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Senator Jane Nelson
Chair, Sunset Advisory Commission
Department of State Health Services
P.O. Box 13066
Austin, Texas 78711

Dear Senator Nelson:

As President of the American Association for Respiratory Care (AARC), a national professional association representing over 53,000 respiratory therapists including the interests of the 14,568 respiratory therapists in Texas, I am writing to express the AARC's grave concerns and strong opposition to the proposal to discontinue the Respiratory Care Practitioners (RCP) program currently regulated by the Texas Department of State Health Services (DSHS).

A vote by the Commission to accept the recommendation noted above would remove from state law the title act and enabling statute as well as any reference to the licensure, certification, or registration of RCPs. Such action could have dire consequences for both Texas RCPs and their patients throughout the state who have been diagnosed with chronic lung disease.

The 119 page (including appendices) Sunset Advisory Commission Staff Report assesses and evaluates a wide range of programs and responsibilities that come under the umbrella of the DSHS. Our concerns and comments focus on Issue 3, *The Unmanageable Scope of DSHS' Regulatory Functions Reduces Needed Focus on Protecting Public Health*, which addresses the regulation of professions and disciplines currently under their purview. In our comments, we use the terms "respiratory care practitioners" as they are referred to in Texas and "respiratory therapists" as they are referred to elsewhere interchangeably.

Background

Appendix G provides an overview of the staff review activities in compiling the subject report. According to the report, staff solicited written comments from various interest groups, stakeholders and the public. However, to the best of our knowledge, no one from the AARC, the Texas Society for Respiratory Care, or the National Board of Respiratory Care (NBRC) which administers the professional credentialing examinations to qualified

graduates of accredited respiratory therapy education programs- clearly important stakeholders in the issue of de-licensing RCPs in Texas - was ever contacted or had knowledge that public comments were being sought on this matter.

While we can appreciate the magnitude of the regulatory burden facing the DSHS, we believe the Sunset Advisory Commission (herein referred to as the “Commission) does not have adequate information regarding the respiratory therapy profession as it makes its deliberations with respect to the impact these professionals have on public health and safety in Texas. This is evidenced by the fact that the discussion of the criteria used to determine programs that should be discontinued under DSHS’ authority never once mentions RCPs except to list the profession in a chart with check marks as to the criteria it is believed to meet to be discontinued.

Respiratory Care Scope of Practice

Appendix E describes licensed RCPs as the following:

“Licensees treat, manage, control, evaluate, and care for patients who have deficiencies and abnormalities associated with the cardiorespiratory system.”

While we appreciate the need for brevity in the chart itself, we question whether the Sunset staff reviewed the Texas statutory language that describes the breath of the RCP scope of practice in evaluating its complexity and details of care, or whether staff actually talked with respiratory therapists.

Without a full understanding of what the profession of respiratory care actually encompasses and requires, the Commissioners cannot possibly render any type of reasoned vote or decision on the future of state licensure for the RCP profession.

The Texas statute defines “respiratory care procedure” as the following:

Sec. 604.001. DEFINITIONS

(5) "Respiratory care procedure" means respiratory care provided by the therapeutic and diagnostic use of medical gases, humidifiers, and aerosols, the administration of drugs and medications to the cardiorespiratory system, ventilatory assistance and ventilatory control, postural drainage, chest drainage, chest percussion or vibration, breathing exercises, respiratory rehabilitation, cardiopulmonary resuscitation, the maintenance of natural airways, and the insertion and maintenance of artificial airways. The term includes a technique used to assist in diagnosis, monitoring, treatment, and research, as ordered by a patient's physician, including:

(A) the measurement of ventilator volumes, pressures, and flows;

(B) the specimen collection of blood and other materials;

(C) pulmonary function testing; and

(D) hemodynamic and other related physiological forms of monitoring or treating the cardiorespiratory system.

Even the language in the Texas statute does not fully convey the reality of the respiratory care profession. For example, respiratory therapists are the only allied health care professionals educated and competency tested in all aspects of pulmonary medicine.

