

Respiratory Update

September 2002



Applicants for Licensure on the Rise

The Respiratory Care Board of California (Board) received 638 applications for licensure from July 1, 2001 through June 30, 2002. This is a significant increase compared to the previous year from July 1, 2000 through June 30, 2001 when the Board received only 397 applications for licensure. Of course, the number of applications the Board is currently receiving still falls short in meeting the demands for therapists in the State.

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New TOLL-FREE Telephone Number

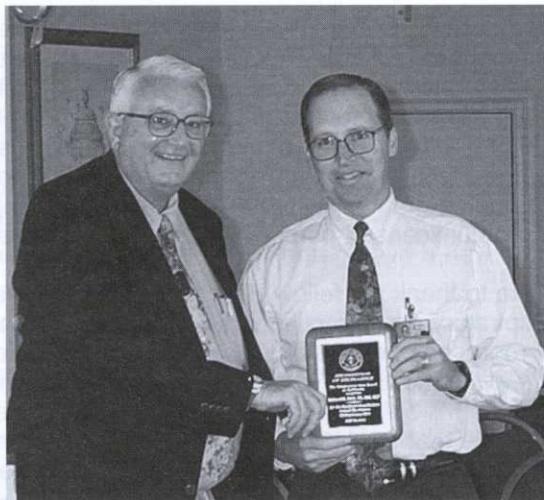
Last Spring, the Board obtained a new toll-free telephone number for anyone calling within California. The new toll-free telephone number is (866) 375-0386.

RCP Recognition

On July 19, 2002, the Board recognized Richard (Rick) M. Ford, BS, RRT, FAARC for his significant contributions to the practice of respiratory care.

Mr. Ford has been working in the field since 1975 and was one of the first therapists to be grandfathered into licensure with the Board in 1985. He has been an active member of the American Association for Respiratory Care (AARC) for 27 years. In fact, last year the AARC awarded Fellowship to him in recognition of his contributions and dedication to the profession and, two years ago, they honored him as the Manager Practitioner of the Year.

His contributions to name a few, include numerous lectures and publications directed at helping others develop cost effective models of respiratory care delivery and effective managing. He is also responsible for bringing managers in the San Diego area together, on a regular basis, to discuss current trends and issues.



President Winn and Mr. Rick Ford

Thank you Mr. Ford for your contributions towards advancing the practice of respiratory care.

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Respiratory Care Board of California



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President's Message

It has been an absolute pleasure to serve the consumers of California over the last 12 years, in my capacity as a Board member. My final term will be complete on May 31, 2003, and with annual elections taking place in November, this will be my final message as the Board's President.

Over the years, I have witnessed first hand the evolution of the licensed profession of respiratory care. In 1982, California was the first state to establish regulation of RCPs. Today, 45 of the 50 states regulate the profession.

In 1985, the first respiratory care practitioner *certificate* was issued by the *Respiratory Care Examining Committee*.

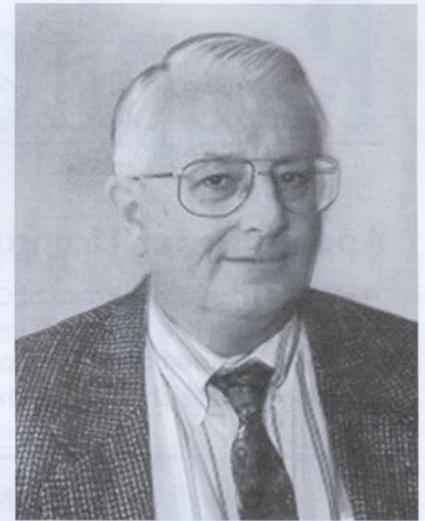
In 1992, the term "certificate" was changed to "license" and in 1995, the name "Respiratory Care Examining Committee" was changed to "Respiratory Care Board of California." These legislative changes gave the real perception of the Board's autonomy and strengthened public perception of the profession.

In 1997, the Board took the lead in promulgating regulations to increase entry-level educational standards requiring the equivalent to an Associate Degree. Many states as well as the national credentialing agency have since followed suit.

The Board successfully completed reviews of its programs by the Joint Legislative Sunset Review Committee in 1998 and 2002. Both reviews resulted in several recommendations with the most critical being the continuance of the Respiratory Care Board and the regulation of respiratory care therapists. The Board was successful in conveying to the Joint Committee that RCPs perform critical lifesaving and life support procedures prescribed by physicians that directly affect major organs of the body. The Joint Committee noted in its recommendations, "Clearly, the enormous health implications of this care necessitate a vigilant regulatory program."

I am delighted with the new direction the Board has taken. Last year, a forward movement emerged to identify and address the issues and concerns facing the profession related to patient safety. The Board's current strategic plan encompasses this movement with goals and objectives that include: improving communications with its stakeholders; reviewing the cost effectiveness of enforcement procedures; increasing the number of licensed practitioners in California; bringing greater awareness to the profession; and ensuring that unqualified and unlicensed persons are not practicing respiratory care.

Finally, I'd like to thank my fellow Board members, colleagues and all the licensed respiratory care practitioners for their support and involvement that has led to the progress of professional licensure for respiratory care practitioners. I know I am leaving the Board in good hands and am confident that my fellow Board members will be successful in meeting all of our existing goals. I have every confidence that the remaining members will continue to take measures to promote the profession, ultimately bringing about greater consumer protection.



Barry Winn, Ed.D., RCP
Board President

National Respiratory Care Week

National Respiratory Care Week is
October 20th through the 26th

Recent Board Appointments

Scott J. Svonkin

Scott J. Svonkin is Chief of Staff to California State Assemblyman Paul Koretz and a community activist. As a former businessman with Prudential Insurance, a former member of Mayor Tom Bradley's staff, and a Community College Instructor, Scott has demonstrated leadership with vision.

Scott's contributions to the local community span civic, political, cultural, and Jewish activities. He is B'nai B'rith Southern California Public Policy Chair, immediate past Vice President of the Jewish Federation/Chair for the Valley Alliance of the Jewish Federation's Community Relations Committee (CRC), Co-Chair of Fiesta Shalom a Jewish/Latino Festival and past Chair for Hillel at Pierce and Valley colleges. Scott also serves as Chair of the Los Angeles County Insurance Commission, a member of the Santa Monica Mountain's Conservancy, Children's Hospital L.A. Huckleberry Fund, and a member of the Valley College Foundation Board. Scott has served as Chair of the LAUSD Advisory Council District Four, on the LA PROSPER Board of the Los Angeles Community College District, the CSUN Legislative Advisory Council, as Vice President of Council Deputies Union, the Center for Southern California Studies Advisory Board, and the Saxophone Club Steering Committee.



Scott J. Svonkin

A native of Los Angeles County, Scott attended public schools and was a student leader at Pasadena City College, where he served as the first two-term Student Trustee. He went on to receive his B.A. from Cal State University, Northridge. His parents, Paula and Stan Svonkin, taught Scott the importance of community service through their active and generous example. Both of his parents have dedicated themselves to the health and betterment of youth. His father taught for the Los Angeles Unified School District for 36 years at Griffith Middle School in East LA, where he was a Dean and Union Representative. His mother owns a small business and has worked for various non-profits dedicated to youth. Scott is proud of his family's commitment to public service and to helping others; he is especially proud of the dedication of his wife, Jennifer, who works with those challenged by mental illness as a mental health care professional.

Two years ago Scott was appointed Deputy Councilman for Paul Koretz. He has worked in this capacity on important legislation, community liaison activities, inter-governmental relations, media relations, and constituent services for the City of West Hollywood. Scott has worked on such important legislative projects as: an aggressive anti-crime program focused on getting guns off the streets; controls on tobacco and its advertising; support of public education; workers protection, and improving city services.

