Report of Final Findings and Recommendations

By The

Technical Committee for the Review of the

Application for Credentialing by the

Nebraska Society for Respiratory Therapy

To The

Director of Health and the Nebraska Legislature

December 10, 1985

The members appointed by Gregg F. Wright, M.D., M.Ed., Director of Health, to serve on the Respiratory Care Credentialing Review Technical Committee are as follows:

Arlene Rhodes - Chair, Board of Health member

Louis W. Burgher, M.D. - Medical Director of Respiratory Therapy, Clarkson Hospital (Omaha)

Irv. L. Deshayes - Clinical Audiologist, Assistant Professor of Audiology, University of Nebraska-Lincoln (Lincoln)

Mike Lafayette, R.N. - Nursing Instructor, University of Nebraska Medical Center (Lincoln)

Ed Miller - consumer (Omaha)

Shirley Paine, P.A.C., M.H.S. - Assistant Professor, Division of Physician Assistant Education, School of Allied Health Professions, University of Nebraska Medical College (Omaha)

Robert Kim Woodward, R.R.T. - Supervisor, Department of Respiratory Therapy, Lincoln General Hospital (Lincoln)

Summary of Committee Recommendations

The committee decided to recommend licensure as the most appropriate level of regulation for Respiratory Therapists with the provision that health professionals for which respiratory care is included in their scope of practice be excluded from the Act. The committee also made recommendations on various provisions of LB 277. The committee recommended that the board be given authority to make the differentiation between new graduates and current practitioners in determining the length of time a person could practice on a temporary license. The committee also recommended that LB 277 specify the number of hours of continuing education required. The committee recommended that the applicants work with the Department of Health to establish the specific number of continuing education hours required. Furthermore, the committee recommended that the applicants work with the Department of Health to clarify some of the technical language of LB 277.

The committee also recommended that a definition of a qualified medical director for respiratory care be attached to the report as appendix one.

Introduction

The Nebraska Credentialing Review Program, established by the Nebraska Regulation of Health Professions Act (LB 407), is a review process advisory to the Legislature which is designed to assess the necessity of state regulation of health professions in order to protect the public health, safety, and welfare.

The law directs those health occupations seeking credentialing or a change in scope of practice to submit an application for review to the Director of Health. At that time, an appropriate technical committee is formed to review the application and make recommendations after a public hearing is held. The recommendations are to be made on whether the health occupation should be credentialed according to the three criteria contained within Section 21 of LB 407; and if credentialing is necessary, at what level. The relevant materials and recommendations adopted by the technical committee are then sent to the Board of Health (after 1985) and the Director of Health for their review and recommendations. All recommendations are then forwarded to the Legislature.

In order to accommodate the health occupations that submitted credentialing legislation in the 1985 session, priority has been given to them so that they may complete the review process before the 1986 legislative session. This accommodation has resulted in a shortened review process in which the technical committee recommendations are sent directly to the Director of Health, bypassing the Board of Health for 1985.

Summary of the Proposal

The Nebraska Society for Respiratory Therapy seeks certification for registered respiratory therapists and respiratory therapy technicians by the State of Nebraska. The proposal would prohibit untrained personnel from calling themselves a certified respiratory care practitioner and practicing, as such, within the state. According to the proposal, the practice of respiratory care would be performed only under direction of a medical director and upon the written or verbal order of a licensed physician. The practice of respiratory care would not be limited to a hospital setting.

The proposal would establish minimum qualifications that respiratory care practitioners would have to meet before state certification could occur. Upon application to become a certified respiratory care practitioner, a person should provide proof that he or she has completed an approved four year high school course of study or an equivalent; and has completed a respiratory care educational program accredited by the American Medical Association's Committee on Allied Health in collaboration with the Joint Review Committee for Respiratory Therapy Education. A person who meets the minimum qualifications listed above, pays an examination fee, and successfully completes the examination for certification should be certified as a respiratory care practitioner.

