Approved 2-25-85
Date sh

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Marvin L. Littlejohn, Chairperson, at

1:30 a.m./p.m. on February 20, 1985 in room 423-S of the Capitol.

All members were present except:

Committee staff present:

Emalene Correll, Research
Bill Wolff, Research
Norman Furse, Revisor
Sue Hill, Secy. to Committee

Conferees appearing before the committee:

Representative Anthony Hensley
Keith Landis, Christian Science Committee on Publication for Kansas
Jerry Slaughter, Kansas Medical Society
Barbara Sabol, Secy. Department Health and Environment
Dr. Joseph Hollowell, Department Health and Environment

Visitor's register, (see Attachment No. 1.)

Chair recognized visitor's today from Ulysses, and Junction City, Kansas. A group of students observing legislature day from group of (CLOSE-UP KANSAS).

Chair recognized Rep. Hensley who will speak to a bill that he is sponsoring.

HB 2208:

Rep. Hensley spoke to HB 2208, in that it came about after hearings were held on HB 2028 in reference to a County ambulance service problem, and at that time an amendment was proposed to cover those wishing to forgo medical treatment in an emergency situation, by Mr. Landis. Rep. Hensley stated he met with Mr. Landis and assured him that he felt it would be better for both issues to be dealt with separately, so he is respectfully sponsoring HB 2208, and asks for favorable approval. It would allow persons to reject treatment, or transportation to a treatment center because of their religious preference. He thanked committee, and answered a few questions.

Mr. Keith Landis, Christian Science Committee on Publication for Kansas spoke to HB 2208, stating that he would like to point out that emergency medical services personnel or firefighters have not required objecting persons to accept medical treatment or transportation, but there have been a few cases where law enforcement officers have insisted. Further, he realizes they are just doing their jobs to the best of their ability. He proposed an amendment, (see Attachment No. 2.), for details, and in this testimony he also cites some specific examples of persons being told their failure to accept offered services would result in their arrest, so they agreed to be transported to a hospital, rather than cause any further disturbances. The amendment he proposed is for Section 1., (a) to delete language "in writing", and to include any person, or member of the person's family in the person's behalf, on religious grounds. There was lengthy discussion following his comments. Mr. Landis answered numerous questions from committee and staff. Several language change proposals were suggested, and he then stated he would be happy to work with committee and staff in order to work out the best possible solution for all concerns.

Mr. Jerry Slaughter, Kansas Medical Society spoke to HB 2208, stating that the physicians in an emergency situation are required to perform treatment, so unless there is objection to the treatment, it is done to keep the physician free of liability problems. In cases of a minor being treated, the physician is encouraged to perform treatment or it could result in technical battery charges.

Hearings closed on HB 2208.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

Barbara Sabol, Secy. to Department of Health and Environment stated she would like to make a request for a bill to provide for the licensure of respiratory therapists by the State Board of Healing Arts. (See Attachment No. 3), for details of this proposed legislation. She explained that this would do the same thing that is being requested for the licensure of occupational therapists. She then answered questions from committee.

Secy. Sabol provided a written statement stating her reasons for recommending licensure for respiratory therapists when the Technical Committee and the Statewide Coordinating Council recommended they not be credentialed, (see attachment No. 4.). (See Attachment No. 4-A for the report of the Technical Committee adopted by the Statewide Health Coordinating Committee for credentialing of respiratory therapists), for details.

Secy. Sabol also provided committee a copy of official memorandum regarding recommendations for occupational therapists, (see Attachment No. 5.), for details.

Rep. Hassler moved the committee request this bill be introduced, seconded by Rep. Wagnon. There was discussion briefly, then vote taken, motion carried.

Rep. Buehler was recognized by Chairman, and he made a bill request in regard to a moratorium on Adult Care Home Construction. It speaks to safeguards, and it is for a period of two years, and he cited specifics shown in Attachment No. 6.) Rep. Buehler moved to have this bill introduced, seconded Rep. Hassler, motion carried.

Hearings began on HB 2185:-

Secy. Sabol, of Dept. of Health and Environment was recognized by chairman, and she began her testimony in regard to HB 2185, saying this bill would allow close association between the screening laboratory and the follow-up system of screening tests done on newborn children for phenylketonuria, hypothyroidism, and galactosemia, since testing would all be done by a centralized system overseen the the State Dept. of Health and Environment. She recommended favorable support of this bill. She then answered questions from committee and staff, along with Dr. Joseph Hollowell of the Department of Health and Environment. (See Attachment No. 7), for details of her testimony.

Hearings closed on HB 2185.

Meeting adjourned at 2:35 p.m.

2-20-85

GUEST REGISTER

HOUSE

PUBLIC HEALTH AND WELFARE

NAME	ORGANIZATION	ADDRESS
Mike Hinds, RRT	Kansas Respiratory Therapy Society	1112 W. 6th Topeka, Ks.
Keith R Landis	Christian Science Committee on Publication for Kansas	Topeka
Lynelle King, RN.	Ks State Nurses' Assn	Topeka
[illegible]	KDHE	Topeka
John Schneider	SRS	Topeka
Jerry Slaughter	KMS	Topeka
Marie Jones	Ks Close-Up	Ozawkie, Ks
Charles Hamm	KDH&E	Forbes Field - Topeka

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2-20-5

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GUEST REGISTER

HOUSE

PUBLIC HEALTH AND WELFARE

NAME	ORGANIZATION	ADDRESS
Russell Phillips	CloseUp Kansas	Ulysses, Ks.
Dawn Fitzsimmons	Close-Up Kansas	Ulysses, KS
Samantha Kaiman	Close-up Kansas	Ulysses, Ks.
Anthony Hensley	State Rep. 58th District	Topeka, KS

Attm. #2
2-20-

Christian Science Committee on Publication For Kansas

820 Quincy Suite K
Topeka, Kansas 66612

Office Phone
913/233-7483

February 20, 1985

To: House Committee on Public Health & Welfare

Re: HB 2208

This bill arose from a request that the House Committee on Federal and State Affairs amend HB 2028, a bill dealing with a local Doniphan County ambulance service problem. The requested amendment would have provided that the act regulating ambulance services would not be construed "to authorize any medical treatment to be given to any person who objects thereto on religious grounds, or to authorize the transportation of such person to any hospital or other medical care facility."

Although the committee wished to help us, it was determined that a more appropriate method could be found to solve our problem. At that point, Representative Hensley graciously offered to introduce a bill which would address our concern.

It should be pointed out that emergency medical services personnel or firefighters have not required objecting persons to accept emergency medical treatment or transportation. However, there have been cases in Kansas where law enforcement officers have insisted that injured or ill persons accept medical care and transportation to hospitals by ambulance.

In one situation, an injured husband and wife who objected were told that failure to accept the offered services would result in their arrest. They were also told, by the same law enforcement officer, that they obviously had extensive injuries which affected their judgment, or they would willingly accept the offered services. Because the couple was not sure of their rights, and in order to avoid further disturbance, they agreed to be transported to a hospital.

The bill before you moves a substantial distance toward meeting our needs. It could be improved, however, by amending Section 1 to read as follows:

> "Section 1. (a) No law enforcement officer, firefighter or employee of an emergency medical service shall be authorized to require any person to accept medical treatment or transportation to a medical care facility if the person, <u>or a member of the person's family in the person's behalf,</u> objects to such treatment or transportation~~, in writing,~~ on religious grounds."

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It is my understanding that the proposed wording, through the word "transportation," represents the current emergency medical services policy in Kansas. Those who reject these services for religious reasons should not be required to meet a higher standard than is required of others who may simply make their objections known personally or through a family member without giving a reason for their objection or making the objection in writing.

This bill, as written or if amended as proposed, would make clear that a person may lawfully refuse emergency medical care or transportation to a medical care facility.

