

# Respiratory Update

September 2003



## New Continuing Education Requirements

The Board has been working with you to strengthen our continuing education (CE) guidelines and is pleased to report the new regulations will go into effect November 1, 2003. All CE acquired on or after November 1<sup>st</sup>, must meet the new criteria.

The new guidelines continue to require a total of 15 hours of CE every two years with a minimum of 2/3 (10 hours) being directly related to clinical practice [the other 1/3 (5 hours) may be related to the general practice of respiratory care]. The most significant changes now require courses to be approved or provided by recognized entities and limit the credit granted for repeating examinations and courses in connection with credentials and certifications as noted on page 14.

## National Respiratory Care Week is October 19th - 25th

## Recognizing Men and Women in Uniform, Board Requests Your Aid

It was only earlier this year when our sons, daughters, mothers, fathers and friends were called upon to protect our country and further our fight against one of the greatest threats our country has ever faced. Terrorism. And they responded. Our men and women in uniform honored their commitment to protect and serve our country.

More than 300,000 troops were deployed to the Middle East as part of Operation Iraqi Freedom. Thousands of reserves were called upon to enter into active combat or assume duties on our homeland for the others who went into battle. There is no question that all Americans continue to stand united in support of our troops.

The major combat operations in Iraq were declared over shortly after Iraqi civilians, with assistance from U.S. troops and an armored vehicle, toppled a statue of Hussein on April 9th. Yet our Marines and soldiers continue to be targets of hostile attacks. Since March 20<sup>th</sup>, when the battles began, over 260 US troops have died while defending our country.

We are all sincerely grateful for every person in uniform who has defended or is defending our country this year in the Middle East. The Board would like to recognize and honor every California respiratory therapist who served or is serving our country in this war, whether the therapist is a full-time service man/woman or a reservist, who was deployed to the Middle East or called to duty to oversee homeland operations during these trying times.

If you or someone you know fits this description, please contact Stephanie Nunez, Executive Officer as soon as possible and let her know the therapist's name and contact information (or your contact information). You can call Ms. Nunez at (866) 375-0386 or send her an e-mail: [rcbinfo@dca.ca.gov](mailto:rcbinfo@dca.ca.gov). The Board would like to make a very special presentation to these courageous service men and women.

## November Board Meeting LOCATION CHANGE

Please note the venue for the Board's November 14<sup>th</sup> meeting, originally scheduled to be held in San Diego has been changed. Due to fiscal restraints, affecting all State agencies, the Board's November 14th meeting will be held in Sacramento.

Please watch our website for the most up-to-date information. The agenda for this meeting will be available after November 4th, on the Board's website: [www.rcb.ca.gov](http://www.rcb.ca.gov).

All Board meetings are open to the public.

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## Respiratory Care Board of California



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*President*

*Larry L. Renner, RCP*  
*Vice-President*

*Gopal D. Chaturvedi*  
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*Kim Cooper, BS, RRT*  
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## Larry Renner, RCP, Vice-President

Larry Renner is currently the Director of Patient Care Informatics at Saint Agnes Medical Center in Fresno, California. Now in his 18th year at Saint Agnes, Mr. Renner has continued his professional and public promotion of the profession through community involvement and public service. His initial association with the profession of Respiratory Care began in 1974 when he worked in a small community hospital cleaning equipment and ordering supplies.

Mr. Renner's formal education in Respiratory Care was obtained at Crafton Hills Community College in Yuciapa, California. Upon graduation he began his clinical career at Stanford University Hospital in Palo Alto, California. Over the years he has held various clinical and management positions in both teaching and community medical centers. He has also had the unique opportunity of managing both nurses and therapists when his administrative responsibilities included the respiratory care department, critical care unit, cardiac surgery unit, post intensive care unit and inpatient dialysis at Saint Agnes Medical Center.

Mr. Renner was appointed to the Board in July 2001 and views his appointment and commitment to the Respiratory Care Board as both an honor and a privilege. Shortly after his appointment he was elected to serve as Vice-President for the Board and Chair of the Professional Licensing Committee. He is committed to identifying areas of the practice that are being performed by unlicensed personnel and mapping out a plan that, with the support of the Legislature and other agencies, will provide consumer safeguards. It is his hope that the work done on this Board will bring about important changes that will catapult the recognition of the advancements and integrity of this profession.



Larry L. Renner, RCP  
Vice-President

### Interesting FACTS

(Taken from data compiled in January 2003)

- ☺ The most common age of California's active licensed RCP is 46.
- ☺ The youngest licensed RCP was born in 1983.
- ☺ The two oldest RCPs with active licenses were born in 1919.
- ☺ Of the 9862 licenses that were issued in 1985, the first year of licensure (certification back then), only 5881 remain in some type of active status.
- ☺ The average number of licenses issued from 1986 through 1990 was 754 a year.
- ☺ The average number of licenses issued from 1991 through 1995 was 880 a year.
- ☺ The average number of licenses issued from 1996 through 2000 was 658 a year.

## President's Message

As the end of 2003 rapidly approaches, I can say without reservation that this has been a very productive year for the Respiratory Care Board. The end of the fiscal year documented an increase in applications consistent with our projections. This increase is a substantial benchmark toward our goal to increase the number of qualified and competent practitioners in California to address the RCP shortage. The Board will continue to strive toward increasing applicant and licensee retention levels and remains optimistic that significant increases in these areas will result in a future renewal fee reduction.

This year has also brought about numerous regulatory changes ranging from protecting the scope of practice to expanding and clarifying continuing education requirements. These changes have been made possible by the contributions and hard work of many dedicated Board members. Our members continue to work on proposals regarding such issues as ethics and ongoing recruitment. We have set a goal of creating an ethics course to establish a tool to empower and educate practitioners regarding the continually evolving practice of respiratory care and the statutes that govern it.

I have also requested the development of a proposal to identify areas and opportunities the Board can pursue to expand our existing recruitment efforts. As with all issues, these proposals will of course be brought before the entire Board before we take formal action and we will seek input from all interested stakeholders. I would like to take this opportunity to commend the Board for its tireless efforts on all our current projects and issues. With the hard work of every Board member, we are closer to achieving our common goal of protecting the public and advancing the respiratory care profession.

Affirming my commitment to build and strengthen working relationships critical to the advancement of the profession, I have continued to communicate regularly with the California Society for Respiratory Care (CSRC) and the American Association for Respiratory Care (AARC). In fact, it was during a recent discussion with the CSRC that I shared an idea to survey the California Legislature on its knowledge of, and interaction with, the respiratory care profession. The survey, compiled with the joint efforts of the Board and the CSRC, will result in information invaluable for the future endeavors of both entities. However, equally important was the opportunity for both organizations to work cooperatively toward accomplishing our shared goal to advance the profession. Further, the AARC has never wavered in making itself available as a resource to the Board on issues ranging from continued competency to the ethics-focused course mentioned above.

