Approved: 3-31-99
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chairperson Sandy Praeger at 10:00 a.m. on March 16, 1999 in Room 526-S of the Capitol.

All members were present except:

Committee staff present: Emalene Correll, Legislative Research Department
Norman Furse, Revisor of Statutes
JoAnn Bunten, Committee Secretary

Conferees appearing before the committee:
Russ Babb, Dir. of Respiratory Care, Salina Regional Health Center
Don Richards, Topeka
Hugh Mathewson, M.D., KUMC
Paul Mathews, Ph.D., KUMC
Mark Aberle, Wichita
Lawrence Buening, Executive Director, Kansas Board of Healing Arts

Others attending: See attached list

Hearing on: HB 2215 - Respiratory therapist licensure

Russ Babb, Salina Regional Health Center, testified before the Committee in support of **HB 2215**, which, if passed, would require the licensing of respiratory therapists by the Kansas Board of Healing Arts. The bill provides that the board may waive the examination and education requirements and issue a license to individuals who have not taken and passed a licensure examination administered by the board under certain conditions. These individuals must have been registered by the board as respiratory therapists since the inception of the initial registration act in 1987. Persons registered by February 29, 2000, would be considered licensed without having to apply for licensure. Mr. Babb noted that they are seeking this change from credentialing to licensure because they 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 should possess the knowledge and expertise to assure the effective outcomes of these interventions as noted in his written testimony. (Attachment 1)

Speaking in support of the bill and submitting written testimony were the following conferees: Don Richards, Registered Respiratory Therapist, Topeka, who noted that it is up to the state to ensure its citizens are protected, and if a profession seeks to upgrade its professional standards, one should not automatically assume it is for economic gain, (Attachment 2); Hugh S. Mathewson, M.D., Respiratory Care Education, KUMC, noted that respiratory care procedures are carried out according to physicians' orders and patient care protocols, and to the standards of care adopted by hospitals; no lesser qualifications should be required for these individuals upon whom the maintenance of vital functions in critically ill patients depends, (Attachment 3); Paul Mathews, Respiratory Care Practitioner, noted that managed care has shifted many technologically dependent patients from acute care hospitals to sub-acute or long-term care institutions; and that medical supervision and direction are several steps away from these centers, and even further from skilled nursing facilities and from patients' homes, (Attachment 4); Mark Aberle, M&E Medical Marketing and President-elect Kansas Respiratory Care Society, noted that 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, (Attachment 5).

Speaking in opposition to **HB 2215** was Lawrence Buening, Executive Director, Kansas Board of Healing Arts, who pointed out that since its creation in 1957, the Board of Healing Arts has only licensed individuals who qualify to use the term "doctor" in the health care setting. M.D.s, D.O.s, D.C.s and Podiatric doctors are able to independently examine, diagnose and treat patients without the intervention or supervision of any other health care professional. The seven professionals 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. Mr. Buening felt this distinction has created a two-tiered credentialing system differentiating independent practice, i.e. licensure, from dependent practice, registration or certification. He also noted several changes in the bill, one of which states that the Board shall "provide for and conduct all examinations." Mr. Buening pointed out that the Board does not administer this examination, nor does the bill specify the place where the examination is to be given. Finally, the Board is uncertain why the language in K.S.A. 65-5508(c) has been deleted as it relates to the authority that is given by the issuance of a special permit. (Attachment 6) After Committee discussion on the bill, the Chair requested staff to review the bill and address concerns that had been expressed before the bill would be considered by the Committee.

Written testimony in support of the bill was received from Ofelia Santiago, Care IV, Inc., (Attachment 7); Anthony Kovac, Professor of Anesthesia, KUMC, (Attachment 8); Curtis Picker, M.D., Wesley Medical Center, (Attachment 9); Emergency Services Professional Association, (Attachment 10); and Associates in Neonatology, (Attachment 11).

Adjournment

The meeting was adjourned at 11:00 a.m.