The introduction of this bill by Representative Hensley and your consideration of our concern are greatly appreciated.

Keith R. Landis
Committee on Publication
for Kansas

Attm. #3
2-20-85

______________ BILL NO. _____

BY ____

An ACT concerning respiratory therapy; providing for licensure of respiratory therapists by the State Board of Healing Arts; establishing a respiratory therapist council; declaring certain acts to be unlawful and providing penalties therefore; amending K.S.A. 75-3170a and repealing the existing section.

Be it enacted by the Legislature of the State of Kansas:

Section 1. Title of act. This act shall be known and may be cited as the respiratory therapy practice act.

Sec. 2. Definitions. As used in this act:

(a) "Board" means the State Board of Healing Arts.

(b) "Respiratory Therapy" is a health care profession employed under the supervision of a / physician licensed by the board to practice medicine and surgery in the therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities which affect the pulmonary system and associated aspects of cardiopulmonary and other systems functions, and includes all of the following:

(1) Direct and indirect pulmonary care services that are safe, aseptic, preventative, and restorative to the patient.

(2) Direct and indirect respiratory care services, including but not limited to, the administration of pharmacological and diagnostic and therapeutic agents related to respiratory care procedures necessary to implement a treatment, disease prevention, pulmonary rehabilitative or diagnostic regimen prescribed by a physician and surgeon.

(3) Observation and monitoring of signs and symptoms, general behavior, general physical response to respiratory care treatment and diagnostic testing and (a) determination of whether such signs, symptoms, reactions, behavior or general response exhibit abnormal characteristics; (b) implementation based on observed abnormalities of appropriate reporting or referral or respiratory care protocols, or changes in treatment regimen, pursuant to a prescription by a physician and surgeon or the initiation of emergency procedures.

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(4) The diagnostic and therapeutic use of any of the following, in accordance with the prescription of a physician and surgeon: administration of medical gases, exclusive of general anesthesia; aerosols; humidification; environmental control systems and baromedical therapy; pharmacologic agents related to respiratory care procedures; mechanical or physiological ventilatory support; bronchopulmonary hygiene; cardiopulmonary resuscitation; maintenance of the natural airways; insertion without cutting tissues and maintenance of artifical airways; diagnostic and testing techniques required for implementation of respiratory care protocols; collection of specimens of blood; collection of specimens from the respiratory tract; analysis of blood gases and respiratory secretions.

(5) The transcription and implementation of the written and verbal orders of a physician and surgeon pertaining to the practice of respiratory therapy.

(c) "Respiratory therapist" means a person who is licensed to practice respiratory therapy as defined by this act.

(d) "Person" means an individual.

Sec. 3. The Board, in the manner herinafter provided, shall administer the provisions of this act.

Sec. 4. Persons and practices not affected. Nothing in this act shall be construed as preventing or restricting the practice, services, or activities of:

(a) Any person employed as a respiratory therapist by the government of the United States, or any agency of it, if such person provides respiratory therapy solely under the direction or control of the organization by which he or she is employed:

(b) Any person pursuing a supervised course of study leading to a degree or certificate in respiratory therapy in an educational program approved by the Board if such activities and services constitute a part of a supervised course of study and if such person is designated by a title which clearly indicates his or her status as a student or trainee;

(c) Any person fulfilling the supervised field work experience requirements of Section 7, if such activities and services constitute a part of the experience necessary to meet the requirements of that section;

(d) Any person employed by or working under the supervision of a respiratory therapist as a respiratory technician;

(e) Any person performing respiratory therapy services in this state who is not licensed under this act, if such services are performed for no more than ninety (90) days in a calendar year in association with a respiratory therapist licensed under this act and if (A) such person is licensed under the law of another state which has licensure requirements recognized by the Board of this state as equal to or greater than the licensure requirements of this state, or (B) such person meets the requirements for registration as a respiratory therapist or a certified respiratory technician established by the National Board of Respiratory Care; or

(f) Persons licensed or registered to practice any branch of the hearing arts, licensed professional nurses, licensed practical nurses, or physical therapists from using respiratory therapy procedures incidential to their profession when practicing their profession under the statutes applicable to their profession.

Sec. 5. Limited permit. The Board may grant a limited permit to persons who have completed the training or education and experience requirements of this act. This permit shall allow the person to practice respiratory therapy in association with a licensed respiratory therapist and shall be valid until the date on which the results of the next qualifying examination have been made public. This limited permit may be renewed by appeal to the Board if the applicant has failed the examination.

Sec. 6. Respiratory Therapist Council.

(a) There is established a respiratory therapist council to assist the Board in carrying out the provisions of this act. The council shall consist of five members, all citizens and residents of the state of Kansas. One member shall be a physician licensed by the Board to practice medicine and surgery. One member shall be the Secretary of the Board of Healing Arts. Three members shall be respiratory therapists. The Board shall appoint persons to membership on the council for terms of four (4) years each with one new member being elected each year. The Board may delegate powers and duties granted to the Board under this act to the council as it deems proper, including the examination of applicants and the carrying out of the mechanics and procedures necessary to administer this act. No member shall serve more than two (2) successive terms on the council. The Kansas Respiratory Therapy Society shall recommend respiratory therapists to the Board in a number equal to at least twice the vacanices to be filled, and the Board shall appoint members to fill the vacanices from the submitted list. The Board shall, insofar as possible, appoint persons from different geographical areas and persons who represent various types of respiratory therapy treatment.

Sec. 7. Requirements for licensure. An applicant applying for a license as a respiratory therapist shall file a written application on forms provided by the Board, showing to the satisfaction of the Board that the applicant meets the following requirements:

(A) Education: Applicant shall present evidence satisfactory to the

Board of having successfully completed the academic requirements of an educational program in respiratory therapy recognized by the Board.

(B) Experience: Applicant shall submit to the Board evidence of having successfully completed supervised field work at a mimimum recognized by the Board.

(C) Examination: An applicant for licensure as a respiratory therapist shall pass an examination as provided for in Section 8 of this act.

Sec. 8. Examination for licensure.

(a) Each applicant for licensure under this act shall be examined by written examination to test the applicant's knowledge of the basic and clincial sciences relating to respiratory therapy, and respiratory care theory and practice, including the applicant's professional skills and judgment in the utilization of respiratory therapy techniques and methods, and such other subjects as the Board may deem useful to detemine the applicant's fitness to practice.

(b) Applicants for licensure shall be examined at a time and place and under such supervision as the Board may determine. Examinations shall be given at least twice each year at such places within this state as the Board may determine and the Board shall give reasonable public notice of such examination at least sixty (60) days prior to their administration.

(c) Applicants may obtain their examination scores and may review their papers in accordance with rules and regulations established by the Board.

Sec. 9. Waiver of requirements for licensure.

(a) The Board shall waive the examination and grant a license to any person registered prior to the effective date of this act as a respiratory therapist by the National Board of Respiratory Care.

(b) The Board may waive the examination, education, or experience requirements and grant a license to any applicant who shall present proof of current licensure as a respiratory therapist in another state, the District of Columbia, or territory of the United States which requires standards for licensure determined by the Board to be equivalent to or exceed the requirements for licensure under this act.

Sec. 10. Issuance of license.

The Board shall issue a license to any person who meets the requirements of this act upon payment of the license fee prescribed by the Board.

Sec. 11. Suspension and revocation of license; refusal to renew.