As a Health Care Executive, Scott arranged for his company to donate almost one thousand computers to public schools. During his six and a half years with Prudential, Scott received their Community Champions Rising Star Award for his commitment to helping others, as well as their Hero Award for creating a voter registration and grassroots lobbying program. During his two years working for Mayor Tom Bradley, Scott was honored for helping to save one of L.A.'s most historic buildings, as well as for reaching out to many of LA's ethnic and religious organizations.

Scott is regarded as an outstanding leader of passion and dedication. He has served as a builder of bridges between his community, elected officials, businesses, and various ethnic and religious groups. Scott and his wife, Jennifer, who is a MFT and works for a Community Mental Health Center, have a new baby, Rose Alise, who was born in February 2001.

Kim Cooper, BS, RRT

Kim Cooper, BS, RRT is presently the Education Coordinator for Respiratory Care Services at Stanford Hospital and Clinics in Palo Alto. Prior to deciding to make California her home, Kim resided in Portland, Oregon. There she had been a practicing Respiratory Care Therapist for over 8 years. Her extensive career in Respiratory Care began in Tucson, Arizona in 1991.

While in Portland, Kim enjoyed a variety of experiences having worked at three of the major medical centers and helping out at their smaller sister hospitals. The majority of her time and experience was at Oregon Health Sciences University Hospital, where she was involved in all aspects of Respiratory Care - from high risk, premature neonates to adult neuro-trauma, and investigational research therapies. In addition, she was a shift supervisor for the staff of 80 Respiratory Care

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Kim Cooper, BS, RRT

Practitioners, involved in staff training and development, and served on multiple committees, each dedicated to an aspect of continuous quality improvement.

In her present position with Stanford, Kim is responsible for the initial training and continuing education for 60 Respiratory Care Practitioners. She is involved in teaching respiratory care issues to medical residents, surgical residents, nursing staff, and patients. Kim also works closely with the Respiratory Care Clinical Specialist and the Director of Respiratory Care Services to develop guidelines and review practices, assuring that California residents and visitors alike receive the best respiratory care possible when they come to Stanford Hospital and Clinics.

Kim received her Bachelors of Science degree in Management, Communication and Leadership from Concordia University in Portland Oregon, June 2001, and is presently working toward her Masters in Business Administration with a specialization in Organizational Effectiveness from Marylhurst University, Marylhurst Oregon.

Board Meeting

The next Respiratory Care Board of California meeting is scheduled for Friday, November 8, 2002 in the Los Angeles area. All Board meetings are open to the public.

Please visit our web site at www.rcb.ca.gov for more information on meeting dates, times and locations. Agendas for upcoming meetings are posted 10 days prior to meeting dates.

Fees and Expenditures

The last issue of the *Respiratory Update* reported several fee reductions, including the reduction of the transcript review fee (paid by applicants) from \$100 to \$75 effective January 1, 2002. At its February 2002 meeting, the Board moved to eliminate the transcript fee entirely effective July 1, 2002.

As previously reported, the Board was forced to implement an increase in its renewal fee from \$200 to \$230. This fee increase was actually established legislatively in 1999 but implementation was postponed until last January. Board members and several RCPs have expressed their concerns with this fee increase and are working towards a reduction. The Board is optimistic that with cuts being made in enforcement, downsizing of staff, and its efforts to increase applicant and licensee retention levels, it will see this fee reduced. The Board has requested that all of its fees be reviewed annually for this purpose and the first "fee schedule" review will be conducted at the Board's November meeting.

The Board has made and is in the process of making several significant budget reductions that total approximately 10% of its overall budget. Last month, the Board submitted a request to the State asking for a permanent reduction of \$132,000 (30%) in monies budgeted for the formal prosecution of cases through the Office of the Attorney General (\$440,000). This request was prompted by legislative advocate Terry McHale of Aaron Read and Associates on behalf of the California Society for Respiratory Care. In addition, the Board has relinquished three enforcement staff positions effective July 1, 2002 which is equivalent to approximately \$150,000 in budget reductions.

The Board is committed to reviewing its programs and procedures regularly to determine if additional reductions can be made, which in turn supports the reduction of your license fees.

Applications for Licensure...continued from Page 1

Following are the number of applications received from July 1st through June 30th for the years indicated:

Year	89/90	90/91	91/92	92/93	93/94	94/95	95/96	96/97	97/98	98/99	99/00	00/01	01/02
No.	965	1148	1200	1143	1164	882	781	730	722	849	614	397	638

The Board's priority and first goal for its outreach efforts, as defined in its strategic plan, is to "increase the number of qualified and competent respiratory care practitioners in the State of California to address the RCP shortage."

In May 2002, the Board's Outreach Committee, chaired by Scott Svonkin, sent pamphlets and brochures it developed to more than 1500 career centers at high schools throughout California. In response to our request, thirteen high schools requested speakers to present opportunities available in the respiratory care field at individual high school career days.

Board staff also began attending career fairs, such as the LA Times Career Fair in June and is scheduled to attend three additional fairs through November.

The Board has also been promoting the profession to high school administrators and educators. Board staff have attended two high school education conferences and is scheduled to attend an additional two conferences through November.

Response to the Board's efforts has been positive. Respiratory Care Program Directors throughout the State and members of the California Society for Respiratory Care have been extremely supportive of these efforts. They have volunteered their time and resources to review our career brochure and pamphlet, attended career fairs with Board staff, and made presentations at high school career days. We'd like to give special recognition to these people, because without their support and assistance, the Board's efforts would be moot. A special thanks to:

Daniel S. Adelman, MEd, RRT

Orange Coast College

Virginia E. Becchine

Foothill College

H. Robert Bence

California Society for Respiratory Care

Kevin Booth, AB, RRT, RCP

Hacienda La Puente

Larry Boutcher, PhD, RRT, RCP

Victor Valley College

Steven Boyd, MS, RRT

Fresno City College

Kenneth R. Bryson, MEd, RRT

Crafton Hills College

Robert S. Chudnofsky, BS, RRT, RCP

CA Paramedical and Technical College

Carol McNamee-Cole, MA, RRT

Ohlone College

Virginia Ettinger, MPH, RRT, RCP

Los Angeles Valley College

Terrance M. Krider, BS, RRT

Mt. San Antonio College

Terry Lyle, MS, RRT, RCP

Modesto Junior College

Lorenda Seibold-Phalan, MA, RCP, RRT

Grossmont College

Louis M. Sinopoli, EdD, RRT

El Camino College

Dr. Shirley Treanor Barker

Foothill College

Wayne Walls, BS, RRT, RCP

Napa Valley College

James L. Warman, PhD, RRT

American River College

The Board also sponsored legislation this year that will amend its statute, allowing the Board to waive its educational requirements, in some cases, these include persons with experience in respiratory care who may have been licensed in another state or licensed in California but allowed their license to cancel and do not meet the new 2-year education requirements. The Board expects this legislation to be in place on January 1, 2003.

The Outreach Committee is also exploring the possibility of major television studios writing RCPs into their shows, the feasibility of establishing other monetary benefits for students entering the field, and the possibility of State universities establishing 4-year respiratory care programs.

The Board is committed to increasing the number of RCPs in the State and is optimistic that its efforts (and those of volunteers) will be rewarded as we continue working towards our goal.

AB 2712: RCP-to-Patient Ratios Dies

Although AB 2712 died in a Legislative Committee, the issue of respiratory care practitioner-to-patient ratios is still alive. This bill would have required hospitals to provide minimum respiratory care practitioner-to-patient ratios established by the bill and to adopt written policies and procedures for training and orientation of respiratory care practitioner staff. Again, **this bill died in Committee and will not become law**, but it is possible for similarly drafted language to be introduced to the Legislature in the future.

