JOINT COMMITTEE OF REFERENCE

SENATE HEALTH AND WELFARE/HOUSE HEALTH

REPORT ON

REGULATION OF RESPIRATORY CARE TECHNOLOGISTS

TO: THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE
Co-Chairmen: Representative Pat Wright
Senator John Mawhinney

Pursuant to Title 32, Chapter 31, Arizona Revised Statutes, your Joint Committee of Reference, after performing a review and conducting a public hearing, recommends the following:

That the respiratory care technologists in the State of Arizona not be regulated by means of licensure.

SENATE MEMBERS:

Carl J. Kunasek, Co-Chairman

Greg Lunn

Jeffrey J. Hill

Alfredo Gutierrez

Juanita Harelson

HOUSE MEMBERS:

Bart Baker, Co-Chairman

Donald Aldridge

Karen R. Mills

Jack C. Jackson

Carolyn Walker

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ARIZONA STATE LEGISLATURE

JOINT COMMITTEE OF REFERENCE

HEALTH AND HEALTH AND WELFARE

Regulation of Respiratory Care Technologists

DATE Monday, February 17, 1986 TIME 6:00 p.m. PLACE House HR 4

Cochairman Baker called the meeting to order at 6:10 p.m.

MEMBERS PRESENT

Senator Lunn
Senator Harelson
Senator Kunasek, Cochairman
Representative Aldridge
Representative Jackson
Representative Walker
Representative Baker, Cochairman

MEMBERS ABSENT

Senator A. Gutierrez (excused)
Senator Hill
Representative Mills

SPEAKERS PRESENT

Karen Schroeder, Attorney, Arizona Society for Respiratory Therapy
Susan Meckert, Licensure Committee of the Arizona Society for Respiratory Therapy
Harry Reafleng, Jr., RRT, Director of Physiology, Phoenix Memorial Hospital
David Eubanks, Ed.D, RRT, President and CEO Biosystems Institute
Diane Milne, LPN, Certified Respiratory Therapist Technician
Thomas Bajo, M.D.
Karen Richards, Director of Respiratory Therapy, Good Samaritan Hospital
Connie Curre, R.N., RRT
Donna Klein, Certified Respiratory Therapist Technician
Stephen O. Stenson, M.ED

GUEST LIST ATTACHED

Cochairman Baker cautioned those testifying to be brief and not to repeat those speaking before. He called on Karen Schroeder, attorney representing the Arizona Society for Respiratory Therapy, who, in turn, introduced Susan Meckert, Chairman of the Licensure Committee of the Arizona Society for Respiratory Therapy. Ms. Meckert then presented people from different areas of the respiratory health care field to share their views with the committee.

Harry Reafleng, Jr., Registered Respiratory Therapist and Director of Physiology at Phoenix Memorial Hospital, spoke as a professional who thinks the state can improve on care for the public by licensing respiratory therapists. In answer to a question, he told the committee that he is registered with the National Board Respiratory Therapists; most therapists are not registered with this group.

Minutes of Meeting
Committee of Reference Regulation of Respiratory Care Technologists
February 17, 1986

After some discussion, Representative Walker moved that the committee return a recommendation for licensure of respiratory therapists, seconded by Representative Jackson. The motion failed by a voice vote, 3 yes, 4 no.

Representative Walker then moved that H.B. 2493 be heard in committee with no recommendation from the Joint Committee. The motion was seconded by Representative Jackson. The motion carried.

The meeting adjourned at 7:10 p.m.

(Attachments are on file in the office of the Senate Secretary.)

Respectfully submitted,

Lee Brown

Lee Brown, Secretary

lb
2-20-86

APPLICATION FOR HEALTH PROFESSION REGULATION
PURSUANT TO A.R.S. § 32-3105

Name of Occupational Group:

RESPIRATORY CARE TECHNOLOGISTS

Organization Submitting Application:

ARIZONA SOCIETY FOR RESPIRATORY THERAPY

Date:

JANUARY 6, 1986

Contact Person:

SUSAN MECKERT, Chairman
Licensure Committee, AzSRT
3020 North 14th Street, #106A
Phoenix, Arizona 85014
Tel. No.: (602) 285-3250

1. A DEFINITION OF THE PROBLEM AND WHY REGULATION IS NECESSARY INCLUDING:

(a) THE NATURE OF THE POTENTIAL HARM TO THE PUBLIC IF THE HEALTH PROFESSION IS NOT REGULATED AND THE EXTENT TO WHICH THERE IS A THREAT TO PUBLIC HEALTH AND SAFETY.

Respiratory therapists help to treat patients who have chronic or acute cardio-pulmonary ailments, i.e., any condition causing a disabling or life-threatening interruption of the normal respiratory functions. Very often the persons who must rely on treatment by respiratory therapists are confined to the intensive care unit of hospitals. Respiratory therapy is prescribed by physicians as a crucial part of the treatment of such serious diseases as pneumonia, lung cancer, cystic fibrosis and tuberculosis.