(a) The Board may deny, refuse to renew, suspend or revoke a license or may impose probationary conditions where the licensee or applicant for license has been guilty of unprofessional conduct which has endangered or is likely to endanger the health, welfare or safety of the public. Unprofessional conduct includes:

(1) Obtaining a license by means of fraud, misrepresentation or concealment of material facts;

(2) Being guilty of unprofessional conduct as defined by rules and regulations adopted by the Board, or violating the code of ethics adopted and published by the Board;

(3) Being convicted of a felony if the acts for which he or she was convicted are found by the Board to have a direct bearing on whether he or she should be entrusted to serve the public in the capacity of a respiratory therapist;

(4) Violating any lawful order, rule, or regulation rendered or adopted by this act; and

(5) Violating any provision of this act.

(b) Such denial, refusal to renew, suspension, revocation or imposition of probationary conditions upon a license may be ordered by the Board after notice and hearing on the matter in accordance with the provisions of

the Kansas Administrative Procedures Act. One year from the date of the revocation of a license, application may be made to the Board for reinstatement. The Board shall have discretion to accept or reject an application for reinstatement and may hold a hearing to consider such reinstatement.

Sec. 12. Foreign trained applicants.

Foreign trained respiratory therapists shall satisfy the examination requirements of Section 8. The Board shall require foreign trained applicants to furnish proof of completion of educational and supervised field work requirements, substantially equal to or greater than those contained in Section 7 prior to taking the examination.

Sec. 13. Renewal of licenses.

(a) Licenses issued under this act shall be effective for a period of time established by the Board and shall expire at the end of such period of time unless renewed in the manner prescribed by the Board, upon the payment of a renewal fee prescribed by the Board. The Board may establish additional requirements for license renewal which provide evidence of continued competency. The Board may provide for the late renewal of a license upon the payment of a late fee, but no such late renewal of a license may be granted more than five (5) years after its expiration.

(b) A suspended license shall expire and may be renewed as provided in this Section, but such renewal shall not entitle the licensee, while the license remains suspended and until it is reinstated, to engage in the licensed activity, or in any other conduct or activity in violation of the order or judgment by which the license was suspended. If a license revoked on disciplinary grounds is reinstated, the licensee, as a condition of reinstatement, shall pay the renewal fee and any late fee that may be applicable.

Sec. 14. Fees, Rules and Regulations.

(a) The Board shall adopt by rule and regulation fees in amounts

determined by the Board for the purposes authorized in this act and may adopt such rules and regulations as may be necessary to carry out the purposes of this act. The Board shall keep a record of all proceedings under this act and a roster of all persons licensed under the act. The roster shall show the name, address, date and number of the original license and the renewal thereof.

(b) The Board shall remit all moneys received by or for it from fees, charges or penalties to the state treasurer at least monthly. Upon receipt of any such remittance the state treasurer shall deposit the entire amount thereof in the state treasury. Twenty percent of each such deposit shall be credited to the state general fund and the balance shall be credited to the healing arts fee fund. All expenditures from such fund shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the president of the Board or by a person or persons designated by the president of the Board.

Sec. 15. Prohibited acts; penalties.

(a) It shall be unlawful for any person who is not licensed under this act as a respiratory therapist or whose licensure has been suspended or revoked to use, in connection with his name or place of business, the words "respiratory therapist," "licensed respiratory therapist," "respiratory care practitioner",or any other words, letters abbreviations or insignia indicating or implying that he or she is a respiratory care practitioner or a respiratory therapist or who is any way, orally, in writing, in print, or by sign, directly or by implication, represents himself or herself as a respiratory therapist.

(b) Any violation of this Section shall constitute a class C misdemeanor.

Sec. 16. Invalidity of Part.

If any section of this act, or any part thereof, shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair or invalidate the remainder or any other section or part thereof.

Sec. 17. (Note: K.S.A. 75-3170(a) needs to be amended to make Sec. 14 of this act come under it--see attached.)

Sec. 18. This act shall take effect and be in force from and after its publication in the statute book.

attm. #4
2-20-5

State of Kansas . . . John Carlin, *Governor*

DEPARTMENT OF HEALTH AND ENVIRONMENT

Barbara J. Sabol, *Secretary*

Forbes Field
Topeka, Kansas 66620
913-862-9360

January 9, 1985

The Honorable Marvin Littlejohn, Chairperson
House Public Health & Welfare Committee
State House
Topeka, Kansas 66612

Dear Representative Littlejohn:

In accordance with the Kansas Act on Credentialing (K.S.A. 65-5005 <u>et. seq.</u>), I submit my final findings and recommendations on the application for credentialing of the Kansas Respiratory Therapy Society.

The Technical Committee appointed by the Statewide Health Coordinating Council, pursuant to K.S.A. 65-5003, recommended that the Respiratory Therapists <u>not</u> be credentialed. The Committee found that two of the needed three criteria were met, but that "means other than credentialing, such as supervision and laws governing the occupation's devices and substances exist to protect the public from harm."

The Statewide Health Coordinating Council reviewed the recommendation of the Technical Committee pursuant to K.S.A. 65-5004 and agreed with the Committee's findings and recommendations.

I reviewed the recommendations of both the Technical Committee and the SHCC; however, pursuant to K.S.A. 65-5005, I recommend that the application for credentialing by the Respiratory Therapists be approved by the legislature. The rationale for my non-concurrence is as follows:

1. No laws govern the standard of practice and their effective enforcement in Kansas;

2. The standards for professional performance are not enforceable because organization involvement is on a voluntary basis;

3. Certification, licensing or accreditation of facilities is not necessarily correlated to employing competent Respiratory Therapist staff;

4. No federal government credentialing mechanisms exist;

5. All members of the applicant group are not required to graduate from an accredited educational institution or training program;

6. There are no legal or professional requirements for on-the-job training programs for Respiratory Therapists; and

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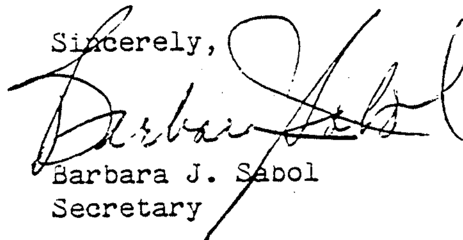
2-20-5

7. A previous application for credentialing by Occupational Therapists was approved by a Technical Committee, the SHCC and me, and a recommendation was forwarded to the legislature. The practices of Respiratory Therapists could lead to untoward health effects at least as serious as those of Occupational Therapists.

The level of credentialing I am recommending is licensure. The agency I recommend to be responsible for the credentialing process is the Board of Healing Arts.

Sincerely,



Barbara J. Sabol
Secretary

BJS:ah

Enclosure

cc: Governor John Carlin

Attm. # 4-7
2-20-5

REPORT OF FINAL FINDINGS AND RECOMMENDATIONS

BY THE

TECHNICAL COMMITTEE FOR THE REVIEW OF THE APPLICATION FOR CREDENTIALING BY THE KANSAS RESPIRATORY THERAPY SOCIETY

Adopted by the

STATEWIDE HEALTH COORDINATING COUNCIL

and Submitted to the Secretary of the Department of Health and Environment

Atch. 4-A
2/20/85

September 26, 1984

Report of Final Findings and Recommendations

by the

Technical Committee for Review of the Application of Credentialing by the Kansas Respiratory Therapy Society

to the

Statewide Health Coordinating Council

INTRODUCTION

During the review of an application for credentialing of a health care occupation the Kansas Credentialing Act (K.S.A. 65-5001, et seq.) the program's Manual for Applicants (Section II., Program Procedures, B.7.b.) specifies that the technical committee reviewing the application shall make findings and recommendations to the Statewide Health Coordinating Council on whether the application meets the manual's Criteria and Standards for Determining the Need for and Level of Credentialing (Section III).

This report contains the technical committee's final findings and conclusion on the criteria and standards for the need for credentialing. These have been made following a public hearing on the application and preliminary findings based on a staff analysis of the information gathered from the applicant against the criteria and standards (Section II.B.7.b. and c.).

