LEGISLATIVE COMMITTEE ON NEW LICENSING BOARDS

RESPIRATORY THERAPISTS

ASSESSMENT REPORT

1995

North Carolina General Assembly
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June 15, 1995

TO THE MEMBERS OF THE GENERAL ASSEMBLY:

Attached for your consideration is the assessment report on the licensing of respiratory care therapists (House Bill 1010). This report serves as both the preliminary and final assessment reports, as required under Article 18A of Chapter 120 of the General Statutes.

Senator David Parnell, Chairman
Legislative Committee on New Licensing Boards

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(1995-96)

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ASSESSMENT REPORT

Respiratory care therapists provide respiratory care services to patients under the direction of and in accordance with the instructions of a physician. Their services include, among other things, the diagnostic and therapeutic use of pharmacological agents related to respiratory care, mechanical and physiological ventilatory support, the insertion and maintenance of artificial airways, pulmonary function testing, and hyperbaric oxygen therapy.

There are over 2,200 persons practicing respiratory care therapy in North Carolina. These practitioners work primarily in the hospital and home health environments. Of special concern to the proponents of the legislation are the training and competency of respiratory therapists working in the home health care setting, where the on-site, direct supervision found in the hospital setting is not present. Employees and independent contractors of hospitals performing respiratory care services are exempt under the proposed legislation. According to information filed with the Legislative Committee on New Licensing Boards, over two-thirds of the states regulate the practice of respiratory care in some manner.

Under the proposal to license respiratory care therapists contained in House Bill 1010, a North Carolina Respiratory Care Advisory Council would be created under the Board of Medical Examiners. The Council, a 7-member group consisting of four respiratory care practitioners, two physicians practicing pulmonology, and a public member, would be responsible for the licensure and disciplining of respiratory care therapists. Each applicant for a license must complete an educational program in

respiratory care approved by the Commission for Accreditation of Allied Health Educational Programs and pass the entry-level examination given by the National Board for Respiratory Care, Inc. A person who has passed the exam by October 1, 1995, may be granted a license. Anyone else practicing respiratory therapy as of that date can obtain a temporary license, which gives the person two years in which to take and pass the exam in order to become licensed. A provisional license is available for 12 months to a person who has completed the approved educational program and has applied to take the exam. A provisional license allows the provisional licensee to work under the supervision of a licensed practitioner.

The Legislative Committee on New Licensing Boards makes the following findings:

(1) The unregulated practice of respiratory care therapy can substantially harm or endanger the public health, safety, or welfare, and the potential for such harm is recognizable and not remote or dependent upon tenuous argument.

(2) The Committee was unable to make a finding on whether respiratory care therapy possesses qualities that distinguish it from ordinary labor.

(3) The Committee was unable to make a finding on whether respiratory care therapy requires specialized skill and training.

(4) A substantial majority of the public does not have the knowledge or experience to evaluate the practitioners' competence.

(5) The public cannot be effectively protected by other means.

(6) Licensure would not have a substantial adverse economic impact upon consumers.

The Legislative Committee on New Licensing Boards recommends the licensing of respiratory care therapists, but recommends that the General Assembly carefully review the scope of practice for respiratory care therapists, as defined in House Bill 1010, to ensure that it is not too broad and reflects only those activities that a respiratory care therapist should engage in.

This assessment report is based on the proposal to license respiratory care therapists, as contained in House Bill 1010. Information submitted to the Committee on this proposal is attached.

90LLJ-880

RECENT HISTORY OF RESPIRATORY CARE LICENSURE EFFORTS IN NC

1987--approved by the Committee for New Licensure Boards, referred to State Government Committee; time ran out

1989--killed in the Committee for New Licensure Boards

1993--approved by the Committee for New Licensure Boards, the State Government Committee, and referred to the Health and Human Services Committee; time ran out

Please take the time to read these facts about respiratory care, at least the last two pages which list scientific studies showing that using trained respiratory care practitioners saves money and suffering. The respiratory therapists and technicians of North Carolina do not have a rich, powerful political organization to present our case. However, we are very much in touch with the patient population of this state. Thank you you for your efforts to represent the people of this state in the midst of so much information from so many sources.

WHY LICENSURE ?

We have met,and will continue to meet, with representatives of the hospital association and the medical society asking them for guidance as how to assure competency of respiratory care givers in North Carolina; we have asked them for alternatives to licensure. All we want is definition and regulation of respiratory care to protect the public.

WHAT OUR BILL PROPOSES

1. All RCP must have a license from the Respiratory Care Advisory Board of the NC Board of Medical Examiners

2. Permits will be granted to RCP who have passed the National Board for Respiratory Care (NBRC) entry level examination; all of the thirty-seven states which regulate RC use this examination as the basis for regulation.