One of the most serious issues that emerged early during my Presidency was the initial report of the highly-publicized SARS epidemic. In light of its direct correlation to respiratory care, I felt compelled to take action to ensure that practitioners, as well as respiratory care consumers, had access to current information related to the SARS virus and its potential effects. This action resulted in a new link to the Board's website titled "Public Health Alert." This link now allows practitioners to quickly obtain vital information on current health-related issues and epidemics. As in many instances, this concept stemmed from a Board member, however, it was the hard work of staff that transformed the idea into a tool to help save lives.

During the Board's May meeting, I had the pleasure of recognizing two staff members, Jennifer Mercado and Paula Velasquez, for their continuous hard work and dedication. Ms. Mercado has put in countless hours toward recruitment which, based on the increased number of applications, have undoubtedly paid off. Ms. Velasquez developed an elaborate cost recovery database system which, since its introduction, has resulted in increased recovery of costs associated with disciplinary actions.

In light of the State's fiscal crisis, we have been faced with making difficult decisions necessary to achieve mandated reductions. While these issues continue to prove challenging, please be assured that all of the Board actions remain focused on providing the highest level of service to those we license and to the public we are obligated to protect. I continue to look forward to the many tasks before us, and I remain confident that with the dedication of the Board and the ongoing hard work of staff, we will continue to be successful in upholding our mission and accomplishing our many goals and objectives.



Scott J. Svonkin  
President

## 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.*

## Updates (since February 2003)

- ☺ At the Board meeting held May 16, 2003, the Board honored Barry Winn, Ed.D., RCP for his years of service and presented him with a Senate Resolution and plaque.
- ☺ The Board entered into a 3-year contract with the National Board for Respiratory Care to be the sole provider for the California Respiratory Care Practitioner Licensing Examination.
- ☺ Board staff and program directors continued to visit numerous high schools throughout California promoting the respiratory care profession as a viable career choice.
- ☺ Pima Medical Institute located in Chula Vista is in the process of beginning a new respiratory care program.
- ☺ The Board continues to accept applications from individuals who request the education requirement of an Associate Degree be waived based on a combination of education and work experience.
- ☺ The Board continues to follow the lead of the American Association for Respiratory Care in supporting legislative changes that will recognize respiratory care practitioners as part of Medicare's home health services benefit.
- ☺ In the last issue (March 2003) of the Respiratory Update, Board staff projected that the number of applications for licensure was on the rise and estimated that the Board would receive 670 applications during the 02/03 fiscal year (July 1, 2002 through June 30, 2003). Final figures are in and the Board actually received 680 new applications for licensure.
- ☺ The last issue of the Respiratory Update identified total projected revenue for FY 02/03 at \$2,105,260. The actual revenue received was \$2,128,960 for a difference of \$23,700 (a 1.1% difference).
- ☺ The last issue of the Respiratory Update identified total projected expenditures for FY 02/03 at \$2,238,599. Actual expenditures totaled \$2,214,052 for a difference of (\$24,547) (a 1.1% difference).



President Scott J. Svonkin presents Dr. Barry Winn with a Senate Resolution.

A special thank you to Christine Molina, Staff Services Manager for her reliable and accurate projections!



Paula Velasquez  
Board Staff

**Jennifer Mercado and Paula Velasquez, Board staff members, were presented with plaques and recognized at the Board's May 16, 2003, meeting for their contributions and dedication to the Board's goals and objectives.**



Jennifer Mercado  
Board Staff

## RCP Recognition Nominations

### New Criteria Established!

Do you know a respiratory care practitioner who has extended an extra measure of care? The Respiratory Care Board would like you to nominate a member of the respiratory care community who deserves recognition for rendering exceptional service and care to a patient, colleague or the profession. The established criteria for recognition includes values relative to service, dignity, responsibility, teamwork, trust, and accountability.

Help the Board identify and recognize deserving practitioners by completing a nomination form available on the Board's website at [www.rcb.ca.gov](http://www.rcb.ca.gov). Nominations can be electronically submitted, or you may print a copy of the nomination form, which can then be completed and returned via fax or mail.

Once the Board has received a minimum of 5 individual nominations, it will review each nomination and vote on who is most deserving of recognition based on the established criteria and how the individual's accomplishments relate to the mission of the Board. The individual will then be recognized, on behalf of the entire respiratory care community, at a future Board meeting and in an upcoming edition of the *Respiratory Update*.

## Advancing Board Technology



Gopal Chaturvedi  
Board Member

Expect to see big changes in the next three years with respect to your ability to perform licensing transactions online. All boards and bureaus under the Department of Consumer Affairs are participating in the replacement of multiple antiquated systems with an integrated enterprise-wide system that will enable process and functional improvements. The new system is referred to as the Professional Licensing and Enforcement Management System (PLEMS). Currently, the Respiratory Care Board is scheduled to "roll out" onto the new system in late 2005 to early 2006, which is the second phase of roll-outs (the last board will be "rolled out" by the end of 2008).

Mr. Gopal Chaturvedi, Board Member, has been an important contributor in ensuring the system is specifically designed to meet the Board's needs and provide up-to-date technology for our applicants and licensees. At the time Mr. Chaturvedi was appointed to the Board in July 2001, he expressed his desire to use his education and experience to bring about positive changes. He is the founder and President of A. G. Industry, a business that provides web design, custom programming, e-commerce and a wide variety of other related services. He is also the founder and President of U.S. Peptides, a business that supplies custom peptides to medical laboratories globally. Mr. Chaturvedi earned a Bachelor of

Science in Math, a Bachelor of Science in Electrical Engineering as well as two Masters in Business Administration with concentrations in Industrial Management and Information Technology. He is also very active in a variety of associations.

Upon Mr. Chaturvedi's appointment to the Board he expressed his interest to update the Board's information systems. He recognized that the Board's website needed expansion to allow for interactive use by consumers and licensees. Mr. Chaturvedi was especially concerned with making sure our applicants and licensees could perform transactions related to their applications or renewals online and pay any fees with credit cards. His ideas are supported by the Board and were added to its Strategic Plan in 2002 as well as carried over into the business process phase used to design the system. Mr. Chaturvedi is committed to oversee the Board's participation in the entire process until the PLEMS is implemented.

Several phases and approval processes remain, though Mr. Chaturvedi has expressed his confidence in the Department based on their hard work and success. The Department's Office of Information Services headed by Shelly Sutton, Chief Information Officer has contributed countless hours towards research and drafting business plans that identify the benefits of the new system and have all been approved to date. We commend Ms. Sutton and her staff for staying on schedule with the plan and their diligent efforts towards producing a system that will enhance and promote consumer protection by improving the accuracy, reliability, and integration of all DCA licensing records.

## Mandatory Reporting

UPDATE!

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. Regulatory changes that went into effect in May require licensees to make such a report to the Board within 10 calendar days from the date he/she knows or should have reasonably known that a violation or probable violation occurred.

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.

Employers are now required to make a report to the Board within 10 calendar days from the date of suspension or termination, whichever occurs first.

RCPs are subject to discipline and will be fined 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. Consideration is given to mitigating and aggravating circumstances surrounding the case.