Summary of Application

The Kansas Respiratory Therapy Society, seeks licensing by the State of Kansas to practice respiratory therapy in Kansas. The applicant envisions one entry level of licensure for all Respiratory Therapists. Licensure laws existing in other states and pending bills contain the same education, experience, and examination requirements for R.R.T's and C.R.T.T.'s. Licensees are required to meet educational requirements and pass the certification examination.

The information gathered and used for the analysis consists of: 1) The application for Credentialing (January 11, 1983); 2) Supplement I (May 20, 1983); 3) Supplement II (labeled exhibits A-N); 4) Public hearing testimony .

Summary of Committee Findings, Conclusions and Recommendations

In making its findings, the technical committee has determined that, although the potential for harm from the unregulated practice of respiratory therapy does exist (thus meeting criterion 1), no client or consumer testimony documented the potential for harm or the reduction of the potential for harm through regulation. The committee found that the profession requires specialized skills and training and the public has assurances of initial and continuing occupational ability (Thus meeting criterion 2). However, the committee felt that the applicant did not document that the absence of their specialized skills and training would increase the incidence and/or degree of harm to the public.

In addition the committee felt that the public is effectively protected from harm by the practice of respiratory therapy through supervision and laws, governing devices and substances used by respiratory therapists. (Thus failing to meet Criterion 3)

In order for a recommendation for credentialing to be made, the technical committee must find that all three criteria for the need for credentialing are met by the applicant. Because all three criteria have not been found to be met, the conclusion is reached that a need for credentialing of respiratory therapists by the State of Kansas does not exist. The technical committee therefore recommends that the Kansas Respiratory Therapy Practitioners not be credentialed by the State of Kansas.

ANALYSIS OF INFORMATION GATHERED FROM APPLICANT AGAINST THE CRITERIA AND STANDARDS FOR THE NEED FOR CREDENTIALING

Presented below is a detailed consideration of each criterion and standard.

<u>Criterion 1</u>

The unregulated practice of the occupation or profession can harm or endanger the health, safety, or welfare of the public and the potential for such harm is recognizable and is not remote or dependent upon tenuous argument.

In applying the standards the following definition of harm will be used:

Harm shall be construed to be a condition representative of physical, emotional, mental, social, financial or intellectual impairment resulting from the functions performed or failed to be performed by the occupation.

<u>Standard 1.a.</u>

The potential for harm to the public's health, safety, and welfare may be present in the form of:

(1) the inherently dangerous nature of the occupation's functions;

<u>Information Provided by Applicant</u>.

<u>Application items 41, 42 and 49</u>. The applicant states that transmission of erroneous information can lead to errors in the application or adjustment of life support equipment, which could cause death. Inappropriate application of therapeutic procedures can cause results that range from innocuous minor inconveniences to death. The possible need for repeat of procedures or extended hospital stays are mentioned as financial burdens. The applicant group asserts that the potential for harm is increased by incompetence of practitioners.

<u>Staff Analysis</u>.

The application listed 7 occupational functions that are considered to be inherently dangerous to varying degrees (see pages 53-55) as stated by the applicant the potential for harm is enhanced by incompetence. The applicant delineates its occupational activities into diagnostic and therapeutic activities (page 3) both activities appear to have a number of inherently dangerous functions involved.

Final Committee Finding.

Some of the functions of the practice of respiratory therapy are inherently dangerous; the standard is met.

Standard 1.a.

(2) the inherently dangerous nature of devices or substances used in performing the occupation's functions;

Information Provided by Applicant.

Application Items 41, 42, and 19. Devices and substances listed include: 1) tubing; 2) flow and pressure generating devices; 3) breathing therapy machines; 4) nebulizers; 5) humidifiers; 6) normal resuscitating devices; 7) laryngoscopes and endotracheal tubes; 8) oxygen analyzers and masks; 9) compressed gas cylinders; 10) bronchoactive drugs in aerosal form; 11) oxygen; 12) sterile water or saline solutions; 13) oro- and nasopharyngeal airways; 14) suctioning equipment. (page 7)

Staff Analysis

The applicant stated all respiratory therapy equipment may be a source of cross contamination if not cleaned properly. The applicant listed several complications that can result from use of R.T. Devices and Substances (page 45-48). The complications included blindness, lung collapse, laryngeal injury, ulcerative endema, inflammation, cervical spine and cord injuries, tracheal injury, tracheal perforation, tissue trauma, rib fractures, lacerated liver, heart or lung, etc. The degree of inherent danger would again depend on the skill of the practitioner.

Final Committee Finding

Some of the devices and substances used in the practice of respiratory therapy are inherently dangerous; the standard is met.

Standard 1.a.

(3) the frequent exercise by a practitioner of an observable degree of independent judgement when identifying or evaluating consumers' problems, planning or coordinating their care, or directly delivering their care.

Information Provided by Applicant.

Application items 11, 17, 44, 45, and 46. The applicant states respiratory therapist spend 25% of their time in diagnostic activities (page 3), although a prescription or order is required from a physician to provide services (page 6). Most routine functions with the exception of those involving direct assistance to a physician are normally not monitored by a physician "on the spot". R.T.'s are responsible for patient evaluation and recognition of problems; they apply both pharmacological and mechanical therapeutic techniques without direct supervision. It is noted that in some hospital settings direct referral to a respiratory care practitioner for recommendation of a treatment plan is standard operating procedure. (page 56)

Staff Analysis.

It is apparent that respiratory therapists exercise a degree of independent judgement.

Final Committee Finding.

Respiratory therapists exercise independent judgement when evaluating a patient's problems or symptoms; the standard is met.

Standard 1.b.

Such potential for harm may be documented by:

(1) expert testimony;

Information Provided by Applicant.

Dan Johnson, Greg Law and Paul Mathews provided testimony which demonstrated the potential for harm of respiratory therapy functions.

April 25, 1984 Public Hearing.

James Dixon Gardner, M.D. stated that "low level" respiratory care can be administered safely in many instances. He defines low level therapy as consisting of incentive spirometry, humidification inhaled aeorosolized medication treatment postual drainage and percussion and nasal oxygen. He defines high level therapy as dealing with acutely ill or hospitalized patients. This therapy would entail the use of oxygen or the start of medication treatments, or the placement of endotracheal tubing and includes making sure the ventilator is prepared and in good working order. He states the responsibility for maintenance of a safe situation rests with the physician , Director of Respiratory Therapy, a designated staff person and responsibility also is delegated to the Chief Respiratory Therapist person in some situations.

Staff Analysis.

Potential for harm was stated by the applicant. An expert witness testified that "high level" and low level respiratory therapy functions exist. He appeared to ackhowledge that the high level repiratory therapy functions can be potentially harmful. However, he felt that the "high level" repiratory therapy functions potential for harm risks, were reduced by professional supervision.

Final Committee Finding.

Potential for harm inherent in the practice of respiratory therapy is documented by expert testimony; the standard is met.

Standard 1.b.

(2) client or consumer testimony;

Information Provided by Applicant or Interested Person

None

Staff Analysis.

No client or consumer testimony has been provided regarding potential for harm of respiratory therapists' functions. The applicant states harm is possible and case studies were submitted to document harm.

Final Committee Finding.

Potential for harm inherent in the practice of respiratory therapy is not documented by consumer or client testimony; the standard is not met.

Standard 1.b.

(3) research findings;

Information Provided by Applicant.

The applicant provided data to document potential harm from functions used in the practice of respiratory therapy.

Staff Analysis.

The applicant provided case studies within the application under Item 41 to document potential harm from the practice of respiratory therapy. (Example: Bibliography, pages 49 - 52)

Final Committee Finding.

Research exists to document the potential for harm inherent in the practice of respiratory therapy; the standard is met.

