Ms. Aguilera was appointed by Governor Schwarzenegger to the Board in May as a public member.

Prior to her appointment, Ms. Aguilera worked for the California Department of Corrections and Rehabilitation for 21 years before retiring from her position as senior youth correctional counselor in 2006.

Ms. Aguilera enjoys performing volunteer work within her community. She frequently volunteers with the Oakdale Police Department's Senior Outreach Program which is designed to assist the elderly with issues such as health, safety and resources. Ms. Aguilera is also a board member for the Oakdale Women's Club which hosts fund-raisers to benefit other non-profit organizations in the community. She has been a commissioner for the Oakdale Parks and Recreation Department since 2002, and is currently the treasurer for the California Correctional Peace Officers Retired Chapter Board.

She is honored to have been selected to serve on the Board and looks forward to addressing the variety of issues from the public's perspective.



Lupe V. Aguilera  
Public Member

## *AARC International Respiratory Congress Comes to California*

Combine "your backyard" with the best in continuing respiratory education and you'll find yourself at the AARC Congress, December 13-16, 2008, in Anaheim.

The Congress is the largest and most comprehensive respiratory care meeting in the world with the foremost experts presenting the latest information you need for your practice. With more than 200 sessions and more than 300 original research papers at the 18 OPEN FORUM symposia, you will find something of value whatever your position or care setting. Most important, the Congress is approved for all the continuing education hours (CRCE) you will need for your state license, up to 26 hours. Visit [aarc.org](http://aarc.org) for a review of the program and registration information.



At the Congress you will experience the largest respiratory care exhibit hall anywhere, with all the companies in the industry displaying the latest equipment and supplies, and many of them introducing their latest products.

But, the Congress is more than the finest in respiratory education and products. There is also a variety of activities such as the Sputum Bowl competition, 5K Fun Run, Welcome Party, and much more. Join your colleagues in Your Back Yard at the AARC International Respiratory Congress and make it your best four days of the year.

**Additional Educational Opportunities in Anaheim:** Asthma Educator Certification Preparation Course, December 11-12; and the Noninvasive Ventilation Course and Workshop, December 12; plus breakfast sessions.

**Special Offer for California Respiratory Therapists:** Receive the AARC's California Ethics Course for free when you attend the AARC International Respiratory Congress. Take the online ethics course anytime during 2009 and meet your licensure requirement.

Learn more at [aarc.org](http://aarc.org).

## *Concurrent Therapy, What is Proper Protocol?*

Periodically, the Board receives inquiries from its licensed respiratory care practitioners (RCPs) on the subject of concurrent therapy. Many hospitals have chosen to implement concurrent therapy policies to control costs and address patient demands. Of course, concerns for patient safety and quality of care arise when more than one treatment is being provided at the same time.

While the Respiratory Care Practice Act does not address specific therapies, the Board does rely upon commonly accepted guidelines and standards established by leading respiratory care organizations. In this case the American Association for Respiratory Care and the California Society for Respiratory Care have developed and published a white paper and a position statement, respectively, on this topic. Both serve as professional resources for all RCPs.

The Board is pleased to publish these papers to guide RCPs who may be faced with concurrent therapy policies.

*... continued on page 6*

### *RCPs in the News*

**Erin O'Neil**, respiratory therapist at Mercy San Juan Medical Center, was among three healthcare workers credited for saving the life of a 53-year-old passenger on a flight from Sacramento to Burbank.

Another Mercy San Juan Medical Center respiratory therapist, **Greg Blom**, was recently featured for "test driving" the hospital's latest technology: the da Vinci robotic surgical system.

The entire pulmonary team at **UC San Diego Medical Center** was recently recognized in *U.S. News & World Report's* 2008 "America's Best Hospitals" issue.

If you know of a respiratory care practitioner who has been recognized in the press, please contact the Board's office to share this information with California's entire respiratory care community.

### *Board Appreciation*

The Board would like to extend its appreciation to **Marianne Shaw**, Clinical Operations Coordinator at Memorial Medical Center, for providing a hospital tour to Public Member Lupe Aguilera.

Ms. Shaw was instrumental in providing Ms. Aguilera with an in-depth perspective of the profession, and familiarizing her with the day-to-day activities of respiratory care practitioners.

Thank you Ms. Shaw for your generosity in sharing your time and expertise!