The next meeting is scheduled for March 17, 1999.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 3-16-99

NAME	REPRESENTING
Don [illegible]	Kans Respiratory Care Society (KRCS)
Paul Mathews	NUMC / Kansas Respi Care Society
Hugh S. Mathewson MD	KUMC - Resp. Care Education
[illegible]	Washburn University - Resp. Care Education
Meg Trumpp	Newman University Resp Care Ed.
Debbie Fox	Ks Respiratory Care Society
Terri [illegible]	Ks Respiratory Care Society
Ed Anderson	KS. Respiratory Care Society
Russ [illegible]	KRCS Salina KS
LARRY BUENING	BD OF HEALING ARTS
JERRY SLAUGHTER	KMS
Eva Curtis	Board of Nursing
Doug Smith	KAPA

March 16, 1999
Testimony on HB 2215
Senate Public Health and Welfare Committee

Madam chairperson
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 in our level of credentials 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.

Senate Public Health & Welfare
Date: 3-16-99
Attachment No. 1

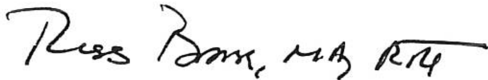
We are concerned that in the changing world of health care, the now common practice of the early release of patients from hospitals, allows a very vulnerable portion of our society to be placed in danger under the present "title protection" registration system.

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

ASA 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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1-4

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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.

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Follow the Leader into the Future

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.

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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 PUBLIC HEALTH AND WELFARE COMMITTEE
MARCH 16 , 1999

Madam Chair,
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 the 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 (35) 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.

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

The University of Kansas Medical Center

School of Allied Health
Department of Nurse Anesthesia Education

STATEMENT

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

MARCH 9, 1999

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 <u>ventilation</u> and the <u>oxygenation</u> 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 <u>few</u> 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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Senate Public Health & Welfare
Date: 3-16-99
Attachment No. 3

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.

Movement of significant numbers of patients from hospitals to less or differently structured institutions has been accompanied by movement of respiratory care practitioners and other health care workers into these same areas. Overall intensity of supervision and control is reduced in these sites. This requires that caregivers act independently and exercise clinical judgement with out specific direction. Limitations on who can make these decisions are not currently clear.

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 minimum standard for Respiratory Care Practitioners licensure in Kansas.

Hugh S. Mathewson, MD

Hugh S. Mathewson, MD
Professor, Respiratory Care Education
Professor Emeritus, Anesthesiology
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Paul J. Mathews, Ph.D, RRT, FCMM 4005 Delp
Judith A. Mathewson, MS, RRT 4001 Delp

Respiratory Care Licensure Bill
HB #2215

MARCH 16, 1999

Madam Chairlady; Ladies and Gentlemen of the Committee:

My name is Dr. 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) the national professional organization for respiratory care practitioners. 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

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Senate Public Health & Welfare
Date: 3-16-99
Attachment No. 4

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.

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.

Managed care has shifted many technologically dependent patients from acute care hospitals to sub-acute or long-term care institutions. These more seriously ill patients put a strain on institutions and staffs unaccustomed to the level and complexity of care needed by these individuals. In addition, current laws and regulations, formulated and enacted before the advent of sub-acute care centers, technology dependent non-hospitalized patients and managed care don't address the level and depth of training or qualifications of care givers in these areas. It is an undisputed fact that medical supervision and direction are several steps away from these centers, and even further from skilled nursing facilities and from patient's homes.

Caregivers in general and Respiratory Care Practitioners in particular make independent judgements and from these make decisions, albeit, under protocols, which affect the implementation and management of life support devices. To do this under the controls available in most hospitals is one thing to do this in the relatively under-controlled settings identified above is another situation entirely.