Standard 1.b.

(4) Legal precedents, financial awards, or judicial rulings.

Information Provided by Applicant.

Application Items 41 and 42. Documentation of actions of R.T.'s and consequences of their actions to consumers and subsequent legal action taken was provided by the applicant in appendices E-1, F, I, and L.

Staff Analysis.

Legal information submitted by the applicant indicate that courts have observed that respiratory therapists and other hospital personnel "have a duty to perform such acts as are within their authority to protect the health and life of said patient." Legal precedents for recognition of potential harm by the profession is documented.

Final Committee Finding

Legal precedents exist to document the potential for harm in the practice of respiratory therapy; the standard is met.

Standard 1.c.

Such potential for harm may be remote when:

(1) instances of impairment are infrequent or rare;

(2) impairment is minor in nature; or

(3) impairment is due to secondary or tertiary effects of the practice of the occupation.

Information Provided by Applicant.

Application Items 41 and 42. The applicant states "Even expertly administered therapy may be associated with complications since some procedures are inherently hazardous" (page 44). The applicant indicates harm may range from an inconvenience, patient discomfort to possible death.

Staff Analysis.

The information provided indicates the potential for harm is immediate.

Final Committee Finding.

The potential for harm from the practice of respiratory therapy is not remote; the standard is met.

Standard 1.d.

Reduction of the potential for harm through regulation shall, when possible, be documented by comparing:

(1) instances of harm occurring when the practice of the occupation is unregulated; and

(2) instances of harm occurring when the practice of the occupation is regulated.

Information Provided by Applicant.

The applicant cited a number of cases where harm occurred to a client and provided the committee with Licensing Bills or Acts of other states however, no documentation was submitted that compared instances of harm that occurred in California and Arkansas before licensure and instances that occurred after licensing.

Staff Analysis.

Although no comparison data was submitted, applicants premise for seeking licensure appears to be to reduce instances of potential harmful practice and to have public assurances of the quality of R.T. services provided in the state of Kansas (Supplement 1, page 3).

Final Committee Finding.

The reduction of the potential for harm through regulation is not documented; the standard is not met.

Criterion 2

The practice of the occupation or profession requires specialized skill and training, and the public needs and will benefit by assurances of initial and continuing occupational or professional ability.

Standard 2.a.

A need for specialized skill and training shall be demonstrated by:

(1) use in the occupation of an identifiable scope of knowledge or procedures acquirable only through a formal period of study and/or training appropriate for such scope of practice.

Information Provided by Applicant.

Application Items 20, 21, and 26. The applicant acknowledges current training of all levels of practice, i.e., for respiratory therapists, the respiratory therapy technician, and O.J.T. trained therapists. These training programs are described by thé applicant as follows:

1) Formal Education: This consists of one, two and four-year respiratory therapy programs. The settings are usually in junior colleges, universities and hospitals. The programs include both didactic and clinical requirements for completion and are reviewed and accredited through the Joint Review Committee for Respiratory Therapy Education under the auspices of the Committee on Allied Health Education and Accreditation.

2) On-the-Job Training (OJT): The training depends upon the individual hospital. It may be training from one to six months duration, depending upon the services provided by the particular hospital.

The credentialing system established by the National Board for Respiratory Care is a voluntary system with set requirements of didactic competency for those individuals completing a formalized program.

The structure of on-the-job training programs is not formalized, thereby, leaving the training and/or training requirements for employment up to the institution. Some hospitals have guidelines which they use to train these individuals, others do not.

Therefore, standardized training and testing of practitioners through formal education and credentialing is favorable for the practice of respiratory therapy. Such standards would allow for improved patient care and geographic mobility for respiratory therapy practioners.

Currently, all respiratory therapy practitioners are not required to have comparable minimum respiratory therapy practice skills. Entrance and graduation requirements for educational institutions in Kansas can be found on pages 22-25. The applicant group states a desire to have all respiratory therapy practitioners function at a given minimum or standard. (page 28) the national accreditation mechanism for training programs for R.T.'s is set by the Joint Review Committee for Respiratory Therapy Education (JRCRTE) which is organized under the auspices of the committee on Allied Health Education of the American Medical Association. The JRCRTE sets guidelines for respiratory therapy educational programs through its Essentials (Page 10 and Attachment 1 to Supplement I).

Staff Analysis.

The scope of knowledge or procedures acquired through formal study appears to differ vastly from OJT study requirements. The vast difference appears to be a factor that can impact on the expertise of a R.T. practitioner. Although specialized skills and training are recognized as necessities in the practice of respiratory therapy - it is questionable whether all OJT training is appropriate for the scope of R.T. practice sometimes required.

Final Committee Finding.

The practice of respiratory therapy requires an identifiable scope of knowledge of procedures acquirable only through a formal period of study or training appropriate for such scope of practice; the standard is met.

Standard 2.a.

(2) increased frequency of actual instances of harm to consumers when such study or training is absent or inadequate for the practice of the occupation.

Information Provided by the Applicant.

The applicant states that training programs that operate without standardized guidelines may further compromise the well being of patients. They assert that qualified practioners must have expertise (pg 8 application).

Staff Analysis.

No documentation was provided that cited increased frequency of harm to consumers when training is absent or inadequate for the practice of respiratory therapy.

Final Committee Finding.

There is no documentation that the absence of specialized skills and training increases the incidence and/or degree of harm from the practice of respiratory therapy; the standard is not met.

Standard 2.b.

The public needs and will benefit by assurances of ability when:

(1) there is objective and subjective evidence that consumers benefit from the practice of the occupation;

Information Provided by Applicant.

Application Items 15 and 46. Consumers are frequently referred by physicians for respiratory therapy services. Common reasons for such referral include: 1) need of consumer for acute respiratory care which may include oxygen/humidity therapy, bronchodilator aerosal therapy, mechanical ventilation, etc. or 2) need of the patient for chronic respiratory care which may include in-hospital or home oxygen/humidity therapy, home care instruction, chest physiotherapy, etc. The applicant states a physician may consult with a respiratory care practitioner when deciding the most appropriate way to treat a patient's particular respiratory problem. Some institutions have established mechanisms to directly refer to R.T. departments for recommendation of a treatment plan.

Staff Analysis.

Information stated indicates that respiratory therapy skills are recognized by physicians. It also is apparent that respiratory therapists play an important role and provide vital input into the medical management plan of the patients requiring their services.

Final Committee Finding.

There is objective and subjective evidence that consumers benefit from the practice of respiratory therapy; the standard is met.

Standard 2.b.

(2) consumers are unable through ordinary and reasonable means to judge the competence of a practitioner or to assess whether the outcome is beneficial or harmful;

Information Provided by Applicant.

Application Item 50. The applicant states that unless a patient has had prior experience in receiving the various modalities of respiratory therapy and has some knowledge either through formal or experiential means the patient could not judge the efficacy of the results of therapy or intervene before permanent harm was inflicted. They also note that frequently a patient is comatose and that family members and other health care personnel are not present. (page 60)

Staff Analysis.

The skills and knowledge required for the practice of respiratory therapy and often the clients' mental state make judgement of competence by the consumer difficult.

Final Committee Finding.

The public is unable through ordinary means to judge the competence of respiratory therapy practitioners or to assess whether the outcome is beneficial or harmful; the standard is met.

Standard 2.b.

(3) changes in or maintenance of the occupation's skills, knowledge, or techniques require the practitioner to undergo continuing study or training in order to meet current standards;

Information Provided by Applicant.