### **In Memoriam**

The respiratory care profession lost a longtime licensee, and dedicated and loyal advocate, with the passing of **Alison Murray** on July 7, 2008. Those staff members who had the privilege of working with Alison will greatly miss her smile, her warm greetings, and her advocacy for improved patient care.

### *Emergency Medical Services Authority Recruiting Licensed RCPs*

If you're a licensed respiratory care practitioner with an active license, and you would like to register with the State of California for volunteer emergency/disaster service, please visit the California Medical Volunteer Site at [www.medicalvolunteer.ca.gov](http://www.medicalvolunteer.ca.gov) to register.

During the online registration process, you will be asked to enter information regarding your license, the best way to contact you, and other relevant background information. Once you've registered, your credentials will be validated—before an emergency—so that you can be deployed quickly and efficiently.

During a State or national disaster, (e.g., an earthquake, severe weather event, or public health emergency), this system will be accessed by authorized medical/health officials at the State Emergency Operations or your county. If a decision is made to request your service, you will be contacted using the information you enter on the Emergency Medical Services Authority (EMSA) site. If you agree to deploy, your information will be forwarded to the appropriate field operational officials.

Please visit the EMSA's Web site at [www.medicalvolunteer.ca.gov](http://www.medicalvolunteer.ca.gov) for additional information.

## *Governor Vetoes Bill . . . (continued from page 1)*

have required criminal background checks for all sleep testing personnel thereby, eliminating or greatly reducing the criminal activity that has occurred in recent years. By providing a mechanism to deny or revoke privileges, SB 1526 would have provided safeguards for consumers and reduce costs associated with unreliable testing.

Initially, the Board sponsored a separate piece of legislation, but it was superseded by SB 1526, sponsored by the sleep associations, which instead gave the Medical Board of California the authority to enforce the registration system. The Board was opposed to SB 1526 as originally introduced. However, in the end, after working with the author and the sponsor for amendments, the Respiratory Care Board was in strong support of this legislation. Most importantly, the legislation would have prevented a shortage of workers, while ensuring competency – especially as it related to respiratory care – and criminal background checks.

The Board acknowledges and respects the efforts of Senator Perata, the Medical Board of California, the California Thoracic Society, the California Sleep Association, the California Society for Respiratory Care and the American Association for Respiratory Care for working with our Board, and getting a final piece of legislation that worked for everyone.

*. . . continued on page 10*

## *Board Recruiting Experts to Review Quality of Care Complaints*

The Respiratory Care Board of California (RCB) uses board-certified respiratory care practitioners as expert consultants to assist in reviewing complaints against respiratory care practitioners in which quality of care is an issue.

If you are interested in reviewing one to five cases per year, and meet the following qualifications, please contact the RCB.

### **Applicants must:**

1. Possess a current and valid respiratory care practitioner license issued by the RCB;
2. Be actively working as a respiratory care practitioner (80 or more hours per month; or if teaching, 40 or more hours of patient care per month), or retired less than two years;
3. Have a least five years experience as a licensed respiratory care practitioner;
4. Have no disciplinary record with the RCB or with a licensing board in another state;
5. Have no open investigations pending or complaints closed with merit within the previous five years.

All applicants are screened to confirm that they meet all requirements.

### **What Do Expert Consultants Do?**

When an expert is sent a case for review, he or she is expected to prepare a report supporting a conclusion regarding whether or not the alleged actions violate the Respiratory Care Practice Act. Approximately one-third of cases where violations are charged actually go to a public hearing (the remainder are settled with stipulated decisions). If a case goes to hearing, the expert will be called as an expert witness to testify for the Board.

If you are asked to review a case, you will be reimbursed \$75 per hour for reviewing records and writing your report. If the case goes to hearing, reimbursement is \$100 per hour, up to \$800 per day, plus actual travel and other expenses.

### **How Do I Apply?**

Send a copy of your curriculum vitae to the RCB. This document should provide your name, current address, telephone number, education, professional affiliations, and work experience, including employer names, addresses, and telephone numbers. Also, you must provide proof that you meet the qualification provided in items 1, 2, and 3. Please send this information with a cover letter stating why you believe you would make a good expert to: Respiratory Care Board, Attn: Enforcement Unit, 444 North 3rd Street, Suite 270, Sacramento, CA 95811.