*New regulatory amendments require reports to be made within 10 days.*

*The Board will begin fining respiratory care practitioners and employers for failure to make a report as required.*

## Scope of Practice Inquiries

**Inquiry:** Since oxygen is considered a medication, can non-licensed hospital personnel place a patient on oxygen? For example, can a transporter or x-ray tech, remove the patient from the wall oxygen and connect the patient to a portable oxygen tank, transport the patient and connect them back to the wall outlet? Do they need a license or can they be trained to do this task? If not, what licensed personnel (OT, PT, LVN, etc.) can connect the patient to oxygen?

**Response:** Section 3702 (d) of the practice act speaks directly to your question regarding the safe administration of medical gases in accordance with the prescription of a physician. There is also similar language in the nurse's practice act and other practice acts that allow for the administration of medications. Since oxygen still requires an order by a physician or protocol to administer, I would recommend that an appropriate licensed individual direct its administration. Anything short of that would represent a safety risk to the patient that could result in the wrong concentration, the wrong medical gas or other serious consequences.



**Inquiry:** Is it within the scope of practice for any licensed RCP to perform Apnea Testing to confirm brain death of a potential organ donor without a physician being present?

**Response:** The qualification of brain death in California requires that two independent physicians assess the patient to establish the patient's brain function or lack thereof. I do not believe that allowing a licensed RCP to perform this function in the absence of a physician meets that brain death criterion. This function would clearly be outside of the RCP's scope of practice.



**Inquiry:** I would like to know if California RCPs are licensed to administer sleep aids such as Ambien during a Polysomnography test. This would be a doctor's order naturally.

**Response:** Section 3701 of the Practice Act allows for the existence of overlapping functions between physicians, nurses and other licensed health care personnel. Section 3702 (d) allows for the administration of pharmacologic agents related to respiratory care procedures including diagnostic testing. As such, I believe that the administration of Ambien, with the prescription of the physician, would be within the scope of practice. As with other medication therapists administer, it would require that the practitioner understand the potential hazards and other clinical benefits and precautions of the medication.



**Inquiry:** I have been approached and asked to join a Medical Reserve Corp in California. While I believe in the concept and see the need, I have a few questions about my license in this type of situation. 1) At the present time there is no Medical

Director of this MRC. It is my belief that in order to perform my duties as an RT there must be a medical director. Is this correct? 2) I have been told by the local Office of Emergency Services Director that in an emergency I could follow the orders and directions of a veterinarian. This doesn't sound right to me, but I have never been faced with a disaster type of situation where an MD or OD was not available. Can you please clarify.

**Response:** The practice of respiratory care does require a medical director. Section 3703 (a) & (b) of the Practice Act qualifies the 'where' and 'under what medical direction.' They state the following:

"(a) The settings in which respiratory care may be practiced include licensed health care facilities, hospitals, clinics, ambulatory or home health care, physician's offices and public or community health services. Respiratory care may also be provided during the transportation of a patient, and under any circumstances where an emergency necessitates respiratory care. (b) The practice of respiratory care shall be performed under the supervision of a medical director in accordance with a prescription of a physician and surgeon or pursuant to respiratory care protocols as specified in Section 3702."

Section 3704 (c) defines what a medical director is and the training they would need. "Medical director means a physician and surgeon who is a member of a health care facility's active medical staff and who is knowledgeable in respiratory care."

Section 3706 describes the liability associated with emergency care. It states, "A person licensed under this chapter who in good faith renders emergency care at the scene of an emergency which occurs outside both the place and the course of employment shall not be liable for any civil damages as the result of acts or omissions by the person in rendering the emergency care. This section does not grant immunity from civil damages when the person is grossly negligent."



**Inquiry:** I am an instructor of Respiratory Care at a private junior college. Many of the clinical sites my students attend practice concurrent therapy (stacking treatments) not all due to treatment load. I know the RCB does not set "treatment load" guidelines but what is the RCB's stance on concurrent therapy? Is it legal? Is it fraud? I have read the AARC white paper on this subject but I am unclear on the legal aspect.

**Response:** The Practice Act currently does not address this fact. However, the Board is aware that some hospitals have chosen to implement concurrent therapy policies to control costs. The question of concurrent therapy as it relates to its legal or fraudulent use is one that should be asked of the Department of Health Services as well as Medicare. I believe the intent of the federal register would consider concurrent therapy as a non-billable service but, I think, that is a decision that would be better clarified from them directly. Contact

information for the Department of Health Services is 714/744 P Street, Sacramento, CA 95814, (916) 445-4171, www.dhs.ca.gov. Medicare's toll-free telephone number is 1-800-MEDICARE (633-4227) and website address is www.medicare.com.



**Inquiry:** I am an RRT/RCP with the following specialized education or credentials: (1) Completed a Medicare approved course in Hyperbaric Oxygen Therapy and am a member of the Underseas Hyperbaric & Medical Society. (2) Completed the requirement to become a Certified Wound Care Specialist through the American Academy of Wound Management. Under the direct supervision of a California licensed, Board Certified Surgeon who has been specially trained in Hyperbaric Oxygen Therapy in accordance with Federal law, I perform the following duties: (1) Administer Hyperbaric Oxygen Therapy including ventilator care Cardiac and TcPO2 monitoring and management on the I.V. pump during Hyperbaric Oxygen procedure. (2) Routine wound assessment and dressing changes as ordered. (3) Minor sharp debridement. In addition, I am required to pass an annual competency examination for all aspects of my duties. The American Academy of Wound Management requires Continuing Education Units in advanced wound care subjects to maintain the Certified Wound Specialist credentials. Under the often cited document 3701, Article 1 of the General Provisions, am I in material breach of any provisions of Respiratory Care Board of California Standards of Practice Act?

**Response:** Based upon the qualification you expressed in your inquiry, I see no material breach of the Practice Act with reference to job duties 1 and 2. Section 3701 of the Practice Act recognizes the ability of therapists to have overlapping functions with physicians, nurses and other licensed health care providers. However, I will qualify my comments by saying that I did not officially see your education and credentials, as they were not provided to the Board.

With regards to duty 3 (Minor sharp debridement), the Board would guard this function as not prohibited but discouraged under the Practice Act. However, if this function is provided in a physician's office than the onus for competency and responsibility would fall to the physician's license that is regulated by the California Medical Board. For clarification from their perspective, I would recommend that you contact them for comment: 1426 Howe Avenue #54, Sacramento, CA 95825; toll-free telephone number: (800) 633-2322; website: www.medbd.ca.gov.



**Inquiry:** I am a nurse analyst with Part B Medicare administration in Chico, California. I am interested in researching any CA state law/regulations regarding the performance of sleep studies, particularly in physicians' offices. I have not been successful in confirming whether there are specific state requirements for the facility/office and for those individuals

performing the testing. Any information/citations that you can share will be appreciated.

**Response:** Your question regarding the qualifications of individuals able to perform sleep studies is excellent. In the past year the Board has held several small group discussions to better understand this new and expanding service and to provide the appropriate guidance and language to the Practice Act to enhance the quality of testing as well as its safety to the patient.