The proposal provides for immediately certifying current practitioners who have passed the Certified Respiratory Therapy Technician or Registered Respiratory Therapy examination administered by the National Board for Respiratory Care or an appropriate accrediting agency before or on the effective date of the proposal. Those practitioners who have not passed either of the above stated examinations, or met the minimum qualifications

for certification; would be issued a temporary permit to practice respiratory care for a period of twenty-four months from the effective date of the proposal. In that time period, the practitioner would have to pass the examination for certification in order to continue to practice respiratory care. The proposal calls for reciprocity with other jurisdictions that license or certify respiratory care practitioners if the qualifications of the applicant are substantially equivalent to those in the proposal.

The proposal would create the State Board for Respiratory Care consisting of seven members appointed by the Governor. Three would be licensed physicians and members of the American College of Chest Physicians, the American Society of Anesthesiologists, or the American Thoracic Society; three members would be certified respiratory care practitioners who are members of the American Association of Respiratory Therapy; and one member would be representative of the general public. Terms of board members would be four years, with no members being appointed for more than three consecutive terms. The Director of Health would be an ex-officio member without voting power. The board would be empowered to administer the proposal and promulgate the necessary rules and regulations. Other procedural guidelines for the board are provided in the proposal, including the selection of the certification examination; establishment of a minimum pass rate on the examination, certification and renewal fees, and continuing education requirements; and suspension and revocation of certificates.

According to the proposal, a respiratory care practitioner certificate would expire on an annual basis. it could be renewed by completion of a recertification application and payment of a renewal fee.

The proposal would not prohibit the practice of respiratory care which is an integral part of the program of study by students enrolled in approved respiratory care education programs or the practice of respiratory care by other licensed medical personnel as authorized by the practice of their particular specialty. Violation of the proposal would result in a Class II misdemeanor.

Overview of Committee Proceedings

The Respiratory Care Credentialing Review Technical Committee first convened on August 14, 1985, in Lincoln at the State Office Building. An orientation session given by the staff focused specifically on the role, duties, and responsibilities of the committee under the credentialing review process. Other areas touched upon were the charge to the committee, the three criteria for credentialing contained within Section 21 of LB 407, and potential problems that the committee might confront while proceeding through the review.

The second meeting of the committee was held on August 28, 1985, in Lincoln at the State Office Building. After study of the proposal and relevant material compiled by the staff and submitted by interested parties between the meetings, the committee formulated a set of questions and issues it felt needed to be addressed at the public hearing. Contained within these questions and issues were specific requests for information that the committee felt was needed before any decisions could be made.

The committee reconvened on September 30, 1985, in Lincoln at the State Office Building for the public hearing. Proponents, opponents, and neutral parties were given the opportunity to express their views on the proposal and the questions and issues raised by the committee at their second meeting. Seven people testified in favor of the proposal and there was no opposition. Interested parties were given ten days to submit final comments to the committee.

The committee met for the fourth time on October 16, 1985, in Omaha at the Peter Kiewitt Center. After studying all of the relevant information concerning the proposal, the committee then formulated its recommendations upon the three criteria found in Section 21 of LB 407. These criteria are as follows:

Criterion 1

Unregulated practice of respiratory care practitioners can clearly harm or endanger the health, safety or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument.

Information Provided by the Applicant Group

Proponents of the proposal cited several incidents which, due to the lack of regulation in the practice of respiratory therapy care, caused patients to suffer physical, emotional, mental, social, and financial consequences; as the results of erroneous or incompetent care in the practice of respiratory therapy.

Due to the lack of minimum education or competence requirements, incidents have occurred, in hospital and home-care settings that have resulted in patient harm. Improper instruction and improper operation of equipment can result in recurrent pulmonary infections, increased morbidity and premature death, according to credentialing proponents.

Individuals trained "on-the-job" in respiratory therapy care have allowed patients to drown in their own pulmonary secretions because "on-the-job" trainees were unable to respond to critical situations (p. 6 Legislative Hearing Testimony.) Another incident cited in the committee public hearing involved the admission of a patient to a hospital who was suffering respiratory failure, or a low oxygen level and a high carbon dioxide level in the blood. The patient was placed on a 5-litre-per-minute oxygen mask by the squad bringing the patient into the hospital. The respiratory practitioner on duty at the hospital allowed the mask to be left on the patient at the 5-litre-per-minute flow. After 30 minutes the

patient was in a coma, due to the effect of the high oxygen flow on the patient's chronic lung disease. The patient was resuscitated and placed on a mechanical ventilator.

