Approved: February 23, 1999
Date

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Garry Boston at 1:30 p.m. on February 9 in Room 423-S of the Capitol.

All members were present except:

Committee staff present: Emalene Correll, Kansas Legislative Research
Norman Furse, Revisor of Statutes
June Evans, Secretary

Conferees appearing before the committee: R. Russell Babb, MA., RRT, Salina Regional Health Center
Don Richards, Registered Respiratory Therapist
Mark Aberle, B.B.A., R.R.T., M&E Medical Marketing Inc.
Paul Mathews, Respiratory Care Practitioner, Overland Park

Others attending: See Attached Sheet

The Chairperson asked staff to review **HB 2215 - Respiratory Therapist Licensure.**

Norman Furse reviewed the changes in the bill. (See Attachment #1)

The Chairperson opened the hearing on **HB 2215 - Respiratory Therapist Licensure.**

R. Russell Babb, MA, RRT, a proponent, Salina Regional Health Center, stating the bill was originally introduced in 1997 as **SB 242** and passed the Senate on a vote of 40-0. In 1998 the bill passed out of the House with a vote of 108-15, however, an amendment was added regarding licensure of another group of health care providers, sending the bill to conference committee. It is felt the people of Kansas need to be assured that the person entrusted with their respiratory health; their ability to breathe should be assured through competency testing to protect the practice, not just the title of Respiratory Care. The change we are seeking is from registration to licensure which would ensure testing. (See Attachment #2)

Don Richards, Registered Respiratory Therapist, a proponent, stated there is a vast scope of responsibility and services that Respiratory Therapists provide. The existing credential for Respiratory Therapists is Registration. This is title protection only. As long as one does not call oneself a Respiratory Therapist, one can be placed into a position to provide these services. In life threatening situations this could prove fatal, and in lesser circumstances this would prove to be very expensive due to improper, unsafe, or the very least, ineffective therapy thus prolonging a patient's stay in a hospital. (See Attachment #3).

Mark Aberle, B.B.A., R.R.T., President-Elect Kansas Respiratory Care Society, testified in favor of **HB 2215**, stating there is an increased need for competent, properly credentialed (licensed), respiratory care practitioners outside of the acute care hospital. The scope of respiratory care services, and the responsibilities of respiratory care practitioners, has developed significantly beyond what it was a few years ago. It has also expanded well outside the supervised hospital setting. The RCP is frequently the ONLY health care professional seeing the patient in the home. Your support in upgrading the RCP credential to protect the public by assuring the practice of Respiratory Care will be performed by properly educated, and trained, that is licensed RCPs. Licensed RCPs are needed to meet the ever increasing demand to care for more acutely ill patients at home as a result of ongoing health care reform. The people of Kansas absolutely required properly educated, trained and credentialed respiratory care practitioners so that the life supporting care they require does not become life threatening when given from the wrong hands. (See Attachment #4)

Paul Mathews, Associate Professor, University of Kansas Medical Center, testified in favor of **HB 2215**, stating respiratory care is a young profession, barely 50 years old. There have been many changes Respiratory care practitioners daily provide a level of service as critical and as complex as many performed by others that are licensed, i.e., physicians, nurses, physicians assistants and paramedics. Respiratory therapists should be licensed also. (See Attachment #5)

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES, Room 423-S of the Capitol at 1:30 p.m. on February 9, 1999.

Lawrence T. Buening, Jr., Executive Director, Kansas Board of Healing Arts, testified in opposition of **HB 2215**. This bill is identical to 1997 **SB 242** as it was amended by the Senate Committee on Public Health and Welfare as it passed the Senate during the 1997. The bill was amended to provide for the licensing of physical therapists. That bill, as amended by this Committee during the 1998 session, passed the House but died in conference committee.

Respiratory therapists are not the only professional group that would like to change their credentialing status from registration to licensure. The list of professionals seeking licensure does not stop with those currently registered. Therefore, the Board urges you to consider the ramifications of modifying the credentialing level of one profession without also determining the impact that would have on other health care professions. The Board simply questions whether licensure is necessary to insure the public's protection. (See Attachment #6)

The Chairman closed the hearing on **HB 2215.**

Representative Geringer moved and Representative Morrison seconded to move **HB 2215** out favorably. The motion carried..

The Chairman stated the committee would return to **HB 2032.** There were some questions on February 8 when the hearing was held and now Mary Ann Gable, Executive Director, Behavioral Sciences Regulatory Board was present and she would provide some answers to questions previously asked.

After discussion, the Chairman stated final action would not be taken until information was received in writing from the Behavioral Sciences Regulatory Board.

The following written testimony was distributed:

Lesa Bray, Director, Health Occupations Credentialing, KDHE (See Attachment #7)
Meg Draper, Director of Government Affairs, Kansas Medical Society (See Attachment #8)
Tom Bell, Senior Vice President/Legal Counsel, Kansas Hospital Association (See Attachment #9)
Hugh S. Mathewson, M.D., Professor, Respiratory Care Education, KU Medical Center(Attachment #10)
Kenneth Davis, MPH, PT, Outreach Director, School of Allied Health, KU Medical Center (Attach #11)
Anthony L. Kovac, M.D., Professor of Anesthesia, KU Medical Center (Attachment #12)
Emergency Services Professional Association (Attachment #13)
Pat Munzer, MS, RRT, Program Director/Associate Professor, Washburn University (Attachment #14)
Curtis B. Pickert, M.D. Wesley Medical Center, Wichita (Attachment #15)
Justus H. Fugate, Jr., MA, Wichita (Attachment #16)
Associates in Neonatology, PA, Wesley Medical Center, Wichita (Attachment #17)

The meeting adjourned at 3:00 p.m. The next meeting will be February 10.

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.

**HEALTH AND HUMAN SERVICES**

Date: February 9, 1999

| | |
|---|---|
| Lesa Bray | KDHE |
| Debbie Fox | KRCS |
| Meg Wurmppe | KRCS |
| Ed Anderson | KRCS |
| Karen Schell | KRCS |
| Suzanne Bollig | KRCS |
| Paul Matt | KRCS |
| Russ Brown | KRCS |
| Don Richard | KRCS |
| Mark Aberle | KRCS |
| Rich Guthrie | Health Midwest |
| Larry Buening | Bd of Healing Art |
| KEITH R. LANDIS | CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS |
| Bill Allen | KRCS |
| Gini Marshall | KRCS |
| Terri Plesser | KRCS |
| Derek A. Blaylock | Intern for Teresa Sittenauer |
| Susie Glynn | KSBN |
| Doug Smith | KAPA |
| Rebecca Rice | KCA |
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**S 0242** Bill by Public Health & Welfare

**Respiratory therapist licensure and physical therapist licensure.** Effective date: Statute Bk

02/10/97 Senate—Introduced—SJ 121
02/11/97 Senate—Referred to Public Health & Welfare—SJ 125
02/28/97 Senate—Withdrawn from Public Health & Welfare; Referred to Ways and Means—SJ 235
03/05/97 Senate—Withdrawn from Ways and Means; Rereferred to Public Health & Welfare—SJ 247
03/28/97 Senate—CR: Be passed as am. by Public Health & Welfare—SJ 437
04/01/97 Senate—COW: CR be adptd; be passed as am.—SJ 529
04/02/97 Senate—FA: Passed as am.; Yeas 40 Nays 0—SJ 564
04/03/97 House—Received and introduced—HJ 752
04/04/97 House—Referred to Appropriations—HJ 768
04/10/97 House—Withdrawn from Appropriations; Referred to Health and Human Services—HJ 804
03/24/98 House—CR: Be passed as am. by Health and Human Services—HJ 1562
03/31/98 House—COW: CR be adptd; be passed as am.—HJ 1695
04/01/98 House—FA: Passed as am., Yeas 108 Nays 15—HJ 1727
04/01/98 Senate—Nonconcurred, CC requested; apptd Praeger, Salmans, Steineger—SJ 1395
04/02/98 House—Acceded; apptd Mayans, Morrison, Henry—HJ 1748
05/26/98 Senate—Died in conference committee

HHS
2-9-99
Atch# 1

February 9, 1999
Testimony on HB 2215
Committee on Health and Human Services

Mr. Chairman
Members of the Committee

Thank you for allowing me the opportunity to address you today concerning HB 2215, regarding licensure of Respiratory Care Practitioners. As I look around the room I see many familiar faces from last year, and as nothing regarding the content of our bill has changed, I will try to keep my remarks brief.

As you know, our bill was originally introduced in 1997 as SB 242 and passed the Senate on a vote of 40 - 0. In 1998 our bill passed the House of Representatives with a vote of 108 - 15, however, at the last minute an amendment was added regarding licensure of another group of health care providers, sending our bill to conference committee.