At least six other states, including our neighboring states of California and New Mexico, have recognized the need for licensing respiratory therapists to protect the public from unqualified practitioners in this area. Almost every other state is currently considering licensing legislation. The Arizona Society for Respiratory Therapy believes it is unfair and unrealistic to expect individuals--especially those who are hospitalized with serious medical problems--to check the credentials of those who administer respiratory therapy to them. There is an obvious need for the formation of an appropriate licensing board to protect the public from unqualified individuals whose lack of expertise and/or training may threaten a patient's life or well-being.

The nature of the potential harm to the people of Arizona can be better understood by focusing on the critical

nature of respiratory care.

Very often the practice of respiratory care includes the management of mechanical ventilators, which must be used in cases where patients have lost the ability to breath on their own. Mechanical ventilation is artificial life support, without which every ventilator-dependent patient would die. This fact alone should make clear the need to establish the minimum competency of those who set up and manage ventilators. Any error--even as simple as neglecting to set an alarm--can and has killed patients. In North Dakota last year, a therapist was charged with negligence when just such an incident occurred. Yet, this therapist could easily find work in Arizona, without any investigation for past negligence.

Similarly, several years ago in Arizona, a working therapist took it upon himself to decrease the amount of oxygen delivered by the ventilator. Unfortunately for the patient, this resulted in death due to hypoxic (lack of oxygen) brain damage. This therapist left that institution, only to seek work elsewhere. The demand for therapists in Arizona is so great that many smaller hospitals, especially those outside Phoenix and Tucson, are forced to hire uncredentialed therapists.

The public is now endangered by the hiring policy of those smaller hospitals and even some of the long-term care facilities in Phoenix. Many uncredentialed new graduates are hired - employment is easier to find outside the large hospitals -- and the credential is expected to follow.

Unfortunately, some of these graduates never become credentialed by the National Board of Respiratory Care - i.e. they never establish even minimum competency in the field. Yet, in Arizona, they can continue to work. For that matter, anyone can walk in off the street, and if that hospital chooses to call him a respiratory therapist, he becomes one, despite having no training, no education, no skills.

That person then takes on the responsibility for mechanical life support of critically ill patients. Even in Phoenix, many nursing homes that accept ventilator-dependent patients have no respiratory therapy staff and may or may not offer inservice training to other personnel regarding ventilator management. In a recent survey of those nursing homes without a respiratory staff, the maximum amount of ventilator training offered to those who are charged with this duty was only eight hours per year. Many of those institutions had no inservice training program. Yet there were 18 of those institutions without a respiratory staff, which stated that they could care for these long-term ventilator patients adequately.

Mechanical ventilation is just a part of the role of the respiratory care practitioner. Although those ventilator patients are the most critical, they account for only approximately 25 percent of the patient population requiring respiratory care. Many more patients are oxygen dependent: they do not need hospitalization but, as documented by arterial blood gases, require home oxygen.

That oxygen may be supplied several ways: optimally,

by a home care company which employs respiratory therapists, or alternatively, by a medical gas supply company or an independent distributor of oxygen. Those patients who receive their oxygen from the home care company with respiratory therapists also receive education and training in the proper use and precautions necessary while administering the gas. The patients who receive their gas from other sources may never be educated about its hazards or use. In fact, it is often the delivery truck driver who will set up the gas and apply it to the patient with no more instruction that how to turn the tank off and on. Oxygen is classified as a drug by the Federal Drug Administration, and is a flammable gas which can be hazardous if misused.

There are many drugs used in respiratory care. Generally, they are classed as Beta stimulants. Beta stimulation affects the heart and central nervous system. Improper use or dosage of any of these medications has resulted in cardiac and/or respiratory arrest, leading to death. It takes an educated therapist to recognize a mistake in a medication order that was taken over the phone from a physician and incorrectly recorded in the patient chart.

And the list goes on and on. For every procedure a respiratory therapist performs, there are associated hazards. Like physicians and critical care nurses who work side-by-side with the therapists in the Intensive Care Unit, their mistakes will <u>always</u> be life threatening. But, in Arizona today, the therapist who makes a mistake, be it deliberate or not, will

not be held responsible. And that therapist, if asked to leave one hospital, will probably find a job in another, where the new employer knows nothing of his past.

A situation similar to this occurred several years ago when a therapist misrepresented himself to patients as a physician. A patient called the respiratory care department and asked for "Dr. _____", who was known to be a therapist. After investigation, he was asked to leave that institution, and was subsequently employed by four other hospitals in Phoenix, before communication between department managers finally forced him to leave the city. He then sought employment in Tucson.

Lastly, the story of a young boy, brain damaged in a car accident, who had been hospitalized in a large, acute care center in Phoenix for several months, and received respiratory care there, as observed by his parents. At the end of the acute care stage, he was transferred to a nursing facility. It was on the very first day, as he received a breathing treatment from an LPN, that his mother observed a mistake in the procedure she had come to recognize after months of watching. The mother asked the LPN to stop the treatment, then inquired where the respiratory therapist was. When she was told there were none on staff at that facility, she contracted with a respiratory home care company to provide what she had learned was proper therapy. This continued, at no small expense, for five months, until the boy was finally transferred to a facility that offered respiratory care provided by credentialed res-

piratory therapists.

The nature of the job is critical, the potential damage, lethal. The time has come for Arizona to demand that its respiratory practitioners be qualified and competent and above all, that they be held responsible for their actions.