These situations occur to a greater degree in nursing homes and home health care settings. Ongoing advances in medicine coupled with increasing costs have resulted in an increased emphasis on home health care. However, this market allows a great opportunity for abuse by individuals motivated by profit who are unqualified and are not supervised as closely as practitioners functioning in hospital settings.

Proponents testified that the rapid growth of the home health care market has motivated individuals with little or no health education to open garage or basement operations to provide respiratory therapy care. Patients leaving hospitals are returning to their homes on continuous ventilators, oxygen and many other forms of therapy. Home-care respiratory care practitioners provide pulmonary rehabilitation to these consumers. Proponents indicated that often these respiratory specialists received their training in the form of a "quickie" course on equipment and respiratory care techniques.

Rehospitalization of persons with chronic diseases can be prevented with proper equipment use and care plans in the home setting. According to proponents, hundreds of infants on SID monitors and persons on respiratory devices and oxygen require supervision and follow-up to be properly maintained in home settings. Many companies providing equipment to patients requiring a regime of home care do not employ qualified, trained personnel in the delivery and instruction in the use of oxygen and drug delivery systems. The consumer, unaware of improper instruction, may be severely harmed (Committee Public Hearing Testimony).

Proponents referred to a $17,000,000 malpractice suit in the State of Florida involving an unqualified respiratory care provider. The provider mismanaged a patient's life-support system, which resulted in the "brain death" of the patient. This suit triggered the 1984 passage of Florida's Respiratory Care Act.

Information from Other Sources

No opposition to this proposal was received by the committee at the committee's public hearing. However, written comments were submitted to the committee that did not deal directly with Criteria 1. At the Legislative hearing on LB 277, general concern was expressed as to the necessity of credentialing in order to protect the health, safety and welfare of the public.

Final Committee Findings

The committee decided by a vote of 5-0 with one member absent and one not voting that unregulated practice can clearly harm or endanger the health, safety, or welfare of the public.

Criterion 2

The public needs, and can reasonably be expected to benefit from, an assurance of initial and continuing professional ability.

Information Provided by the Applicant Group

The application submitted by the respiratory care practitioners indicated that the general public is unable to discriminate between complete/competent services provided by respiratory therapy practitioners and services which are not complete/competent (p. 8 application). In order to ensure complete and competent services in both traditional and

non-traditional settings, minimum standards in the practice of respiratory therapy should be established. These settings include hospitals and home-care settings, the two key places where respiratory care is practiced (pp. 2 and 3 Legislative Hearing Testimony).

Proponents of the proposal stated in the application for credentialing that no minimum competencies or skills have been established for the field of respiratory therapy, thereby allowing anyone to utilize the title of respiratory therapist. By credentialing of practitioners, a minimum level of respiratory therapy skill will be ensured to consumers. The proposal allows the continuation of the practice of respiratory therapy by other qualified licensed medical personnel and states that all credentialed respiratory care practitioners can practice respiratory therapy only under the prescription and supervision of a licensed physician.

Current occupational regulation of respiratory therapy consists of a national mechanism of non-governmental credentialing that began in 1960. The objectives of this process were to assist in the development and maintenance of educational and ethical standards and to prepare, conduct, and control investigations and examinations of the qualifications of voluntary candidates and to encourage high standards. The proponents argued that approval of this proposal would make mandatory the current voluntary nature of the regulation of respiratory therapy. Testimony at the Legislative hearing indicated that the credentialing process will include passage of a national exam and will allow individuals currently practicing respiratory care to be "grandfathered" during the two years after enactment of the proposal. During that period those individuals who have not passed the national exam will have an opportunity to do so as determined by the State Board of Respiratory Care (p. 3 Legislative Hearing Testimony).