We come before you today, asking that our bill be presented "clean" and allowed to stand on its own merit, without attachments. If other health care providers are seeking action regarding their practice, let them stand before you as we are, and be judged on the merits of their particular issues.

As you are all probably aware, as the law regarding respiratory therapists is now written, registration or "title protection" protects only the title Respiratory Therapist. As long as you do not call yourself a Respiratory Therapist there is nothing legally preventing you from administering medication, or participating in patient interactions. We feel the people of Kansas need to be assured that the person entrusted with their respiratory health; their ability to breathe should be assured through competency testing to protect the practice, not just the title of Respiratory Care. Surely, the educational competency of individuals we intrust with our ability to breathe warrants as much scrutiny as those individuals the state of Kansas "licences" to cut and style our hair, do our nails, or draw our tattoos.

We are seeking a change from registration to licensure, because we feel the person who is charged with administering therapy, medications and instructions to patients with respiratory problems, such as asthma, bronchitis, emphysema, cystic fibrosis, and pneumonia just to name a few, should possess the knowledge and expertise to assure the effective outcomes of these interventions. The only way to assure this, is to have these people competency tested, which would be required by licensure.

HHS
2-9-99
Atch #2

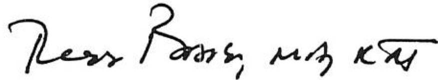
We are concerned that in the changing world of health care, the now common practice of the early release of patients from hospitals, allows a very vulnerable portion of our society to be placed in danger under the present "title protection" registration system.

It is interesting to note that physicians who deal with Respiratory Therapists in their daily practice support licensure of the profession. Among these groups whose endorsements are enclosed are the American Society of Anesthesiologists, The American College of Chest Physicians, The American College of Allergy and Immunology and the National Association of Medical Directors of Respiratory Care.

Also enclosed for your review is an information sheet addressing some of the issues which have risen regarding our request for licensure, including "turf protection" independent practice , and cost issues.

Thank you for your time and attention. I will be happy to answer any questions.

Sincerely,



R. Russell Babb, MA, RRT
Director of Respiratory Care Services
Salina Regional Health Center
Salina, Kansas
Board of Directors - Kansas Respiratory Care Society

AMERICAN SOCIETY OF ANESTHESIOLOGISTS

**STATEMENT OF SUPPORT FOR RESPIRATORY CARE PRACTITIONERS OCTOBER 1996**

Health care organizations have sought to implement the use of substitute caregivers. The American Society of Anesthesiologists is particularly concerned about this trend in the area of respiratory care.

Respiratory care is a highly specialized allied health profession. Respiratory Care Practitioners (RCPs) are trained to care for patients under the supervision of a qualified medical director in multiple clinical settings including home care, subacute care and hospitalized patients. The patients under their care frequently include a disproportionately sicker population than is the case for most other allied health practitioners and RCPs have responsibility for the control of life support equipment in critically-ill patients. RCPs also play an indispensable role in the coordination and utilization of respiratory care services in these multiple settings.

RCPs undergo unique and rigorous formalized training, the programs of which are nationally accredited. They are qualified by a valid and reliable national testing system. They work under the leadership and guidance of a qualified medical director and have done so for many years.

ASA is deeply concerned about the use of other practitioners delivering respiratory care services. The standard of care to patients could be compromised unless these other individuals received the same extensive education, training and competency testing as required of RCPs.

ASA strongly supports the continued use of nationally credentialed Respiratory Care Practitioners working under the supervision of a qualified medical director as they are the most highly qualified health care personnel to deliver respiratory care services to patients.

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American College of Chest Physicians
Section on Respiratory Care

**RESOLUTION**

Role of Respiratory Care Practitioners in the Delivery of Respiratory Care Services

In today's ever-changing health-care field, efforts have been made to decrease costs by having a variety of health-care providers deliver respiratory care services. We are concerned that the quality of these services may be inferior if the health-care provider has not had adequate training and experience. Respiratory care practitioners (RCPs) are particularly qualified to assess patients with respiratory problems and to deliver the various modalities of respiratory care because of their unique educational background and training. Their profession has assured practitioner competence by requiring national accreditation of all training programs. This is supplemented by a national credentialing mechanism, often linked with state licensure. Continued competence is bolstered in almost every state by the legal requirement for continuing education in respiratory care. Further, RCPs provide these services under the direction of a qualified medical director.

Because RCPs have specialized training and experience, they play a vital role in the coordination and utilization of respiratory care services. This role is particularly pertinent in this era of managed care, which has resulted in an increased severity of illness in hospitalized patients, as well as in those cared for in their homes and other out-of-hospital sites. Although other health-care providers may possess the necessary training and experience to deliver simple modalities of respiratory care, the RCP is uniquely qualified to assist the physician in assessing the overall respiratory needs of patients, and in recommending and delivering the necessary care. Respiratory care modalities can be most beneficial and cost-effective when the RCP functions within the guidelines of physician-approved respiratory care protocols.

In order to assure the safety, quality, and appropriateness of respiratory care services delivered to the patients in need, the American College of Chest Physicians strongly endorses the essential role of the competent RCP in providing respiratory care under the direction of a qualified medical director.

July, 1997

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-IONAL ASSOCIATION FOR MEDICAL DIRECTION OF RESPIRATORY CARE
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## NAMDRC Statement
## Non Physician Providers of Respiratory Care Services

In the changing health care system that is currently in progress, NAMDRC unequivocally supports the premise that respiratory care practitioners are the non-physician care givers who are best qualified by both education and examination to render respiratory care services in the hospital and at alternate sites, including the home. Due to the complex nature of these services and the patient risks involved, respiratory care services should be provided under the direction of a qualified medical director. NAMDRC has confidence that outcome studies, which are currently in progress, will provide further scientific validation of the benefits attributable to respiratory care practitioners.

The hours of education and the curriculum required for credentialing of a respiratory care practitioner should be the standard for all non-physician providers of respiratory care services. Verification of the knowledge and skills acquired through this educational process should be documented by appropriate testing, which includes input from physicians who specialize in respiratory medicine in the preparation of certifying examinations.

The current educational process required for credentialing of respiratory care practitioners makes them best qualified to carry out orders for respiratory care clinical interventions. Therefore, respiratory care practitioners play a critical and unique role in the coordination and utilization of respiratory care services at all sites, which is essential for appropriate patient care.

*Representing all physicians interested in*
*Respiratory Care • Critical Care • Pulmonary Rehabilitation • Hyperbaric Oxygen Therapy • Sleep Disorders Centers • Pulmonary Physiology Assessments • Respiratory Home Health Care Services*

# American College of Allergy & Immunology

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Statement Regarding Respiratory Care Practitioners Credentialing

Allergy is a practice of medicine which includes the diagnosis and treatment of a variety of respiratory illnesses, including those which overlap acute and chronic care modalities generally referred to as respiratory care. Respiratory care practitioners, technicians and therapists should provide respiratory care only under the medical direction of a qualified physician.

The American College of Allergy and Immunology believes that all personnel providing direct patient care must possess appropriate qualifications and competence. To accomplish this, the Society supports the efforts of the joint Review Committee for Respiratory Therapy, education, and the National Board of Respiratory Care to provide accredited educational programs and national credentials for respiratory care practitioners.

Several states have enacted legislation and more are considering legislation which credentials respiratory care practitioners by establishing a state licensing system. Any legislation relating to the credentialing of respiratory care practitioners, whether or not providing for formal licensure should be consistent with the following principles:

1. The scope of practice must be defined.
2. The practice should be committed only under medical direction of a qualified physician.
3. The minimum standards of education, training and competency should be consistent and compatible with existing national standards of nongovernmental credentialing of these practitioners.

The American College of Allergy and Immunology supports state credentialing systems which are based upon these principles. When called upon to assist with proposed legislation involving the credentialing of respiratory care practitioners, members of the American College of Allergy and Immunology are urged to support through testimony and legislative advocacy any proposed credentialing statute which is consistent with the previous stated principles.

EXECUTIVE OFFICES • 800 E. Northwest Highway • Suite 1080 • Palatine, IL 60067 • (708) 359-2800 • FAX: (708) 359-7367

# Key Issues Regarding Licensure of Respiratory Therapists

The Respiratory Therapy Licensure bill upgrades the credentialing status of Respiratory Therapists from state registration to state licensure status. Currently Kansas has only registration, or "title protection", that identifies who can call him/herself a respiratory therapist. Registration does nothing to actually limit who can practice respiratory care.