(b) THE EXTENT TO WHICH CONSUMERS NEED AND WILL BENEFIT FROM A METHOD OF REGULATION IDENTIFYING COMPETENT PRACTITIONERS AND INDICATING TYPICAL EMPLOYERS, IF ANY, OF PRACTITIONERS IN THE HEALTH PROFESSION.

The vast majority of respiratory care practitioners currently working in the State of Arizona are employed by hospitals--approximately 83 percent. (Attachment 1, Figure 1).

Virtually every other medical care practitioner with whom a patient would come in contact during his/her stay in a hospital is currently required to have a license to practice in Arizona. Yet to date in Arizona there ~~has~~ have been no licensing programs for respiratory care practitioners, who often help to treat patients with extremely serious injuries or diseases.

The licensing of respiratory care practitioners would benefit consumers both directly and indirectly. In those instances where a patient can select a respiratory therapist, the patient would have the ability to be able to identify competent practitioners in this area. In addition, the consumers would benefit indirectly from licensing in that the hospitals, physician's offices and home health agencies who hire respiratory care practitioners would be able to have an objective, standard basis for evaluating job applicants in this area.

(c) THE EXTENT OF AUTONOMY A PRACTITIONER HAS, AS

INDICATED BY THE FOLLOWING:

(i) THE EXTENT TO WHICH THE HEALTH PROFESSION CALLS FOR INDEPENDENT JUDGMENT AND THE EXTENT OF SKILL OR EXPERIENCE REQUIRED IN MAKING THE INDEPENDENT JUDGMENT.

(ii) THE EXTENT TO WHICH PRACTITIONERS ARE SUPERVISED.

Most of the routine functions performed by respiratory therapists (with the exception of those involving direct assistance to a physician, such as stress testing, bronchoscopy and portions of resuscitation efforts) are normally not monitored on the spot. For the most part, respiratory care practitioners function when no physician is present. Physician supervision normally consists of:

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

2) Transmittal of written or verbal orders;

3) The physician's assessment of a patient's general progress; and

4) Medical staff access to the results of periodic hospital-wide audits for the appropriateness of certain types of therapy for certain categories of patients.

Thus, in general, respiratory care practitioners provide diagnostic and therapeutic services on a physician's order. No matter what type of respiratory care is ordered, it must be kept in mind that no modern health care facility can function without the extensive use of verbal orders from physicians to nurses and other allied health care providers. Respiratory care practitioners also commonly accept verbal

orders, especially in the emergency room but also in other acute and chronic care settings. Errors in communications are always possible. The inherent danger of communication errors between physicians and respiratory care practitioners will obviously be less, however, when the recipient of the order is trained to anticipate what treatment is normally required in a given situation and, therefore, able to recognize inappropriate orders or obvious errors in either written or oral communication.

Even though physicians are generally responsible for supervising the care provided by respiratory care practitioners, in many cases the instructions given by the physicians are fairly general and the details of carrying out the procedure are left up to the respiratory therapist. One example of this would involve the use of continuous mechanical ventilation. In this procedure, many of the hazards are related to the fact that positive, i.e. superatmospheric, pressures are being applied to the patient's airways and that pressure can, of necessity, never be completely dispensed with. Therefore, the risk of complications attributable to the use of positive pressure, e.g. barotrauma, reduced cardiac output, and the changes in intracranial pressure can never be eliminated.

It is interesting to note that although all physicians competent to manage patients on continuous mechanical ventilators are aware of and concerned about the possible hazards of positive pressure, pressure limits are seldom ordered by physicians. Rather, they are usually left to the

discretion of the respiratory care practitioner. There are methods for reducing airway pressure on a given patient, such as adjustment of peak flow rate or flow pattern, but these techniques are often understood better by the respiratory therapy practitioner than by the ordering physician. Therefore, the training of the respiratory care practitioner will have a tremendous influence on the degree to which a patient is exposed to the hazards of positive pressure.

The most sophisticated mechanical ventilators available, regardless of how many alarms and monitors they incorporate, depend on the respiratory care practitioner to decide what conditions should and will activate an alarm. In other words, the respiratory care practitioner must set and adjust the alarms in the first place. It is very unusual for the supervising physician to specify the instructions concerning the setting of alarms on mechanical ventilators. The failure to set alarms could result in undetected disconnection or gas leak, the most serious possible consequence of which would be the death of the patient.

Although respiratory care practitioners do not diagnose injuries or diseases, they are responsible for patient evaluation and the recognition of problems. They are responsible for the unsupervised application of both pharmacologic and mechanical therapeutic techniques, often to critically ill or injured patients. This means they must be able to recognize adverse patient reactions to therapy, complications relative to the course or kind of therapy, changes in the patient's cardio-

pulmonary status (from whatever cause), and technical irregularities or failures in the life support equipment attached to the patients in their care. It is common knowledge among experienced practitioners that very subtle mechanical problems can result in clinical catastrophes. Often the respiratory care practitioner is the only person present or competent to recognize such problems.

Respiratory care practitioners do contribute to establishment of treatment plans in some cases. While the ultimate responsibility for the prescription is and must be the physician's, it is common practice for many physicians, who are confronted with a rapidly expanding array of technical options, to consult with either another physician specializing in pulmonary medicine or with the respiratory care practitioner when deciding the most appropriate way to treat a patient's particular respiratory problem.