Respiratory therapists treat, across the health care site continuum, high-risk patients with both acute and chronic conditions. These include adults and children of all ages who require mechanical ventilation and those with other intensive care needs, as well as patients suffering from asthma and chronic obstructive pulmonary disease (COPD), including emphysema and chronic bronchitis.

Attached are the Content Outlines for the Certified Respiratory Therapist (CRT) exam and the Registered Respiratory Therapist (RRT) exam administered by the NBRC that graduates of accredited programs are expected to have mastered during their years of formal education. Texas law requires applicants for a RCP license to hold at a minimum the CRT credential. The advanced RRT credential builds upon the CRT exam. A growing majority of Texas licensed RCPs have earned the advanced RRT credential.

Criteria Used to Determine Deregulation of Certain Programs

The report states that Sunset staff gathered standard data on 70 programs and developed a matrix of questions in determining whether a program should be discontinued from DSHS authority. The staff concluded that if at least two of the six criteria were met, it should be considered for deregulation. Respiratory Care Practitioners met four of the criteria according to the chart on page 46 of the report. Our comments on those criteria are noted below:

1. Would deregulation have little impact on public health or safety?

One of the criteria in determining whether regulatory programs remain in DSHS is to determine the risk to public health using a risk-based matrix. According to the report, “risk matrices compare license types against each other based on risk factors such as the primary consumers, number of consumers, and risk to consumers if an error occurs. For example, potential high risk programs are considered to be preventing foodborne illnesses and radiological disasters while the manufacturing, sanitizing and selling of new and used bedding is a low risk program.

Thus, it is critical to evaluate how the risk and cost of treating patients with chronic lung disease fit into the equation of protecting the public’s health when people’s lives are at stake. For example, there are a significant number of Texans that warrant the treatment regimen, assessment and care provided by licensed RCPs.

- COPD is the 3rd leading cause of death in the United States according to the Centers for Diseases Prevention and Control.
- According to the data from *May 2013 Report on the Prevalence of Lung Disease in the United States* by the American Lung Association, in Texas there are:
 - 559,153 children with Pediatric Asthma
 - 1,393,546 adults with asthma

- 1,027,506 diagnosed with COPD
- The Centers for Medicare and Medicaid Services' (CMS) 2012 *Medicare Chronic Conditions Dashboard: State Level* shows the percentage of Medicare beneficiaries in Texas with COPD and asthma who present with 5 or more other chronic conditions at 57.50% and 54.20%, respectively, both of which are higher than the corresponding national averages of 51.84% and 46.82%.
- According to the CMS Dashboard, per capita Medicare spending in Texas for beneficiaries with 6 or more chronic conditions was \$34,260 compared to the national average of \$30,214.

The reason State legislatures undertake the process of requiring licensure of a health profession is because there is a recognition that without mandated standards and criteria from those who provide the services, the health and safety of the citizens of the state is jeopardized.

Licensure of the respiratory therapist can ensure that respiratory therapy services provided to patients in any setting are performed by a respiratory therapist who meets standards of accredited education and competency that the state deems necessary to render such care. As individuals, we expect as much from professions performing services not nearly as technical, life-sustaining, or critical to the well-being of family and friends. We should expect the same from the respiratory therapist performing life-sustaining procedures, diagnostic evaluations and rendering interpretations of a patient's condition.

The profound negative impact of de-licensure would permit unqualified and undocumented individuals the unfettered legal ability to attest that they are RCPs and perform the ranges of services outlined in both the CRT and RRT Content Outlines for which they may not be competent. We implore the Commission to prevent this from happening by continuing to license RCPs in Texas to protect public health and safety.

2. Do practitioners operate in a highly regulated environment?

The critical element to be considered in licensing is patient care and access to qualified health professionals. As noted elsewhere, the practice of respiratory care should be regulated to protect the public from the unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care.

Traditionally, hospital control has been considered appropriate in regulating the services provided within its domain. But this view was developed at a time when the hospital was at the apex of medical care in the United States. It was a time when physicians made house calls and sicker patients were sent to hospitals for treatment.