In 1997, the Licensure Bill (SB 242) was passed by the Kansas Senate with a vote of 40-0. The Bill passed the House of Representatives with a vote of 108-15 in 1998. However, a last-minute amendment regarding licensure of Physical Therapy sent the bill to Conference Committee. The session ended before further action was taken on this bill. Licensure of Respiratory Therapists is supported by the Kansas Hospital Association and the Kansas Medical Society.

## The Licensure of Respiratory Therapists will Provide Greater Protection to the Citizens of Kansas.

- Licensure of Respiratory Therapists will ensure that those providing respiratory care to the citizens of Kansas meet specified standards of education and competency.
- Untrained individuals will be prevented from performing respiratory procedures.
- Respiratory Therapists will be required to meet continuing education requirements to maintain their license and to assure ongoing competence.

## The Licensure of Respiratory Therapy is NOT:

- **Not a "Turf" Issue:** Licensure of Respiratory Therapists is not about "turf protection". The Licensure bill is **non-exclusionary** and recognizes the crossover between health providers. It allows other licensed health care professionals to perform respiratory care procedures following education and documented competency.
- **Not Independent Practice:** Licensure of Respiratory Therapists does not mean independent practice. Respiratory therapists will continue to practice **only** under the direction and written order of a physician. Therapists will **not** be allowed to practice independently now or in the future.
- **Not Increase Costs:** Licensure of Respiratory Therapists will be budget neutral. Since Respiratory Therapists are currently registered by the Kansas Board of Healing Arts the organization and fee structure is already in place. The citizens of Kansas will receive greater protection with licensure without spending any additional monies. The cost of the current system is met by the fees collected with all excess funds designated to the State General Fund.
- **Not a Billing Issue:** Licensure is not a "billing" issue. State licensure of respiratory therapists will not change the billing procedures in any way.
- **Not Legislate Anyone out of a Job:** The Licensure Bill allows all individuals legally recognized as a Respiratory Therapist under the current registration act to be deemed licensed under the new act.
- **Not Create a Manpower Shortage:** No staffing shortage is expected since the Bill does not restrict other licensed health care providers from performing certain aspects of Respiratory Therapy. Plus there are seven Respiratory Therapy educational programs in the State, to help assure an ongoing supply of therapists in the future.

TESTIMONY ON HOUSE BILL 2215
BEFORE THE HEALTH AND HUMAN SERVICES COMMITTEE
FEBRUARY 9, 1999

Mister Chairman,
Members of the Committee,

My name is Don Richards, I am a Registered Respiratory Therapist with almost thirty years experience in Respiratory Care and a member of the Kansas Respiratory Care Society (KRCS). I wish to speak in favor of upgrading the Respiratory Therapist's credential to licensure.

The goal of any healthcare credentialing process is to establish a minimum standard of achieved competency on the part of a provider in order to protect the public from harm from unqualified individuals.

To better understand the seriousness of this issue, one has to have an understanding of the vast scope of responsibility and services that Respiratory Therapists provide. Respiratory Therapists are unique in that we deal with patients in virtually all patient care settings because our area of expertise is the respiratory system, which can be immediately life-threatening regardless of where the patient may be. As respiratory system specialists, Respiratory Therapists receive special training in emergency airway management, mechanical life support, and the treatment of both sudden and chronic respiratory problems. Respiratory Therapists are critical members of hospital wide and emergency room resuscitation teams, critical care teams, trauma teams, and other protocols developed to deal with airway problems. We deal with all patients, from the moment of delivery of premature infants to long term home care for individuals suffering from chronic pulmonary diseases such as emphysema and chronic bronchitis. When a sudden asthma attack strikes, it is the emergency room physician and the respiratory therapist that are most needed to provide appropriate, corrective care. Respiratory Therapists are also recognized experts in very complex pulmonary function diagnostic laboratory procedures that detect hidden lung disease and give the physician a very accurate description of both the nature and the severity of the disease. Respiratory Therapists obtain arterial blood for oxygen and chemical analysis, they perform diagnostic sleep apnea studies and recommend appropriate therapy, they assess and recommend on-going therapy to physicians on all types of patients, from infants to the elderly, that suffer from some type of respiratory disease, and they provide home care to countless individuals providing everything from supplemental oxygen to home mechanical ventilation. Routinely a Respiratory Therapist must make quick decisions given certain patient circumstances, and many times these decisions are life-saving in nature, requiring instant and appropriate responses with no time for consultation. Ladies and gentlemen, Respiratory Therapists are nationally recognized health care professionals specializing in the delivery of very sophisticated and life-saving services.

To date, thirty five (38) states, the District of Columbia, and Puerto Rico have full licensure of Respiratory Therapists. The states surrounding Kansas except Colorado have licensure, and Colorado is in the process of putting a bill together.

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The existing credential for Respiratory Therapists is Registration. Quite simply, this is title protection only. As long as one does not call oneself a Respiratory Therapist, one can be placed into a position to provide these services. The consumer, thus, has no assurance that a trained and competent individual is providing for their care. In life threatening situations this could prove to be fatal, and in lesser circumstances this would prove to be very expensive due to improper, unsafe, or the very least, ineffective therapy thus prolonging a patient's stay in a hospital.

Some individuals may take the assumption that applicants requesting a change in their respective credentialing or scope of practice are doing this to reflect an enhanced economic benefit subsequent to their requested change. This simply is not true in this case. Consider the following: A system already exists to regulate the credential ( the Board of Healing Arts), and is fully funded by Respiratory Therapist fees. The boards' Executive Director, Mr. Larry Beuning , noted to the Respiratory Therapists that they "need to be licensed" to keep out unqualified individuals. Not one therapist would be legislated out of a job because a grandfather clause in the bill will allow these individuals that have been working since the original registration act to continue to work. Salaries will not go up as licensure vs. registration will not affect wages as the criteria for legally qualified Respiratory Therapists will remain the same, the passing of a national board exam. Respiratory Therapists can only provide care under the express prescription of a physician, and this will not change. Finally, the bill recognizes other credentialed health care providers and allows these individuals to perform respiratory care procedures if it is in their scope of practice and they were appropriately trained. This takes us back to our original premise, we seek a change in our credential because we want to enhance the quality of caregivers and protect the public from unqualified practitioners. It is up to the state to ensure it's citizens are protected, and if a profession seeks to upgrade it's professional standards, one should not automatically assume it is for economic gain.. This is simply a patient protection issue. The gain to our profession is identical to the gain to the consumer, one of eliminating unscrupulous and untrained individuals. As healthcare expands more into the home and long term care settings, it is more critical than ever that only qualified individuals are allowed to provide this care.

The Kansas Respiratory Care Society endorses a health care delivery system that meets the criteria of reduced cost, access to qualified practitioners, and the elimination of "turf" boundaries for other qualified practitioners. We feel our bill accomplishes this.

Thank you for allowing us to provide you with this testimony.

Don Richards, MS,RRT

# M&E MEDICAL MARKETING
INCORPORATED

February 9, 1999

TO: HEALTH AND HUMAN SERVICES COMMITTEE
HOUSE OF REPRESENTATIVES

FROM: Mark Aberle, B.B.A., R.R.T.; President-Elect Kansas Respiratory Care Society; November 1996 to present, Independent Medical Equipment Representative; prior, Account Executive, Apria Healthcare; prior, Clinical Director, Respiratory Services for Total HomeCare/Columbia Wesley Medical Center. Respiratory Care Practitioner since 1967, involved in homecare since 1975.

SUBJECT: INCREASED NEED FOR COMPETENT, PROPERLY CREDENTIALED (LICENSED), RESPIRATORY CARE PRACTITIONERS OUTSIDE OF THE ACUTE CARE HOSPITAL.

Respiratory care is an allied health specialty performed for the diagnostic evaluation and assessment, treatment, care, and ongoing management of patients with diseases, deficiencies, and abnormalities, of the cardiopulmonary system. Respiratory Care Practitioners, (RCPs), care for patients ranging from the premature infant whose lungs are underdeveloped to the elderly patient whose hearts and lungs are diseased. Individuals who suffer from such diseases as emphysema, bronchitis, lung cancer, sleep apnea, and cardiovascular disease; children who suffer from asthma or are afflicted with cystic fibrosis: and patients of all ages who require the use of medications, oxygen, and a ventilator to breath; they are all cared for by the respiratory care practitioner. RCPs regularly set-up, instruct, and, on an ongoing basis, care for and treat patients on a variety of oxygen systems, breathing apparatus, related equipment, and ventilators in the home. They evaluate patients' needs, survey home environments, case manage by bringing together resources and making recommendations based on good medical practice and reimbursement guidelines, administer medications, perform diagnostic procedures, and even adjust or modify systems to meet individual patient needs. They are an integral component in the complex hospital discharge planning process of high risk and ventilator dependent patients. RCPs are frequently the clinical resource for physicians in managing patients, and keeping physicians informed on the status of these patients at home.



