REPORT

on the
Respiratory Care
Periodic Regulatory Evaluation Process (PREP)

From:

Respiratory Care PREP Committee

To:

Joann Schaefer, M.D., Chief Medical Officer, Director

Department of Health and Human Services Regulation and Licensure
(Department of Health and Human Services, Division of Public Health as of July 1, 2007)

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Executive Summary

2006-2007 Respiratory Care PREP

The Respiratory Care PREP Committee met nine times and made eight affirmations and eleven recommendations.

Affirmations

An affirmation is an acknowledgement of what is right about the regulatory system for Respiratory Care. Affirmations should support public safety and provide valuable information to others interested in improving the regulation of health professionals by noting something outstanding.

Affirmation #1: The public is protected by the current State regulation practice of using the national Certified Respiratory Therapist (CRT) examination given by the National Board of Respiratory Care (NBRC) as an entry level test for basic competency.

Affirmation #2: The title Licensed Respiratory Care Practitioner (LRCP) should be continued in Nebraska. Different credentials are used by respiratory care practitioners in other states and this can be confusing. However, until there is agreement on one title that will be recognized and used by all states, Nebraska should keep LRCP and encourage the LRCPs to also use specialty initials based on NBRC examinations.

Affirmation #3: Ten hours can be earned toward continuing competency requirements for license renewal when the LRCP passes nationally recognized specialty certification examinations related to an area of specialty practice in the field of respiratory care. Specialty certification is identified in the rules and regulations as an option to meet continuing competency requirements. This option encourages LRCPs to pursue advanced certification and increase competency.

Affirmation #4: The Board of Respiratory Care Practice (Board) has worked hard to assure regulations are in place that allow the public to receive needed respiratory care services. Essential to this effort has been the provision of flexibility in statute and regulations so there is access to quality services by the patient in a manner that is best for the patient. The Board:

a. Recognizes that the rural areas of the State do not have the number of respiratory care practitioners necessary to provide support, so other appropriately trained licensed health care professionals must fulfill those needs when necessary.
b. Encourages minimum standards that allow for flexibility to meet the needs of the patient by recognizing other professions have some training in areas where there is crossover with respiratory care practitioners. Appropriately trained health care professionals can therefore handle some of the respiratory care basics when necessary as outlined in statute.

Affirmation #5: Respiratory Care Practitioners have historically recognized a concern about access to respiratory care services in Nebraska. The respiratory care statutes were written to exempt nurses, pharmacists, physical therapists and other licensed professionals acting within their scope of practice to allow more access to respiratory care services when a respiratory care practitioner is not available.

Comment: The delivery of respiratory care in Nebraska may not be the same throughout the State. There exists a difference in care mainly because some areas of the State lack numbers of patients needing respiratory care and numbers of LRCPs to provide services.

Affirmation #6: In general, the Board and LRCPs have established good working relationships with other health professions and work to promote public safety.

Affirmation #7: The credentialing support provided for the Board and profession is excellent. Department administration and staff are available to advise and suggest options. The value of an assistant attorney general assigned to the Board by the Office of the Attorney General is recognized.

Affirmation #8: Durable Medical Equipment (DME) providers supply necessary services. **Most** are using appropriate personnel if they are providing respiratory care.

Comment: The importance of following existing respiratory care statutes when providing respiratory care services in order to protect the public from harm is recognized by most DME providers. Statutes pertaining to the practice of respiratory care require that if a practitioner is providing respiratory care, he/she is a LRCP or an appropriately trained licensed professional.

Recommendations

Recommendations are suggestions for improvements to the regulation of respiratory care.