Indeed, some institutions have established mechanisms for direct referral of respiratory patients to the respiratory therapy department for recommendation of a treatment plan. Elsewhere, pre-arranged protocols have been established for the care of certain categories of patients, e.g. surgical, chronic lung disease, or ventilator cases. In such instances, the physician may depend on the respiratory care practitioner to implement the details of each step of the protocol, calling on the physician only under unusual or specified circumstances. In such situations it is fair to say that the respiratory care practitioner, no less than the patient's nurse, has been

deputized to, at the very least, recognize developments which require the physician's intervention or a change in the treatment plan.

Finally, in recent years the practice of respiratory therapy has spread out of the hospital setting into the patient's home. As such, the practitioner has taken on a role calling for more independent practice and with less supervision and is often the individual who is relied upon by the prescribing physician to assess the effectiveness of home therapy and/or the need for therapy modification. The unsupervised work by respiratory therapists in the home setting is especially common in Arizona, with its many elderly and retired persons.

2. THE EFFORTS MADE TO ADDRESS THE PROBLEM INCLUDING:

(a) VOLUNTARY EFFORTS, IF ANY, BY MEMBERS OF THE HEALTH PROFESSION TO EITHER:

(i) ESTABLISH A CODE OF ETHICS.

(ii) HELP RESOLVE DISPUTES BETWEEN HEALTH PRACTITIONERS AND CONSUMERS.

The National Board for Respiratory Care (NBRC) is a non-profit organization administering examinations for respiratory care practitioners. Two examination systems are available for those meeting the established admission criteria: the basic entry-level Certification Examination for Respiratory Therapy Technicians (CRTT) and the advanced two-part Registry Examination for Respiratory Therapists (RRT). The purposes and objectives of the NBRC are to prepare and conduct examinations

for certification and registration, to cooperate in supporting schools for respiratory therapy, to pass on qualifications of candidates for certification and registration, and to prepare and maintain a Directory of Registered Respiratory Therapists and Certified Respiratory Therapy Technicians.

The NBRC is endorsed by the American Association for Respiratory Therapy and functions merely as a voluntary peer review agency for the profession. Currently the NBRC credentials less than 75 percent of the practitioners in Arizona. Thus, although the NBRC does have a code of ethics and a procedure available for filing complaints against practitioners who participate in the NBRC registration and certification process, this has no impact on the many practitioners who do not take part in the NBRC program. Moreover, even if a person loses their CRTT or RRT qualifications, there is nothing to prevent them from continuing to practice as a respiratory therapist.

(b) RECOURSE TO AND THE EXTENT OF USE OF APPLICABLE LAW AND WHETHER IT COULD BE AMENDED TO CONTROL THE PROBLEM.

Existing laws covering unfair trade practices, consumer protection, deceptive advertising, etc. have little or no applicability to the practice of the respiratory care practitioner. This is primarily because most respiratory therapists are employed by hospitals or physician's offices and therefore, do not advertise directly to the public.

Civil law protections are, of course, applicable in certain situations but do not provide any assurance of quality

in the practice of a respiratory care practitioner or serve as a protection against mistreatment. Without standards set by a state regulatory act, there is truly little basis for effective malpractice litigation. Through the creation of a regulatory board, an easily accessible forum would be created in which a patient can raise charges of malpractice and unethical conduct, and have an opportunity to take his complaint through a well-defined process.

Certain sections of the Federal Medicare Act define the circumstances and situations under which respiratory therapy services are considered reasonable and necessary. Over the past several years, advances in treating patients with cardio-pulmonary problems have led to the establishment of respiratory therapy as a distinct professional entity. In response to this development, the Health Care Financing Administration issues guidelines for reviewing requests for reimbursement for various respiratory services. However, none of these federal statutes or programs contains any standards for determining competence by respiratory care practitioners or any mechanisms by which incompetent practitioners can be kept from harming the public.

At the current time there is no regulating mechanism in Arizona regarding the practice of respiratory therapy which precludes <u>any</u> individual from being a part of the occupation. The only limitations are those established by institutions, such as hospitals, which hire respiratory therapists. These limitations are exercised primarily through personnel policies

which state who may be precluded from employment. Such policies generally provide that any individual may be denied employment for conviction of an offense involving moral turpitude, misrepresentation, malpractice or drug or alcohol abuse.

Finally, although a hospital and/or an employing physician could be held liable under the tort theory of "respondent superior" or the master/servant relationship in a civil lawsuit, such lawsuits are expensive and time consuming. Moreover, even if the plaintiff in such a lawsuit recovers damages for malpractice by a respiratory care practitioner, there is still no legal mechanism for preventing such a practitioner from continuing to negligently treat patients. In the long run such lawsuits could be minimized by imposing minimum, fair standards of competence and training which persons wishing to work as respiratory care therapists would be required to meet and maintain.

3. THE ALTERNATIVES CONSIDERED INCLUDING:

(a) REGULATION OF BUSINESS EMPLOYERS OR PRACTITIONERS RATHER THAN EMPLOYEE PRACTITIONERS.