The Assembly Committee on Health performed an analysis of this bill wherein the following was noted:

“PURPOSE OF THIS BILL.

According to the author, existing staffing for [Licensed Respiratory Care Practitioners] LRCP in facilities is inadequate. The author argues that LRCP staffing may be worse once the existing nurse-to-patient ratios are implemented.”

“SUPPORT.

According to the sponsors of this bill, the Service Employees International Union (SEIU), LRCPs provide vital services to hospital patients. Working within their scope of practice and the orders of a physician, LRCPs help patients breathe by using various devices and medications. This is common after most surgeries and for older patients. SEIU argues that this bill is needed because 1) some hospitals do not now have adequate LRCP staff; and 2) sadly many more hospitals have threatened to reduce staff other than licensed nurses as the hospitals comply with licensed nurse-to-patient ratios. SEIU adds that the numbers contained in this bill were developed by their active members who are LRCPs.”

“OPPOSITION.

According to the Los Angeles County Board of Supervisors (LACBS), this bill removes the hospital's flexibility to effectively manage LRCPs to meet the needs of patients, while controlling costs. Ratios should not be based on the number of patients, but on the acuity level of patients. LACBS estimates that this bill will cost the county \$15 million annually. According to the California Healthcare Association (CHA), implementing this bill may prove disastrous for many reasons including delaying the time in which an emergency patient is seen in an emergency department. LRCP-to-patient ratios would also have the [effect] of hindering appropriate care given at the appropriate time as it depends on numbers and not the needs of patients.

The University of California (UC) states that the scope of a LRCP's role varies significantly from hospital to hospital, depending upon the complexity and volume of the respiratory care needed and the extent of complementary services provided by the hospital. There are many areas of overlap among the responsibilities of respiratory care, nursing, and other allied health professions. Consequently, the same order may be interpreted as a nursing order, respiratory care order, or a physical therapy order in three different institutions. UC argues that LRCP staffing ratios, imposed uniformly in a variety of settings, could result in either absurdly excessive staffing or marginalization of the respiratory care scope of practice. In either case, the result would be a disservice to patients in California hospitals. Lucile Packard Children's Hospital (LPHC) states that they have reviewed the ratios suggested by this bill with experts in the field and believe the ratios are excessive and beyond what are necessary and appropriate for high-quality care. LPCH adds that while they appreciate the vital services LRCPs provide to patients, the proposed ratios could force their hospital to make reductions in other vitally needed areas of care.”

“PRIOR LEGISLATION.

AB 394 (Kuehl), Chapter 945, Statutes of 1999, requires DHS to adopt regulations that establish minimum, specific, and numerical licensed nurse-to-patient ratios by licensed nurse classification and by hospital unit for all GACHs, APHs, or SHs. DHS is still in the process of developing these ratios. AB 1075 (Shelley), Chapter 684, Statutes of 2001, requires DHS to develop regulations that become effective August 1, 2003, that establish staff-to-patient ratios for direct caregivers working in a skilled nursing facility.”

“QUESTIONS AND COMMENTS.

a) In 1999, California enacted AB 394 which requires DHS to adopt regulations that establish minimum licensed nurse-to-patient ratios by licensed nurse classification and by hospital unit for all GACHs, APHs, or SHs. DHS is still in the process of developing these regulations. Given that DHS still has not implemented these ratios for licensed nurses, is it premature to enact mandatory staffing ratios for GACHs, APHs, or SHs?

b) Is there evidence as to whether there is a sufficient workforce of LRCPs to satisfy this bill's mandate?”

To review the complete analysis or to find out more information about this or any bill, visit the Official California Legislative Information website at: www.leginfo.ca.gov.

Mandatory Reporting

Respiratory care practitioners (RCP) and their employers are required by law to report violations of the Respiratory Care Practice Act and the regulations governing the practice of respiratory care to the Respiratory Care Board of California (Board). RCPs are required by law to report to the Board any person that may be in violation of, or has violated, any of the laws and regulations administered by the Board. Employers are required by law to report to the Board the suspension or termination of any RCP in their employment, for any one or more of the following causes:

- Use of controlled substances or alcohol that impairs a RCP's ability to safely practice;
- The unlawful sale of controlled substance(s) or prescription item(s);
- Patient neglect, physical harm to a patient, or sexual contact with a patient;
- Falsification of medical records;
- Gross incompetence or negligence, and
- Theft from patients, other employees, or the employer.

RCPs are subject to discipline and will be subject to a fine of up to \$2,500 and employers are subject to a fine of up to \$10,000 for failure to make a report as required.

REPORTING IMMUNITY

Any employer, RCP, or any other person, is protected from incurring any civil penalty as a result of complying with the mandatory reporting requirements, pursuant to Business and Professions Code, section 3759 which reads:

"Pursuant to section 43.8 of the Civil Code, no person* shall incur any civil penalty as a result of making any report required by this chapter."

Section 43.8 of the Civil Code reads in part, "In addition to the privilege afforded by Section 47, there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any person on account of the communication of information in the possession of such person to any hospital, hospital medical staff, ... professional licensing board or division, committee or panel of such licensing board, ... when such communication is intended to aid in the evaluation of the qualifications, fitness, character, or insurability of a practitioner of the healing ... arts. The immunities afforded by this section and by Section 43.7 shall not affect the availability of any absolute privilege which may be afforded by Section 47.

You can access the complete language for the sections cited above as well as all of California law, by visiting the Official California Legislative Information website at: www.leginfo.ca.gov.

*Pursuant to Civil Code, section 2981, "'Person' includes an individual, company, firm, association, partnership, trust, corporation, limited liability company, or other legal entity."

RCP Recognition: Nominations Now Accepted!

The Board is now accepting nominations for RCPs deserving of recognition for outstanding performance or dedication to furthering education and/or the respiratory care field.

The Board is especially interested in recognizing those individuals who have made a positive impact on patient care, whether it is as a result of outstanding performance that affected one particular patient or contributions toward furthering their own education or the profession that have affected patient care overall. The Board plans to recognize one individual at each of its Board meetings, followed by recognition in its newsletter.

Nominations should be received four weeks prior to each scheduled Board meeting. The cut-off date for the November 8th meeting to be held in Los Angeles is **October 11th**.

To nominate an RCP for recognition, send a letter to the Board's Sacramento Office and include:

- the name of the RCP nominated
- the RCP's employment address and telephone no.
- your name, address and telephone no.
- a description on how the efforts or accomplishments of the nominee affected/affects patient care.
- the details of one or more special event which directly affected patient care or the efforts made by the nominee that affected overall pt. care

Sunset Review

In the last year, the Board successfully underwent its second sunset review by the Joint Legislative Sunset Review Committee. The Sunset Committee is responsible for determining whether the State should continue to regulate various practices, such as respiratory care, to ensure that the interests of California's consumers are protected against incompetent practice or illegal activities.

The Sunset Committee made several recommendations for the Board as follows:

Recommendation #1: *Recommend the continuance of the Respiratory Care Board (RCB) and the regulation of respiratory care therapists.*

Status: SB 1955 extends the Board's sunset date the standard 4 years, through July 31, 2007.

Recommendation #2: *The Department and the Joint Committee support: a) the Board's effort to review the function and skill of currently unlicensed technicians and b) further study to determine the need for regulation of these technicians.*

Status: This recommendation was incorporated into the Board's Strategic Plan on July 19, 2002. On July 18, 2002, the Board's Unlicensed Personnel Task Force held its first meeting to discuss the current trends of the practices of polysomnography, pulmonary function testing, and the practice of respiratory care in home health.