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Home care services have proven to be an integral part of the health care delivery system and a cost-effective alternative to hospital stays. With the dramatic increase in managed care, and capitated reimbursement, patients are leaving the acute care setting sooner (and sicker), going into subacute and homecare environments requiring skilled care. And this trend continues to increase.

The aging population, the spread of AIDS and tuberculosis, the increasing incidence of asthma, and advances in medical technology allowing technology-dependent patients to lead more productive lives outside the institutional setting are increasing the need for the services of properly educated and trained RCPs. Respiratory patients are increasingly being discharged from the hospital still requiring skilled care, thereby increasing the demand for respiratory care services in alternate sites such as the home. These patients are presently left vulnerable, and at risk, to those that lack proper training, and education, and simply jump into the durable medical equipment business by obtaining a delivery van, and a Medicare Part B provider number (fill out the form, and not have a prior conviction of Medicare fraud).

Presently, Kansas registration only protects the title name of the Respiratory Care Practitioner. What is necessary is to protect the public through the protection of the actual practice of respiratory care with licensure. Most of our surrounding states, thirty something at present, and growing in number, currently require state licensure for RCPs. It would be most unfortunate if Kansas becomes a haven for poorly or non-trained practitioners that are no longer able to practice respiratory care in their own states because of those states licensure acts requiring basic competency.

The scope of respiratory care services, and the responsibilities of respiratory care practitioners, has developed significantly beyond what it was a few years ago. It has also expanded well outside the supervised hospital setting. The RCP is frequently the ONLY health care professional seeing the patient in the home. I am asking for your support in upgrading the RCP credential to protect the public by assuring the practice of Respiratory Care will be performed by properly educated, and trained, THAT IS LICENSED, RCPs. Licensed RCPs are needed to meet the ever increasing demand to care for more acutely ill patients at home as a result of our ongoing health care reform. The people of Kansas absolutely require PROPERLY EDUCATED, TRAINED and CREDENTIALED respiratory care practitioners so that the life supporting care they require does not become life threatening when given from the wrong hands.

# The University of Kansas Medical Center

School of Allied Health
Department of Respiratory Care Education
4006 Delp

Barbara A. Ludwig, MA, RRT, Chair 4002 Delp
Michael P. Czervinske, RRT 4004 Delp
Bethene L. Gregg, MS, RRT 4003 Delp
Paul J. Mathews, Ph.D, RRT, FCMM 4005 Delp
Judith A. Mathewson, MS, RRT 4001 Delp

**February 9, 1999**

**Respiratory Care Licensure Bill**
**HB #2215**

Mr. Chairman; Ladies and Gentlemen of the Committee:

My name is Paul Mathews. I am a resident of Overland Park and I am a Respiratory Care Practitioner. Let me spend a few moments to inform you about my background. I am employed as an Associate Professor at the University of Kansas Medical Center in the School of Allied Health. Let me first state that my comments here do not represent the official position of my Department, the School of Allied Health or The University of Kansas. Copies of this testimony and letters of support from Hugh Mathewson MD, Anthony Kovak, MD and Mr. Kenneth Davis MHA, RPT have been provided for you.

My primary appointment is in the Department of Respiratory Care Education. I have secondary appointments to the graduate faculty in Physical Therapy, the Center on Aging and the Cancer Center. I have been employed by KU for 18 years and have been a Respiratory Care Practitioner for 33 years. I am member of the American College of Chest Physicians (ACCP) and the American Society of Critical Care Medicine (SCCM) and am a Fellow of the College of Critical Care Medicine (FCCM).

I am a former Board member and President of the American Association for Respiratory Care (AARC). I chaired its Licensure Committee for several years and am a co-author of the AARC's Model Licensure Act. I have served as a consultant and special representative to the Council of State Governments and to CLEAR (Committee on Licensure, Enforcement And Regulation). I am a consultant to the National Institutes of Health (NIH), the US Public Health Service (USPHS), the Food and Drug Administration (FDA), the University of Costa Rica, and the Singapore General Hospital.

Respiratory Care is a young profession, barely 50 years old. It has evolved in that fifty years from a job dominated by the "oxygen orderly" who moved heavy oxygen cylinders from location to location in hospitals to highly skilled and knowledgeable medical professionals. Our duties have evolved from moving these oxygen cylinders to maintaining and operating sophisticated life-support devices, technologically complex and invasive monitoring systems, and computerized multi-system diagnostic devices. The Respiratory Therapist (Care Practitioner) has evolved into a well-trained specialist who often must act quickly and appropriately in an independent manner in the care of their patients.

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Decisions, which have the potential to cause great harm if incorrect, are common place in Respiratory Care. Their professional groups have offered the support of our Physician colleagues for licensure. In point of fact, nationally, the medical professional groups have been in the forefront of the development of protocols and patient driven care, which implement the therapist's independent judgement and decision making in patient care. Assess and treat orders are becoming increasingly more common.

Many of our physician colleagues in the state of Kansas have offered written and verbal support in past hearings and more have been submitted today. The Kansas Medical Society has issues no objections to this Bill, the Kansas Board of Nursing last year stated that they had "no problem with this bill". Representatives of our patients have testified before prior committees in support of passage of this measure (including Kansas's legislators with personal knowledge of the services we provide and the level of technology we use to provide our service). If those who deal with us daily as Medical Directors, patients' physicians, nursing colleagues, and patients believe that we need a higher level of regulation, should the current committee not agree?

We have been at this process for 11 years, we have undergone pre-screenings, screenings, pre-submission hearings at the Agency and Department level, we have passed the House, we have passed the Senate. With all of this view and review, all these hearings and re-hearings, submissions and re-submissions the bill retains its in its overall aim. "To provide the citizens of Kansas with assurances that the people diagnosing their sleep apnea, treating their asthmatic child, testing their elderly father with emphysema, controlling and maintaining their spouses life support ventilator are properly trained, educated and credentialed to do these things in a safe and efficacious manner."

Thirty-eight (38) other states plus Puerto Rico And Washington DC have licensed their RCPs, four (4) others including Kansas, Illinois, Indiana and Virginia certify them. (Please note that this data uses the CLEAR definitions of levels of regulation). Eight states (most of them with small populations) have passed no laws regulating Respiratory Care. These include Colorado, Wyoming, Alaska, Hawaii, Alabama, North Carolina, Vermont and Michigan. The majority of these laws have been passed in the last 12 years.

Respiratory Care Practitioners met the requirements for licensure:

- **Their activities have potential for harm to the public.**
- **Act independently with out direct or on site supervision.**
- **Perform life-sustaining activities**
- **Perform invasive procedures in the course of their duties**
- **Routinely administers potent prescription medications**
- **Have a distinct and specialized scope of practice**
- **Have a well defined and accredited educational system**
- **Have a well established and recognized voluntary testing and credentialing system**

The bill under consideration has the following characteristics:

- **It is non-exclusionary**
- **Builds on the current registration system**
- **It recognizes that overlaps occur in scopes of practices and provides accommodation for these areas of overlap**
- **It contains a grandfather clause.**
- **It is budget neutral**
- **It is written to recognize evolutionary changes in both the practice of and educational system for Respiratory Care**

In some sites of practice non-Respiratory Care personnel who are untrained to provide the therapy are currently practicing Respiratory Care. This is occurring due to budgetary constrains forced upon the sites by federal policy. Currently about 30% of RCPs are employed in those alternative sites where governmental or voluntary regulation or oversight does not apply.

The changes in the health care system predicate faster, more economical care in acute care hospitals, rapid treatment and discharge, to sub-acute care centers, skilled nursing care or to home care venues. This tendency to discharge "quicker and sicker" leads to more acutely ill and/or technologically dependent patients being transfer to these alternate sites of care often with out the appropriate staff to care for them. In addition to these patients the numbers of elderly entering long term and custodial care centers are increasing bringing with them the infirmities of aging; including both acute and chronic pulmonary and cardiac disease.

Ladies and gentlemen; the state has seen fit to license physicians, nurses, physicians assistants and paramedics and properly so. Respiratory Care Practitioners daily provide a level of service as critical and as complex as many performed by those groups. They do this professionally, independently acting by the prescription of the physician and with the sanction of our licensed colleague. It might be worth noting that, in addition to the groups mentioned previously, RCPs are the only other group to be routinely allowed to become Advanced Cardiac Life Support (ACLS) Providers and Instructors.