Today, individuals testing patients in physician's offices are essentially working under that supervising physician. In this scenario, the physician is responsible for ensuring the appropriate training and competency of the tester. At present, The Medical Board of California makes no reference to any required training or qualification of these individuals when it comes to sleep testing.

Currently, there are national certifications for both technicians and physicians that address the knowledge one needs to have for performing or interpreting sleep studies. Unfortunately, these are not currently required for reimbursement in California except by Blue Shield.

I can assure you that this dilemma concerns the Respiratory Care Board and we intend on completing our research in the hopes of passing appropriate legislation that will lend itself to consumer safety.



Scope of Practice Inquiries and Responses are also available on the Board's website. Please visit:

<http://www.rcb.ca.gov/scopeofpracmain.htm>

to review inquiries and responses processed over the last 2+ years.

## We Want to Hear from You

If you have issues, concerns or ideas you think would better serve the consumers of California or the respiratory care profession, we want to hear from you. E-mails can be addressed to [rcbinfo@dca.ca.gov](mailto:rcbinfo@dca.ca.gov).

Please be an active participant in licensing your profession.

## The Center for the Health Professions Takes Notice

The Center for the Health Professions (The Center) released a new publication in July addressing the respiratory care profession. The 8-page document touches on an overview of the profession, the current challenges the profession is facing, including workforce shortages and potential solutions. The Board, the AARC, and Rick Ford, RCP, as well as a handful of others, were interviewed and used as sources for the publication.

To review the complete 8-page paper, please visit The Center's website at:

[www.futurehealth.ucsf.edu/home.html](http://www.futurehealth.ucsf.edu/home.html).

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

Website: [www.rcb.ca.gov](http://www.rcb.ca.gov) Toll-free: (866) 375-0386 E-Mail: [rcbinfo@dca.ca.gov](mailto:rcbinfo@dca.ca.gov)

## Pharmacy Compounding

Pharmacy compounding has historically involved the manipulation of FDA-approved drug products into alternative dosage forms to meet the unique needs of individual patients. For instance, the compounding of tablets into a liquid dosage form for a pediatric patient is often medically necessary and indeed legitimate. But increasingly, pharmacy compounding is moving into the realms of unregulated drug manufacturing, with the potential to expose large populations to substandard drug products. This emerging, contemporary compounding industry has manufactured, marketed and distributed large quantities of drugs in the absence of confirmed potency, purity, or sterility—and in many cases without full, knowledgeable and express consent of physicians and patients.

### Benefits and Risks

Compounding serves a valuable professional role in cases where no dosage forms exist to meet a patient's specific needs and expected benefits outweigh anticipated and unanticipated risks. In some cases, however, financial benefits to pharmacies and providers may be the primary determinant of compounding, exposing patients to unnecessary and unacceptable risks.

*Considered tip of the iceberg by public health officials, recently publicized cases throughout the US involving the large scale, substandard compounding of respiratory drugs raises concern...*

Poorly manufactured, unregulated respiratory drugs represent a serious public health concern as they may result in increased drug-related morbidity and mortality. Patients may inadvertently experience:

- Toxicity from super-potency
- Failed responses to therapy from sub-potency
- Infection from bacterial or fungal contamination
- Respiratory complications from intolerable levels of endotoxins or other adulterants

Such concerns have been heightened by a recent FDA survey which found a 34% failure rate for compounded drugs evaluated for potency and purity (1). Throughout the country, compounded medications have been associated with deaths from meningitis, cases of paralysis, hospitalizations from toxic overdoses, exposures to contaminated drug products, and disease exacerbation due to dangerously sub-potent medications. Alarmingly, there are no current requirements to report adverse events associated with compounded drugs—nonetheless, known cases of injuries and deaths have surfaced gaining broad attention (2, 3).

How widespread is the problem? We really do not know, but public health experts are concerned. The CDC recently recommended that physicians consider exposure to substandard, compounded drugs for unexplained sources of infection following spinal or intra-articular injections (4). CDC further cautioned that health systems may not even realize they are purchasing compounded drugs (4), mandating diligence and caution in drug purchasing procedures to minimize the inadvertent acquisition of substandard products.

### Respiratory Compounding Industry

Considered tip of the iceberg by public health officials, recently publicized cases throughout the US involving the large scale, substandard compounding of respiratory drugs raises concern:

*Case 1:* In 2001, Med-Mart pharmacy, located in Novato, California issued a Class I recall of thousands of doses of compounded respiratory medications distributed to managed care patients that were discovered to be contaminated with

*Continued on Page 9*

serratia liquiformis. A subsequent Warning Letter issued to Med-Mart by the FDA noted the agency's serious concern about the public health risks associated with "large-scale production of massive quantities of inhalation solutions without these products being required to meet all the laws and regulations applicable to a drug manufacturer" (5). After a joint inspection with the California Board of Pharmacy and the FDA found the pharmacy did not have proper training, equipment or control procedures in place to ensure the quality of dosage forms produced and testing of finished drug products was inadequate to ensure potency, purity and sterility, the pharmacy's next lot of drug produced, after the *Serratia liquifaciens* contaminated lots were detected, contained another contaminant, *Bacillus megaterium* (5).

Case 2: Two Florida pharmacists were convicted of Medicare fraud in July of 2002 for their role in the large scale compounding of adulterated respiratory medications by unlicensed individuals under unsanitary conditions. During the trial, testimony from an expert witness for the defense highlighted larger respiratory compounding operations throughout the US, suggesting the invasive nature of this practice.

Case 3: Med-4-Home Pharmacy in Kansas City, Missouri recently distributed more than 1.3 million doses of compounded albuterol and ipratropium solution for nebulization to an estimated 18,000 patients nationwide—the purportedly sterile drugs were contaminated with *Pseudomonas cepacia* (6). The Missouri State Board of Pharmacy found Med-4-Home failed to completely recall the distributed medication and did not adequately inform physicians and patients of the contamination risk (6).

### **Current Legal Framework**

In April of 2002, the US Supreme Court struck down provisions in Federal law that had provided FDA oversight of pharmacy compounding, leaving primary regulatory enforcement with state boards of pharmacy. However, state compounding regulations are discrepant and in some cases nonexistent—today's patchwork of state laws provides little protection to unsuspecting patients who typically believe all drug products are safe, effective and well regulated by the FDA.

In California, the state Board of Pharmacy recently introduced new sterile compounding regulations in response to deaths from contaminated spinal injections; however, the new regulations, though offering some public health protections for parenteral products, do not apply to the compounding of sterile respiratory drugs.

### **Policy Initiatives**

Recognizing the real and growing danger to patient safety posed by unregulated, compounded drugs, the FDA has expressed concerns that current law is insufficient to adequately protect public health and safety. According to Jane Axelrad, Associate Director for Policy at the FDA's Center for Drug Evaluation and Research, the Agency plans to issue a new draft guidance on compounding for comment, and that the FDA may seek new legislation to regain statutory authority to regulate pharmacy compounding. In addition, congressional interest and concern is growing in both houses.