## *AARC's White Paper on Concurrent Therapy (continued from page 4)*

### **Introduction**

The American Association for Respiratory Care (AARC) has been made aware of the practice of concurrent therapy (sometimes referred to as “stacking”) within the context of respiratory care. The following information is made available because there are major concerns of respiratory therapists which center on the issues of patient safety and quality of care.

This paper outlines causes, ramifications and alternatives to providing respiratory therapy concurrently.

### **The Current Health Care System Places Increased Demands on Health Care Providers**

Patients with cardiopulmonary diseases need access to safe, cost-effective care. Respiratory therapists provide care that can improve patient outcomes and reduce morbidity, mortality and costs.

Under the current health care system, increasing demands are placed on providers due to the aging population and a decrease in the supply of health care professionals. Respiratory therapy is impacted by these shortages as well. In 2000, we observed a 5.9% vacancy rate of staff positions for respiratory therapists. This fact, when coupled with the lack of sufficient respiratory therapy graduates to fill these vacancies has resulted in increased workloads for respiratory therapists.<sup>1, 2</sup> In some cases, respiratory therapists feel pressured to provide treatments concurrently (stacking) although it is against their best professional judgment. In providing care, respiratory therapists are bound by ethical and professional principles, and in most cases, state practice acts.<sup>3</sup>

Although today's health care system demands increased efficiency, it is imperative to balance that demand with the need for appropriate, effective and skilled patient care. In order to provide safe, cost-effective care, the respiratory therapy profession must address the issue of concurrent therapy (sometimes referred to as “treatment stacking”).

In respiratory therapy, concurrent therapy occurs when one therapist administers treatments utilizing small volume nebulizers, metered dose inhalers, or intermittent positive pressure treatments to multiple patients simultaneously.

The Joint Commission on Accreditation of Health Care Organizations (JCAHO) cites concurrent therapy as a problem. According to JCAHO, if concurrent therapy is done, there must be a clear indication for it and a policy and procedure that govern its application. It must be differentiated from treatments given individually. Concurrent treatments, when provided in order to meet the convenience needs of the respiratory therapy staff, is considered inappropriate by JCAHO.<sup>4</sup>

### **The Federal Government's Response to Concurrent (Stacking) Therapy**

In a Federal Register notice dated May 10, 2001, related to the Prospective Payment System (PPS) for Skilled Nursing Facilities (SNF), the Centers for Medicare and Medicaid Services (CMS) raised the issue of concurrent therapy. According to CMS, “concurrent therapy is the practice of one professional therapist treating more than one Medicare beneficiary at a time -- in some cases, many more than one individual at a time. Concurrent therapy is distinguished from group therapy, because all participants in group therapy are working on some common skill development and the ratio of participants to therapists may be no higher than four to one.”<sup>5</sup>

Furthermore, CMS goes on to state “A beneficiary who is receiving concurrent therapy with one or more beneficiaries likely is not receiving services that relate to those needed by any other participants. Although each beneficiary may be receiving care that is prescribed in his individual plan of treatment, it is not being delivered according to Medicare coverage guidelines: that is, the therapy is not being provided individually, and it is unlikely that the services being delivered are at the complex skill level required for coverage by Medicare.”<sup>5</sup>

### **Sources of Concern Regarding Concurrent (Stacking) Therapy**

**Medical Errors:** The appropriate administration of respiratory therapy involves assessing and monitoring the patient. Assessment and monitoring include the need for therapy, administration of medications, the type of medication delivery device, patient education, patient tolerance, patient coordination, and outcomes documentation.<sup>6, 7, 8</sup> Concurrent therapy may encourage

the elimination of one or more of these essential elements and could result in medical errors. According to recent reports by the Institute of Medicine, there are serious problems associated with medical errors, particularly medication errors.<sup>9</sup> These errors are often associated with inadequate staffing levels. Again, an increased demand for efficient care coupled with work force shortages, has resulted in increased workloads. In some instances, such demands far exceed a facility's resources.

**Billing Errors:** Concurrent therapy can cause billing problems and result in possible fraud. According to Medicare policy for Medicare Part A services (i.e., hospital inpatient services, skilled nursing facility services and intermediate care services), "respiratory therapy services cannot be recognized when performed on a mass basis with no distinction made as to the individual patient's actual conditions and need for such services."<sup>5</sup> This language, in addition to the concerns raised by CMS in the May 10, 2001 Federal Register notice cited previously indicate that concurrent therapy associated with respiratory services is not covered under Medicare. Although Medicare payments are made according to a prospective payment system, these payments are based on professional standards and the therapist's time spent in providing patient care.