Application Item 51. The advent of the artificial life support system, mechanical positive pressure ventilation, replaced the previously utilized negative pressure iron lung support system. Between 1972 and now the delivery of respiratory therapy has become more technical in both delivery of care and in the monitoring of the respiratory system. The mechanical ventilator systems now require not only a working knowledge of the physical principals of gases and fluids but also a basic understanding of electronics. In recent years the practice has spread out of the hospital setting into the patient's home. The practitioner has taken on a more independent role. The respiratory therapy practitioner is also beginning to take an active role in the area of medical respiratory research. The typical practitioner must now possess a wider variety of skills than was necessary 10 years ago and therefore must possess a broader knowledge base regarding cardiopulmonary physiology and respiratory medicine. The applicant states "rapid technological change is a rule rather than an exception" (minutes 1/24/84).

Staff Analysis.

Based on the information provided by the applicant changes in the skills level and knowledge base required by the occupation have been rapid and continual during the past 20 years. However, from the information provided by the applicant no mechanism exists, although continuing education opportunity is available (page 34) to assure that continued competency or study occurs in the R.T. occupation so that the practitioner can meet current standards.

Final Committee Finding.

Changes in or maintenance of the occupation's skills, knowledge or techniques require the practitioner to undergo continuing study or training in order to meet current standards; the standard is met.

Standard 2.b.

(4) mechanisms exist to assure consumers of initial and, if necessary, continuing ability in the practice of the occupation.

Information Provided by Applicant.

Application Items 27, 29, 31, and 33. The applicant states that the NBRC examination is designed for respiratory care practitioners although currently some practitioners cannot meet the educational requirements to take the examination. (page 30) Also, continuing education opportunities exist in the state of Kansas, however, there is no current mechanism that exists to assure a periodic measure of continuing ability of R.T. practice.

Staff Analysis.

Association credentialing requirements do not appear to be fully defined in the area of recommended measuring of continual competencies of a respiratory therapy practitioner. More importantly, the association's stated credentialing requirements are essentially voluntary. No effective enforcement procedures are currently available to prevent unqualified persons from attempting to practice respiratory therapy techniques and functions.

Final Committee Finding.

Voluntary mechanisms do exist although, they are not consistently utilized to assure consumers of initial and, if necessary, continuing ability in the practice of respiratory therapy; the standard is met.

Criterion 3

The public is not effectively protected from harm by means other than credentialing.

Standard 3.a.

Insufficient protection of the public from harm and assurance of ability by means other than credentialing shall be demonstrated through:

(1) inadequate supervision by practitioners of a regulated occupation;

Information Provided by Applicant.

Application Items 44, 47 and 36. Most routine R.T. functions are normally not monitored on the spot. Physician supervision normally consists of:

1) approval of standard written respiratory care procedures by the medical director of the respiratory therapy department

2) transmittal of written or verbal orders

3) the physician's assessment of the patient's general progress

4) medical staff access to the results of periodic hospital-wide audits of the efficacy and appropriateness of certain types of therapy for (page 56) certain categories of patients

The applicant described respiratory therapy related supervision as follows:

Health occupations which:

A. are frequently supervised by members of the occupation;
   1) EKG technician 2) EEG technician

B. frequently supervise members of the occupation;
   1) Physicians
   2) Some hospitals having less than 200 beds do not have formal Respiratory Therapy Departments. In these hospitals Respiratory Therapy may be included in other departments such as Anesthesia, Surgery, or Nursing. Supervision in these situations could be by physicians and/or nurses.

C. perform the same types of functions as the occupation but at a different level of skill or training;
   1) Physicians
   2) Nurse anesthetist
   3) Registered nurses
   4) Emergency medical technicians
   5) Lab technicians
   6) Physical therapists

D. perform different but related functions in association with the occupation;
   1) Physicians
   2) Nurse anesthetist
   3) Registered nurses
   4) Emergency medical technicians

E. perform the same functions as the occupation but in a different setting or employment situation.
   1) Physicians
   2) Nurse anesthetist
   3) Registered nurses
   4) Emergency medical technicians

Staff analysis.

Supervision of practitioners by a regulated occupation is not a means to insure protection of the public.

Final Committee Finding.

Varying degrees of supervision of Respriatory Therapists by practitioners of a regulated occupation were reported such supervision appears to be an adequate means to protect the public. The standard is not met.

Standard 3.a.

(2) inadequate laws governing devices and substances used in the occupation and their effective enforcement;

Information Provided by Applicant.

Application Item 53. The applicant mentions the "respondent superior" relationship between the R.T.'s and physician and states that the Medical Practice Act enables therapists to use devices and administer substances regulated by the physician's prescription for use. Additionally, they mention the following federal regulatory bodies which govern the dispensing, use and quality of respiratory therapy devices and substances: Food and Drug Administration, Bureau of Radiologic Health Devices, Federal Communication Commission, the National Fire Protection Association and the Department of Transportation (see page 63).

Staff Analysis.

Although, the occupations use of devices and substances is essentially mandated through the Medical Practice Act, the laws governing R.T. utilized devices and substances are enforceable and substances and devices are controlled through a variety of agencies.

Final Committee Finding.

The current laws governing devices and substances used in the occupation and their effective enforcement appear adequate; the standard is not met.

Standard 3.a.

(3) inadequate laws governing the standard of practice and their effective enforcement;

Information Provided by Applicant.

Application Item 52. Respiratory Therapy is an occupation recognized by the Medicare Act for reimbursement of services. Health Care Financing Administration has issued guidelines for reviewing requests for reimbursement for various respiratory therapy services (page 62). The Joint Commission on accreditation of hospitals also has guidelines which hospitals may voluntarily follow.

Staff Analysis.

Although guidelines are established for reimbursement purposes no laws exist in Kansas to enforce the standard of practice of Respiratory Therapists.

Final Committee Finding.

No laws governing the standard of practice and their effective enforcement exist in Kansas; the standard is met.

Standard 3.a.

(4) inadequate standards such as a code of ethics for professional performance and their effective enforcement;

Information Provided by Applicant.

Application Item 55. The applicant states the American Association for Respiratory Therapy recommends standards of practice. The Ethics Committee of this association monitors compliance of its by-laws by the membership and may expel a member who is in violation, but cannot prevent an individual from practicing respiratory therapy (page 63).

Staff Analysis.

The standards for professional performance are not enforceable because association involvement is on a voluntary basis. Enforcement of professional standards would help protect the public.

Final Committee Finding.

No enforcement of professional performance standards exist; the standard is met.

Standard 3.a.

(5) lack of employment in licensed or certified health facilities which are required to employ competent staff;

Information Provided by Applicant.

Application Items 12 and 46 (Supplement). The applicant states that approximately 85% of Respiratory Therapists practice in the public or private hospital setting, 15% work for home care and equipment companies and 3% are employed by colleges or universities (page 4). The applicant adds that hospitals are under no compulsion to consider NBRC credentials when hiring management or staff for respiratory therapy departments and there currently is no necessary correlation between job description and the level of voluntary credentialing one has achieved (Supplement I, page 3).

Staff Analysis.

Since numerous hospitals were not accredited, the 3 processes; certification, licensing or accreditation of facilities is not a meaningful alternative to credentialing members of the occupation to protect the public.

Final Committee Finding.

Certification licensing or accreditation of facilities is not necessarily correlated to employing competent Respiratory Therapy staff; the standard is met.

Standard 3.a.

(6) inadequate federal licensing or credentialing mechanisms and their effective enforcement;

Information Provided by Applicant.

Application Item 27. The National Board for Respiratory Care has developed examinations for those meeting established admission criteria for CRTT's and RRT's. The NBRC has established guidelines for use by states of the certification examination for regulatory purposes (see Exhibit D-1).

Staff Analysis.

Credentialing mechanisms for respiratory therapists are established, however, there is no enforcement of these mechanisms.

Final Committee Finding.

No federal governing mechanisms exist. The standard is met.

Standard 3.a.