Recommendation #3: *Recommend a comprehensive review of the Board's disciplinary policies to ensure that its disciplinary actions are relevant to consumer protection and appropriate to the violations. In addition, the Board's statute should ensure that penalties are based on the facts of each case. In particular, the statute should ensure that in situations where license revocation is sought, such action is taken only if necessary to protect the public.*

Status: The Board implemented its In-House Review Policy and is also promulgating regulations revising its disciplinary guidelines that will satisfy this recommendation. Regulations are expected to be effective by the end of this calendar year.

Recommendation #4: *The Board should designate a staff liaison to work with the International Medical Graduates and programs devoted to facilitating their licensure and re-entry into their profession.*

Status: In March 2002, Christine Molina, Staff Services Manager, was appointed as the Board's liaison to work with the International Medical Graduates. The Board welcomes this opportunity as another avenue to bring awareness to the profession.

Recommendation #5: *The Board's changes in education requirements and reliance upon national accreditation should be ratified by the Legislature by enacting a statute that (i) codifies the new two-year and AA requirements; and (ii) specifically permits the Board to fulfill its school approval obligations by using national accreditation; however, if the Board is to rely solely upon national accreditation, it must also annually contact the post-secondary schools bureau to see if any of the schools are then or have been disciplined or investigated.*

Status: SB 1955 includes amendments to require and codify the minimum education requirement of an Associate Degree and require completion of respiratory care programs approved by the Committee on Accreditation for Respiratory Care.

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 or 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 licensing your profession.

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.

2002 Strategic Plan

In February, the Board conducted an intensive strategic planning session, at which the Board established several goals and addressed the Joint Legislative Sunset Review Committee's recommendations. The strategic planning session resulted in the development of new mission and vision statements. The new mission statement is reflective of the current issues facing the profession and, for the first time ever, includes the promotion of the profession.

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.

Highlights of the strategic plan include:

- * modifying education requirements
- * supporting efforts to have respiratory therapists recognized by health insurers
- * enforcing the Respiratory Care Practice Act against persons unlicensed and unqualified to practice respiratory care
- * revising the disciplinary guidelines and enforcement policies consistent with the Board's mission
- * reducing enforcement expenditures
- * improving communications with stakeholders
- * addressing the RCP shortage
- * ensuring an equitable and fair fee structure

Please visit our website at: www.rcb.ca.gov to review the complete strategic plan.

California Society for Respiratory Care New Leadership

The Board is pleased to welcome Mr. H. Robert Bence as the California Society for Respiratory Care's (CSRC's) new President.

The CSRC is an affiliate chapter of the American Association for Respiratory Care (AARC). The CSRC represents the respiratory care profession in California before lawmakers and administrative agencies and has been instrumental in advancing the profession. Mr. Bence has 25 years of education and experience to draw upon as he takes on his new role as the President of the CSRC.

Mr. Bence earned a Baccalaureate in Science from California State University Chico in 1977 and went on to earn a Certificate of Completion in Respiratory Care from Foothill College in 1981. He began his respiratory care career at Alexian Brothers Hospital in San Jose as a therapist in 1981. In 1990, he was appointed as the Assistant Director of Cardiology, Cardiac Cath Laboratory, Respiratory and Neurodiagnostics at Alexian Brothers Hospital and in 1998, he acquired his current position as Clinical Specialist with Fisher & Paykel Healthcare.

Mr. Bence has a strong work ethic and commitment to continuing education, as evidenced by his dedication and advancement in the respiratory care profession. He holds 15 professional and clinical certifications including Registered Respiratory Therapist, Registered Pulmonary Function Technologist, and Perinatal/Neonatal Specialist, to name just a few. He has been an active member of the respiratory care profession, dedicating his time to improving patient care through staff development and volunteering regularly to promote the profession. He was jointly responsible for organizing monthly managerial meetings for resource sharing in the San Jose metro area.

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Board Appreciation

Earlier this year, the California Society for Respiratory Care (CSRC) and Virginia Ettinger, MPH, RRT, RCP were extremely generous in providing hospital tours to our entire staff and two public Board members.

On behalf of the CSRC, **Steve Kutler** provided tours of the UC Medical Center to each of the Board's 20+ staff members. Staff were sensitized by the pressures placed on many therapists and a newfound respect for the lifesaving practice of respiratory care emerged.

Mark Goldstein, Secretary and Treasurer for the CSRC, was also instrumental in making the tours for staff happen.

Ms. Virginia Ettinger provided tours of Cedar Sinai to two of our Board members, which gave them an additional perspective of the profession.

The Board would like to extend its appreciation to these individuals for their time and effort in providing these tours.

Ethical Guidelines

The largest portion of RCP's fees is directed to operate the Board's Enforcement Program. Though only a small percentage of licensees and applicants enter the Board's Enforcement Program, each enforcement case incurs anywhere from \$200 to \$5,000 in costs, not including Board staff wages. The Board is striving to educate and inform respiratory care practitioners of their responsibilities as professionals to prevent incidents that will result in enforcement action. One way leaders in this profession can help is by supporting these guidelines and educating colleagues about their responsibility as licensed practitioners and the need to act responsibly at work and in their communities. It is one of the ways we can decrease costs and ultimately reduce licensure fees.

On July 19, 2002, the Board motioned to recognize and support the American Association for Respiratory Care's Statement of Ethics and Professional Conduct for the purpose of promoting professionalism.

American Association for Respiratory Care Statement of Ethics and Professional Conduct

In the conduct of professional activities the Respiratory Therapist shall be bound by the following ethical and professional principles. Respiratory Therapists shall:

Demonstrate behavior that reflects integrity, supports objectivity, and fosters trust in the profession and its professionals. Actively maintain and continually improve their professional competence, and represent it accurately.

Perform only those procedures or functions in which they are individually competent and which are within the scope of accepted and responsible practice.

Respect and protect the legal and personal rights of patients they care for, including the right to informed consent and refusal of treatment.

Divulge no confidential information regarding any patient or family unless disclosure is required for responsible performance of duty, or required by law.

Provide care without discrimination on any basis, with respect for the rights and dignity of all individuals.

Promote disease prevention and wellness.

Refuse to participate in illegal or unethical acts, and refuse to conceal illegal, unethical or incompetent acts of others.

Follow sound scientific procedures and ethical principles in research.

Comply with state or federal laws which govern and relate to their practice.

Avoid any form of conduct that creates a conflict of interest, and shall follow the principles of ethical business behavior.

Promote health care delivery through improvement of the access, efficacy, and cost of patient care.

Refrain from indiscriminate and unnecessary use of resources.

Effective 12/94; Revised 3/00

Enforcement Procedures

The Board established its in-house review policy this February and is moving forward with promulgating regulations to amend its disciplinary guidelines and expand its cite and fine program. These amendments are being made in order to promote cost effectiveness and to ensure the availability of funds to prosecute high priority complaints.

A good example of the difference in how cases are prosecuted is a licensee with a DUI. A licensee who received a DUI prior to February 2002, would have most likely been placed on probation for a period of three years subject to several terms and conditions including random drug testing. With the proposed cite and fine regulations, a licensee with an otherwise clean record for the past 7 years who receives 1 DUI conviction will now be issued a citation and fine in an amount ranging from \$100 to \$500. I encourage you to visit our website to review the complete in-house review policy.

The Board expects the new regulations to be in place by the end of this calendar year.

Patients' Rights

The Board endorsed "Respiratory Care Patients' Rights" shown below, at its July 19, 2002 meeting. These Rights will be promoted at various State and National consumer protection events and used by the Board as a tool for educating consumers.

RESPIRATORY CARE PATIENTS' RIGHTS

Patients have the right to professional, conscientious, and competent care.