Respiratory therapists work in a number of different settings including hospitals, physician's office and for home care companies. It would be difficult if not impossible to derive fair and comprehensive regulations which would apply in all of these different types of settings.

More importantly, Arizona has already concluded that employer regulation is not adequate for doctors, nurses, x-ray technicians, anesthesiologists and physical therapists. Why should the health profession of respiratory therapy be any

different?

(b) REGULATION OF THE PROGRAM OR SERVICE RATHER THAN THE INDIVIDUAL PRACTITIONERS.

Again, this is not the course of action which Arizona has chosen for virtually any other health profession. An attempt to regulate the program or service would actually be more cumbersome than regulating the individual. This is particularly true in the field of respiratory therapy, which is a rapidly advancing field in which the scope of practice is constantly changing.

(c) REGISTRATION OF ALL PRACTITIONERS

This method would accomplish virtually nothing other than the creation of a mass alphabetical listing of the names and addresses of everyone claiming to be a respiratory therapist in Arizona. Any unqualified person could get himself/herself listed in such a registry, thus lending them an undeserved aura of competence based on their inclusion in such an "official" directory.

(d) CERTIFICATION OF ALL PRACTITIONERS.

This method is unsatisfactory for two reasons. First, it assumes that the "consumers" of respiratory care services -- namely, the patients -- would have the time and expertise to "shop around" and pick a qualified respiratory therapist. This is simply not the case, since most recipients of respiratory care services are patients in hospitals who really have no choice in the matter. Second, this method lacks

"teeth" in that the availability of a certification process would not prevent an unqualified individual from practicing respiratory care or an employer from hiring unqualified individuals, either because qualified persons must be paid more or they are fewer in number and thus more difficult to locate, especially in rural areas.

(e) OTHER ALTERNATIVES.

The only other alternative is continuation of the present system, which does not do the job of satisfactorily protecting the public.

(f) WHY THE USE OF THE ALTERNATIVES SPECIFIED IN THIS PARAGRAPH WOULD NOT BE ADEQUATE TO PROTECT THE PUBLIC INTEREST.

As explained above, the public interest can only be adequately protected by a regulatory method which has "teeth" i.e. which prohibits unqualified, incompetent persons from performing vital respiratory care services on persons in life-threatening situations.

(g) WHY LICENSING WOULD SERVE TO PROTECT THE PUBLIC INTEREST.

If a licensing system were established, it would create minimum standards of training and competency which anyone practicing respiratory care would be required to meet. The public could thus be assured that they would not be treated by unqualified individuals in the vital area of respiratory services. Also, if a practitioner holding a license were guilty of negligence or malpractice, there would be a readily available system for bringing proceedings to revoke or suspend such a person's license.

4. THE BENEFIT TO THE PUBLIC IF REGULATION IS GRANTED INCLUDING:

(a) THE EXTENT TO WHICH THE INCIDENTS OF SPECIFIC PROBLEMS PRESENT IN THE UNREGULATED HEALTH PROFESSION CAN REASONABLY BE EXPECTED TO BE REDUCED BY REGULATION.

By allowing only those persons who possess adequate training and knowledge to practice respiratory care, licensing should significantly reduce the incidents where patients receive incompetent care. Moreover, respiratory care practitioners would have an incentive to maintain or improve their level of knowledge and skill so as to avoid the possibility of having their licenses suspended or revoked, thus preventing them from obtaining employment in the field.

(b) WHETHER THE PUBLIC CAN IDENTIFY QUALIFIED PRACTITIONERS.

Under the proposed system, there would be no need for the public to identify qualified practitioners, since only qualified persons would be allowed to practice. Because respiratory therapy involves complex medical and technical issues which the average person is not familiar with, it is unrealistic to expect the members of the public to be able to distinguish between qualified and unqualified practitioners -- even assuming they had a choice in the matter, which most patients do not. The concept of a patient in an intensive care unit of a hospital rationally "choosing" a respiratory care practitioner is obviously ludicrous. Nor is the patient's family in a much better position to be able to make such a choice -- they are generally distraught and determined only that their loved one receive the necessary care immediately.

(c) THE EXTENT TO WHICH THE PUBLIC CAN BE CONFIDENT THAT QUALIFIED PRACTITIONERS ARE COMPETENT INCLUDING:

(i) WHETHER THE PROPOSED REGULATORY ENTITY WOULD BE A BOARD COMPOSED OF MEMBERS OF THE PROFESSION AND PUBLIC MEMBERS OR A STATE AGENCY, OR BOTH, AND, IF APPROPRIATE, THEIR RESPECTIVE RESPONSIBILITIES IN ADMINISTERING THE SYSTEM OF REGISTRATION, CERTIFICATION OR LICENSURE, INCLUDING THE COMPOSITION OF THE BOARD AND THE NUMBER OF PUBLIC MEMBERS, IF ANY, THE POWERS AND DUTIES OF THE BOARD OR STATE AGENCY REGARDING EXAMINATIONS AND FOR CAUSE REVOCATION, SUSPENSION AND NONRENEWAL OF REGISTRATIONS, CERTIFICATES OR LICENSES, THE ADOPTION OF RULES AND CANONS OF ETHICS, THE CONDUCT OF INSPECTIONS, THE RECEIPT OF COMPLAINTS AND DISCIPLINARY ACTION TAKEN AGAINST PRACTITIONERS AND HOW FEES WOULD BE LEVIED AND COLLECTED TO PAY FOR THE EXPENSES OF ADMINISTERING AND OPERATING THE REGULATORY SYSTEM.