### **What Clinicians Can Do**

- Review the FDA's Compliance Policy Guide Sec. 460.200 Pharmacy Compounding at: [http://www.fda.gov/ora/compliance\\_ref/cpg/cpgdrg/cpg460-200.html](http://www.fda.gov/ora/compliance_ref/cpg/cpgdrg/cpg460-200.html)
- Recognize that financial incentives and convenience are inappropriate reasons to compound respiratory drugs
- Be alert to the potential for unapproved, substandard compounded drugs to enter drug supply chains without appropriate authorization
- Report any medication-related adverse events, including failed therapies, to the FDA's MedWatch program, state boards of pharmacy and state boards of health.
- Be aware that medically necessary compounded drug products should be filled pursuant to a unsolicited prescriber's request, on a per-prescription basis and should include complete disclosure of risk to patients.

### **More Information**

For more information on this issue, please contact Sarah Sellers, Pharm D, The Center for Pharmaceutical Safety at (847) 207-0216 or E-Mail: [ssellers@jhsph.edu](mailto:ssellers@jhsph.edu).

### **Notes**

1. Subramaniam V, Sokol G, and Zenger V et al. Survey of drug products compounded by a group of community pharmacies: Findings from a Food and Drug Administration study. Available at <http://fda.gov/cder/pharmcomp/communityPharmacy/default.htm>
2. Russell S and Hallissy E. Chronicle Investigation: Who's mixing your drugs? Bad medicine: Pharmacy mix-ups a recipe for disaster. *San Francisco Chronicle* June 23, 2002. Available at: <http://www.sfgate.com/cgi-bin/article.cgi?file=/chronicle/archive/2002/06/23/MN12273.DTL>
3. Morris M and McGuire D. Rx for disaster: Some pharmacists who mix medicines dispense unsafe drugs. *The Kansas City Star* October 6-8, 2002.
4. From the Centers for Disease Control *Exophiala* Infection from contaminated injectable steroids prepared by a compounding pharmacy—United States, July—November 2002. *MMWR* December 13, 2002/51(49):1109-1112. Available at [www.cdc.gov/mmwr/preview/mmwrhtml/mm5149a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5149a1.htm)
5. FDA warning letter to Med-Mart Pulmonary Services available at: [http://fda.gov/foi/warning\\_letters/g3527d.htm](http://fda.gov/foi/warning_letters/g3527d.htm)
6. Harlow S. Missouri officials begin tracking contaminated drug. *The Kansas City Star* March 13, 2003.

## FDA Works to Reduce Preventable Medical Device Injuries

The following information was extracted from an article by Carol Rados titled "FDA Works to Reduce Preventable Medical Device Injuries" in the July-August 2003 issue of the FDA Consumer magazine.

Medical devices help to alleviate pain, overcome disability, and sustain life. They also, on occasion, fail to operate properly or are misused in ways that are associated with injuries and deaths. Inadequate device design, poor manufacturing quality, improper device maintenance, and user error all contribute to adverse events associated with medical devices. In 2002 alone, the FDA received reports of more than 111,000 adverse events, including serious injuries and deaths, related to medical devices.

Whether it's failure of a device to operate properly or failure of the user to operate the device correctly, the Food and Drug Administration says that many of the adverse events associated with product problems are preventable. As health care and the system that delivers it become more complex, opportunities for errors increase.

For example, because breathing tubes used in ventilators often pop out of place, manufacturers have alarms built into the ventilators to alert health care workers when a tube becomes disconnected. Future designs featuring networking systems could recognize that health care workers are not always present when an alarm goes off. Built-in networking systems would allow the appropriate health care providers to be notified of an alarm wherever they may be.

Postmarket medical device problems—those seen after a device has been approved and is in general use—generally fall into one of three broad categories: device problems, use problems, and clinical problems.

Mechanical, electrical or software-related malfunctions, manufacturing defects in product design or development, or problems with materials are all considered to be device-related problems. Use problems may be associated with inadequate or misleading labeling, confusing instructions, inadequate packaging, design problems that make the device difficult to use, or inadequate training in the use of the device. Clinical problems can occur with a patient who is sensitive or allergic to a device, or who has a pre-existing condition that makes the device difficult or risky to use.

### Did You Know...

*The Manufacturer User Facility and Distributor Experience (MAUDE) database contains reports of adverse events consisting of all voluntary reports since June 1993, user facility reports since 1991, distributor reports since 1993, and manufacturer reports since August 1996. Visit MAUDE on-line at [www.fda.gov/cdrh/maude.html](http://www.fda.gov/cdrh/maude.html).*

The following simple steps can help consumers and health care providers avoid common problems associated with medical devices:

- ◆ Read and understand the instructions and labeling, and know for whom the device is appropriate.
- ◆ Inspect and test equipment prior to use.
- ◆ Make sure that devices are properly maintained and serviced.
- ◆ Avoid using a device that has malfunctioned.
- ◆ Avoid using a device past its suggested expiration date for sterility or shelf life (length of time before the product deteriorates).

Reporting medical device problems is an important part of patient safety. Concerns about the quality, performance, or safety of any medical device should be reported. Consumers and health care providers using medical

devices are in the best position to provide the information that manufacturers and the FDA need to determine whether an adverse event presents a public health risk.

The key to effective reporting is to understand the difference between the FDA's two complementary systems for national medical device adverse event reporting.

- \* Through the Medical Device Reporting (MDR) system, manufacturers and distributors of devices, as well as user facilities (hospitals, outpatient treatment, diagnostic and surgical facilities, and nursing homes) are required to promptly notify the FDA about device-related events that have or may have caused or contributed to a death, serious illness or injury.
- \* MedWatch, the FDA's medical products reporting program, is a voluntary system that encourages health professionals and consumers to notify the FDA and manufacturers, not only about adverse events involving serious injury and death, but also about other problems with medical products.

*Improved patient safety through reducing preventable adverse health events is one of five agency priorities set by Commissioner of Food and Drug Mark B. McClellan, M.D., Ph.D. Other priorities include science-based risk management, better information for consumers, counterterrorism, and a strong FDA at the forefront of biomedical science and technology.*

Continued on Page 11

Reporting through MedWatch is quick and simple. Consumers and health care professionals can report by telephone, fax, mail, or online, as follows:

Call 1-800-FDA-1088 to report by phone

Fax report to 1-800-FDA-0178

Mail to MedWatch, FDA, 5600 Fishers Lane, Rockville, MD 20852-9787

Log onto the MedWatch Web site at [www.fda.gov/medwatch/](http://www.fda.gov/medwatch/).

Product recalls and withdrawals involve the firm's correction or removal of a product from the market and may require taking the product off the market permanently. Recalls usually are conducted voluntarily by the manufacturer, and are completed within six to 12 months. In rare instances, where the manufacturer or importer fails to initiate a recall voluntarily, the FDA has the regulatory authority to order the firm to recall the defective device.