3. Temporary permits will be granted to

a-students of AMA-approved respiratory care programs

b-graduates awaiting NBRC exams

c-special cases, such as RCP from out of state pending formal licensure

d-RCP who are not NBRC eligible or credentialled, i.e., OJT's (see below)

4. "grandparent clause" Persons working in respiratory care (as defined in the act) who are not NBRC credentialled or eligible will have two years in which to pass an exam. This exam will be the NBRC entry-level exam, which the NBRC will administer for licensing purposes. Upon passing the exam, the person will be issued a permit, but will not be credentialled by the NBRC. The NCSRC will assist these persons in preparing for the exam with study materials, mock tests, and review sessions. The goal here is that, after a certain future date, all RCP will have demonstrated minimal competency, that is, passed the NBRC entry-level exam.

5. The advisory board will consist of four RCP's , a public member, and two physicians.

6. The board will establish continuing education requirements for RCP.

7. Nothing in the act would infringe or interfere with the performance of other licensed healthcare providers, such as MD, EMT, LPN, RN, PT, RD, RPh, or others.

8. Nothing in the act encourages or mandates direct third-party reimbursement of RCP.

9. Nothing in the act allows the practice of respiratory care except on the order of a physician (that is, independent practice is expressly forbidden). In its 40 year history, respiratory care has evolved and progressed not in spite of, but due to, physician medical direction.

BACKGROUND INFORMATION ON RESPIRATORY CARE IN NC

1. Human Resources-The NCSRC conducted surveys of all NC hospitals in 1987 and 1990 to see what kind of and how many RCP are out there. According to the 1990 study

a-Total number of RCP in hospitals 2000

b-NBRC credentialled or eligible 1550

c-Other credential (eg., EMT, LPN) 100

d-OJT's enrolled in non-traditional educational programs 150

e-OJT 200

f-Estimated RCP in homecare 150
(the training-or lack of training-of RCP outside the hospital is of special concern to us.)

2. Educational Programs-there are thirteen respiratory care programs in the community college system of NC. This is up from seven programs from when we did our first human resources study. These programs will graduate 150 respiratory therapists or technicians this year (150-175 in coming years) compared with 60-65 in 1987. We think that the supply of new graduates meets the demand and will continue to do so.

3. Other states-Thirty-seven states and Puerto Rico have some form of legal definition and regulation of respiratory care. Six or seven other states will hear proposed legislation in 1995. All the states bordering NC regulate the practice of respiratory care. (Are unlicensed and non-competent persons moving from these states to work in NC?) The NBRC entry-level exam is the basis for regulation in all these states; this reciprocity eliminates any mobility problems between states.

4. Support-Professional organizations supporting licensure for RCP in NC include

- -NC Thoracic Society
- -NC Lung Association
- -NC Chapter- American Academy of Pediatrics
- -NC Pediatric Society
- -American Society of Anesthesiology (which has directed its state affiliates to testify in favor of RC licensure)
- -NC Association of Medical Equipment Dealers
- -American Lung Association of NC
- -numerous allied health groups.

RESPIRATORY CARE LICENSURE AND COSTS

It has been claimed that respiratory care licensure would increase health care costs. Not only has this claim never been proven, but it has been shown repeatedly that the utilization of trained respiratory care personnel reduces costs to patients by reducing length of stay and number of procedures actually needed per patient and more effective staff utilization. Furthermore, net costs savings to the hospital are also realized and reduced personnel turnover is often reported. A benefit which it is difficult to assess in dollars is the increase in appropriateness of respiratory care which keeps many patients from progressing to the costly critical care areas. A cursory scan of the literature turns up the following relevant studies concerning utilization of licensed and/or trained RCP.

The studies which are summarized below were published in the journal, Respiratory Care. Following these are summaries of pertinent studies from other sources. Credentialled RCP were used to evaluate patients and iniatiate, evaluate, and modify therapy on a physician's order and using a protocol approved by the medical staff .