Mr. Chairman - Members of the Committee - I thank you for your time, attention and consideration to this matter. I trust you will vote to move this bill to the full house for immediate action with a positive "Pass" recommendation. I would be happy to address your questions or refer them to another member of our group.

**Paul Mathews PhD, RRT, FCCM**
Associate Professor
Respiratory Care Education
Physical Therapy Education

# KANSAS BOARD OF HEALING ARTS

**BILL GRAVES**
**Governor**

**235 S. Topeka Blvd.**
**Topeka, KS 66603-3068**
**(785) 296-7413**
**FAX # (785) 296-0852**
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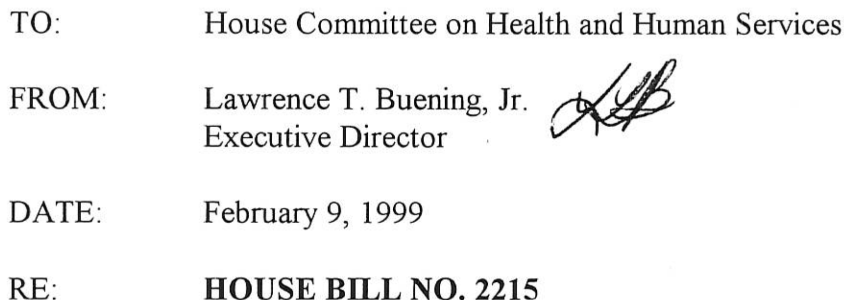
**MEMORANDUM**



TO: House Committee on Health and Human Services

FROM: Lawrence T. Buening, Jr.
Executive Director

DATE: February 9, 1999

RE: **HOUSE BILL NO. 2215**

Chairman Boston and members of the Committee, thank you for allowing me the opportunity to appear before you on behalf of the State Board of Healing Arts regarding House Bill No. 2215. The purpose of my appearance is to oppose favorable consideration of this bill.

House Bill No. 2215 is identical to 1997 Senate Bill No. 242 as it was amended by the Senate Committee on Public Health and Welfare and as it passed the Senate during the 1997 session. 1997 Senate Bill No. 242 was subsequently heard in this Committee and amended to also provide for the licensing of physical therapists. That bill, as amended by this Committee during the 1998 session, passed the House but died in conference committee. Both this bill and 1997 Senate Bill No. 242 are also similar to 1996 House Bill No. 2765 in that they provide for the licensing rather than registration of respiratory therapists. Therefore, the issue of licensing respiratory therapists is now before the Legislature for the fourth year in a row.

Since this is my first appearance before this Committee this session and there are several members who have not previously served on this Committee, I would like to provide a very brief description of the State Board of Healing Arts. The Board was created by the 1957 Legislature to regulate what became known as the three branches of the healing arts–medicine and surgery, osteopathic medicine and surgery, and chiropractic. Prior to that time, these three professions had

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EXECUTIVE DIRECTOR

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been regulated by three independent boards. Since 1957, the Board has been given eight additional professions to regulate. The individuals in these professions are podiatrists, physical therapists, physical therapist assistants, physicians' assistants, respiratory therapists, occupational therapists, occupational therapy assistants and athletic trainers. All told, the Board currently regulates almost 16,000 individuals in these 11 professions.

Since its creation in 1957, the State Board of Healing Arts has only licensed individuals who qualify to use the term "Doctor" in the health care setting. Members in each of the three branches of the healing arts have all earned the degree of doctor through their educational experiences. In 1975, by Executive Reorganization Order No. 8 issued by the Governor, the State Podiatry Board of Examiners was abolished and the powers, duties and functions transferred to the State Board of Healing Arts. Podiatric doctors, like M.D.s, D.O.s, and D.C.s, are also licensed by the Board. Each of these four licensed professions are able to independently examine, diagnose and treat patients without the intervention or supervision of any other health care professional. On the other hand, the other seven professions regulated by the Board, including respiratory therapists, are not licensed and cannot independently diagnose and treat individuals without authority from a licensee of the Board. This distinction has created a two-tiered credentialing system differentiating independent practice, i.e. licensure, from dependent practice, i.e. registration or certification.

Respiratory therapists are not the only professional group that would like to change their credentialing status from registration to licensure. H.B. No. 2235 was introduced this session and has been assigned to this committee. That bill provides for the licensure of physical therapists. Therefore, this issue may come before you again yet this session. The list of professionals seeking licensure does not stop with those currently registered. S.B. No. 144, if enacted, would add acupuncturists to the professional groups licensed by the Board. S.B. No. 144 is scheduled for hearing before the Senate Public Health and Welfare Committee on Thursday of this week. Therefore, the Board urges you to consider the ramifications of modifying the credentialing level of one profession without also determining the impact that would have on other health care professions.

Finally, the Board would also urge you to consider the provisions of the Kansas Act on Credentialing as set forth in K.S.A. 65-5001 et seq. K.S.A. 65-5007 specifies that credentialing regulation should be consistent with the policy that the least regulatory means of assuring the protection of the public should be preferred. Licensure is appropriate when statutory regulation, other than registration or licensure, or registration are not adequate to protect the public's health, safety and welfare and when the health care profession to be licensed perform function not ordinarily performed by persons in other occupations or professions. The Board's lack of support for H.B. No. 2215 is not intended to indicate that respiratory therapy is not a vital profession in the health care delivery system. The Board simply questions whether licensure is necessary to insure the public's protection.

Thank you for the opportunity to appear before you. I would be happy to respond to any questions you might have.

# KANSAS
## DEPARTMENT OF HEALTH & ENVIRONMENT
BILL GRAVES, GOVERNOR
Clyde D. Graeber, Acting Secretary

February 9, 1999

The Honorable Garry G. Boston, Chair
Committee on Health and Human Services
156-E
State House

Dear Chairperson Boston:

I am writing in regard to HB 2215, which would amend the practice qualifications for respiratory therapy. In order for the Committee to make an informed decision, some history may be helpful.

Several bills have come before the legislature over the years asking for the change in level of practice. The vehicle through which credentialing of health care personnel in Kansas can be objectively assessed is established by the Kansas Health Occupations Credentialing Act (K.S.A. 65-5001 et seq.). Under the jurisdiction of the Statewide Health Coordinating Council, an application for the credentialing of the practice of respiratory therapy in Kansas was first received January of 1983. Technical review was conducted under the authority of the Credentialing Act. During subsequent months, evidence was gathered through hearings and applicant-supplied materials and testimony in accordance with the criteria recognized at that time. The result of these deliberations was a recommendation for denial of credentialing by the technical committee based upon a lack of evidence to meet the criteria in place at that time. In 1985 the legislature passed a registration law.

Subsequently, respiratory therapists applied for a change in the level of credentialing (from registration to licensure) under the criteria of the Credentialing Act in 1993. Again the technical committee recommended that there was not sufficient evidence that the group met the criteria necessary to warrant licensure.

Passage of this bill would further reduce the effectiveness of the Kansas Health Occupations Credentialing Act as a mechanism through which the legislature is provided objective data upon which to make credentialing decisions. It is anticipated that any increase in costs which would arise from the inclusion of changes to the insurance industry or health care industry would be passed along either to the taxpayer or the consumer of health care or insurance benefits program. This is the kind of data which is considered in the credentialing review process.

The Credentialing Act has been the topic of much consideration by previous legislatures. This bill contains significant language pertaining to a health occupation, which is precisely why the Credentialing Act and its provisions are important tools for legislative decision-making. The applicant group desires to be able to "upgrade" its practice by amending several sections of Kansas law when this action had been determined six years ago, under a legislatively mandated process, to be unnecessary.

Certainly practice of health occupations change over time as has the health care delivery system as a whole. It may be more appropriate for expansion of the practice qualifications for respiratory therapists to be the result of the review contemplated by the Kansas Health Occupations Credentialing Act, addressing any criterion which was previously determined to be unmet.

Please let me know if you have any questions.

Sincerely,

Lesa Bray, Director
Health Occupations Credentialing

c: Acting Secretary Graeber, KDHE
Lorne Phillips, PhD, Acting Director of Health
Joseph F. Kroll, Director, Bureau of Health Facility Regulation

# KANSAS MEDICAL SOCIETY

February 9, 1999

To: House Health and Human Services committee

From: Meg Draper M. Draper
Director of Government Affairs

Subj: HB 2215: Respiratory Therapy

The Kansas Medical Society appreciates the opportunity to provide written comments today in support of HB 2215 relating to respiratory therapists. The bill would change the level of credentialing for RTs from registration to licensure.

Respiratory therapists play an important role in the healthcare system, working closely with physicians in a number of different settings including hospitals, clinics and nursing homes to provide respiratory care services. They perform complex tasks which, in many cases, are critical to the overall well-being of patients. Many physicians rely on RTs to provide appropriate and safe care to their patients in these settings. KMS believes that licensure of RTs would help to ensure that patients receive these services from individuals with the requisite education and training necessary to provide safe and effective care.