Recommendation #1: Consider options to improve regulation by making changes in the continuing competency requirements for respiratory care licensure renewal:

a. A major change in continuing competency requirements was made during the 2006 renewal period (attestation instead of pre-approval). The Board and Department staff should evaluate the impact of this change.
b. Coordination among the Board, the Nebraska Society for Respiratory Care, and the Department is needed to facilitate better communication between vendors of continuing education programs and LRCPs. The question "Does the continuing education program meet the continuing competency requirements for renewal of an LRCP license?" should have a clear answer.

c. Specialty certifications should be evaluated by the Board. While the NBRC sponsored specialty examinations have established requirements that increase competency, this may or may not be the case for all specialty certifications. Specialty certifications that increase the competency of a practitioner should be recognized. When appropriate, rules and regulations should state that the specialty certification will qualify as ten contact hours toward continuing education requirements for renewal of a license. (Example: The asthma specialty certification for LRCP is not by NBRC sponsored examination. Instead the examination is sponsored by the National Asthma Educator Certification Board. There are established requirements that increase competency and so it should be an option for continuing competency.)
d. Establish that passing the national registered respiratory therapist (RRT) examination offered by the National Board of Respiratory Care (NBRC) during the 24 month renewal period will qualify as contact hours toward the continuing education requirements for renewal of a license. The number of contact hours would be determined by the Board. The intent is to encourage RRT certification in the State. (The entry-level of CRT is all that is required to be credentialed as a LRCP in Nebraska.)
e. Add a license renewal requirement for 500 practice hours during the previous five years through a process modeled after that used by the nursing profession. This would involve developing a mechanism for this change in renewal requirements and considerations include:
    - Issuance of a temporary license
    - Refresher course requirement if not enough practice hours
    - Determine appropriate supervision
    - Evaluate and develop alternatives to passing the RRT exam within five years

Recommendation #2: The Nebraska Society for Respiratory Care and the Board should explore establishing Registered Respiratory Therapist (RRT) qualifications for Nebraska credentialing. Exploration should include:

a. At a minimum, monitor the direction of national requirements for respiratory care, and if the national entry-level standard for respiratory care changes from CRT to RRT, the Nebraska entry-level requirements should change accordingly;
b. Consider implementing two levels of Nebraska respiratory care credentialing based on entry-level requirements. One level would be based on achieving the CRT national certification and the second level would be based on achieving the RRT national certification;
c. Consider making Nebraska's entry-level requirement the RRT and establish a grandfather process for current CRTs;
d. Consider options for students from other states with respiratory care education programs offering only CRT; and
e. Consider a temporary license for CRT.

Recommendation #3: Establish the use of a jurisprudence examination as part of the requirements for initial licensure. Future options for continuing competency requirements may include adding the jurisprudence exam as an element for license renewal. (Jurisprudence means the science or philosophy of law; in this case, the Nebraska laws for the practice of respiratory care therapy.)

Recommendation #4: Consider steps to enhance and encourage communication with the public:

a. Pursue recent discussions about improved communication to the public. [Example: The board has discussed making educational information (brochures, electronic media) available to provide the public with a better understanding about the role of a respiratory care practitioner in health care.]
b. Pursue communication (brochures, electronic media) to explain the role of respiratory care in relation to sleep labs and the provision of certain durable medical equipment related to respiratory care.
c. Because of the increased reports regarding unlicensed respiratory care practice, consider a special education effort for health care providers and providers in the home who are not required to be credentialed.
d. Encourage communication about the role of the Board and the role of public membership on the Board. The goal is to improve understanding of the State regulatory system, and improve recruitment for boards.

Comment: These communication concepts would be valuable Department-wide for all health professions: What do you expect from your health provider? What services does the profession provide? What is the role of the Board? Brochures and other information available through the various health care settings (i.e. doctor's offices, health clinics) would be beneficial.

Recommendation #5: Consider steps to enhance and encourage communication within the profession and with other professions:

a. Consider utilizing the Nebraska Society for Respiratory Care (NSRC) as a conduit for improved communication about Respiratory Care State regulations, especially when changes are implemented.
b. NSRC could encourage membership in the State Society by offering society-sponsored socialization that includes education about the Society, State regulations and licensure to students in the State's respiratory care educational programs.
c. NSRC could distribute a flyer to all respiratory care students and LRCPs once a year with State society membership information (including the Web site). Consider distributing NSRC information about current professional issues, discipline and mandatory reporting concerns on a regular basis (i.e. newsletter, Web site, electronic media).
d. Encourage respiratory care educational programs to include discussion of the importance for interaction and communication with health professionals in other disciplines. Recognize that support for a teamwork approach can start in the educational program and carry through to professional practice and should be

encouraged as a part of the education programs for all health professions.

e. Encourage more communication to licensed respiratory care practitioners about the Board role. The goal is to improve understanding of the State's regulatory system and improve recruitment for boards.