### **Alternatives to the Practice of Concurrent (Stacking) Treatments**

The American Association for Respiratory Care (AARC) appreciates the fact that even though human resources temporarily may not be adequate to meet the demand for respiratory services, there exist service delivery models and strategies which can close the gap between the demand for services and an institution's ability to meet that demand without jeopardizing patient safety, care quality and cost containment objectives. Brief descriptions of alternatives to concurrent therapy are presented in the following paragraphs.

### **Protocols**

The use of established protocols may help respiratory therapists deliver appropriate and efficient care under conditions of an increased workload. Protocols are based on scientific evidence and include guidelines and options at decision points.<sup>10</sup> The use of protocols can help assure that all treatments have established indicators but also are highly effective in reducing the volume of unnecessary

care. Evidence based literature exists supporting the use of protocols to minimize unnecessary treatments<sup>11</sup> and provide self-administration options for patients who demonstrate their ability to do so as documented by the respiratory therapists.<sup>12</sup> Research has shown that there exists a high percentage of misallocated respiratory therapy treatments. Indeed the range of misallocation, according to the scientific literature, goes from a low of 25% to a high of 60% depending on the modality.<sup>13, 14</sup> It is important to note that numerous studies have concluded that protocols can reduce the volume of unneeded care, and therefore, contribute to an overall reduction in workload. For patients who require bronchodilator therapy, protocols can be effective in switching patients from small volume nebulizers, to the less time-consuming metered dose inhalers administered via hand held spacer devices. Other technology such as breath-activated nebulizers can be incorporated into protocols to increase efficiency without jeopardizing patient safety or quality of care.

### **Developing a Formal Procedure to Assess Patients' Needs**

The AARC recognizes that not all health care provider organizations are in a position to take advantage of the benefits of patient-driven protocols. The Association recommends that a policy and procedure be developed which governs the application of the practice of concurrent therapy. This policy should include assessment of the appropriateness of the order for respiratory therapy utilizing AARC's Clinical Practice Guidelines (CPGs). Numerous studies have observed that CPGs are an invaluable tool in assessing whether the therapy in question is an appropriate allocation of resources. Moreover, if the therapy is appropriate, frequency of its administration should be evaluated as well.

Assessment of the patient is an indispensable component to this process, with patient safety and quality of care foremost. The patient's cognitive status, understanding of therapeutic goals, coordination and tolerance of the therapy must be considered. Moreover, the patient's attitude and ability to cooperate with the therapy should be recognized as indispensable to the success of the treatment itself. The incidence of cognitive impairment among older people ranges from 30-50% in acute care hospitals, and 50-80% in skilled nursing facilities.<sup>15</sup>

... continued on page 8

## *AARC's White Paper on Concurrent Therapy (continued from page 7)*

Finally, the proximity of the therapist should be taken into consideration, to assure adequate monitoring for quality and safety purposes.

### **Self-Administration**

There are many instances where patients can be transitioned to a self-treatment program and thus avoid a significant demand for the therapist's time. You are encouraged to investigate this alternative in order to decrease workload for respiratory therapists without compromising care quality and patient safety. Policies and procedures must be developed which govern patient self-administration of respiratory therapy treatments. This process should include a thorough assessment of the patient similar to the one described in the previous alternative. Patients can then be categorized as those who require the services of a respiratory therapist or those, who after appropriate instruction from a respiratory therapist can self-administer their therapy. Patients in the first group would be treated the traditional way, while those in the latter group should be assessed and observed on a daily basis in order to assure that the therapy ordered is still appropriate, the patient's clinical condition has not worsened and the patient can still demonstrate correct technique regarding self-administration of the treatment.

The foregoing alternatives are not intended to be all-inclusive. The recurrent themes contained in each are patient assessment, safety, quality of care, appropriateness of the order, monitoring all aspects of the patient's response to therapy, and organizing a formal policy and procedure to implement the alternative in question.<sup>16</sup>

### **Conclusions**

Patient safety is the primary reason for respiratory therapists not to deliver care via concurrent therapy without a thorough patient assessment. Indiscriminate use of concurrent therapy may lead to declines in quality and may jeopardize patient safety. Aerosolized medications administered during treatments have potential adverse reactions. Recognition of these reactions is not possible if the patient is left unattended and thus a safety hazard exists.