How and whether people find out about device recalls depends largely on manufacturers' and retailers' diligence, consumer vigilance, and media assistance. Recalls are officially announced in two ways: the FDA publishes a press release and a weekly Enforcement Report that contains all enforcement actions including recalls, field corrections, seizures, and injunctions. This report is published on the Internet at [www.fda.gov/opacom/Enforce.html](http://www.fda.gov/opacom/Enforce.html). Secondly, manufacturers distribute recall notifications to communicate the potential medical device hazard. Consumers and health care professionals can also sign up for E-mail notifications of recalls from the FDA at [www.fda.gov/medwatch/safety.htm](http://www.fda.gov/medwatch/safety.htm) and Center for Devices and Radiological Health at <http://www.fda.gov/cdrh/safety.html>.

## CDC's Yellow [Travel] Book

The Centers for Disease Control announced on June 26, 2003, that a revised travel health resource will better assist travelers in planning safer trips abroad.

The new edition of the *Yellow Book*, a health information tool for international travel published by the Centers for Disease Control and Prevention and considered by many to be the gold standard on travel information, has been expanded to offer new information on scuba diving safety, high altitude travel, travelers with special needs, and traveling with children.

The *Yellow Book* also offers vaccination and medication information for disease risks by destination as well as helpful health hints for cruise ship travel, international adoptions, motion sickness and much more.

For more information visit: [www.cdc.gov/travel/](http://www.cdc.gov/travel/).

## Voice Your Ideas

Your opinion matters. If you have issues or concerns you would like to express or ideas you think would better serve the consumers of California or the respiratory care profession, we want to hear from you. Please send Stephanie Nunez, Executive Officer an e-mail at: [rcbinfo@dca.ca.gov](mailto:rcbinfo@dca.ca.gov).

## Satisfaction Survey

We need your feedback. Please visit our website at: [www.rcb.ca.gov](http://www.rcb.ca.gov) and complete the Satisfaction Survey on-line.

## New Breath Test for Asthma Patients

On May 1, 2003, the Food and Drug Administration (FDA) cleared for marketing a first-of-a-kind, non-invasive test system to measure the concentration of nitric oxide in exhaled human breath. The test system should help make it easier for doctors to monitor a patient's asthma.

Doctors can use the device in their office to evaluate their patient's response to anti-inflammatory treatment. A decrease in exhaled nitric oxide concentration suggests that the anti-inflammatory treatment may be decreasing the lung inflammation associated with asthma. Recent evidence has shown that nitric oxide levels are increased in the breath of people with asthma and that changes in nitric oxide levels may indicate whether or not treatment for asthma is working.

The test system, called the NIOX Nitric Oxide Test System, is made by Aerocrine AB, of Sweden. It combines equipment that detects nitric oxide and equipment that analyzes exhaled breath with a special computer system.

For more information, contact the FDA at : 1-888-INFO-FDA.

## JOINT COMMISSION ANNOUNCES 2004 NATIONAL PATIENT SAFETY GOALS

On July 21, 2003, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) announced its 2004 National Patient Safety Goals. The Goals, approved by the JCAHO Board of Commissioners continues all of the 2003 Goals and adds a new Goal that will focus on reducing the risk of health care-acquired infections.

For each of the National Patient Safety Goals, there are evidence-based requirements that set forth clear expectations for health care organizations to address specific types of health care errors. The 2003 requirement to "read back" verbal and telephone orders in order to confirm their accuracy has been expanded for 2004 to include the read-back of critical test results that are communicated verbally.

The 2004 National Patient Safety Goals and Requirements are:

### **Goal 1: Improve the accuracy of patient identification.**

Requirements: 1) Use at least two patient identifiers (neither to be the patient's room number) whenever taking blood samples or administering medications or blood products and 2) prior to the start of any surgical or invasive procedure, conduct a final verification process, such as a "time out," to confirm the correct patient, procedure and site, using active B not passive B communication techniques.

### **Goal 2: Improve the effectiveness of communication among caregivers.**

Requirements: 1) Implement a process for taking verbal or telephone orders or critical test results that requires a verification "read-back" of the complete order or test result by the person receiving the order or test result and 2) standardize abbreviations, acronyms and symbols used throughout the organization, including a list of abbreviations, acronyms and symbols not to use.

### **Goal 3: Improve the safety of using high-alert medications.**

Requirements: 1) Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride >0.9%) from patient care units and 2) standardize and limit the number of drug concentrations available in the organization.

### **Goal 4: Eliminate wrong-site, wrong-patient and wrong-procedure surgery.**

Requirements: 1) Create and use a preoperative verification process, such as a checklist, to confirm that appropriate documents, (e.g., medical records, imaging studies) are available and 2) implement a process to mark the surgical site, and involve the patient in the marking process.

### **Goal 5: Improve the safety of using infusion pumps.**

Requirement: Ensure free-flow protection on all general-use and PCA intravenous infusion pumps used in the organization.

### **Goal 6: Improve the effectiveness of clinical alarm systems.**

Requirements: 1) Implement regular preventive maintenance and testing of alarm systems and 2) assure that alarms are activated with appropriate settings and are sufficiently audible with respect to distances and competing noise within the unit.

### **Goal 7: Reduce the risk of health care-acquired infections.**

Requirements: 1) Comply with current CDC hand-hygiene guidelines and 2) manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-acquired infection.

For more information on JCAHO's 2004 Patient Safety Goals, visit [www.jcaho.org](http://www.jcaho.org).

## JCAHO Revises Performance Areas for 2004 Random Unannounced Surveys

Beginning next year, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will revise the fixed and variable performance areas evaluated during random unannounced surveys.

Under the current accreditation process, the identification of fixed and variable performance areas have been at the grid element (performance category) level. However, beginning in 2004, the reporting of standards compliance will be organized by Critical Focus Area B processes, systems, or structures in a health care organization that significantly impact the quality and safety of care B rather than by grid element.

This change is part of a series of significant standards and survey process improvements known as the Shared Visions-New Pathways initiative.

The 2004 fixed performance areas recently approved are

- the critical focus areas of:
  - ◆ Staffing
  - ◆ Infection Control
  - ◆ Medication Management and
- National Patient Safety Goals that are relevant to an organization's care and services.

The variable performance areas that are part of the random unannounced surveys will be based on prioritized Critical Focus Areas that are specific to each organization.

A sample of five percent of organizations accredited under the ambulatory care, behavioral health care, home care, hospital and long term care programs are randomly selected for unannounced surveys each year. Random unannounced surveys will end in January 2006 when JCAHO begins conducting all regular accreditation surveys on an unannounced basis.