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

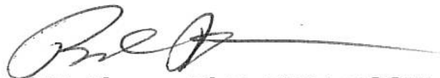
In some sites of practice non-Respiratory Care personnel who are untrained to provide the therapy are currently practicing Respiratory Care. This is occurring secondary to budgetary constrains forced upon the sites by federal policy. Currently about 30% of RCPs are employed in those alternative sites 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.

Madam Chairlady - Members of the Committee –
I would remind the Committee that this Bill – HB 2215 – Is essentially identical to the Respiratory Therapy Licensure Bill that not only passed this committee unanimously but also passed the full Senate without any opposition and was resoundingly passed by the House last year. The House this year passed the current bill by a vote of 116 to 19 after a unanimous vote in favor of passage by the House Health and Human Services 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 Senate 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

M&E MEDICAL MARKETING
INCORPORATED

March 16, 1999

TO: PUBLIC HEALTH & WELFARE
KANSAS SENATE

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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Attachment No. 5

12160 Fox Woods Dr. • DeSoto, Missouri 63020 • 1.800.394.7074 • Fax 314.586.38

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.

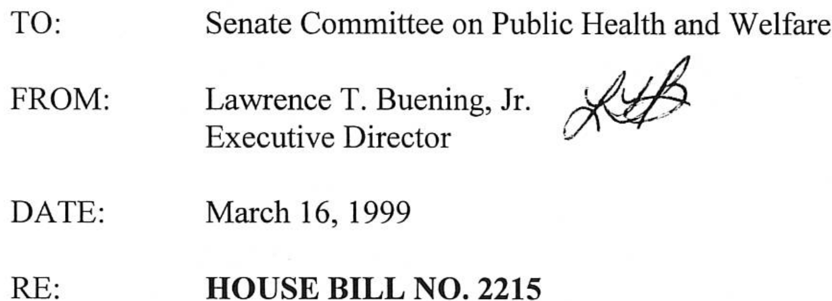
The scope of respiratory care services, and the responsibilities of respiratory care practitioners, has developed significantly beyond what it was a few years ago. It has also expanded well outside the supervised hospital setting. The RCP is frequently the ONLY health care professional seeing the patient 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.

KANSAS BOARD OF HEALING ARTS

BILL GRAVES
Governor

235 S. Topeka Blvd.
Topeka, KS 66603-3068
(785) 296-7413
FAX # (785) 296-0852
(785) 368-7102

MEMORANDUM



TO: Senate Committee on Public Health and Welfare

FROM: Lawrence T. Buening, Jr.
Executive Director

DATE: March 16, 1999

RE: **HOUSE BILL NO. 2215**

Madam Chair 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. That bill, as amended by this Committee during the 1998 session, passed both the Senate and 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 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

LAWRENCE T. BUENING, JR.
EXECUTIVE DIRECTOR

MEMBERS OF THE BOARD
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JOHN P. GRAVINO, D.O., LAWRENCE
JANA D. JONES, M.D., LANSING
LANCE MALMSTROM, D.C., TOPEKA

LAUREL H. RICKARD, MEDICINE LODGE
CHRISTOPHER P. RODGERS, M.D., HUTCHINSON
HAROLD J. SAUDER, D.P.M., INDEPENDENCE
EMILY TAYLOR, LAWRENCE

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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. A hearing on S.B. No. 144 was previously held in this Committee. That bill would add acupuncturists to the professional groups licensed by the Board. H.B. No. 2235 was heard in the House Committee on Health and Human Services on February 16 and provides for the licensure of physical therapists. During the hearing conducted on H.B. No. 2235, the occupational therapists requested that the bill be amended to also provide for the licensure of that profession. The Board would 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 is not adequate to protect the public's health, safety and welfare and when the health care profession to be licensed performs functions 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.