Patients have the right to health care that meets community standards regardless of the setting.

Patients have the right to adequate explanations regarding therapy, management, rehabilitation, and diagnostic evaluations or services performed.

Patients have the right to refuse any treatment to the extent permitted by law and to be informed of the medical consequences of refusing such treatment.

Patients have the legal right to request and review the license of any respiratory care practitioner and be apprised of the current status of the license (i.e. valid, expired, canceled, probationary, revoked).

Patients have the right to be informed of the physician(s) responsible for medical direction and the supervision of the respiratory care practitioner.

Patients have the right to expect that all records and/or communications pertaining to their care are treated as confidential.

Patients have the right to access all health records pertaining to their care as provided by statute.

Patients have the right to refuse observation by those not directly involved in their care.

Patients have the right to be fully informed and advised of their rights in all health care settings.

...CSRC – New Leadership continued from Page 9

In 1998, Mr. Bence was honored with the Rick Urband Award, an award bestowed annually to recognize an outstanding RCP in the San Francisco Bay area.

As the President of the CSRC, Mr. Bence is looking forward to and is committed to working towards specific goals over the next two years, some of which include:

- * Active recruitment and development of future CA leadership of CSRC and the Respiratory Profession
- * Increasing CSRC/AARC membership in part by building network bridges to the care-giving therapist in all work places
- * Making available CSRC "consensus benchmark standards" for various required RCP departmental documents and procedures
- * Participating proactively with the Respiratory Care Board in determining the methodology and direction of the Respiratory Care profession's future in CA
- * Facilitating retention and recruitment of RCPs with the guarantee of continued license reciprocity and assuring qualified RCPs are not by regulation and regulated cost, excluded from CA practice
- * Facilitating retention and recruitment of RCPs by keeping to a minimum or reducing, the regulatory fees imposed to become and remain a RCP in CA

The Board is looking forward to partnering with Mr. Bence and the CSRC over the next two years to work towards reaching mutual goals.

Unlicensed Personnel

On July 18, 2002, the Board's Unlicensed Personnel Task Force, chaired by Barry Winn, Ed.D, RCP, President, held a roundtable meeting to address the quality of respiratory care in areas of specialties and different settings. This was the first of several meetings to come, to identify the problems and concerns in these areas and develop resolutions that will ensure patient safety. Discussion was focused on the practices of polysomnography, pulmonary function testing, home care, and cardiac catheter laboratories. Over 30 representatives among these practices participated in the discussion.

Polysomnography. It was noted that there are approximately 150 polysomnographers in California that belong to the American Sleep Disorders Association. There was some discussion as to whether or not this practice was being performed in homes. The most notable concern raised at this meeting was the fact that many polysomnographers who are not RCPs are performing CPAPs. The improper use can be a hazard to patient safety.

Pulmonary Function Testing. It was estimated that there are approximately 200 pulmonary technologists in California. While this is a relatively small number, all agreed that the role well-trained pulmonary technologists play alters the care and treatment in patients dramatically. Well trained pulmonary technologists allow for proper diagnoses which affects managed care and health care costs.

Twenty years ago, there was specialized training available at colleges by way of pulmonary programs. But since those programs went by the wayside, there are very few people with education and experience in pulmonary function training, other than the few that remain in the field.

It was noted that great technology advancements have been made with pulmonary function equipment. A number can be produced from the equipment with minimal instruction to the operator. The trend today with many pulmonary function instruments and tests performed by unlicensed personnel is to produce a number...never minding its source. What results, in many cases where tests are performed by unqualified personnel that lack education in physiology, are erroneous numbers.

Many believe because pulmonary laboratories and medical offices are not required to have licenses or certificates to perform these tests, that many of these facilities hire assistants that have little if any understanding that the test results are effort-dependent as well as technically dependent upon instruction and coaching patients for reliable results.

It was agreed that a person performing anything other than a simple "blowout" maneuver should hold a CPFT certification through the National Board for Respiratory Care (as well as a current and valid California RCP license).

Some suggested that respiratory care educational programs should include physiology and pulmonary function courses. Others believed the respiratory care programs are at their full capacity. Some possible solutions included having separate pulmonary programs, identify a pulmonary function program curriculum (that does not necessarily need a formal program) and work with pulmonary labs to take on the clinical practice portion of the education.

It was agreed that the California Thoracic Society should be involved in future discussions.

Home Care. The practice of respiratory care as well as other practices in the home, is virtually occurring without any regulation. This is a nationwide problem that has captured the attention of many regulators and people concerned for patient safety. The concern has been growing since the 1980s, when hospitals began sending very ill patients home.

Many of the concerns raised do not reflect the practices of all home health or durable medical companies. Rather, there are valid concerns with the trends of some companies that are jeopardizing patient safety. Consumers should ask their home care company where they stand on the issues raised herein.

The practice of respiratory care in the home requires the most skilled practitioners, as the needed care often requires quick responses to critical situations. Many home care companies concerned for patient safety recruit only those RCPs with experience in critical care.

There is a need for home medical companies to have clear medical direction. Many in attendance noted the fact that many home care companies hire a medical director in name only.

Some home care companies are employing equipment delivery personnel to perform patient care. Equipment delivery personnel are NOT qualified to perform any type of clinical assessment or care. Rather, they should be limited to delivering equipment, setting up the equipment (not to the patient), and instructing, how to operate the equipment from a mechanical perspective. They are not qualified or authorized to adjust settings for a patient.

...continued on Page 13

...Unlicensed Personnel continued from Page 12

It was noted that some equipment delivery personnel are delivering oxygen tanks improperly that could result in catastrophic disasters (i.e. placing tanks next to gas pilot lights). The Federal Drug Administration (FDA) issued a warning in 2001 about the mishandling of medical gas mix-ups that resulted in patient deaths and stresses the proper handling of these. It was also noted that ventilator checks and medication delivery is being performed by unlicensed personnel.

Participants said most home care companies do not have enough respiratory care practitioners on staff to perform the functions of respiratory care. This was attributed to the shortage of RCPs and the fact that some home care companies focus on how to get reimbursement rather than what is in the best interest of its patients. Failure of health insurers to provide financial reimbursement supports the use of unlicensed personnel. Furthermore, it was noted that the majority of home care patients have no idea who is treating them and if those people are qualified to do so.

Participants also suggested that if respiratory care educational programs included home care rotations, more therapists would be encouraged to enter the practice in home care.

It was agreed that future discussions should include representatives from the Department of Health Services and various insurance payers.

Cardiac Cath Laboratories

It was requested that the practices occurring in Cardiac Catheter Laboratories be explored further for the possibility of creating a certification for these technicians.

If you have any information that may help the Board in its fact-finding mission, please send your written comments to the Sacramento Board office or by way of e-mail to: rcbinfo@dca.ca.gov. Please direct all correspondence to Stephanie Nunez, Executive Officer.

Scope of Practice

Inquiry: On pages 11 and 12 of the *Respiratory Update* for January 2002 (with regards to home medical devices 1 through 13), what devices need to be set up by a licensed respiratory therapist or need to be followed by an RT?

Response: The January 2002 issue of the *Respiratory Update* quotes sections 109948 and 109948.1 of the Health and Safety Code, wherein (home medical devices) are listed as follows:

- (1) Oxygen delivery systems and prefilled cylinders.
- (2) Ventilators.
- (3) Continuous Positive Airway Pressure devices (CPAP).
- (4) Respiratory disease management devices.
- (5) Hospital beds and commodes.
- (6) Electronic and computer driven wheelchairs and seating systems.
- (7) Apnea monitors.
- (8) Low air loss continuous pressure management devices.
- (9) Transcutaneous Electrical Nerve Stimulator (TENS) units.
- (10) Prescription devices.
- (11) Disposable medical supplies including, but not limited to, incontinence supplies as defined in Section 14125.1 of the Welfare and Institutions Code.
- (12) In vitro diagnostic tests.
- (13) Any other similar device as defined in regulations adopted by the department.