(7) inadequate civil service procedures which effectively screen potential employees for competence;

Staff Analysis.

The State Civil Services Register lists:

R.T.'s I and II, Respiratory Team Leader, and Respiratory Therapy Equipment Aides I and II. Employment for all positions is based on a rating of training and transcripts submitted (if required on job specifications) no written or performance examinations are required.

Final Committee Finding.

Civil Service procedures which effectively screen potential employees for competence appear inadequate; the standard is met.

Standard 3.a.

(8) lack of graduation of members of applicant groups from an accredited educational institution or training program;

Information Provided by Applicant.

Application Items 23, 24, and 26. National accreditation guidelines are established by the Joint Review Committee for Respiratory Therapy Education (JRCRTE). The JRCRTE sets the guidelines for respiratory therapy programs through its Essentials.

Most respiratory therapy programs offer advanced standing of one kind or another to students with experience or previous education. The Joint Review Committee has a system of recognition for programs which have curricular offerings particularly designed to meet special student needs. The Committee requests that these special curricula be based on currently accredited traditional programs. Graduates of the "special programs" receive the same diploma as graduates of the "traditional program" and are then accepted to the credentialing system.

Various designs for these special programs are reviewed and granted recognition.

Two major categories of design exist, those which presume prior experience, knowledge, or employment in respiratory therapy and those that do not. Each category might have two or four kinds of design components which are especially molded for specific student needs:

RECOGNITION CODE.

A - Non-traditional component is recognized by the Joint Review Committee for Respiratory Therapy Education as meeting the standards for non-traditional programs.

R - Non-traditional component is not recognized, but is currently being reviewed by the Joint Review Committee for Repsiratory Therapy Education.

Currently through the state, especially in the small communities, respiratory therapy departments will hire inexperienced individuals and train them on-the-job. This practice allows for a wide variation in the standards of therapy delivered and does not insure minimum standards of quality patient care.

Staff Analysis.

Accreditation of institutions should be viewed as a means to strengthen rather than replace credentialing of workers of an occupation. The diversity of educational opportunities for R.T.'s appears vast. Information indicates formal and non-traditional training allows for great disparity in knowledge and skills acquired.

Final Committee Finding.

All members of the applicant group are not required to graduate from an accredited educational institution or training program; the standard is met.

Standard 3.a.

(9) inadequate participation in on-the-job training programs which are required by law or by professional organization of the occupation.

Information Provided by Applicant.

Application Item 24. The occupation's on-the-job training programs vary in length and quality. Only respiratory practitioner courses offered in the formal education components are required by the profession.

Staff Analysis.

As with accreditation of institutions or training programs, on-the-job training should be viewed as a means to strengthen rather than replace credentialing of an occupation to protect the public.

Final Committee Finding.

There are no legal or professional requirements for on-the-job training programs for Respiratory Therapy. The standard is met.

Standard 3.b.

Indicators of protection by means other than credentialing shall be assessed and evaluated at least in view of the extent to which they:

(1) address all practitioners within the occupation;

(2) appear sufficient to protect the general public from harm caused by the practice of the occupation; and

(3) appear to be permanent and ongoing mechanisms.

Staff Analysis.

Indicators 3(a)(1). Varying degrees of supervision by members of other regulated professions is given to respiratory therapists. Such supervision appears to be an adequate means to protect the public. Therefore, the standards would be satisfied.

Indicators 3(a)(2). Laws governing devices and substances used in the occupation and their enforcement appear adequate. The standards would be satisfied.

Indicators 3(a)(3). No laws governing the standard of practice and their effective enforcement exist in Kansas. The standards would not be satisfied.

Indicators 3(a)(4), 3(a)(5), 3(a)(6), 3(a)(7). No enforcement of professional standards exist; certification, licensing or accreditation of facilities is not necessarily correlated to employment of competent respiratory therapy staff, no federal licensing or credentialing mechanisms exists, no enfocement of the professions credentialing mechanism exist, and exisitng civil service procedures do not appear fully effective in screening potential employees of competence. The standards would not be satisfied.

Indicator 3(a)(8). The profession does not have uniform educational standards for all respiratory therapy practitioners, all members are not required to graduate from an accredited educational institution or training program. The standards would not be satisfied.

Indicator 3(a)(9). The only on-the-job training required by the profession appears to be the practitioner experiences required in the formal education components. The on-the-job training programs that are developed basically do not appear to be for professional enhancement but are designed by employers for hiring purposes. There are no legal requirements for on-the-job training programs for respiratory therapists. The standards would not be satisfied.

Overall findings and Conclusions on the Criteria and standards for the Need for Credentialing

Criterion 1

Final committee findings on the Standards for Criterion 1 show the following:

1. Some functions, devices and substances used in the practice of respiratory therapy are inherently dangerous. These standards are met.

2. Respiratory therapists excercise a degree of independent judgement when evaluating a patients problems or symptoms. This standard is met.

3. The potential for harm from the practice of respiratory therapy is documented by expert testimony, research findings and legal precedents. These standards are met. It was not documented by client or consumer testimony. This standard is not met.

4. The potential for harm from the practice of Respiratory Therapy is not remote. This standard is met.

5. The reduction of the potential for harm from the practice of Respiratory Therapy through regulation is not documented. This standard is not met.

The committee makes the final finding that Criterion 1 is met.

Criterion 2

Final committee findings on the Standards for Criterion 2 show the following:

1. The practice of respiratory therapy requires an identifiable scope of knowledge of procedures acquirable only through a formal period of study or training appropriate for such scope of practice. This standard is met.

2. No documentation was submitted that supported the theory that the absence of specialized skills and training increases the incidence and/or degree of harm from the practice of respiratory therapy. The standard is not met.

3. There is objective and subjective evidence that consumers benefit from the practice of respiratory therapy. The standard is met.

4. The public is unable through ordinary means to judge the competence of respiratory therapy practitioners. The standard is met.

5. Changes in or maintenance of Respiratory Therapy skills, knowledge or techniques requires the practioner to undergo continuing study or training to keep current. The standard is met.

6. Voluntary mechanisms exist although, they are not consistently utilized to assure consumer of initial and if necessary, continuing ability in the practice of respiratory therapy. The standard is met.

The committee makes the final finding that Criterion 2 is met.

Criterion 3

Final committee findings on the standards for Criterion 3 show the following:

1. Varying degrees of supervision of Respiratory Therapists by practitioners of a regulated occupation were reported such supervision appears to be an adequate means to protect the public. The standard is not met.

2. The current laws governing devices and substances used in the practice of respiratory therapy and their effective enforcement appears adequate. The standard is not met.

3. No laws governing the standard of practice and their effective enforcement exist in Kansas. The standard is met. The standards for professional performance are not enforceable because organization involvement is on a voluntary basis. The standard is met.

4. Certification, licensing or accreditation of facilities is not necessarily correlated to employing competent Respiratory Therapy staff. The standard is met.

5. No federal government credentialing mechanisms exist. The standard is met.

6. Civil Service procedures which effectively screen potential employees for competence appear inadequate. The standard is met.

7. All members of the applicant group are not required to graduate from an accredited educational institution or training program. The standard is met.

8. There are no legal or professional requirements for on-the-job training programs for respiratory therapists. The standard is met.

The committee finds that means other than credentialing such as supervision and laws governing the occupations' devices and substances exist to protect the public from harm. The committee makes the final finding that Criterion 3 is not met.

The Need for Credentialing

The committee makes the final findings that Criteria 1 and 2 have been met but that Criterion 3 has not been met. Therefore, because all three criteria for the need for credentialing have not been met, the committee reaches the final conclusion that a need for credentialing of Respiratory Therapists in Kansas does not exist.

Committee Recommendations

The committee recommends that Kansas Respiratory Therapy Practitioners not be credentialed by the State of Kansas.