In the course of delivery of respiratory care, respiratory care practitioners deliver medications affecting patients' heart rate, blood pressure, respiratory rate and breathing volume. These activities require professional training to administer and monitor the effects of these medications. By establishing qualifications and requiring credentialing of respiratory therapy providers, consumers can be assured of quality, cost-effective care and greatly increase their quality of life.

Testimony presented to the Legislature suggested that patients coming to hospitals have little choice regarding who will provide care after admission. The proponents detailed the events of a Nebraska hospital that contracted with a respiratory therapy service company. The company provided an "on-the-job," trained staff person. The hospital was charged for procedures that were not completed and equipment that was not utilized (p. 6 Legislative Hearing Testimony).

The increased use of home-care settings allows for an even greater potential for unqualified and unregulated persons to practice respiratory therapy care. The enactment of LB 277 would allow Nebraskans to receive the most cost-effective services in treating their pulmonary diseases.

Information from Other Sources

As in Criterion 1, the committee received no opposition at the public hearing that would impact on this criterion. Written comments submitted to the committee suggested that credentialing of the respiratory care practice could result in fragmentation of health care to consumers and a lack of continuity and accountability in patient care. Testimony at the Legislative hearing reiterated these concerns and further suggested that requiring credentialing would increase health care costs to consumers (p. 19 Legislative Hearing).

Committee Findings

The committee decided by a vote of 5-0 with one absent and one not voting that the public needs and can be expected to benefit from an assurance of initial and continuing professional ability.

Criterion 3

The public cannot be effectively protected by other means in a more cost-effective manner.

Information Provided by the Applicant Group

In their application and in public hearing comments before the committee, the applicant group outlined and discussed the mechanisms available for training to become a Certified Respiratory Therapy Technician (CRTT) and Registered Respiratory Therapist (RRT). But the group argued that the availability of training in itself is not sufficient to ensure the completion of training and resulting ability to practice respiratory therapy. Because of the lack of minimum educational or minimum competency standards, incidents have occurred that have resulted in and continue to result in patient harm.

Membership is voluntary in the American Association for Respiratory Therapy (AART). Members are placed under a code of ethics and a National Ethics Committee. A code of ethics has not been established at the state level. Identification of problems or incompetency in hospital settings is usually the result of reports from fellow employees or hospital patients. Presently there are no laws that provide recourse for patients or cover the scope of practice of Respiratory Care.

While some monitoring occurs in hospital settings, according to proponents, virtually none, other than the knowledge of the person

receiving respiratory therapy care, exists in home-care settings. Regulation of specific programs or services would require frequent legislative changes due to the rapidly changing nature of the health care field. This would also limit the options of specialized care being developed to meet specific patient needs. Registration of respiratory therapy practitioners would not require a minimum competency and thus would not assure the public that it is receiving competent care. In the application for credentialing the proponents suggest that licensure of respiratory therapy practitioners would not serve to restrict the public options of sources of respiratory care and thus would not increase the cost of services (p. 10 of the Application).

Proponents stated at the Legislative Hearing on LB 277 that the need for minimum stnadards of competency in respiratory therapy has become more evident due to the increase in home health care, which is a result of earlier hospital dismissal and Nebraska's ever-growing senior citizen population. This trend has been reflected in several other states. In these states the most efficient method of monitoring of respiratory therapy has been in the form of some type of state regulatory credentialing.

Licensure bills have been passed in California, Arkansas, New Mexico, Florida, and North Dakota. An additional 22 states currently have Legislative bills pending that would require licensure or certification (p. 6 Application). Proponents further noted that while members of the AART are bound by a code of ethics, membership in the AART is voluntary.

Information from Other Sources

Written comments submitted to the committee suggested that licensure of additional health care workers would infringe upon the role of nurses, a practice which encompasses respiratory therapy care. Comments made at the

Legislative hearing further substantiated this allegation. Other comments indicated that an increased cost in the provision of health care would result with the passage of LB 277 (pp. 19 and 20 Legislative Hearing).

Committee Findings

The committee decided by a vote of 5-0 with one absent and one not voting that the public cannot be effectively protected by other means in a more cost-effective manner.