Items numbered 1, 2, 3, 4, 7, and 8 and in some cases items numbered 10 and 13 are associated with the practice of respiratory care. Therefore, set-up or application of these devices to a patient or the instruction in the use of the equipment **for the purpose of deriving an intended medical benefit** must be performed by a licensed respiratory care practitioner or other qualified licensed persons authorized by their respective licensing statute to practice respiratory care. This does not prohibit unlicensed persons from setting up or instructing in the use of the equipment if it is not done for the purpose of deriving an intended medical benefit and is solely restricted to the operation of the equipment (i.e. pointing out locations of switches, filters, etc.). In order to ensure unlicensed personnel are performing legally, any discussion or communication with a patient or caregiver of a prescription or medical condition, in any

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manner, should be prohibited to safeguard against false accusations of practicing unlawfully and to prevent a patient or caregiver's misperception that unlicensed personnel are qualified to offer medical advice or instruction. If a patient or caregiver initiates such discussion, the unlicensed personnel should immediately refer the caregiver or patient to a respiratory care practitioner or other qualified licensed personnel on staff. Unlicensed persons are prohibited from practicing respiratory care in the State of California.

The American Association for Respiratory Care has developed some clinical practice guidelines for specific education for patients discharged from acute care facilities or general respiratory care education. The AARC's address is 11030 Ables Lane, Dallas, TX 75229.

For regulations regarding the appropriate clinical follow-up and monitoring, I would recommend you contact the Department of Health Services at: 714 / 744 P Street, Sacramento, CA 95814, (916) 445-4171.



Inquiry: I have read the most current issue of the RCB's "Respiratory Update," January 2002, and I now have some questions. Exactly who may set up an oxygen concentrator or compressed gas system in a patient's home other than a respiratory therapist? For example, could an EMT, LPN, Physicians Assistant, Pharmacy Tech, etc. be employed to set up this type of equipment, provide basic instruction on how to turn it on, adjust liter flow, clean the filter and place the cannula, if under the supervision of a CRT?

Response: Unlicensed personnel are not authorized to administer any form of respiratory care. This includes, but is not limited to, set-up or application of devices to a patient and instruction in the use of the equipment for the purpose of deriving an intended medical benefit prescribed by a physician. Only licensed respiratory care practitioners can perform this practice. It is also acceptable for other licensed personnel to perform these functions as long as they are authorized by their respective licensing statute to practice respiratory care. Unlicensed persons are prohibited from practicing respiratory care in the State of California.

To determine which licensed personnel may perform respiratory care you will need to contact their individual licensing board for clarification.



Inquiry: I am a Certified Pulmonary Function Technologist and I need your help with the following questions about Respiratory Care Board regulations. 1) Is it legal for a Certified Pulmonary Function Technologist to perform pulmonary function studies in a hospital setting with a physician's order? 2) Is a RCP license required to perform pulmonary studies in a hospital setting? 3) Do you know of any programs in California that allow candidates with previous respiratory care experience to challenge portions of their program in order to expedite the process of obtaining a RCP license?

Response: It is legal for a certified pulmonary function technologist to perform this function as long as they are licensed in the state of California as a respiratory care practitioner. Since the NBRC currently requires successful completion of the CRT exam prior to sitting for the CPFT exam all CPFT individuals should meet the criteria to obtain licensure. The specific statute that defines this practice is section 3702 of the Respiratory Care Practice Act.

The Board is unaware of any programs that allow challenging the exam to expedite licensure. You are encouraged to contact an approved educational program to clarify this question. You can obtain a list of approved programs from the AARC Web site at: www.aarc.org or at their address: 11030 Ables Lane, Dallas, TX 75229 (Telephone: (972) 243-2272).



Inquiry: Is there a law in the state of California that states a physician's order is required in order to perform a spirometry test on another person? How about oximetry?

Response: The performance of any spirometry or oximetry measurement without an order from a physician is not allowed under the current practice act unless its obtainment is part of a respiratory care protocol as outline in section 3702. The Board recommends that the development of such a protocol be discussed with the Medical Director of your home care service.

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Inquiry: A relatively new procedure is being performed called percutaneous tracheostomy and usually requires a bronchoscopist and surgeon. The bronchoscopist is responsible for visualizing the insertion of the needle into the airway and to determine proper placement of the tracheostomy tube. In addition, instillation of medications and normal saline lavage with suction and specimen collection would be involved and performed by the bronchoscopist. The surgeon would perform the tracheostomy.

Is it within the scope of practice for respiratory therapists to perform the bronchoscopy portion of the percutaneous tracheostomy procedure if properly trained?

Response: It is the Board's opinion that licensed respiratory care practitioners could assist physicians in performing percutaneous tracheostomy utilizing bronchoscopy techniques (excluding tissue sampling) provided an appropriate training program was developed, approved and supported by your medical director and the medical staff at your facility.

The intent of the practice act does recognize the existence of overlapping functions between physicians and surgeons, registered nurses, physical therapist, respiratory care practitioners, and other licensed health care personnel (3701, Article 1, General Provisions). As such, the onus is on the licensed health facility to develop appropriate training and competencies that would provide this function in a manner that would be safe when administered to the public.



Inquiry: For the seventeen years I have been in the DME/home respiratory business (Home Care) it has been the general practice to have delivery/service technicians perform initial set-up and instruction for basic oxygen, nebulizer compressor and suction units. These technicians were always trained by a licensed respiratory therapist and certification of training documented. A licensed respiratory therapist would then perform an initial follow-up/assessment within 48 - 72 hours of initial delivery.

The home care bulletin released by the Joint Commission (JCAHO) sights the California Department of Health Services' Food and Drug Administration Division as the source of a State of California "regulation," which is to be interpreted to say that an unlicensed individual such as a delivery/service technician cannot do anything except deliver/drop off any respiratory equipment. The California Department of Health Services stated that JCAHO was in error in sighting them and that you, the RCB, are the governing authority of this regulation.

I have spent nearly a week researching all applicable agencies and cannot find any language in actual law anywhere that states that delivery of respiratory equipment and instruction on the use of the same prior to assessment and follow-up by a licensed respiratory therapist is considered respiratory care. The home care company does not initiate treatment or benefit. That is initiated by the physician at the time he prescribes the service. Please inform me where this is a matter of law or regulation and not interpretation.

Response: In section 3701 of the Respiratory Care Practice Act the statement clearly reflects the Board's continued position regarding the practice of respiratory care by unlicensed personnel. It states, "...that the practice of respiratory care in California affects the public health, safety and welfare and is subject to regulation and control in the public's interest to protect the public from the unauthorized and unqualified practice of respiratory care."

It is the intent of the Board to ensure that unlicensed personnel are not practicing respiratory care illegally and jeopardizing patient safety. However, it is not the intent to mislead or confuse Home Medical Device Retail Facilities (HMDRF) or unlicensed personnel.

There is a fine line as to when the "instruction in the use of a home medical device" crosses over to the "instruction in the use of a home medical device for the purpose of deriving the intended medical benefit." If the instruction in the use of the equipment is solely focused on the equipment and in no way includes discussion of the patient's condition, a prescription, or any other conversation that would lead to instruction for the "purpose of deriving the intended medical benefit," there is no question that unlicensed personnel are not crossing this fine line.

... continued on Page 16



Inquiry: I want to know if the Respiratory Care Board has any guidelines concerning verbal or telephone orders taken from a physician. Are there any business and professional codes regarding this?