56-E

Attm. #5
2-20-5

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

MEMORANDUM

September 21, 1984

TO: The Honorable John Carlin, Governor
Senator Ross Doyen, President of the Senate
Representative Mike Hayden, Speaker of the House of Representatives
Senator Roy Ehrlich, Chairperson, Senate Committee on Public Health and Welfare
Representative Marvin Littlejohn, Chairperson, House Committee on Public Health and Welfare
Mike Johnson, D.D.S., Chairperson, Statewide Health Coordinating Council
Guillermo Barreto-Vega, Executive Director, Health Systems Agency of Northeast Kansas
Carlene King, Executive Director, Health Systems Agency of Southeast Kansas
Linda Baker-Nobles, Kansas Occupational Therapy Association

FROM: Barbara J. Sabol, Secretary, Department of Health and Environment

In accordance with the Kansas Act on Credentialing (K.S.A. 65-5001, et seq.), I submit my final findings and recommendations on the application for credentialing submitted by the Kansas Occupational Therapy Association. I am recommending that Occupational Therapy Practitioners be licensed by the State of Kansas.

I wish to thank the members of the Statewide Health Coordinating Council and especially the members of the Technical Review Committee for the time and effort spent in completing the review process and developing a recommendation.

BSJ:cvs
Enclosure
cc: Rosemary O'Leary
Pamela Johnson-Betts

Attm. #5
2-20-85

Final Report to the Legislature
on the
Application for Credentialing
by the
Kansas Occupational Therapy Association

In accordance with the Kansas Act on Credentialing (K.S.A. 65-5001, *et seq.*), I have received from the Statewide Health Coordinating Council its "Report of Final Findings and Recommendations" on the application for credentialing made by the Kansas Occupational Therapy Association.

I have also received from the Council the record of the review of the application, consisting of the applicant's notice of intent, the completed application and various supplements, minutes of technical committee meetings including a public hearing and preliminary technical committee findings. I have examined the information in the review record and the "Report" and find them to be complete.

After reviewing the "Report of Final Findings and Recommendations" and the record, I hereby concur with and adopt the detailed findings on the criteria and standards, the conclusion, and the recommendation on the need for credentialing.

In summary, I find that:

The Kansas Occupational Therapy Association (the applicant) seeks to be licensed by the State of Kansas to practice occupational therapy. The proposed licensing would allow two levels of practice: 1) the occupational therapist level, consisting of engaging a client in purposeful activity in conjunction with therapeutic methods, to achieve identified goals. 2) the occupational therapy assistant level, consisting of working under the direction of an occupational therapist.

- The applicant has met Criterion 1 of the need for credentialing by demonstrating that the unregulated practice of occupational therapy can harm or endanger the health, safety, or welfare of the public and that the potential for such harm is recognizable and not remote or dependent on tenuous argument.

- The applicant has met Criterion 2 of the need for Credentialing by demonstrating that occupational therapists require specialized skill and training, and they have provided the public with the assurance of the initial and continuing ability necessary for the practice of occupational therapy.

- The applicant has met Criterion 3 of the need for credentialing by demonstrating that no other means other than credentialing exists to protect the public from harm by the practice of occupational therapy.

- Because all three criteria for the need for credentialing have been met by the applicant, a need for credentialing of the applicant does exist.

- The Board of Healing Arts is an appropriate licensing body.

I, therefore, recommend that Kansas Occupational Therapy Practitioners be licensed by the State of Kansas.

Barbara J. Sabol, Secretary

Attm. # 6
2-20-5

HOUSE BILL NO. ______

AN ACT concerning adult care homes; limiting the construction, modification or establishment of adult care homes prior to July 1, 1987; authorizing actions to enjoin violations.

Be it enacted by the Legislature of the State of Kansas:

Section 1. As used in this act, the term "adult care home" shall have the meaning ascribed thereto by K.S.A. 39-923 and amendments thereto.

Sec. 2. The following construction or modifications shall not be commenced prior to July 1, 1987:

(a) Any erections, building, alteration, reconstruction, modernization, improvement, extension, lease or other acquisition by or on behalf of an adult care home that increases the bed capacity of an adult care home or relocates adult care home beds from one physical facility or site to another; or

(b) the establishment of a new adult care home.

Sec. 3. This act shall not apply to the following:

(a) The total relocation of an adult care home's beds from one physical facility or site within the community to another physical facility or site within the same community if the relocating adult care home is the only adult care home in the community;

(b) consolidation of two or more adult care homes located within the same community, if the maximum bed capacity after consolidation is set at a level which would accomodate a 70% rate of occupancy based on the aggregate average daily census of the consolidating adult care homes during the previous fiscal year of each adult care home;

(c) the relocation or redistribution of adult care home beds within an adult care home building or identifiable complex

Attm. #6
2-20-85

of buildings on the same site if the relocation or redistribution does not result in an increase in the overall bed capacity at that site; or

(d) a project for which an adult care home held a valid certificate of need under K.S.A. 65-4801 et seq. on June 30, 1985, and which project is not yet completed, regardless of the date of expiration of the certificate of need.

Sec. 4. (a) The secretary of health and environment upon application of an adult care home may grant an emergency waiver from the provisions of this act if the need for the adult care home project is a result of fire, tornado, flood, storm damage or other similar disaster, if adequate health care facilities are not available for the people who previously used the applicant adult care home's facility and if the request for an emergency waiver is limited in nature and scope only to those repairs necessitated by the natural disaster.

(b) The secretary of health and environment may adopt rules and regulations necessary to administer the provisions of this section.

Sec. 5. The secretary of health and environment or an adult care home may bring an action to enjoin any alleged violation of this act.

Sec. 6. This act shall take effect and be in force from and after its publication in the statute book.

Attm #7.
2-20-5

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

February 20, 1985

Testimony on HB 2185

Presented to the House Committee on Public Health and Welfare

This is the official position taken by the Kansas Department of Health and Environment on HB 2185.

Current Kansas statute, 65-180, requires that each newborn child be tested for phenylketonuria, hypothyroidism and galactosemia but does not stipulate how or where this should be done. These diseases result from inborn errors in metabolism which can lead to lifelong mental retardation in the absence of rapid detection and treatment. Prevention is accomplished through laboratory screening test, prompt follow-up and supportive therapy initiated within the first fourteen to thirty days of life. Time frames are short. The consequences of a missed case or a delay in treatment can result in permanent damage to the infant. Close association between the screening laboratory and the follow-up system is crucial.

The prevention of mental retardation is a significant public health issue. The Kansas Department of Health and Environment has operated a successful laboratory screening and follow-up program for many years. This program began with phenylketonuria in 1965. Screening for hypothyroidism was added in 1977 and galactosemia was instituted in 1985. Over thirty thousand Kansas newborn now receive screening tests and follow-up from the Department of Health and Environment each year. The remaining ten thousand infants are tested at one of eight private laboratories located across the state. While there may be some advantage to this diversified approach, the liabilities include the following:

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2-20-85

1. No centralized system to test, screen and track high risk infants.
2. No uniform standard laboratory methods.
3. No comprehensive quality assurance review or performance evaluation for these neonatal tests performed in local laboratories.
4. High costs associated with unnecessary diagnostic tests performed at some laboratories compared with low cost screening tests performed in a central high volume laboratory.

Most states have addressed these and similar concerns with a centralized program at the state or regional level. This approach is recommended by the American Academy of Pediatrics. These public health screening tests do not represent an intrusion upon the several million clinical diagnostic tests performed each year by the more than one hundred sixty certified Kansas hospital and independent laboratories.

Department's Position:

The Kansas Department of Health and Environment supports this bill.

Presented by:

Barbara J. Sabol, Secretary
Kansas Department of Health
and Environment