A draft bill setting up a system for licensing respiratory care technologists is attached to this application. The bill as drafted would create a "Board of Respiratory Care Examiners" consisting of five members, including two physicians, two licensed respiratory technologists and one member of the public. The Board would be responsible for establishing minimum standards for qualification, administering examinations and issuing licenses to qualified applicants. The Board would also have a procedure for taking disciplinary action against anyone found to have violated any of a specified list of prohibited actions.

The activities of the Board would be funded by the collection of various fees from applicants and practitioners, such as an initial application fee, an examination fee, etc. No public monies would be used.

(ii) IF THERE IS A GRANDFATHER CLAUSE, WHETHER GRANDFATHERED PRACTITIONERS WILL BE REQUIRED TO MEET

THE PREREQUISITE QUALIFICATIONS ESTABLISHED BY THE REGULATORY ENTITY AT A LATER DATE.

According to the draft bill which is attached, any person who is actively engaged in the practice of respiratory care in Arizona on the date the bill becomes effective may continue to engage in the practice of respiratory care without being licensed until January 1, 1990 if he applies for a license on or before December 31, 1987. Such a licensure applicant will be exempted from the formal training requirements specified in the bill, but would still be required to pass an examination for entry-level competence.

(iii) THE NATURE OF THE STANDARDS PROPOSED FOR REGISTRATION, CERTIFICATION OR LICENSURE AS COMPARED WITH THE STANDARDS OF OTHER JURISDICTIONS.

The standards for licensure would be based on those established by the National Board for Respiratory Care, which are uniform throughout the country. These standards are intended to measure basic entry-level competence.

(iv) WHETHER THE REGULATORY ENTITY WOULD BE AUTHORIZED TO ENTER INTO RECIPROCITY AGREEMENTS WITH OTHER JURISDICTIONS.

The bill provides for someone licensed and practicing as a respiratory care technologist in another state to receive an Arizona license without taking the examination otherwise required of applicants.

(v) THE NATURE AND DURATION OF ANY TRAINING INCLUDING WHETHER THE TRAINING INCLUDES A SUBSTANTIAL AMOUNT OF SUPERVISED FIELD EXPERIENCE, WHETHER TRAINING PROGRAMS EXIST IN THIS STATE, IF THERE WILL BE AN EXPERIENCE REQUIREMENT, WHETHER EXPERIENCE MUST BE ACQUIRED UNDER A REGISTERED, CERTIFIED OR LICENSED PRACTITIONER, WHETHER THERE ARE ALTERNATIVE ROUTES AND ENTRY OR METHODS OF MEETING THE PREREQUISITE QUALIFICATIONS, WHETHER ALL APPLICANTS WILL BE REQUIRED TO PASS THE EXAMINATION, AND IF AN EXAMINATION IS REQUIRED, BY WHOM IT WILL BE DEVELOPED AND HOW THE COSTS OF DEVELOPMENT WILL BE MET.

Qualification would generally be based upon graduation from a respiratory therapy training program and successful completion of an examination. There are currently seven schools in Arizona which are accredited by the American Medical Association's Committee on Allied Health Education. These Schools all require a minimum of 20 weeks of supervised clinical training. However, there would be certain circumstances under which the examination would be waived, such as when the applicant is licensed in another state or is registered or certified by the NBRC. Thus, almost 75 percent of those currently practicing respiratory care in Arizona would be exempted from the examination required because they are registered or certified by the NBRC.

The Board is authorized to use a uniform examination system, such as the ones utilized by the NBRC. The costs of administering the examination will be raised solely through the collection of specified fees from applicants. No public monies will be used.

(d) ASSURANCE OF THE PUBLIC THAT PRACTITIONERS HAVE MAINTAINED THEIR COMPETENCE INCLUDING:

(i) WHETHER THE REGISTRATION, CERTIFICATION OR LICENSURE WILL CARRY AN EXPIRATION DATE.

There will be a requirement that the licenses must be renewed every other year.

(ii) WHETHER RENEWAL WILL BE BASED ONLY ON PAYMENT OF A FEE OR WHETHER RENEWAL WILL INVOLVE RE-EXAMINATION, PEER REVIEW OR OTHER ENFORCEMENT.

Normally, license renewal will involve only payment of a fee. Once a respiratory care practitioner is licensed, he will have an incentive to maintain a high quality of expertise and care by the potential sanction of having his license suspended or revoked if he does not. If problems have developed with a specific individual resulting in suspension or revocation of his license, the Board would have the authority to require an examination before that person could have his license reinstated.

5. THE EXTENT TO WHICH REGULATION MIGHT HARM THE PUBLIC INCLUDING:

(a) THE EXTENT TO WHICH REGULATION WILL RESTRICT ENTRY INTO THE HEALTH PROFESSION INCLUDING:

(i) WHETHER THE PROPOSED STANDARDS ARE MORE RESTRICTIVE THAN NECESSARY TO ENSURE SAFE AND EFFECTIVE PERFORMANCE.