Action should be taken to remedy situations that cause concern for patient safety and appropriateness of care.

Possible actions include establishing protocols and other procedures, as well as conferences with managers and supervisors, if necessary. Additional actions may include reporting unsafe practices to appropriate authorities within the hospital or other health care agencies.

Concurrent therapy may not only adversely affect quality of care and patient safety, but can lead to a decline in job satisfaction and a loss of trained personnel. Such adverse results further exacerbate the health care work force shortage. Ultimately, it is the ethical and professional responsibility of respiratory therapists to assure their patients receive both safe and effective care of the highest quality.

### **References**

- American Association For Respiratory Care Human Resources Survey, 2000, <http://www.aarc.org>.
- Costello, Demand for respiratory therapists exceeds supply at nation's hospitals, AHA News, February 1, 2002. <http://www.ahanews.com>
- AARC Position Statement. AARC Statement of Ethics and Professional Conduct. March 2000, [http://www.aarc.org/resources/position\\_statements](http://www.aarc.org/resources/position_statements)
- Tracking JCAHO's problematic respiratory standards. Accreditation Connection ID 18289. [http://www.accreditinfo.com/content.cfm?content\\_id=18289](http://www.accreditinfo.com/content.cfm?content_id=18289)
- Medicare Manuals: Section 230.10 Pub. 12 (SNF Manual); Section 210.10 Pub. 10 (Hospital Manual); Section 3101.10 Pub. 13 (Intermediary Manual).
- AARC Clinical Practice Guideline. Selection of Aerosol Delivery Device. *Respir Care* 1992; 37:891-897.
- AARC Clinical Practice Guideline. Delivery of Aerosols to the Upper Airway. *Respir Care* 1994; 39(8):803-807.
- AARC Clinical Practice Guideline. Assessing Response to Bronchodilator Therapy at Point of Care. *Respir Care* 1995 40(12); 1300-1307.
- The Quality of Health Care in America Committee, Institute of Medicine, To Err is Human: Building a Safer Health System, September 1999 report.
- AARC Position Statement. Respiratory Therapy Protocol Position Statement. May 16, 2001, [http://www.aarc.org/resources/position\\_statements](http://www.aarc.org/resources/position_statements)
- Kollef M., Shapiro S, et al. The Effects of Respiratory Therapist-Initiated Treatment Protocols on Patient Outcomes and Resource Utilization. *Chest* 2000; 117: 467-475.
- Jasper A, Kahan S, Goldberg H., Koerner S. Cost-Benefit Comparison of Aerosol Bronchodilator Delivery Methods in Hospitalized Patients. *Chest* 1987; 91: 414-418.
- Stoller JK, Haney D, Burkhardt J., Fergus L, Giles D, Hoisington E, Kester L, Komara J, McCarthy K., McCann B. Physician-ordered respiratory care vs. physician-ordered use of a respiratory therapy consult service: early experience at The Cleveland Clinic Foundation. *Respir Care* 1993; 38(11):1143-54.
- Stoller J, Mascha E, et al. Randomized Controlled Trial of Physician-directed versus Respiratory Therapy Consult Service-directed Respiratory Care to Adult Non-ICU Inpatients. *Am J Crit Care Med* 1998; 158:158: 1066-1075.
- Kane R.L., Abrass I.B., *Essentials of Clinical Geriatrics*, third edition McGraw Hill, New York. 1994.
- Giordano, Sam P. What We Say Versus What We Do. *Respir Care* 1996; 41:6 504-505.

## *CSRC's Position Statement on Concurrent Therapy*

The California Society for Respiratory Care (CSRC), having completed comprehensive research into the practice of "Concurrent Therapy," has concluded that, aside from declared disaster, there is no compelling medical, ethical or safety rationale for the continuation of this practice.

The CSRC takes the position that concurrent therapy (CT), as defined below, should rapidly be abandoned and as needed, legislatively addressed; in the interest of patient safety, interventional efficacy and the ethical practice of Respiratory Therapy.

"Concurrent therapy" in Respiratory Care is defined as rendering simultaneous inhaled medication aerosols, to more than one patient, in unmonitored patient care areas, by one therapist.