I know of a hospital that has a policy and procedure for this, but the therapists are afraid to follow their protocol because of its vagueness, and it makes them liable for mishaps due to their protocol, which is not clear. They do not attempt to change this policy and have the therapists unprotected. There have been situations where patients have been at risk due to the management neglecting to change their policy. The therapists are afraid to take verbal and telephone orders from a physician because of the vagueness of the policy. Do you have anything regarding this in respect to guidelines?

Response: It is not within the scope of the Respiratory Care Board to render or establish policy regarding issuance of verbal or telephone orders at a facility. The medical staff of the facility and the manager and medical Director of the department determines that practice. It is however within the Board's authority to expect public safety, health and welfare be maintained through effective policy and procedure. Should you be able to provide the Board with sufficient evidence that patient safety is at risk, then the Board would be compelled to investigate the evidence and act accordingly.

From a practice perspective, it is recommended that you investigate and explore any internal mechanisms that may be available to you. Enlisting these may prompt a change in the policy or procedure to ensure safe practice exists. These would include, but not be limited to, the risk management department, the medical director or the manager of the department.



Inquiry: In my HMO, we have nine RRTs acting as asthma care managers. In this role, the RRTs follow patients/families with asthma for about six months to stabilize their asthma and to teach them self-managements skills. My question is, are RRTs legally able to adjust (either increase or decrease) inhaled medications (albuterol, QVAR, Flovent, salmeterol) according to established, approved protocols? The initial prescription is ordered by an MD and the RRT has written authorization from the primary care MD to care manage each patient and to adjust medication according to these protocols. (1) If this is indeed an approved procedure, do you have a template for a document to accompany the protocols? (e.g. signature sheet for those that are approving the RRT protocol, stipulations, etc.)

(2) One more question, can RRTs also adjust oral medications according to protocols?

Response: Section 3702(e) of the Respiratory Care Practice Act specifically defines the clinical practice you described. In summary, it states that Respiratory Care Protocol means policies and protocols developed by a licensed health care facility through collaboration with physicians, registered nurses, physical therapists, respiratory care practitioners and other licensed health care practitioners. In other words, your facility could develop a protocol for the evaluation and treatment of asthma management that includes clinical indicators that would warrant a change in therapy or medication (including oral medications). The requirement to initiate the protocol would be an order from the patient's physician initiating the protocol.

As far as a template is concerned, the Board does not develop or provide that level of detail to individual departments or health care facilities. It is recommended that you contact the American Association for Respiratory Care (AARC) to see if they have a National standard or protocol. I would also recommend contacting the California Society for Respiratory Care (CSRC). They might have resources that would get you in touch with a department(s) that has implemented similar protocols. Their contact information is as follows: **American Association for Respiratory Care**, 11030 Ables Lane, Dallas, TX 75229, (972) 243-2272; **California Society for Respiratory Care (CSRC)**, 505 North Brand Blvd., Suite 740, Glendale CA 91203, (818) 247-2053.

The approval process for a protocol is determined by each health care facility and not by the Respiratory Care Board. That process may be as simple as getting the approval of the medical director for respiratory care or as complex as obtaining approval from a protocol committee.