(ii) WHETHER THE PROPOSED LEGISLATION REQUIRES REGISTERED, CERTIFIED OR LICENSED PRACTITIONERS IN OTHER JURISDICTIONS WHO MIGRATE TO THIS STATE TO QUALIFY IN THE SAME MANNER AS STATE APPLICANTS FOR REGISTRATION, CERTIFICATION AND LICENSURE IF THE OTHER JURISDICTION HAS SUBSTANTIALLY EQUIVALENT REQUIREMENTS SO REGISTRATION, CERTIFICATION OR LICENSURE AS THOSE IN THIS STATE.

The standards proposed are completely in keeping with the need to protect the public from incompetent care in this area which is potentially life-threatening. Practitioners

who are licensed in other states would be allowed to obtain an Arizona license without taking an examination so long as that other state has licensure requirements at least equivalent to those in Arizona.

(b) WHETHER THERE ARE PROFESSIONS SIMILAR TO THAT OF THE APPLICANT GROUP WHICH SHOULD BE INCLUDED IN, OR PORTIONS OF THE APPLICANT GROUP WHICH SHOULD BE EXCLUDED FROM, THE PROPOSED LEGISLATION.

Respiratory care should be carried out in all instances by someone who is qualified to do so, whether that person is a licensed respiratory care practitioner or a licensed doctor or nurse. The bill would specifically not limit or interfere with the practices of other regulated health professionals.

6. THE MAINTENANCE OF STANDARDS INCLUDING:

(a) WHETHER EFFECTIVE QUALITY ASSURANCE STANDARDS EXIST IN THE HEALTH PROFESSION, SUCH AS LEGAL REQUIREMENTS ASSOCIATED WITH SPECIFIC PROGRAMS THAT DEFINE OR ENFORCE STANDARDS OR A CODE OF ETHICS.

The bill lists numerous grounds for disciplinary action against respiratory care practitioners, including negligence, fraud, conviction of a crime, etc.

(b) HOW THE PROPOSED LEGISLATION WILL ENSURE QUALITY INCLUDING:

(i) THE EXTENT TO WHICH A CODE OF ETHICS, IF ANY, WILL BE ADOPTED.

(ii) THE GROUND FOR SUSPENSION OR REVOCATION OF REGISTRATION, CERTIFICATION OR LICENSURE.

There are no plans for the specific adoption of a code of ethics because there is really no need for one. The NBRC already has a code of ethics for all those who are registered or certified under that organization.

The grounds for suspension or revocation of licenses are specifically listed in the bill. The public will be protected by the ability of the Board to take disciplinary action against anyone found to have violated those standards.

7. A DESCRIPTION OF THE GROUP PROPOSED FOR REGULATION, INCLUDING A LIST OF ASSOCIATIONS, ORGANIZATIONS AND OTHER GROUPS REPRESENTING THE PRACTITIONERS IN THIS STATE, AN ESTIMATE OF THE NUMBER OF PRACTITIONERS IN GROUP AND WHETHER THE GROUPS REPRESENT DIFFERENT LEVELS OF PRACTICE.

The group proposed for regulation is all those persons who are trained to actively participate in the health care practice consisting of the monitoring and treatment of cardio-pulmonary functions of patients pursuant to the orders of a licensed physician. The only association representing this group in Arizona is the Arizona Society for Respiratory Therapy. In order to belong to the AzSRT, an individual must also belong to the American Association for Respiratory Care.

There are just over 1300 practitioners in Arizona, of whom approximately 300-350 belong to the AzSRT.

8. THE EXPECTED COSTS OF REGULATION INCLUDING:

(a) THE IMPACT REGISTRATION, CERTIFICATION OR LICENSURE WILL HAVE ON THE COSTS OF THE SERVICES TO THE PUBLIC.

(b) THE COST TO THIS STATE AND TO THE GENERAL PUBLIC OF IMPLEMENTING THE PROPOSED LEGISLATION.

It is anticipated that licensure should have no impact on the costs of services to the public. As illustrated by Figures 5 and 6 in Attachment 1, there will be a surplus of persons seeking jobs as respiratory care practitioners, so that limiting employment to those who are sufficiently educated and qualified should not result in any shortage which might drive up costs.

All other costs of regulation will be covered by the fees collected, with no cost to the state or general public. Indeed, the general fund will actually benefit from the regulation, since it will receive ten percent of all fees collected.

R-1.8

1985 MANPOWER SURVEY

Over the summer of 1985, the Licensure Committee of the Arizona Society for Respiratory Therapy conducted the yearly survey to determine the number of individuals working as respiratory care practitioners in the state of Arizona. Credentialing, as well as place of work, was compiled during the survey.