Today, the health paradigm is quite different. The hospital is not the only alternative for medical care. More and more respiratory therapists are providing services as employees of durable medical equipment companies, home health care agencies, hospice centers,

outpatient clinics and centers, physicians' offices, and as asthma disease managers and smoking cessation counselors.

Without licensure laws, employers may take less time to provide the necessary oversight to determine whether the person who is providing respiratory therapy has the appropriate education and training or is competency tested. Further, with large numbers of patients being discharged "sicker and quicker" in today's cost containment environment, more fragile patients will need care by licensed and competent staff outside of the acute care arena.

3. Is regulation also provided by another state or local regulatory programs or private sector accreditation?

This criterion looks at those situations in which DSHS regulates a program while at the same time it is regulated at the state or local level. Examples given where an overlap exists include manufacturers who bottle and sell water in Texas and food handlers or restaurant workers. With respect to private sector accreditation, it is available to a number of healthcare professions but accreditation is not the same as licensure nor does it take the place of licensure.

The NBRC, which we noted earlier, is a voluntary credentialing agency that administers professional credentialing exams to students who graduate from accredited education programs to become a "certified" or "registered" respiratory therapist. The NBRC is not structured to assume the responsibilities required by states when licensing health care professionals. For example, it cannot check criminal and abuse backgrounds of individuals applying for its voluntary credentials; only licensing boards do that.

The NBRC is not in a position to legally enforce actions taken against therapists who commit practice offenses or demonstrate other behaviors that would cause someone to question the practitioner's ability to perform his or her duties in a competent and professional manner. Moreover, the NBRC has no investigative or subpoena powers to gather the information to fulfill this function.

4. Does the program generate little regulatory activity?

This criterion assumes that if there are limited inquiries as to complaints, enforcement actions or investigations within a program given the number of licenses, there is a low-risk for harm. One could also argue that because there is relatively little regulatory activity involving disciplinary actions and assessment it can mean that licensure is "doing" its job and indeed is preventing unqualified RCPs from entering the profession.

We do not have access to the information and data on disciplinary and investigative actions of RCPs under the Texas Professional Licensing and Certification Unit; therefore, we are not in a position to comment directly on whether deregulation under this criterion with respect to RCPs is appropriate or not. However, the answer is not to discontinue or

de-license Texas RCPs but to strengthen the regulatory authority over the profession, a move that would be welcomed by Texas RCPs.

If there are systemic structural issues that limit the authority to pursue investigations and disciplinary actions, they should be fixed. We firmly believe that to summarily recommend 14,568 RCPs be de-licensed because the agency has not been given the tools to robustly regulate the profession is unacceptable not only to the RCPs but the millions of Texas patients with lung disease who are and will be cared for by RCPs in their state.

Alternative to Discontinuing RCP Programs under the Auspices of DSHS

A key question for occupational licensing is “Does the occupational licensing program serve a meaningful public interest and provide the least restrictive form of regulation needed to protect the public interest?”

In addition to discontinuing certain programs, the Sunset Staff Review recommends transferring 12 regulatory programs from DSHS to the Texas Department of Licensing and Regulation (TDLR). The report states that these programs would be better suited under the TDLR authority in addition to being better managed.

The fact that RCPs are included with opticians, x-ray technicians, dietitians, food handlers, food managers and personal emergency response systems as professions to be discontinued while orthotists, prosthetists, professional counselors, social workers, midwives, and speech-language pathologists and audiologists are to be transferred to TDLR makes absolutely no sense and indicates a complete lack of understanding on the part of the Sunset staff as to the value of state-licensed RCPs.

Continuing licensure for RCPs is critical to continuing continuity of care for those with chronic lung disease in Texas. Patient education and proper device selection for both inhalers and oxygen systems are critical for optimal clinical outcomes and cost effectiveness. Respiratory therapists are experts in this field. Teaching patients with chronic lung disease to recognize the symptoms and triggers of their disease can prevent acute exacerbations that lead to costly emergency department and inpatient hospital admissions and readmissions. Respiratory therapists’ expertise bridges the gap in fulfilling chronic lung patients’ needs in order to minimize unnecessary, ineffective or wasteful interventions.