5/1981 Lutheran Medical Center,Wheatridge, Colorado
- -decreased # treatments to COPD patients from 30 to 20 per admission
- -decreased # treatments to orthopedic patients from 30 to 4 per admission
- -decreased RCP turnover from 44% to 7%

12/1980 Northwestern University Memorial Hospital, Chicago, Illinois
- -decreased costs of respiratory care to patients by 48%
- -decreased # procedures by 58%

1/1986 York Hospital, York, Pennsylvania
- -used RCP to evaluate necessity for oxygen for BCBS guidelines; cut costs by 62%

3/1989 University of Virginia Medical Center, Charlottesville, Virginia
- -decreased inappropriate orders for bronchial hygeine procedures from 48% to 11%

11/1990 University of Washington Medical Center, Seattle, Washington
-decreased chest physiotherapy procedures by 64%
-decreased inappropriate orders for respiratory care by 30%

11/1990 Saint Mary's Regional Medical Center, Reno, Nevada
-RCP evaluation of oxygen use decreased oxygen hours by 20%

10/1982 Blue Cross of Western Pennsylvania, Pittsburgh, Pennsylvania
-use of credentialled RCP in home care saved an average of $2,625/patient per year
-Blue Cross of Western Pennsylvania added RCP to home health benefits
-Federal Black Lung Program added RCP to home health benefits

1983 Northwestern University Memorial Hospital, Chicago, Illinois
1989 University of Virginia Medical Center, Charlottesville, Virginia
1985 University of California, Los Angeles, California
1987 Parkland Memorial Hospital, Dallas, Texas
1985 University of California, San Diego, California
-the studies above show similar reductions in costs, number of procedures, and LOS

OTHER PERTINENT STUDIES

1985 Blue Cross and Blue Shield Audit, Fargo, North Dakota
-cost and usage of respiratory services is a greater section of the total bill when the services are delivered by the uneducated individual, eg.,
- $7.04 per day for educated provider and $22.76 for the uneducated provider
-$12.50 per day for educated provider and $20.87 for the uneducated provider

1992 American Association for Respiratory Care, survey results are being reviewed by Arthur Anderson Company, to be published in 6/1993
-study of salaries of respiratory therapists in licensed states versus RCP in unlicensed states shows unlicensed therapists with slightly higher salaries(no statistical difference); states with licensure have lower job turnover

1985 University of Chicago, Chicago, Illinois
-study of 157 occupations comparing licensed versus licensed persons showed no difference in salaries and decreased job

turnover among licensed persons

7/1986 New England Deaconness Hospital,Boston, Massachusetts
New England Journal of Medicine
-This study by Blue Cross Blue Shield and the Massachusetts Medical Society showed use of credentialled RCP decreased patient length of stay, decreased complications, decreased number of procedures, and decreased number of respiratory FTE's, resulting in savings to the patient and hospital.

PAPERS PRESENTED AT RESPIRATORY CARE OPEN FORUM DECEMBER, 1992

"Reduction of Unnecessary Care through Utitization of a Respiratory Care Plan"
Chase Cancer Center, Philadelphia, PA
-decrease in bronchodilator treatments, 49%
-decrease in chest physiotherapy, 93%
-decrease in LOS for thoracotomy patients, 1.5 days
-decrease in LOS for pneumonia patients, 0.8 days
-improved documentation of Medical Necessity by physicians

"Analysis of an Intubation Service Provided by Respiratory Care Practitioners"
Duke University Medical Center, Durham, NC
-cost savings due to centralizing equipment, $450,000
-cost savings due to respiratory care salaries versus anesthesia salaries not reported
-95% of patients successfully intubated by respiratory care (other 5% by anesthesia)

"Outcome of a Pediatric Utilization Review Program for Intermittent Respiratory Care"
Loma Linda University Medical Center, Loma Linda, CA
-decrease in direct labor hours, 45%
-decrease in total procedures, 40%

"Primary Patient Care Task Force: A Strategy to Change Utilization Patterns, Improve Quality, and Reduce Costs Outside of the Critical Care Unit"
UCSF Medical Center, San Francisco, CA
-reductions of one respiratory care practitioner round the clock (4.5 FTE). >$160,000

"Savings Associated with Therapist-Driven Protocols for Bronchodilators"
General Hospital Medical Cneter, Everett, WA
-cost savings for this single procedure, $40,000

-reduced staffing by 0.5 FTE for this procedure

"Reduction of Chest Physiotherapy by a Respiratory Care-Initiated Discontinuance Policy"
University of Washington Medical Center, Seattle, WA
-decrease of 1,381 chest physiotherapy procedures
-decrease in inappropriate physician orders from 64% to 20%

"A Strategy to Reduce Costs Associated with Pulse Oximetry in Non-Critical Care Areas"
UCSF Medical Center, San Francisco, CA (Open Forum, 1991)
-savings in rentals and supplies, $141,310
-reduced staffing in this area, 1.2 FTE

ALSO, TEN STUDIES FROM NC HOSPITALS WERE PUBLISHED IN THE FALL, 1994 NCSRC NEWSLETTER DEMONSTRATING THE BENEFITS OF UTILIZING TRAINED RCP'S

APPROXIMATELY 20 PAPERS PRESENTED AT RESPIRATORY CARE OPEN FORUM DECEMBER, 1994 AND 1994