# Disciplinary Actions Taken

January 1 - June 30, 2003

## FINAL DECISIONS REVOKED OR SURRENDERED

Armour, Benjamin, RCP 17836  
Burries, Solomon Lee III, RCP 11961  
Carlson, Kimberly Grace, RCP 885  
Caruthers, Jeffery Lynn, RCP 9919  
Case, Kathleen M., RCP 11190  
Demouchet, Kerry Donald, RCP 617  
Farrar, Theresa Monica, RCP 10818  
Foley, Edwin David, RCP 12993  
Forncrook, Donald Dean, RCP 5360  
Garza, Robert, RCP 2580  
Gilles, Cesar H., RCP 18653  
Gwilliam, Alfred Hans, RCP 17521  
Houlb, James Steven, RCP 5032  
Jones, April N., RCP 20700  
Jordan, Richard Carl, RCP 2238  
Mickens, Crystal G., RCP 16216  
Moore, Emery E., RCP 5938  
Motlagh-Arani, Famaraz, RCP 20704  
Nicola, Clarissa Denise, RCP 9290  
Pierson, Melinda Nicole, RCP 21964  
Pulos, George Thomas, RCP 16081  
Stacker, Fred, RCP 5073  
Stirling, Beverly Jean, RCP 14332  
Strackbine, Brad, RCP 19099  
Sturtz, Stephanie J., RCP 12085  
Tager, Robert, RCP 3058  
Weseloh, Donald N., RCP 12576  
Williams, Jason Desean, RCP 21900  
Wilson, Reginald H., RCP 17198  
Wooley, Johnny II, RCP 14957

## OTHER DECISIONS

Georgeon, Mathew L. – Denial  
Egert, Janet S. aka Haynes – Interim  
Suspension Order

## PLACED ON PROBATION / ISSUED CONDITIONAL LICENSE

Bailey, John Robert, RCP 22997  
Bergmann, Jason M., RCP 22968  
Correa, Fermin, RCP 19401  
Cudney, Cindy Marie, RCP 21840  
Diwa, Jonathan T., RCP 22785  
Felomino, Jennie L., RCP 6534  
Hopkins, Janalyn Marie, RCP 9694  
Huber, Scott Patrick, RCP 20179  
Huch, Steven, RCP 4904  
Ivery, Lamont Otis, RCP 22791  
Jantz, Dana Jeanette, RCP 11396  
Mack, Kim Dion, RCP 12961  
Maxson, Ronald M., RCP 20373  
Miller, Joe V., RCP 4286  
Munoz, Estelle, RCP 22915  
Padden, Brett Richard, RCP 7527  
Steed, Reginald D., RCP 10870  
Temple, Evelyn, RCP 20522

## PUBLIC REPRIMANDS

Aparicio, Nancy Espejo, RCP 6480  
Barajas, Rosa, Alicia, RCP 16937  
Bell, Dwayne Allen, RCP 10145  
Byrd, Don Michael, RCP 13958  
Carlson, Richard D., RCP 8164  
Chesnut, Jonathan T., RCP 17807  
Conklin, John J., RCP 13897  
Connors, Francine L., RCP 21471  
Dimacali, Erica Joy, RCP 22788  
Gargarita, Albert L., RCP 19669  
Graviloni, Samuel N., RCP 20022  
Harper, Yolanda Lynn, RCP 17614  
Hebert, Rona Michelle, RCP 19526  
Hightower, James, RCP 20483  
Karim, Patricia Ann, RCP 12453  
Owens, Chuck, RCP 13384  
Pena, Steven Fernando, RCP 15392  
Roper, Kimberly L., RCP 17706  
Stanich, Cliff Mark, RCP 9093  
Sterling, Robin D., RCP 15017  
Thompson, Howard J., RCP 21883  
Waterbury, Christina, RCP 21723

## CITED & FINED

Duran, Ruben, RCP 13805

## ACCUSATIONS

Adams, Suzette M., RCP 20226  
Barry, Roger Lamar, RCP 15692  
Biggs, Jeffery Alan, RCP 10231  
Boyle, Douglas Michael, RCP 9518  
Brown, Eric Clifton, RCP 9108  
Brown, Gayla Marie, RCP 16864  
Brown, Karla R., RCP 13828  
Camonayan, Reden Meris, RCP 14031  
Eckert, Lewis Dewayne, RCP 13680  
Egert, Janet S. aka Haynes, RCP 4247  
Garber, Jennifer Ann, RCP 18297  
Gruzd, Lynda M., RCP 4790  
Higa, Kevin Kiyoshi, RCP 16803  
Higgs, Cheryl, RCP 15800  
Horton, Wilbur Joseph, RCP 3515  
Howard, Colin C. II, RCP 1034  
Love, Irene A., RCP 16297  
Luevano, Juan Carlos, RCP 5837  
Lujan, Mia E., RCP 21761  
Mallet, Julie Delores, RCP 6128  
Mann, Michael Allan, RCP 18734  
Martinez, Alexander, RCP 14703  
Nada, Mohamed, RCP 11889  
Narvaez, Alexander B., RCP 21371  
Oehmen, Judith Immen, RCP 18516  
Sunderman, Peter James, RCP 21930  
Syed, Nasreen, RCP 12930  
Tam, Steven Tom, RCP 53  
Tuthill, Cynthia L., RCP 18575  
Virula, Joseph Alfred, RCP 9809  
Vithal, Ritu, RCP 20264  
Viveros, Christopher R., RCP 22287  
Wadford, Aubrey, RCP 20240

## STATEMENTS OF ISSUE

Benajan, Charles Louis  
Davis, Marshall A. Jr.  
Gouge, Chris M.  
Grider, Ryan K.  
Vasquez, Jose Raymon  
Velasquez, Raymond Jr.

## ACCUSATIONS AND/OR PETITIONS TO REVOKE PROBATION

Austin, Pamela Jean, RCP 17565  
Bolivar, Raymundo, RCP 19262  
Bunce, Polly Catherine, RCP 13506  
Dorsey, Larry Allen, RCP 14698  
Ferguson, Cleophas Jr., RCP 2340  
Greenwood, Thomas W., RCP 12066

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

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

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

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

## Notice on Collection of Personal Information

The Respiratory Care Board of California of the Department of Consumer Affairs collects personal information requested on many of its forms as authorized by Sections 30 and 3730 of the Business and Professions Code. The Board uses this information principally to identify and evaluate applicants for licensure, issue and renew licenses, enforce licensing standards set by law and regulation, and collect outstanding costs ordered in final decisions resulting from enforcement action.

**Mandatory Submission.** Submission of the requested information is mandatory. The Board cannot consider your application for licensure or renewal unless you provide all of the requested information.

**Access to Personal Information.** You may review the records maintained by the Board that contain your personal information, as permitted by the Information Practices Act. See below for contact information.

**Possible Disclosure of Personal Information.** We make every effort to protect the personal information you provide us. The information you provide, however, may be disclosed in the following circumstances:

- In response to a Public Records Act request (Government Code Section 6250 and following), as allowed by the Information Practices Act (Civil Code Section 1798 and following);
- To another government agency as required by state or federal law; or
- In response to a court or administrative order, a subpoena, or a search warrant.

**Address of Record.** Please be advised that your address of record is not considered personal information and may be disclosed to the public. However, the Board will attempt to notify a licensed Respiratory Care Practitioner prior to releasing an address of record (if it appears the address may be a home address).