The following types of institutions were surveyed:

1. Hospitals (59)
2. Pulmonary Clinics/Physician Offices (15)
3. Respiratory Therapy Schools (7)
4. Durable Medical Equipment Vendors (45)
5. Home Health Agencies (12)
6. Professional Contract Agencies (10)

The survey showed 1,302 individuals currently employed by the institutions surveyed. These 1,302 individuals are employed in positions requiring the skills of a respiratory care practitioner, as defined by our Licensure bill. The number does not include any Registered Nurses, Licensed Practical Nurses, Nursing Assistants, Registered Cardio-Pulmonary Technologists, Certified Cardio-Pulmonary Technologists, Cardio-Pulmonary Technologists, durable medical equipment vendor drivers or clerical staff.

Figure 1 represents the distribution of these individuals by the type of employer. In this survey, hospitals whose R.T. Departments were staffed by professional contract services are reported in the hospital employees section.

FIGURE 1

Employer	Number of Employees	% of Employees
Hospitals	1,081	83%
Pulmonary Clinics/Physician Offices	47	3.6%
Respiratory Therapy Schools	41	3.1%
Durable Medical Equipment Vendors	66	5.1%
Home Health Agencies	0	0
Professional Contract Agencies	67	5.2%
Totals	1,302	100%

Figure 2 shows the four hospital size categories (Arizona Hospital Association established standards of hospital size categories were used to breakdown hospital data in the survey) surveyed by the committee, as well as number of responses per category. Included are the response percentages from the other institutions as well.

FIGURE 2

Institutions Surveyed	# Surveyed	# Responses	% Responses
Hospitals			
0-100	20	20	100%
101-200	14	14	100%
200-400	16	16	100%
401 & up	6	6	100%
Pulmonary Clinics/Physician Offices	15	3	20%
Respiratory Therapy Schools	7	7	100%
Durable Medical Equipment Vendors	45	23	51%
Home Health Agencies	10	1	12.5%
Professional Contract Agencies	12	2	16.6%

Distribution of staff credentialing and their percentage in each hospital bed size category are represented in Figure 3. Note: "On-the-job-training" ("O.J.T.") was defined as an individual who has not obtained a National Board for Respiratory Care ("N.B.R.C.") credential or is not currently eligible to obtain one, thus not eligible for licensure in Arizona.

FIGURE 3

Hospital Size	0-100	101-200	201-400	401-up	Total
RRT*/CRTT**	9	43	84	100	236
%	3.8%	18.2%	35.6%	42.4%	21.8%
CRTT	31	50	148	94	323
%	9.6%	15.5%	45.8%	29.1%	29.9%
CRTT/RRT eligible	17	25	36	118	196
%	8.7%	12.7%	18.4%	60.2%	18.1%
RRT eligible	1	13	39	23	76
%	1.3%	17.1%	51.3%	30.3%	7.0%
CRTT eligible	16	38	77	72	203
%	7.9%	18.7%	37.9%	35.5%	18.8%
OJT	16	9	19	3	47
%	34.0%	19.1%	40.5%	6.4%	4.3%
TOTAL	90	178	403	410	1081
	8.3%	16.5%	37.3%	37.9%	100%

*Registered Respiratory Therapist
**Certified Respiratory Therapy Technician

Figure 4 represents the distribution of staff credentialings and their percentage in institutions other than hospitals.

FIGURE 4

	Pulmonary Clinics/ Phycisian Offices	Schools	DME Vendors	Home Health Agencies	Pool	TOTALS
RRT/CRTT	1	32	13	0	3	49
%	2.0%	65.3%	26.5%		6.2%	22.2%
CRTT	17	5	23	0	12	57
%	29.8%	8.8%	40.4%		21.0%	25.8%
CRTT/RRTe	14	3	14	0	0	31
%	45.2%	9.7%	45.1%	0		14.0%
RRTe	1	0	5	0	12	18
%	5.5%		2.8%	0	66.7%	8.1%
CRTTe	13	0	5	0	40	58
%	22.4%		8.6%		69%	26.3%
OJT	1	1	6	0	0	8
%	12.5%	12.5%	75%			3.6%
TOTALS	47	41	66	0	67	221
%	21.2%	18.5%	29.9%		30.3%	100%

The number of new positions (not replacement positions) which have occured in Arizona in the past five years for respiratory care employees, as well as the number of new positions which will occur within the next five years are represented in Figure 5.

FIGURE 5

	New Positions Past 5 Years (1980-1985)	New Positions Future 5 Years (1985-1990)
Hospitals		
0-100	44	30
101-200	93	34
201-400	43	21
401 - up	76	24
Pulmonary Clinics/Physician Offices	2	3
Respiratory Therapy Schools	8	15
Durable Medical Equipment Vendors	30	55
Home Health Agencies	0	0
Professional Contract Agencies	10	40
TOTALS	306	222

The graduates of respiratory therapy schools in Arizona (both technicians and therapists) for the past 5 years, as well as the projected graduates for the next 5 years are represented in Figure 6.

FIGURE 6

Respiratory Therapy Schools	Graduated Past 5 Years	Graduated Future 5 Years
	1875	2155

Figure 7 represents the breakdown of experience of the O.J.T.'s reported in this survey.

FIGURE 7
Number of years of experience of O.J.T.'s

	# of O.J.T.'s	0-1 Year	2-5 Year	6-10 Year	10 plus Years
0-100	16			6	10
101-200	9		3	2	4
201-400	19		4	4	11
400-up	3			1	2
TOTALS	47		7	13	27