Respiratory therapists work under the supervision of physicians, and it is critical that this relationship be preserved if RTs become a licensed group. KMS is satisfied that the language of this bill preserves this physician-supervised relationship. The definition of "respiratory therapy" on page 11 of the bill plainly states that it is a profession whose members practice under the supervision of and with the prescription of a physician. The bill also includes on pages 12 and 13 a definition of "qualified medical director" and states that he or she is responsible for the quality of RT services, and for ensuring that RT care is ordered by a physician.

Thank you for considering our comments on this issue.

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# Memorandum

**Donald A. Wilson**
President

TO: House Health and Human Services Committee

FROM: Kansas Hospital Association; Tom Bell, Senior Vice President/Legal Counsel

RE: House Bill 2215

DATE: February 9, 1999

The Kansas Hospital Association appreciates the opportunity to comment regarding the provisions of House Bill 2215, which would grant licensure status to "respiratory care practitioners". This is not a new issue to come before state policymakers. In 1984 the Kansas Respiratory Care Society submitted an application to the Kansas Department of Health and Environment requesting they be licensed by the state. Subsequently, the 1985 Kansas Legislature passed a registration law. Then in 1993, the same group submitted an application to KDHE requesting licensure again. After consideration, the Secretary of that agency found that the current registration law is the appropriate level of credentialing and recommended that no legislative action be taken.

Before discussing the provisions of HB 2215, it is appropriate to review the statutory criteria that is to be applied when a particular health care provider group seeks credentialing by the state. Our statutes state that credentialing by the state is only appropriate when the following findings are made:

(1) 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 not remote;

(2) the practice of the occupation or profession requires an identifiable body of knowledge or proficiency in procedures, or both, acquired through a formal period of advanced study or training, and the public needs and will benefit by assurances of initial and continuing occupational or professional ability;

(3) if the practice of the occupation or profession is performed, for the most part, under the direction of other health care personnel or inpatient facilities providing

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health care services, such arrangement is not adequate to protect the public from persons performing noncredentialed functions and procedures;

(4) the public is not effectively protected from harm by certification of members of the occupation or profession or by means other than credentialing;

(5) the effect of credentialing of the occupation or profession on the cost of health care to the public is minimal;

(6) the effect of credentialing of the occupation or profession on the availability of health care personnel providing services provided by such occupation or profession is minimal;

(7) the scope of practice of the occupation or profession is identifiable;

(8) the effect of credentialing of the occupation or profession on the scope of practice of other health care personnel, whether or not credentialed under state law, is minimal; and

(9) nationally recognized standards of education or training exist for the practice of the occupation or profession and are identifiable.

Previously, KHA has presented testimony in opposition to respiratory therapy licensure legislation, focusing on the potential detrimental impact on cost and access, especially in the more rural areas of the state. Like it or not, there are simply not enough respiratory therapists to provide all the services that fall into the bill's definition of respiratory therapy. Legislators must continue to recognize this fact. We also pointed out that prior versions of this bill would have had a substantial impact on other health care personnel in the state. Previous proposals established a broad scope of practice for respiratory therapists, as does HB 2215, without providing much in the way of recognizing other providers' scope of practice.

While access and cost must remain important in the discussion of any licensure proposal, House Bill 2215 is more sensitive to these issues. Although Section (b) does establish a wide-ranging scope of practice for respiratory therapists, the current proposal goes much further in recognizing the fact that other providers may often perform tasks crossing over into the defined respiratory therapy area. Section 12 of House Bill 2215 contains numerous examples of other types of health care providers who may, under the proper circumstances, be allowed to perform certain overlapping functions. While it does not address all the statutory criteria for credentialing, the inclusion of Section 12 alleviates many of our concerns with respiratory therapy licensure proposals. Thank you for your consideration of our comments.

/pc

# The University of Kansas Medical Center

School of Allied Health
Department of Nurse Anesthesia Education

**February 9, 1999**

STATEMENT

RE: **Mandatory Licensure for Respiratory Care Practitioners in Kansas HB # 2215**

A statement concerning mandatory licensure for Respiratory Care practitioners in Kansas.

In the past ten years we have witnessed a technological revolution in Respiratory Care, with the development of both diagnostic and therapeutic instruments that have refined the clinical management of the critically ill to an unprecedented degree. Largely through microprocessor-controlled devices, ventilation and oxygenation can be measured and monitored with much greater accuracy and predictability. Our salvage rate of the critically ill is improved where these instruments of modern design are used. Consequently there are improved numbers of successful patient outcomes, a result that can be supported by annual public health statements.

Respiratory Care began as a recognized specialty when we realized that many patients who cannot breathe for prolonged periods could, with proper resuscitative efforts, be salvaged. The Respiratory Care Practitioner is now entrusted with the ventilation and the oxygenation of these patients, two of the most immediately critical of the vital functions. Many of these patients are gravely ill, with multiple organ system complications, and the allowable margin of error in clinical management often is small indeed.

Respiratory Care procedures are carried out according to physicians' orders and patient care protocols, and to the standards of care adopted by hospitals. These standards may require use of life support systems. The Respiratory Care practitioner is charged with the maintenance of mechanical ventilatory support, a situation where the patient is totally dependent during the period of respiratory failure. Setting up and operating a mechanical ventilator is a process familiar to few physicians and nurses; therefore, the specialized knowledge and skill of the Respiratory Care practitioner must be relied upon. The public cannot be adequately protected if unlicensed individuals are allowed to manage ventilator patients.

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Other hazardous tasks entrusted to the Respiratory Care Practitioner include the administration of oxygen to those who cannot survive without it, and administration of aerosolized drugs to patients with severe asthma. If these powerful drugs are given injudiciously great harm can come to the patient. Obviously physicians and nurses cannot monitor these activities closely, and the skill and judgement of the Respiratory Care practitioner must be relied upon. In addition, Respiratory Care practitioners obtain and analyze physiologic data, related blood sample procurement and perform pulmonary function testing which provide vital information for appropriate decision making regarding patient care.

It is conceivable that such grave responsibilities may be given to personnel who are not qualified to bear them. Unless mandatory licensure is established there is little or no assurance to the consumer that Respiratory Care personnel are capable of meeting current standards of care. Licensure should be established as soon as possible as the minimum standard for Respiratory Care practice in Kansas. No lesser qualification is acceptable for these individuals, upon whom the maintenance of vital functions in critically ill patients depends.

The burden of responsibility for instituting, operating and maintaining these valuable and vital devices in operation falls upon the Respiratory Care Practitioner. It is inconceivable that such responsibility should be given to personnel who are not properly qualified. Unless mandatory Licensure is established there is little or no assurance that personnel who are below a specified level of training and experience are capable of meeting accepted standards of care.

There is at present an Entry Level Examination of national scope and validity, sponsored by the National Board for Respiratory Care, Incorporated. The American Medical Association maintains this organized body under auspices and approval. Certification by this Board does not assure that the Care Practitioner can meet all standards of medical care, but it does confirm that the individual has completed Respiratory Therapy training in an AMA - accredited program, and demonstrates an acceptable level of competence. No lesser qualification should be required for these individuals, upon whom the maintenance of vital functions in critically ill patients depends. Let this credential be established as a <u>minimum</u> standard for Respiratory Care Practitioners licensure in Kansas.

Hugh S. Mathewson, MD
Professor, Respiratory Care Education
Professor Emeritus, Anesthesiology
University of Kansas Medical Center
Kansas City, KS 66160-7282

# The University of Kansas Medical Center

**School of Allied Health**
Murphy Administration Bldg. Rm. 1004
3901 Rainbow Boulevard
Kansas City, Kansas 66160-7600

**Ken Davis, Outreach Director**
Office: (913)588-5235
Fax: (913)588-5254

February 9, 1999

RE: **HB # 2215**
Respiratory Care Licensure Act

To: Members of the House Committee on Health and Human Services

Honorable Representatives:

I am writing in support of **House Bill # 2215**, which proposes that credentialing and regulation of Respiratory Care Practitioners (Respiratory Therapists) be increased from Certification to Licensure. The Kansas Respiratory Care Society (KRCS) has sponsored the development and introduction of this bill since it's initial introduction to the Department of Health and Human Services Credentialing Approval Screening Program in 1988. Through their efforts the KRCS has successfully met all criteria for licensure.