Concerns surrounding this practice have been widely expressed, including those from: JCAHO, Medicare/Medicaid (CMS), and the California Respiratory Care Board. JCAHO calls CT "a problem,"<sup>1</sup> Medicare says of CT, "it is not being delivered according to Medicare coverage guidelines: that is, the therapy is not being provided individually."<sup>2</sup> The California Respiratory Care Board states "we would strongly discourage any organization from adopting a policy which leaves patients unattended for administration of medication and continues "this practice would be contradictory to safe practice."<sup>3</sup>

While each group addressed primarily, the safety compromise of concurrent therapy, none directly speak to the ethical dilemma of the conscientious therapist. This ethical morass is created when an employer requires or actively condones the practice of CT. It is for the aforementioned with patient safety concerns, that the CSRC implores the profession, healthcare providers, healthcare institutions and the public, to bring to a halt this example of misused, misguided and unsafe healthcare practice.

Based on clinical data, which concluded that Respiratory Care interventions are over utilized by as much as sixty percent,<sup>4,5</sup> the CSRC recommends the use of clinical tools to optimize utilization in an effort to diminish the perceived need of CT. Such tools may include, but should not be limited to assessment driven, evidence based and outcome oriented interventional protocols. Utilization appropriateness may also be geared to patient education toward self administration.

Aside from Clinical Tools, computer workload leveling tools should be considered in providing better scheduling of therapy which is more in line with clinical and patient needs. Such tools used in conjunction with assessment based protocols as opposed to existing schedule formulation practices, may lead to a decrease in utilization as well as an improved concentration of skilled Therapist time for higher acuity patients.

In summary, the CSRC advocates for patient safety, therapeutic efficacy and ethical responsibility in proposing the abandonment of the practice of CT. The CSRC supports appropriate assessment driven use of Respiratory Care services to minimize misallocation of ordering practices, to relegate the unsafe and unconscionable practice of CT, to a thing of the past.

1. Tracking JCAHO's problematic respiratory standards. Accreditation Connection ID 18289. [http://www.accreditinfo.com/content.cfm?content\\_id=18289](http://www.accreditinfo.com/content.cfm?content_id=18289)

2. Medicare Manuals: Section 230.10 Pub. 12 (SNF Manual); Section 210.10 Pub. 10 (Hospital Manual); Section 3101.10 Pub. 13 (Intermediary Manual).

3. CA Respiratory Care Board Website, License Information, Scope of Practice, Table of Inquiries and the Board's responses Listed by Subject, Reference 2003 C-15

4. Stoller JK, Haney D, Burkhart J, Fergus L, Giles D, Hoisington E, Kester L, Komara J, McCarthy K, McCann B. Physician-ordered respiratory care vs. physician-ordered use of a respiratory therapy consult service: early experience at The Cleveland Clinic Foundation. *Respir Care* 1993; 38(11):1143-54.

5. Stoller J, Mascha E, et al. Randomized Controlled Trial of Physician-directed versus Respiratory Therapy Consult Service-directed Respiratory Care to Adult Non-ICU Inpatients. *Am J Crit Care Med* 1998; 158:1066-1075

## *Governor Vetoes Bill . . . (continued from page 5)*

Throughout the Board's review of this emerging practice and, more recently, this legislative process, pending the outcome of this bill, the Board limited its enforcement activity against the unlicensed practice of respiratory care as it relates to polysomnography. However, in light of the Governor's veto, the Board has no reasonable alternative but to begin fully enforcing existing law.

Tasks that are considered respiratory care that are commonly associated with polysomnography include, but are not limited to, all of the following:

- The diagnostic and therapeutic use of oxygen.
- Noninvasive ventilatory assistance of spontaneously breathing patients and cardiopulmonary resuscitation.
- Establishment of baseline oxyhemoglobin saturation.
- Routine fitting of positive airway pressure mask or cannula.
- Maintenance of nasal and oral airways that do not extend into the trachea.
- Continuous observation, analysis and recording of carbon dioxide concentrations in respiratory gases, and other respiratory events.
- Validation of respiratory-related data integrity
- Calibration of respiratory care devices
- Implementing appropriate interventions, including actions necessary for patient safety.
- Applying the knowledge and skills necessary to recognize and provide age specific respiratory care in the treatment, assessment, and education of neonatal, pediatric, adolescent, adult, and geriatric patients.