**Contact Information.** For questions about this notice or access to your records, you may contact the Respiratory Care Board at 444 North 3<sup>rd</sup> Street, Suite 270, Sacramento, CA 95814; Toll-free: (866) 375-0386, or e-mail: [rcinfo@dca.ca.gov](mailto:rcinfo@dca.ca.gov). For questions about the Department of Consumer Affairs' privacy policy or the Information Practices Act, you may contact the Office of Privacy Protection in the Department of Consumer Affairs, 400 R Street, Sacramento, CA 95814, (866) 785-9663 or e-mail [privacy@dca.ca.gov](mailto:privacy@dca.ca.gov).

## Notice on New Continuing Education Requirements

All Continuing Education (CE) taken after November 1, 2003, is subject to new regulatory changes. To review all of the requirements and complete regulatory language, please logon to our website at: [www.rcb.ca.gov](http://www.rcb.ca.gov) and click on "Laws/Regulations."

Following are highlights of the new requirements:

◆ All CE courses must be approved by or provided by one of the following recognized organizations:

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

◆ Successful completion of each of the following examinations in connection with a course approved by one of the above entities may be counted only once for credit (towards any of the required CE hours) and must be for initial certification. However, repeating or "recertifying" in one of these areas may be counted towards the 5 hours of CE that is *not* required to be "directly related to clinical practice."

Advanced Cardiac Life Support (ACLS)  
Neonatal Resuscitation Program (NRP)  
Pediatrics Advanced Life Support (PALS)  
Advanced Trauma Life Support (ATLS)

◆ Passing one of the following examinations offered by the National Board for Respiratory Care continue to be accepted for credit towards any of the required CE hours, but may now only be counted once for credit.

- 1) Registered Respiratory Therapist (RRT) 15 hrs.
- 2) Certified Pulmonary Function Technologist (CPFT) 15 hrs.
- 3) Registered Pulmonary Function Technologist (RPFT) - 15 hrs.
- 4) Neonatal/Pediatric Respiratory Care Specialist (NPS) - 15 hrs.

Licensees (as well as providers) are still required to maintain proof of completion for CE courses completed for a period of 4 years. Proof of completion now includes identification that each course was provided by or approved by one of the above organizations.

Each month, Board staff take a random sample of renewals, generally 5%, and request proof of completion for auditing purposes (as required by California Code of Regulations, Title 16, Division 13.6, Section 1399.353). "If documentation of the CE requirements is improper or inadequate, or the licensee fails to provide the requested documentation within 30 days, the license becomes inactive. The practice of respiratory care, or representation that one is an RCP, is prohibited while the license is inactive." However, a provision was added to the regulations that if the Board determines that through no fault of the licensee the CE does not meet the criteria set forth in the CE requirements, the Board may grant an extension, up to 6 months, to complete approved CE.



## Legislation Would Give Homebound Patients Access to R.T.s

On July 28, 2003, Congressman Rick Renzi (R) of Arizona introduced a bill in the U.S. House of Representatives that will give homebound Medicare patients with pulmonary diseases access to care from respiratory therapists.

The bill, H.R. 2905, would amend the Social Security Act to recognize the services of respiratory therapists under Medicare's home health services benefit. H.R. 2905 will benefit those homebound patients suffering from emphysema and other forms of chronic obstructive pulmonary disease as well as those who are dependent on ventilators.

The AARC continues to work with its members to urge congressional support for H.R. 2905. We especially need help from those of you who live in the congressional districts of members on the House Ways & Means Committee and the House Energy & Commerce Committee, the two key committees that will consider this issue in the House:

The Honorable Mary Bono (R-45th)  
404 Cannon House Office Building  
Washington, D.C. 20515  
D.C. Telephone: (202) 225-5330  
District Office (Palm Springs): (760) 320-1076  
[www.house.gov/bono](http://www.house.gov/bono)

The Honorable Lois Capps (D-23rd)  
1707 Longworth House Office Building  
Washington, D.C. 20515  
D.C. Telephone: (202) 225-3601  
District Office (Santa Barbara): (805)730-1710  
[www.house.gov/capps](http://www.house.gov/capps)

The Honorable Christopher Cox (R-48th)  
2402 Rayburn House Office Building  
Washington, D.C. 20515  
D.C. Telephone: 9202) 225-5611  
District Office (Newport Beach): (949) 756-2244  
[www.house.gov/cox](http://www.house.gov/cox)

The Honorable Anna Eshoo (D-14th)  
205 Cannon House Office Building  
Washington, D.C. 20515  
D.C. Telephone: (202) 225-8104  
District Office (Palo Alto): (650) 323-2984  
[www.house.gov/eshoo](http://www.house.gov/eshoo)

The Honorable Darrell Issa (R-49th)  
211 Cannon House Office Building  
Washington, D.C. 20515  
D.C. Telephone: (202) 255-3906  
District Office (Vista): (760) 599-5000  
[www.house.gov/issa](http://www.house.gov/issa)



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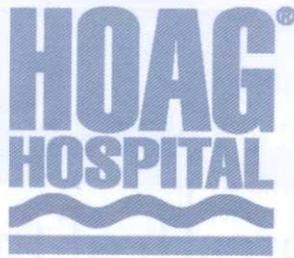
The Honorable George Radanovich (R-19th)  
438 Cannon House Office Building  
Washington, D.C. 20515  
D.C. Telephone: (202) 225-4540  
District Office (Fresno): (559) 449-2490  
[www.house.gov/radanovich](http://www.house.gov/radanovich)

The Honorable Hilda Solis (D-32nd)  
1725 Longworth House Office Building  
Washington, D.C. 20515  
D.C. Telephone: (202) 225-5464  
District Office (El Monte): (626) 448-1271  
[www.house.gov/solis](http://www.house.gov/solis)

The Honorable Henry Waxman (D-30th)  
2204 Rayburn House Office Building  
Washington, D.C. 20515  
D.C. Telephone: (202) 225-4099  
District Office (Los Angeles): (323) 483-1425  
[www.house.gov/waxman](http://www.house.gov/waxman)

California respiratory therapists can help give patients access to their services by writing to your Members of Congress in the U.S. House of Representatives. Ask them to support H.R. 2905 and become a cosponsor of this bill by contacting Sara Hiner in Congressman Rick Renzi's office.

For further information on this issue, please visit the Advocacy page of AARC's web site ([www.aarc.org](http://www.aarc.org)).



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You may also send your resume to:  
Email: [mtecson@hoaghospital.org](mailto:mtecson@hoaghospital.org)  
Fax: 949-760-2313

Hoag Hospital, Attn: Human Resources  
One Hoag Drive PO Box 6100  
Newport Beach, CA 92658-6100

The Respiratory Care Board does not promote or endorse the product, service, organization, or other information contained in the advertisement on this page.

**Respiratory Care Board of California**  
444 North 3<sup>rd</sup> Street, Suite 270  
Sacramento, CA 95814

### **Address Change Notification**

Remember, you must notify the Board in writing if you have changed your address of record within 14 days of such change. Failure to do so could result in a \$25-\$250 fine.

Your written request must include your RCP number, your previous address, your new address, and your signature.

The Board office will accept requests received by U.S. Mail, faxed notifications and changes made via the Board's website.