

JUN 16 2014

Daniel H. Ericson, RCP

Tom Luce, member
c/o Sunset Advisory Commission
PO Box 13066
Austin, Texas 78711

Re: May 2014 Sunset Advisory Commission report

Sir:

I am writing today to emphasize the mistake that the Sunset Advisory Commission is making with the proposal to discontinue the Respiratory Care Practitioner's (RCP) program that is currently under the regulations of the Texas Department of State Health Services (DSHS).

To de-license or deregulate, that is the question?

Most of the debate to continue licensing for any particular specialize group of individuals is to maintain the educational, social, and ethics of their profession. An individual remains align within the profession he/she chooses and maintains that standard according by this license.

Yes, there may be some truth that individuals will continue to align professional without being watched by 'big-brother', but this is not why I am writing today.

I feel that the de-licensing of RCPs will deeply hurt the current healthcare arena as a whole. I have been working in an acute hospital setting here in Texas for the last 23 years, so I will confine my discussion to this area. Let me select a number of examples.

1] Code Blue, Code Heart, or Code 99, any of these names refer to emergency situations that the patient has stopped breathing and/or heart functions. Many times before a code is called, the nurse or RCP can intervene by calling the physician in charge. If the communication with the physician is not established in a timely manner a pre-code alarm is called, in our institution we call a Code Green. Three individuals then respond, the director of nurses, the nurse taking care of the patient, and a RCP. Licensing allows the RCP to be a part of this integrated code team. In this situation, the RCP has as much at stake with the welfare of the patient as does the nurse. True we practice within a set of guidelines, established by the hospital itself, but these guidelines, like a set of laws, are subject to interpretations. We have to work outside of the guidance of the (absence) physician until a physician is found, many times too late in the process of saving the life of the patient. Interventions that the RCP would carry out include drawing blood, giving oxygen (a drug in itself), a breathing treatment (another drug), intubating the patient, and placing the patient on life-supporting measures. Licensing allows the RCP to take ownership of these critical and crucial moments. Many times, a matter of minutes pass, thus preventing the proper individuals of the team to provide the necessary help for the patient. Does someone really believe that the physician is called 2:00 AM to solve these problems?

2] Licensing of RCPs allow us to stay on board, tracking only the interventions (procedures) that we take ownership in. Yes, institutions can adjust these interventions as needed, requiring the RCP to carry out duties not assign to us. If a code is called the RCP focuses on the respiratory/cardiac intervention side, leaving the other team members to focus on their particular strengths. Can a nurse intervene and provide respiratory care, yes: For example, functions are sometimes reverse due to how individuals are position within the room -- whose closes, or furthest, from the patient. Other times another department is helping, or there is failure of the RCP or the nurse to response to code, once it is called. The license RCP takes ownership with their set interventions at the soonest available time that he/she is available to care for the patient at hand. A license RCP does not waver from the duties of a RCP.

3] Many of our functions in our institution require RCPs to translate information to the physicians. We recently had a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) visit, and I was asked, by JCAHO, about our involvement within the patient care arena. JCAHO was very interested to know if we had a license as RCPs, and how we interacted with the physicians in carrying out orders. With a license a RCP can assess the patient, call the physician, write the intervention, and carry out the necessary procedure in a timely matter. This is what JCAHO wanted to hear from the RCP community.

Most cost of dealing with the patient's care is due to the slowness of the healthcare delivery system. This is well document within the literature. RCPs in our institution can streamline through some of this by making 1 phone call instead of 2 or 3 to the physician.

Here is the long way of doing the same thing:

- a] The nurse calls the physician to inform the physician something is wrong, with the patient. The physician asks the nurse to obtain an arterial blood gas (ABG) on the patient. ABG's are used to assess respiratory functions.
- b] The nurse calls the RCP to tell him/her of an ABG order.
- c] The RCP arrives bedside, draws the blood, runs the sample (because of a license), and calls the physician with the results.
- d] The RCP writes the order (because of a license) and places the patient on oxygen (a drug).
- e] The RCP comes back 20 minutes later to find out the oxygen is not working and must call the physician again.

In the above example, this is a typical problem, if the RCP did not have a license, [c] the RCP could not run the blood sample --the lab would probably have to run the sample. The RCP could draw the sample, but the lab technician would prevent non-license individuals to run samples. JACHO requirements would further prevent the RCP from running the sample. Further, the lab, or the nurse would have to call the physician, because a non-license individual is not allowed to communicate results, due to the provision within the Health Care Financing Administration act (HCFA). [d] The lab could not write the orders, so the nurse would have to wait for the lab to publish the results and then the nurse could call the physician with the results. Now the nurse needs to call the RCP back to inform him/her that an order for oxygen was written and needs to be carried out. [e] The RCP informs the nurse that the oxygen is not working and informs the nurse he/she must again call the physician so that some other intervention can be started. This shows how cumbersome this simple process will get.

4] Many of our physicians rely on our knowledge base to provide proper direction in treatment of their patients. True education is probable all that is needed. Licensing is only a burden. But true ownership of the responsibility within the RCPs field is dictated by the scope of what is within our license. Mechanical ventilation is a great example. Any nurse with some experience in an intensive care unit (ICU) can operate a mechanical ventilator. The ownership of the mechanical ventilators is under the direction of the RCPs who monitor, maintain, direct, and

control the usage of such equipment. A license requires individuals to update their education with continuing education units (CEU), most RCPs focus on their primary area of interest for this update. So an ICU RCP would focus on mechanical ventilation for example. Without this, most RCPs would continue within their field without any advance education except for the requirements on their job. Within most institution that requirement means taking CPR every two years, and citing federal, and state regulations. CPR which is the driving force of keeping patients alive in codes, is only required every two years in most hospitals. Going back to the assumption that the hospitals, or the public will police the RCP field, how is updating a CPR card every two years going to make me a better RCP?

5] With a RCP license, each institution can establish therapist-driven protocols that allows quicker interventions and provide solutions that then allows the RCP to inform the physician of the remedy to a problem after it is addressed and solved. Therefore a physician called at 2:00 AM, will only need to be called once when the patient is back to status quo. The physician does not have to be interrupted several times for a mundane problem that a license person should be able to address and solve.

6] With de-licensing all of this RCP (lingo) will go away. We will be called respiratory therapist, actually, we will be called respiratory technicians, because we will not be able to assess, order, and evaluate our patients. Third-party reimbursement will cease within the respiratory arena. Healthcare delivery will be suppressed due to the time constraints. Respiratory technicians will more than likely fall again under the direction of nursing again. This will reduce the number of respiratory technicians in the field.

Specialize positions in the healthcare field should be continued with individuals license to perform in these critical fields and not surrender due to the lack of control due to regulatory agencies that do not have time to censor individuals that do not belong in these fields in the first place. A patient must have the right to know that the individual treating him/her is license and not just the person under a watchful eye of say -- the nurse.

A handwritten signature in black ink, appearing to read "Daniel H. Ericson, RCP". The signature is stylized and cursive, with the letters "D", "H", and "E" being particularly large and prominent.

Daniel H. Ericson, BSRC, RRT-NPS, RPFT, RCP