Recommendation:

- The AARC is strongly opposed to, and cannot support in any way, the deregulation and de-licensing of respiratory care practitioners in Texas for the reasons discussed above.
- As an alternative, we recommend transferring licensing authority for respiratory care practitioners to the Texas Department of Licensing and Regulation and include them in the first phase of the transfer to begin September 1, 2015 to be completed by August 31, 2017.

Advantages to Licensing Respiratory Care Practitioners

Continued licensure for respiratory therapists in Texas under the auspices of the TDLR has numerous advantages. It provides the least restrictive regulation for public protection by requiring the individual to have successfully graduated from an accredited respiratory therapy education program and have passed a valid competency examination. Continuing education requirements help maintain and update a therapist's knowledge in the field. These requirements alone establish a baseline for competency in providing respiratory therapy services.

It is not enough to assume that other state or local regulatory programs are sufficient to replace licensure of RCPs. Although respiratory therapists work at the direction of a physician, they often practice without direct supervision and exercise a great degree of independent judgment, especially outside of the hospital setting. A high degree of specialized education and clinical skill is essential in treating serious respiratory illnesses. Without assurances as to the competency of the individual, injury and even death can result from even the most routine interventions (e.g., administration of medical gases) due to incompetent practice. Licensure adds a safety net for patients.

State respiratory therapy licensing boards across the nation participate in a consortium that submits disciplinary action activities to a clearinghouse administered by the NBRC. Respiratory therapy licensing boards may access this data bank when reviewing licensure applications. If Texas decides to de-license respiratory therapists, they would no longer have access to all the other respiratory therapy state licensing board disciplinary data bases to verify the status of the respiratory therapist applicant.

In 49 states, the District of Columbia, Puerto Rico and Guam, the profession of respiratory therapy is regulated; that is, it is licensed by the state. Only Alaska at present has no state oversight of the profession. Alaska is in the process of addressing state licensure for respiratory therapists.

If Texas were to repeal licensure, it would become a refuge as the only state in the contiguous United States without respiratory therapy licensure. Texas would become a magnet for individuals who do not meet the qualifications for licensure in their own states. Texas would become a haven for those who have had their license rescinded or attract those who had committed an act that would render them ineligible for licensure in other states.

Conclusion

Continued licensure of RCPs in Texas is mandatory to protecting the public's health and safety.

The AARC strongly recommends the Commission give special consideration to transferring RCPs to the licensing authority of the TLRB rather than deregulating them and effectively wiping the profession from the books, which can have a demoralizing effect on the dedicated RCPs who provide care to the multitude of Texas patients diagnosed with chronic lung disease.

As a national professional association representing the interests of tens of thousands of licensed respiratory therapists across this country, the intent of the AARC's comments is to provide a much more detailed and accurate explanation of the profession as a whole. This is especially important given the fact that in Issue 3 there is absolutely no discussion of the regulatory burden of RCPs under the DSHS programs except mention in a chart with check boxes.

Respiratory care practitioner licensure in Texas has been a success and has accomplished the intent of the legislature, which is to protect the public safety and health from incompetent individuals rendering the complex cardio-pulmonary services and procedures that is the profession of respiratory therapy.

Rescinding RCPs' licensure equates to removing any state scrutiny of the individuals who will provide life sustaining respiratory therapy to the public. The NBRC's voluntary credential is not a substitute for legal state licensure and should not be taken into account in the Commission's decision making.

The AARC urges you to use your authority as Commissioners to remove respiratory care practitioners from the list of health care professions recommended to be "discontinued" and, as an alternative, transfer the licensing authority of these professionals to the Texas Department of Licensing and Regulation where the function is better suited.

Respectfully,



George Gaebler, MBA, RRT, FAARC
President

Enclosures

CRT Exam Content Outline

RRT Exam Content Outline