Effective immediately, the Board will revitalize its investigations and enforcement of the unlicensed practice of respiratory care as it relates to polysomnography as identified above. The Board understands that major personnel shifts will need to occur for many, though not all, sleep testing organizations. Employers using RPSGT credentialed personnel may consider shifting their duties to focus directly on all sleep diagnostic testing and treatment (as applicable) that are not associated with respiratory care. Respiratory diagnostic testing for Obstructive Sleep Apnea and treatment via therapeutic interventions requiring positive airway pressure must be performed by a licensed respiratory care practitioner pursuant to the Respiratory Care Practice Act. To avoid legal penalties and/or discipline it is imperative that each organization begin making the necessary changes, as applicable, immediately.

If you have any questions, please contact the Board directly.

## *Enforcement Actions Definitions*

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

**Application Denied** means the application filed has been disapproved by the Board.

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

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 violations of the Respiratory Care Practice Act.

A **Public Reprimand** is a lesser form of discipline that can be negotiated for minor violations.

An **Interim Suspension Order** is an administrative order, issued in the interest of consumer protection, prohibiting the practice of respiratory care.

**Revoked or Surrendered** means that the license and all rights and privileges to practice have been rescinded.

**Placed on Probation/Conditional License** means the Board has approved a conditional or probationary license issued to an applicant or licensee with terms and conditions.

A **Citation and Fine** may be issued for violations of the Respiratory Care Practice Act. Payment of the fine is satisfactory resolution of the matter.

All pleadings associated with, and decisions processed after January 2006, are available for downloading on the Board's Web site at [www.rcb.ca.gov](http://www.rcb.ca.gov).

To order all other copies of legal pleadings, disciplinary actions, or penalty documents, please send a written request, including the respondent's name and license number (if applicable), to the Board's Sacramento office or e-mail address at [rcbinfo@dca.ca.gov](mailto:rcbinfo@dca.ca.gov).

## *Enforcement Actions January 1, 2008 - June 30, 2008*

### **STATEMENTS OF ISSUE**

Coppock, Christopher D., Applicant  
Cruz, Jose R., Applicant  
Cruz, Oscar A., Applicant  
Grosman, Vadim, Applicant  
Jackson, Jillian L., Applicant  
Marklein, Susan M., Applicant  
Messore, Nick D., Applicant  
Murray, Cheryl, E., Applicant  
Odeh, Rami A., Applicant  
Wiescinski, Chad M., Applicant

### **APPLICATION DENIED**

Ashe, Steven D., Applicant  
Clark, Alden E., Applicant  
Sierra, Marcia A., Applicant

### **ACCUSATIONS**

Bell, Thomas M., RCP 1915  
Borey, Dennis, RCP 3079  
Fainblit, David V., RCP 13298  
Ford, Mark L., RCP 20578  
Lovato, Jeanne L., RCP 16065  
Miraglia, Belinda R., RCP 15278  
Moscatiello, Kim L., RCP 13312  
Myers, Sue A., RCP 19702  
Rivera, Sheryl L., RCP 25623  
Simhachalam, John D., RCP 12640  
Sprague, Richard A., RCP 19625  
Thomas, Augare, RCP 22838

### **ACCUSATIONS AND/OR PETITIONS TO**

#### **REVOKE PROBATION**

Davis, Alden G., RCP 26416  
Lopez, Domingo F., RCP 24281  
MacNeil, Kelly L., RCP 22486  
Ramirez, Geoffrey, RCP 21716  
Sherman, Mika K., RCP 21980  
Smith, Steven A., RCP 24213

#### **PUBLIC REPRIMANDS**

Jager, Daryle A., RCP 27186  
Lopez, Paul J., RCP 27238  
Meza, Paul A., RCP 27327  
Michael, Michelle S., RCP 20231

### **INTERIM**

#### **SUSPENSION ORDER**

Bell, Thomas M., RCP 1915  
Moscatiello, Kim L., RCP 13312

#### **REVOKED OR SURRENDERED**

Barton, Robert L., RCP 9512  
Griffin, Janine D., RCP 20644  
Hallmark, Aaron J., RCP 21719  
Johnson, Angie M., RCP 23652  
Lemmons, Sheila B., RCP 16201  
Meyers, Sarah A., RCP 25152  
Navarro, George A., RCP 24834  
Nielson, Jody M., RCP 23913  
Santos, Khristen M., RCP 25858  
Sullivan, David P., RCP 14123  
Trinidad, Don Carlo M., RCP 25143