If the Committee is supportive of the licensure of respiratory therapists, the Board would like to point out several changes the bill makes. Section 9 increases the size of the respiratory care council by adding two public members. In Section 10, at lines 5 and 6, the bill states that the Board shall "provide for and conduct all examinations". The Board has approved the entrance level examination administered by the National Board of Respiratory Care as the examination needed to be passed in order to be credentialed in Kansas. The Board does not administer or conduct this examination. Similarly, in Section 12, at lines 10 through 15 on page 15, the language provides that the applicants shall be examined "at a time and place and under such supervision as the board may determine". This subsection also states that the examinations are to be given at such places as the board may determine. Again, since the Board does not administer the examination, it does specify the place where the examination is to be given. Finally, the Board is uncertain why the language in K.S.A. 65-5508(c) has been deleted as it relates to the authority that is given by the issuance of a special permit.

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

care IV

March 10, 1999

The Honorable Sandy Praeger
Chair, Senate Public Health & Welfare Committee
Kansas Senate
Room 128-S, State Capitol
Topeka, Kansas 66612

I am writing this letter in support of House Bill 2215, the licensure of Respiratory Therapists. This issue is important to me as a consumer and a provider of health care services.
As a consumer, I want only qualified staff involved with the care of family and myself. The passage of this bill would help to meet this standard.

As a provider of health care services in the home, I am being asked to provide complex care for individuals in the home setting and to stay within reimbursement limits. One way providers can decrease the cost of complex healthcare is to have the most appropriate, qualified person to teach and deliver home care services. The passing of this bill would give the public and providers another avenue to provide quality, cost effective care.

Please feel free to call and visit with staff, clients or myself to discuss this issue.

Thank you,

Ofelia Santiago CRNI, CCM
Director of Clinical Service
Care IV Inc.

625 N. Carriage Parkway
Suite 170
Wichita, Kansas 67208
(316) 686-9555 • Fax (316) 686-9752
1-888-686-9555 • Fax 1-888-686-9762
www.care4.com

Senate Public Health and Welfare
Date: 3-16-99
Attachment No. 7

The University of Kansas Medical Center

School of Medicine
Department of Anesthesiology

Anthony L. Kovac, M.D.
Professor

February 15, 1999

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

To: Members of the Senate 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.

3901 Rainbow Boulevard, Kansas City, Kansas 66160-7415 •

Senate Public Health and Welfare
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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.

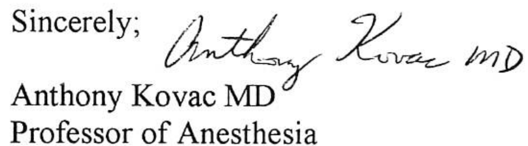
Increasing numbers of RCPs are employed in non-hospital environments where supervision and oversight are generally even more scarce and the need for independent judgements are more likely to be realized. These venues include homes, sub-acute care centers, Skilled Nursing Facilities. Also included in 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

WESLEY
Medical Center

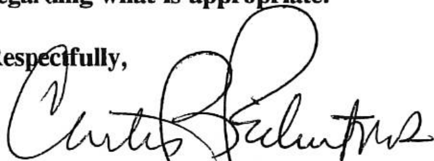
March 10, 1999

Senator Sandy Praeger, Chair
Senate Public Health & Welfare Committee
State Capitol, Room 128 S
Topeka, KS 66612

Dear Senator Praeger:

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

550 North Hillside
Wichita, Kansas 67214-4976
Telephone 316/688-2468
FAX 316/688-7093

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Senate Public Health and Welfare
Date: 3-16-99
Attachment No. 9

"Physicians in emergency medicine."

EMERGENCY SERVICES PROFESSIONAL ASSOCIATION

March 9, 1999

Senator Sandy Praeger, Chair
Senate Public Health & Welfare Committee
State Capitol, Room 128 S
Topeka, Kansas 66612

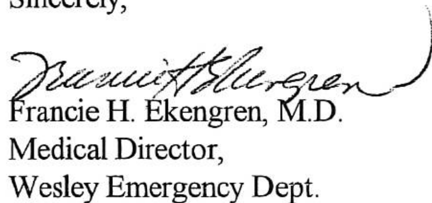
Dear Senator Praeger,

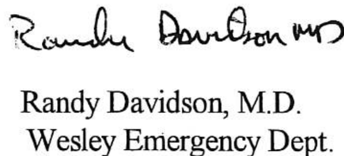
The physicians of Emergency Services P.A. recognize the importance of and strongly support licensure for Respiratory Care Practitioners in Kansas.