Disciplinary Actions Taken

From July 1, 2001 through June 30, 2002

FINAL DECISIONS REVOKED OR SURRENDERED

Anderson, Michael, RCP 17825
Orange, CA

Aragon, Michael A., RCP 4260
Orange, CA

Berard, Brent, RCP 21081
Kings, CA

Brackemyre, Phillip J., RCP 17055
Del Norte, CA

Brodsky, Ted Marc, RCP 1668
Los Angeles, CA

Brooks, Janice Yvonne, RCP 2218
San Bernardino, CA

Broomfield, Shirley, RCP 18637
Los Angeles, CA

Burns, Lois Elaine, RCP 19790
San Joaquin, CA

Calnan, Jerome Peter, RCP 5404
Los Angeles, CA

Cesena, Albert, RCP 9112
Imperial, CA

Clack, John Steven, RCP 19606
Los Angeles, CA

Contreras, Micael A., RCP 15693
San Joaquin, CA

Currie, Deborah Lynn, RCP 18346
Riverside, CA

Elizalde, Christian, RCP 20330
Los Angeles, CA

Hill, Ronnett E., RCP 9530
San Bernardino, CA

Janolino, Rudivar A., RCP 15688
Santa Barbara, CA

Khan, Farhad Parvez, RCP 17188
Ventura, CA

King, Daniel Lee, RCP 12286
Napa, CA

Knapp, Eric, RCP 15833
San Bernardino, CA

Lake, Ronald A., RCP 13304
San Luis Obispo, CA

Le, Trung Duy, RCP 17080
Los Angeles, CA

Leo, Harold Reith, RCP 4770
Los Angeles, CA

Merris, Kathleen S., RCP 5524
Alameda, CA

Mitchell, Elvin, RCP 19125
Orange, CA

Montgomery, James, RCP 16997
Orange, CA

Murray, Lawrence F., RCP 4929
Lake, CA

Pocknett, Dwayne, RCP 19276
Los Angeles, CA

Reyes, Antonio Cutin, RCP 21802
Los Angeles, CA

Schnuch, Fredrick H. RCP 19985
Ventura, CA

Spencer, Karen Lynn, RCP 17805
Orange, CA

Sprague, Thomas, RCP 19099
Butte, CA

Stadiem, Jacqueline W., RCP 11083
San Diego, CA

Stouffer, Mark William, RCP 4327
Los Angeles, CA

Tuttle, Eileen Ruth, RCP 5000
Humboldt, CA

Valdez, Kenneth Lee, RCP 15950
Alameda, CA

OTHER DECISIONS

Atkins, Marilyn – Denial
Los Angeles, CA

Baker, Joanne L., RCP 1301
Santa Clara, CA

Anderson, Ursula, RCP 12936
Los Angeles, CA

PLACED ON PROBATION / ISSUE CONDITIONAL LICENSE

Austin, Pamela Jean, RCP 17565

Azar, Rashid N., RCP 22257

Battle, Franklin Joseph, RCP 7951

Boghosian, Joyce, RCP 1030

Bolivar, Raymundo, RCP 19262

Breazeale, Wally W., RCP 18938

Case, Kathleen M., RCP 11190

Clark, Raymond, RCP 17564

Clark, Stephen, RCP 15334

Day, Linda Sherry, RCP 6661

De Guzman, Faustino C., RCP 16819

Fine, Jay Gary, RCP 21693

Fly, Tonya Christina, RCP 16648

Ford, Brian, RCP 2115

Fox, Don, RCP 13807

Gonzales, Stephanie G., RCP 19296

Gwilliam, Alfred Hans, RCP 17521

Hauser, Scott Dewitt, RCP 16084

Hill, Jeffrey Lance, RCP 22164

Johnson, April Joy, RCP 15932

Johnson, John Rogers, RCP 8738

Johnson, Kenneth, RCP 16250

Kusch, Marick M., RCP 20718

Larocco, Michael, RCP 13061

Love, Trina Sally, RCP 16215

Martin, Albert Allen, RCP 4132

McGuire, Thomas M., RCP 21941

McKinney, Ronald, RCP 17769

Mendoza, Charles L., RCP 16621

Miller, Larry R., RCP 7159

Myers, Cariann Marie, RCP 22156

Nicola, Clarissa Denise, RCP 9290

Paraguay, Rodines, RCP 15103

Pearson, Allen, RCP 2862

Pierson, Melinda N., RCP 21964

Piscitello, Dawn S., RCP 22241

Quitasol, Edgar, RCP 19317

Reese, Arthur, RCP 20764

Simmergren, Philip J., RCP 1001

Stanford, Celeste K., RCP 17455

Strauss, Thomas W., RCP 10794

Vipond, Mark, RCP 21352

Weseloh, Donald N., RCP 12576

West, Robert G., RCP 3605

Winn Jr., Venius C., RCP 17534

PUBLIC REPRIMAND

Albelo, Carleen Andrea, RCP 15529

Ancheta, Danny A., RCP 14497

Baez, Rafael B., RCP 19078

Benton-Powless, Karen, RCP 17831

Chartier, Charlene Ann, RCP 9731

Evans, Julia Diane, RCP 19912

Gardner, Tatia H., RCP 19312

Higa, Kevin Kiyoshi, RCP 16803

Loy, Liza Yvonne, RCP 15899

...Disciplinary Actions continued from Page 17

Lyle, Terry Patrick, RCP 7042
Marlow, William J., RCP 10846
McCartney, Ian A., RCP 18355
Moran, Rosemary, RCP 14303
Nabulungi, Hatshepsut, RCP 13029
Nilsen, Andrew, RCP 12014
Ordonez, Henry S., RCP 17556
Ryan, Susan Marie, RCP 10533
Sengendo, Julius, RCP 18216
Sutton, Jacqueline L., RCP 21864
Ventura Jr., Carmine, RCP 16701
Watson, Lori, RCP 20765
Wiesinger, Jeffry Clark, RCP 1616

CITED & FINED

Brodsky, Ted Marc, RCP 1668
Dempsey, Michael W., RCP 19843
Diaz, Guadalupe G., RCP 3553
Gwynn, Patricia Jeanne, RCP 20085
Herrera, Damien Mark, RCP 20799
Jeansonne, Deborah, RCP 13293
Kloppenborg, Richard, RCP 19968
Lange, DeeAn Sara, RCP 11027
Martinez, Steven Scott, RCP 19825
Newsome, Shelli, RCP 20114
Pasos, Irene M., RCP 7926
Pederson, Courtney, RCP 11427
Phillips, Gregory R., RCP 14671
Pravdin, Yevgeniy, RCP 18100
Pullins, Monique C., RCP 15150
Reed, Eddie Jr., RCP 8763
Rosa, Debra Michelle, RCP 17155
Sall, Maura Mari, RCP 21389
Umayam, Kristofferson, RCP 21380
Vierra, Maria I., RCP 15146
Wolfe, Richard C., RCP 17073

STATEMENT OF ISSUES

Gonzales, Raymond Martin
Horrell, Crystal Ann
Johnston, James Edward
Lee, Brian Po-Lin
Mensonides, Dennis James
Peraza, Ernie Rangel
Smith, David James
Viveros, Christopher Richard

ACCUSATIONS FILED

Aguiar, Raul Grimaldi, RCP 21438
Allen, Sean C., RCP 19935
Allison, William M., RCP 8652
Amisola, Jude M., RCP 21381
Anderson, Darrell Scott, RCP 15691
Anderson, Paul David, RCP 17217
Bailes, William, RCP 20387
Beljan, Gerald, RCP 15317
Capdeville, Matthew J., RCP 17958
Caruthers, Jeffery Lynn, RCP 9919
Chamberlain, Keith Allen, RCP 11622
Conley, Darby Morgan, RCP 18617
De Jesus, Mario M., RCP 15450
Duff, Glenn Roderic, RCP 16750
Duffey, Faith Beryl, RCP 2232
Figgins-Johnson, Karen, RCP 5157
Frandsen, Charles W., RCP 7904
Galpin, Kenneth Scott, RCP 2181
Gilles, Cesar H., RCP 18653
Green, Don, RCP 9685
Harper, Yolanda Lynn, RCP 17614
Hebert, Rona Michelle, RCP 19526
Hernandez-Castillo, Reuben, RCP 19356
Hoover, Melissa Marie, RCP 15958
Hopkins, Janalyn Marie, RCP 9694
Howell-Sardar, Zenith Z., RCP 1312
Huber, Scott Patrick, RCP 20179
Ivie, Richard John, RCP 14622
Jones, Viola Maria, RCP 19621
Kauble, James B., RCP 8225
Knoepfel, Susan Lee, RCP 8625
Leask, Dave B., RCP 20272
Lim, Steve Michael, RCP 1663
Manister, Dawn Helane, RCP 16116
Marcu, Florin, RCP 21173
Padden, Brett Richard, RCP 7527
Pickett, Michele Eileen, RCP 17206
Powell, Stewart Gary, RCP 20470
Richardson, Andre Joey, RCP 19890
Roscoe, James Timothy, RCP 13526
Santini, Mark A., RCP 21080
Shaw, Randolph Todd, RCP 15152
Silverio, Maria A., RCP 19600
Stirling, Beverly Jean, RCP 14332
Thomas, Karen Ann, RCP 2874
Thornton, Douglas G., RCP 17978
Yates, Roy L., RCP 12727
Yu, Bonito Chua, RCP 11946

ACCUSATION AND/OR PETITION TO REVOKE PROBATION FILED

Armour, Benjamin, RCP 17836
Battle-Montoya, Susan, RCP 16238
Breazeale, Wally W., RCP 18938
Butler, Beth Lorene, RCP 9848
Case, Kathleen M., RCP 11190
Duffey, Ervin Wayne, RCP 3840
Enyeart, Mark Leroy, RCP 11238
Greenwood, Thomas W., RCP 12066
Mendoza, Serafin Perez, RCP 6292
Miller, Larry R., RCP 7159
Releford, Steven W., RCP 21481
Taylor, Kenneth Edward, RCP 6998
Townsend, John L., RCP 7145
White, Katherine R., RCP 21905

DEFINITIONS

Final Decisions. Decisions become operative on the effective date, except in situations where the court orders a stay. 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 pleaded.

Statements of Issues Filed. When an applicant for licensure is informed that the license will be denied for cause, the applicant has a right to demand a formal hearing, usually before an Administrative Law Judge (ALJ). This process is initiated by the filing of a Statement of Issues (SOI), which is similar to an Accusation, wherein the cause for denial is formerly pleaded.

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 the legal pleadings, please send a written request, including the name and license number (if applicable) of the respondent, to the Board's Sacramento office or e-mail address.

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 over 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.



RESPIRATORY CARE PRACTITIONERS

Saddleback Memorial Medical Center is a highly respected, 235-bed acute care hospital. At this time we have excellent full-time, part-time and per diem positions. Enjoy the flexibility of 8 and 12 hour shifts.

The selected applicants will work with neonatal, pediatric, adolescent, adult and geriatric cases and should have a minimum of 1 year acute care experience. Requirements include: RRT or eligible; adult critical care experience; CA RCP license; NALS; and BCLS. ACLS and PALS and Level III NICU experience are desirable.

New salary ranges now in effect!

Up to a \$3000 Sign-On Bonus Available

A member of the prestigious MemorialCare system, we offer a comprehensive benefit package as well as a friendly, team environment. For immediate consideration, please send/fax resume to Human Resources, 24451 Health Center Dr., Laguna Hills, CA 92653. (949) 452-3633, FAX: (949) 452-3549. E-MAIL: hremployment@memorialcare.org
You may apply on-line at any time at www.memorialcare.org EOE.



RESPIRATORY CARE SERVICES

Sutter Health has a variety of respiratory care service opportunities for days, evenings, nights, and 8- and 12-hour shifts at the following facilities:

**SUTTER AUBURN FAITH HOSPITAL
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SUTTER MEDICAL CENTER, SACRAMENTO
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**New salary ranges now in effect!
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Apply on-line at www.childrenscentralcal.org

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Have You Moved?

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 faxed notification. However address changes are not taken over the telephone for security reasons.