This bill passed both the House and Senate last year but was held up in the conference committee. The rationale for passage is stronger and more compelling today than it was last year. Changes in health care delivery systems continue unabated with related reductions in staff, even in the face of increasingly ill patient populations in hospitals. Admissions have increased and patients are more acutely ill in sub-acute and skilled nursing care centers.

Respiratory Care Practitioners (RCPs) are highly skilled and knowledgeable in the areas of critical care life support, pulmonary rehabilitation, sub-acute technology application and ventilator weaning, diagnostic testing and analysis of cardio-pulmonary disorders, sleep related disorders, hyperbaric medicine and emergency care of accident and trauma victims. The patients served by these medical professionals range in age from the pre-mature infants to the frail elderly. Medical conditions range from injuries due to gunshot wounds and automobile accidents, to the childhood asthma and chronic emphysema of older adults.

The care provided by RCPs in Kansas is both life saving and life supporting. It is care that is provided by persons with unique skill sets, based on a diverse and unique base of knowledge. In providing this care the RCPs work under a doctor's order or prescription, but not direct supervision. The RCPs perform invasive diagnostic and therapeutic procedures, administer potent drugs which affect the heart, lungs and central nervous systems. RCPs are experts in airway maintenance and control, cardiac resuscitation, mechanical ventilation and trauma support.

Respiratory Care Practitioners are involved in and act independently in emergent, acute and chronic situations, which demand rapid, exact and appropriate care. These life saving and supporting actions require knowledge, skill and ability to undertake complex diagnoses, reliable decision making and immediate clinical interventions.

Current changes in health care systems have moved the RCP into non-hospital environments, where practitioners are expected to exercise greater self-sufficiency and independent judgment. These locations include homes, sub-acute care centers, skilled nursing facilities. RCPs also practice in sites, such as ambulatory care clinics, sleep disorders clinics and hyperbaric facilities.

RCPs are required to manage high level technology, providing quality care to both critically ill patients and those with chronic pulmonary diseases. As the aging population increases in numbers, long-term chronic conditions are anticipated to increase at least in the foreseeable future.

I urge the committee act favorably regarding the passage of this bill. The people of Kansas deserve the protection of their health and safety, which this bill would provide.

Thank you for your attention to this important matter.

Sincerely,

Kenneth Davis, MPH, PT
Outreach Director
School of Allied Health

# The University of Kansas Medical Center

School of Medicine
Department of Anesthesiology

Anthony L. Kovac, M.D.
Professor

February 9, 1999

RE: **HB # 2215**
**Respiratory Care Licensure Act**

To: Members of the House Committee on Health and Human Services

Ladies and Gentlemen:
I am writing on behalf of and in support **of <u>House Bill # 2215</u>** which proposes that the current level of credentialing and regulation of Respiratory Care Practitioners (Respiratory Therapists) be increased from Certification to Licensure.

As you are aware this bill passed both the House and Senate last year but was held up in the conference committee. The rationale for passage is as strong if not stronger and more compelling today than it was last year. Changes in health care delivery systems continue unabated with concomitant reductions in staff even in the face of increasingly ill patient populations in hospitals, increased and more acutely ill admissions to sub-acute and skilled nursing care centers.

Respiratory Care Practitioners (RCPs) are highly skilled and knowledgeable in the areas of critical care life support, pulmonary rehabilitation, sub-acute technology application and weaning, diagnostic testing and analysis of cardio-pulmonary disorders, sleep related disorders, hyperbaric medicine and emergency care of accident and trauma victims. The patients served by these medical professionals range from the pre-mature infants to the very old elderly – from the shooting or automobile accident patient to the child with asthma and to the emphysematous 80+ year old senior citizen.

The care provided by RCPs in Kansas is both life saving and life supporting. It is care that is provided by persons with unique skill sets based on a diverse and unique base of knowledge. In providing this care the RCPs work under a doctor's order or prescription but not direct supervision. The RCPs perform invasive diagnostic and therapeutic procedures, administer potent drugs which affect the heart, lungs and central nervous systems. RCPs are experts in airway maintenance and control, cardiac resuscitation, mechanical ventilation and trauma support.

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The Respiratory Care Practitioners are expected to respond and act independently to emergent, acute and chronic situations demanding rapid, exact and appropriate care.

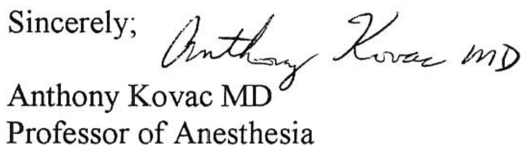
Increasing numbers of RCPs are employed in non-hospital environments where supervision and oversight are generally even more scarce and the need for independent judgements are more likely to be realized. These venues include homes, sub-acute care centers, Skilled Nursing Facilities. Also included in this list, as not wholly inclusive examples of 'alternative' sites of practice sites, are ambulatory care clinics, sleep disorders clinics and hyperbaric facilities.

In closing, it is important to remember that RCPs are closely involved in delivering sophisticated, technologically advanced and quality care to groups of patients who represent not only the most critically ill and fragile populations but also those with long lasting, progressive, and chronic diseases. The aging population suggests that these conditions will be sustained for at least the foreseeable future.

I urge the committee and the legislature as a whole to reaffirm their actions of the last session and pass this important bill. The people of Kansas deserve no less than the best – this can only be assured by hold the highest standards for those who serve the public.

Thank you for your attention to this important matter.

Sincerely;



Anthony Kovac MD
Professor of Anesthesia

*"Physicians in emergency medicine."*

EMERGENCY SERVICES PROFESSIONAL ASSOCIATION

February 8, 1999

Health & Human Services Committee
Representative Garry Boston, Chair
State Capitol Room 156 E
Topeka, Kansas 66612

Dear Mr. Boston,

The physicians of Emergency Services P.A. recognize the importance of and strongly support licensure for Respiratory Care Practitioners in Kansas.

Respiratory Care Practitioners are important members of our Emergency Department. RCPs have specialized knowledge and are trained in the application of complex life support equipment. RCP's provide rapid response to our patients when in respiratory crisis. They are trained in up-to-date therapies which include meter dose inhaler therapy, nebulizer treatments with appropriate drugs and doses, as well as heliox treatments. They are cruicial members of our trauma team and critical care code team. They are ventilator proficient and provide therapy across a broad patient spectrum from infants to adults.

We support the upgrading of RCPs from registration to licensure, to assure the practice of respiratory care will be performed by adequately trained professionals.

Sincerely,

Francie H. Ekengren, M.D.
Medical Director,
Wesley Emergency Dept.

Randy Davidson, M.D.
President, ESPA
Wesley Emergency Dept.

Kathy Forred, M.D.
Wesley Emergency Dept.

Mark Mosley, M.D.
Wesley Emergency Dept.

Paul Sovell, M.D.
Wesley Emergency Dept.

Rodney M. Staats, M.D.
Wesley Emergency Dept.

550 North Hillside • Wichita, Kansas 67214 • (316) 688-2239

HHS
2-9-99
Atch# 13

DATE: February 5, 1999

TO: Committee Members

FROM: Pat Munzer, MS, RRT (PM)
Program Director/Associate Professor
Washburn University

RE: **HB 2215**

The Commission on Accreditation of Allied Health Education Programs (CAAHEP) accredits programs in respiratory care education, upon the recommendation of the Committee on Accreditation for Respiratory Care (CoARC).

The American Association for Respiratory Care (AARC), the American College of Chest Physician (ACCP), The American Society of Anesthesiologists (ASA), and the American Thoracic Society (ATS) wish to establish, maintain and promote appropriate measures of quality for educational programs in Respiratory Care and to provide recognitions for educational programs that meet the minimum criteria of quality outlined in the Accreditation standards.

Accreditation Standards are the minimum measures of quality to be used in accrediting programs that prepare individuals to enter the Respiratory Care profession. There are 480 respiratory care programs that are accredited. Of those only 60 are non-degree programs. The average training is 16 months. These 60 programs must convert to degree granting by January 1, 2002 or they will no longer be able to train respiratory therapist. (See attached position statement)

Education is the key to obtaining the knowledge, theory skills, and competencies in respiratory care. In order to develop this knowledge, theory and skills students in Washburn University's program must complete:

1. 77 credit hours of didactic course work.
2. approximately 150 hours of scheduled laboratory course work, plus countless hours of laboratory practice on their own.
3. over 1200 hours of clinical training in hospitals and home care settings.
4. the type of curriculum that is taught at Washburn is listed under "curriculum" at the end of this testimony.

Respiratory Therapist can either complete an associate or baccalaureate degree. The respiratory therapist applies scientific knowledge and theory to practical clinical problems of respiratory care. Knowledge and skill for performing these functions are achieved through formal programs of didactic, laboratory, and clinical preparation. The respiratory therapist is qualified to assume primary responsibility for all respiratory care modalities. Under the supervision of a physician the respiratory therapist is able to exercise considerable independent, clinical judgement in the respiratory care of patients.