#### **PLACED ON PROBATION/ CONDITIONAL LICENSE**

Arce, Hector E., RCP 22505  
Armenta, Maximo, RCP 27493  
Berry, James, RCP 3230  
Black, Nicolas M., RCP 27382  
Blackwell, Jeffrey L., RCP 27445  
Calaunan, Lawrence P., RCP 24169  
Chormicle, Brian A., RCP 19563  
Dixon, Caycee D., RCP 27066  
Gill, Sharnjit K., RCP 27065  
Green, Keturah C., RCP 20709  
Hayes, Eric J., RCP 27134  
Hinsley, Barton W., RCP 12244  
Huddleston, John C., RCP 12514  
Johnson Gerald E., RCP 27324  
Lockett, Clara M., RCP 12633  
Loffin, Derek D., RCP 24445  
Navarro, Joshua A., RCP 27125  
Paredes, Miguel G., RCP 5946  
Zellmer, Keri L., RCP 27304

### **CITATIONS AND FINES**

Bobar, Virgil, RCP 25179  
Coen, Cynthia A., RCP 1919  
Dix, Roland H., RCP 19844  
Esa, Abdusamad S., RCP 26533  
Fief, Barbara J., RCP 4638  
Forrest, Rudolph R., RCP 9780  
Fox, Burke W., 5619  
Garcia, Maria Fe B., RCP 22343  
Giacalone, Anthony, RCP 3169  
Gutierrez, Melodee A., RCP 3885  
Howard, Aaron J., RCP 19006  
Iqbal Aasia, RCP 13458  
Jarmin, Dennis P., RCP 17154  
Kalicinsky, Vera T., RCP 24919  
Knight, Marjorie L., RCP 9699  
Knott, Milissa A., RCP 25885  
Kruska, Susan L., RCP 13138  
Lapp, David A., RCP 21639  
Lum, Calvin D., RCP 1380  
Macias, Ronald G., RCP 11400  
Maguyon, Alexis M., RCP 23373  
Marques, Frank W., RCP 19020  
Martin, Herman E., RCP 6550  
McDowell, Regine A., RCP 26085  
Melicor, Angelo O., RCP 17136  
Mushok, Lorraine S., RCP 320  
Ortiz, Melanie M., RCP 18745  
Pearson, Allen S., RCP 2862  
Perez-Mir, Eduardo A., RCP 20229  
Regenhardt, Kari L., RCP 20329  
Riley, O'Neal, RCP 25875  
Rinnader, Paul V., RCP 23361  
Rodriguez, Omar J., RCP 19681  
Safire, Elizabeth, RCP 2888  
Salom, John Bernard J., RCP 19998  
Shapiro, Irina, RCP 16853  
Silva, Martin, RCP 15920  
Silvano, Pete O., RCP 17659  
Smith, Kimberly A., RCP 24038  
Sternadel, Heather L., 25872  
Tan, Joel J., RCP 13145  
Toland, Stephen P., RCP 11434  
Wachter, Ryan N., RCP 24156  
Warmerdam, Albert G., RCP 9826  
Williams, Kenneth A., RCP 8314  
Willis, Gregory M., RCP 8156  
Zysk, Robert, RCP 25192

## *Respiratory Care Board Mandate*

*The Respiratory Care Board of California'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. Protection of the public shall be the highest priority for the Respiratory Care Board of California 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.*

## **UPCOMING EVENTS**

*Department of Consumer Affairs  
Professionals Achieving  
Consumer Trust Summit  
November 18-21, 2008*



*Respiratory Care Board Meeting  
November 20, 2008*

*Westin Los Angeles Airport Hotel  
5400 West Century Boulevard  
Los Angeles, CA 90045*

*[www.dca.ca.gov/summit](http://www.dca.ca.gov/summit)*

## *Respiratory Care Board's Mission Statement*

*To protect and serve the consumer by enforcing the Respiratory Care Practice Act and its regulations, expanding the delivery and availability of services, increasing public awareness of respiratory care as a profession and supporting the development and education of all respiratory care practitioners.*

Respiratory Care Board of California  
444 North 3rd Street, Suite 270  
Sacramento, CA 95811

Presort STD  
U.S. Postage  
PAID  
PERMIT 685  
SACRAMENTO, CA

### **Address Change Notification**

You must notify the Board in writing within 14 days of an address change.

Failure to do so could result in fines ranging from \$25 to \$250, and delay your receipt of important materials.

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, fax, and changes made via the Board's Web site.