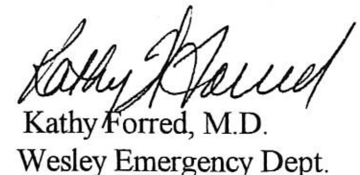
Respiratory Care Practitioners are important members of our Emergency Department. RCPs have specialized knowledge and are trained in the application of complex life support equipment. RCP's provide rapid response to our patients when in respiratory crisis. They are trained in up-to-date therapies which 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.

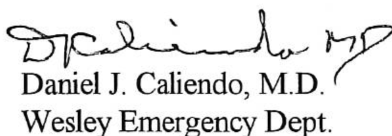
We support the upgrading of RCPs from registration to licensure, to assure the practice of respiratory care will be performed by adequately trained professionals.

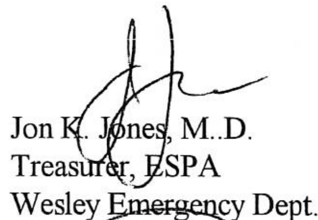
Sincerely,

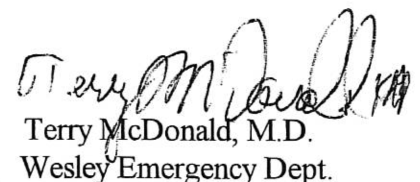

Francie H. Ekengren, M.D.
Medical Director,
Wesley Emergency Dept.

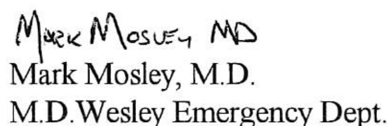

Randy Davidson, M.D.
Wesley Emergency Dept.

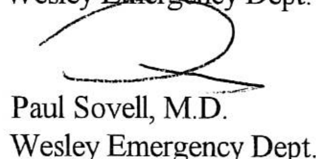

Kathy Forred, M.D.
Wesley Emergency Dept.

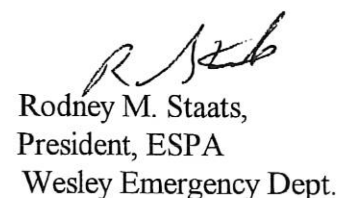

Daniel J. Caliendo, M.D.
Wesley Emergency Dept.


Jon K. Jones, M..D.
Treasurer, ESPA
Wesley Emergency Dept.


Terry McDonald, M.D.
Wesley Emergency Dept.


Mark Mosley, M.D.
M.D.Wesley Emergency Dept.


Paul Sovell, M.D.
Wesley Emergency Dept.


Rodney M. Staats,
President, ESPA
Wesley Emergency Dept.

550 North Hillside • Wichita, Kansas 67214 • (316

Senate Public Health and Welfare
Date: 3-16-99
Attachment No. 10

ASSOCIATES IN
NEONATOLOGY, P.A.

an affiliate of

MEDICAL GROUP OF KANSAS, P.A.

March 11, 1999

Senator Sandy Praeger, Chair
Senate Public Health & Welfare Committee
State Capitol, Room 128 S
Topeka, Ks 66612

Dear Senator Praeger:

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 members of 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.
Neonatal-Perinatal Medicine

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

BTB:gm

Wesley Medical Center • 550 N. Hillside • Wichita, Kansas 672
(316) 651-8580 • (800) 723-6076 • Fax (316) 651-8581 • Transport (800) 362-3292 • Corporat

Senate Public Health and Welfare
Date: 3-16-99
Attachment No. 11