HHS
2-9-99
Atch #14

Curriculum

As outlined by CoARC instruction should be based on a structured curriculum which clearly delineates the competencies to be developed and the methods whereby they are achieved.

The following units, modules, and/or courses of instruction are included in the program:

1. General Education Competencies

   a. Mathematics
   b. Written and oral communication
   c. Social/behavioral sciences
   d. Computer science

2. Basic Sciences Related to Respiratory Care

   Human anatomy and physiology
   Cardiopulmonary anatomy and physiology
   Chemistry
   Physics
   Microbiology
   Pharmacology

3. Specific Respiratory Care Content Areas

   Assessment of patients' cardiopulmonary status
   Medical gas therapy
   Aerosol and humidity therapy
   Airway management
   Lung inflation (pulmonary volume and expansion) therapy
   Bronchial hygiene therapy
   Infection control
   Cardiopulmonary assessment, monitoring and interpretation
      Pulmonary function testing
      Arterial blood gases
      Hemodynamics
      Electrocardiography
      Noninvasive cardiopulmonary diagnostics
      Exercise testing
      Sleep studies
   Cardiopulmonary rehabilitation
   Cardiopulmonary resuscitation
      Basic life support
      Advanced life support
   Use of clinical practice guidelines to assure appropriate rc
   Principles of case management
   Alternate site care, as deemed appropriate by the program's communities of interest
   Health promotion and disease
   Geriatrics
   Medical record keeping, reimbursement
   Respiratory therapy as a profession
      Medical ethics
      Licensure and credentialing
      Membership in professional associations

Professional behavior
Cultural awareness/diversity
Mechanical ventilation management
Pediatrics and perinatology

Thank you for allowing me to provide this written comment regarding education for respiratory therapist. I would like to leave you with this thought: **"any profession that is life supporting can be life threatening in the wrong hands"**.

**POSITION STATEMENT ON**
**EDUCATIONAL PREPARATION FOR ENTRY INTO PRACTICE AS A RESPIRATORY CARE PRACTITIONER**

The American Association for Respiratory Care (AARC), the National Board for Respiratory Care (NBRC), and the Joint Review Committee for Respiratory Therapy Education (JRCRTE) share the goal of insuring that the respiratory care practitioner (RCP) entering the work force is fully qualified to meet the demands of employers and patients, regardless of the setting for the delivery of health care.

With the growth of managed care and increasingly aggressive efforts to curb health care costs, the scope of practice for RCPs has broadened and the need for practitioners to serve as members of multidisciplinary teams has accelerated. Both the PEW Health Professions Commission and the National Commission on Allied Health have identified expanded roles for allied health workers. For these reasons, we anticipate that the need for individuals with multiple skills will increase. RCPs will need to understand the systems approach to the organization and delivery of health care and be able to work collaboratively with other health care practitioners. Critical thinking and problem solving skills are mandatory for survival in this environment. Strong verbal and written communication skills are necessary when interacting with other members of the multidisciplinary health care team as well as with patients and their families. Such an expanded role will also require a broad educational background in English composition, communications, and interpersonal relations. Computer literacy will be especially important in this changing health care environment.

Job analysis research by the NBRC reveals that employers now expect higher skill levels from entry level practitioners. Additionally, the NBRC has noted diverging success rates on the entry level examination that directly correlates with the Respiratory Care educational level of the candidate. A technologically qualified practitioner who lacks the skills afforded by a broad education, is disadvantaged by the demands of our evolving health care system.

The AARC and JRCRTE recently agreed to the formation of a new accrediting agency for Respiratory Care education programs which is scheduled to begin its activities on January 1, 1998. This agency (Committee on Accreditation for Respiratory Care or CoARC) will propose to its sponsors that new *Essentials* (Standards) include a minimum of an associate degree in Respiratory Care at the entry level. The NBRC fully supports both the new accrediting agency and the proposed increased entry level requirement. Therefore, the AARC, JRCRTE, and the NBRC support the minimum educational requirement for entry into the practice of Respiratory Care to become the completion of an accredited Respiratory Care program granting an associate degree or higher.

It is obvious that such a significant change in the *Essentials* will require extensive dialogue. To facilitate a consensus, information will be provided to, and input solicited from, all communities of interest including employers, educators, students, educational institutions, and physician sponsoring organizations, during a formal discussion period. Once agreement is reached, the four sponsoring organizations of the new CoARC, as well as the CAAHEP, will need to approve any new changes. Assistance and guidance will be available to program personnel using various formats such as workshops, newsletters, and seminars. The AARC, JRCRTE, and NBRC look forward to your participation in this challenging and exciting process.

Revised 3-12-97

550 North Hillside
Wichita, Kansas 67214-4976
Telephone 316/688-2468

February 4, 1999

Representative Garry Boston, Chairman
Health and Human Services Committee
State Capitol Room 156E
Topeka, KS 66612

Dear Mr. Boston:

As a Pediatric Critical Care specialist and Pediatrician, I have been placed in a position to deal with respiratory disease in childhood on a daily basis over the past 15 years. This has also granted me the opportunity to see the evolution and explosion of knowledge and expertise of Respiratory Care Practitioners. In the setting of a critically ill child, the Respiratory Care Practitioners are an integral part of the team and are responsible for the provision of global care involving the respiratory tract. In many cases, RCP's have knowledge of technology and pharmacology which exceeds that of physicians. I am writing to you to support the development of licensure of Respiratory Care Practitioners in our state. It is an issue of patient safety that members of the care team with such an important responsibility have accomplished those steps which allow them to be identified by licensure.

It is somewhat astounding to think that individuals who place tattoos are licensed, but the person I see at the head of the bed managing a patient's airway during the most critical moment of their life does not require the same level of licensure. I wish you and your Committee the best of luck as you evaluate this process and reach agreement regarding what is appropriate.

Respectfully,

Curtis B. Pickert, M.D.
Pediatric Critical Care
Medical Director, Pediatric ICU/Pediatrics
Wesley Medical Center
Associate Professor, Dept. of Pediatrics
University of Kansas School of Medicine-Wichita

CBP:sp

HHS
2-9-99
Atch# 15

January 29, 1999

Health & Human Service Committee
Representative Garry Boston, Chair
State Capitol Room 156E
Topeka, Kansas 66617

Dear Representative Boston,

I am responsible for seeing that my wife gets daily respiratory care as part of her Home Health program.

This care is managed and paid for by me personally. It is vital that I only retain fully qualified respiratory therapists.

I strongly support an upgrade of the credentialing status of respiratory therapists from registration (title protection) to licensure.

Sincerely,

Justus H. Fugate, Jr. MA
7622 Dublin
Wichita, KS 67206-1605
Bus 316-634-0415
Fax 316-634-1201
Res 316-634-0366

HHS
2-9-99
Atch #16

ASSOCIATES IN
NEONATOLOGY, P.A.

an affiliate of
PEDIATRIX
MEDICAL GROUP OF KANSAS, P.A.

February 3, 1999

Health & Human Services Committee
The Honorable Garry Boston, Chair
State Capitol, Room 156 E
Topeka, KS 66612

Dear Mr. Boston:

The physicians signed below provide neonatal care at Wesley Medical Center. We recognize the importance of and strongly support licensure for Respiratory Care Practitioners in Kansas.

Respiratory Care Practitioners are important members of our NICU team. RCPs have specialized knowledge and are trained in the application of complex life support equipment. RCPs utilize not only conventional methods of mechanical ventilation to support our critically ill babies but also are involved in the application of high frequency ventilation and surfactant therapy. RCPs worked with us in conducting the research necessary to obtain FDA approval for both of these treatments. As valued membersof our LifeWATCH Perinatal Transport Team, RCPs have additional training in advanced life support, special procedures and evaluation and communication of patient needs.

We support the upgrading of RCPs from registration to licensure, to assure the practice of respiratory care will be performed by adequately trained professionals.

Sincerely,

Barry T. Bloom, M.D.
Neonatal-Perinatal Medicine

Yeai Roan, M.D.
Neonatal-Perinatal Medicine

Wm. Randy Reed, M.D.
Neonatal-Perinatal Medicine

Carolyn Johnson, M.D.
Neonatal-Perinatal Medicine

Curtis Dorn, M.D.
Neonatal-Perinatal Medicine

Susan Laudert, M.D. /gm
Neonatal-Perinatal Medicine

Michael J. Lang, M.D.
Neonatal-Perinatal Medicine

BTB:gm

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HHS
2-9-99
Attch #17