Discussion of the Appropriate Level of Credentialing

In the proponents' initial application for credentialing certification of practitioners was sought as the appropriate level of state regulation. Proponents indicated that other less restrictive levels of credentialing were not an option for the respiratory therapy practice and that licensure, a more restrictive measure, would restrict the public options of sources of respiratory care and thus increase the cost of these services (pp. 10 and 11 Application).

At ensuing committee meetings, the appropriateness of certification was discussed. Concern was expressed that those individuals who would be certified would then be subject to regulation, but persons who would not become certified would not be regulated, thus monitoring the practitioners but not the practice. If certification were imposed as mandatory for all respiratory therapy practitioners, then the practice of respiratory therapy would, in effect, become regulated and thus become licensure rather than certification.

In testimony given by the proponents at the committee's public hearing, it was stated that the applicant group was willing to support any bill that would protect the public from inappropriate, inefficient and

improper delivery of respiratory care and would provide assurance of the delivery of respiratory procedures (p. 11 Committee Public Hearing Testimony).

Information from Other Sources

Written opposition to the proposal suggested that licensure would result in increased health care costs. Testimony at the Legislative hearing also addressed the issue of increased health care costs as a result of any credentialing measures (pp. 19 and 20 Legislative Hearing Testimony).

The Committee discussed a letter dated October 10, 1985, from Louis W. Burgher, a member of the Committee. The letter stated that the committee should recommend licensure as the appropriate level of credentialing, as opposed to the certification of respiratory therapy practitioners.

Committee Findings

The Committee determined that certification of respiratory practitioners was not the most appropriate level of credentialing consistent with the protection of the public. The committee, by a vote of 5 to 0 with one member not present and one member not voting, recommended licensure as the level of regulation for respiratory care personnel with the provision that registered nurses, physicians, physician assistants, physical therapists and any other group for which respiratory care is included in the scope of practice be excluded from coverage by the Act.

Other Committee Recommendations

The Committee addressed Section 10, item (3) of LB 277, with regard to the amount of time available to an applicant for examination from the date

of issuance of a temporary license until the successful completion of the examination. The committee determined that this amount of time should be up to two years and by a vote of 5 to 0, with one not present and one not voting, passed a motion to that effect. By passage of this motion, the committee determined that the inclusion of "up to" in the bill would give the board authority to make a differentiation between new graduates and current practitioners. This would allow applicants to have up to two years, but Section 11 of LB 277 allows the board to adopt rules and regulations and to choose to make a differentiation between new graduates and existing practitioners. The committee determined that the board would have the expertise required to make the decision.

The committee further determined by a vote of 5 to 0, with one not present and one not voting, that the applicant group should work with the Department of Health to clarify the technical language of LB 277. This motion was passed after the committee discussed the contents of the examination that would be required for credentialing and annual renewal requirements.

The committee also discussed the requirements for continuing education as a part of LB 277. Section 7 item (4) of LB 277 states that the board may establish relicensure requirements, including continuing education requirements. The committee was informed that the Attorney General had recently ruled, in regard to another legislative bill, that the board does not have sufficient authority to require continuing education and the law must specify the number of hours of continuing education required.

The committee passed a motion in a vote of 4 to 0, with two not present and one not voting, instructing the applicant group to work with

the Department of Health to establish a specific number of continuing educations hours to be required as a component of LB 277.

The committee also recommended that a definition of a qualified medical director for respiratory care be attached to the report as appendix one.

APPENDIX ONE

DEFINITION OF A QUALIFIED MEDICAL DIRECTOR FOR RESPIRATORY CARE

The Medical Director for any inpatient or outpatient respiratory care service, department or home care agency shall be a licensed physician who has special interest and knowledge in the diagnosis and treatment of respiratory problems. This physician must be an active medical staff member of a licensed health care facility, and whenever possible should be qualified by special training and/or experience in the management of acute and chronic respiratory disorders. This physician should be competent to monitor and assess the quality, safety, and appropriateness of the respiratory care services which are being provided. The Medical Director should be accessible to and assure the competency of respiratory care practitioners, as well as require that respiratory care be ordered by a physician who has medical responsibility for that patient.