Recommendation #6: Consider adding another LRCP to the Board along with an additional public member for a six member board. Diverse LRCP representation, in both the area of expertise and geographic locations, would be beneficial to the Board. LRCPs from outside the Lincoln and Omaha geographic areas and LRCPs with experience representing the varied scopes of practice for respiratory care (hospital, education, home care) should be encouraged to apply for Board membership. The Board should communicate with the State Board of Health to explain the importance of having LRCPs on the Board that represent professional and geographic diversity.

Recommendation #7: Clarify the practice overlap area related to EMT-P and continued care in the hospital. There is a difference between stabilization/transportation and ongoing disease management, and that should be understood.

Recommendation #8: There is a need for more communication among the boards. Consider a process for reaching mutual agreement on regulatory issues that affect more than one board (e.g. boards – nursing, respiratory care – considering an issue that impacts both). The Department has an informal process; however, most interactions with other boards are situational, not routine, and some routine interaction may be beneficial.

Recommendation #9: Update the Respiratory Care Practitioner statutes since there has been little statutory change in twenty years of technical advances in the profession. Such work would include considerations about anticipated future changes in practice, the appropriateness of current statutes, and any professional boundary issues that need clarification.

Recommendation #10: Conduct a study of sleep labs and sleep clinics in relation to respiratory care regulation. The qualifications of the people providing patient care in the lab/clinic are important and some may not have appropriate training. This creates a potential for harm to the public.

Recommendation #11: Conduct a study of Durable Medical Equipment (DME) and the provision of services by the DME industry. Encourage the DME industry to continue efforts to ensure that appropriate standards are in place within their profession. The potential for harm to the public exists especially since the DME industry often comes in contact with vulnerable members of the community.

a. Areas to explore include:
   - Educating providers and the public about requirements that must be met for public safety. Of special concern is the potential harm that exists when oxygen or other respiratory care services are provided by unregulated personnel in relation to DME. Collaboration with the respiratory care

providers, Society and Board on this issue is encouraged.

- Develop information handouts to increase public awareness. It is especially important that the public be given information when receiving equipment since this can be a confusing and stressful period. Important information should include: Clarification about the roles and responsibilities of various personnel (pharmacist, DME driver, LRCP); Easy-to-read information about essential patient care considerations while using the equipment; and who to contact for answers to questions. (When oxygen is provided, a licensed and appropriately trained provider must be consulted with patient care and use questions.)
- Develop guidelines that can be followed by all DME providers. This could include what kind of information should be given to patients and their families.

b. The Department should make an effort to communicate the DME discussion held with the Respiratory Care PREP Committee to DME providers.

Comment: While most DME providers (see Affirmation #8) are doing everything right to supply needed services, there are some providers that may not understand and/or completely comply with the existing statutes. The intent of Recommendation #11 is not to impose some kind of new regulation on DME providers but to encourage DME providers to look at their practices and see what can be done to help assure public safety.

Introduction

The Periodic Regulatory Evaluation Process (PREP) is a product of Nebraska Credentialing Reform (NCR). In January 1999, the report, "A Model for the Regulation of Health Care Professions by State Government in Nebraska: Part 2 of the Study Directed by LB 183" was published after many months of work by the NCR 2000 Steering Committee. The Legislative study was to result in a comprehensive design for a model system for the credentialing and regulation of health care practitioners and providers in Nebraska. The Department of Health and Human Services Regulation and Licensure has been implementing many of the 144 NCR recommendations. Involvement by the public, professional organizations and credentialed individuals has been and will continue to be important in the implementation process.

The report uses the term *credentialing* to encompass licensure, registration, and certification. In the NCR implementation work, there has been a great deal of discussion about the regulatory system. The *regulatory system* has been defined as the programs and procedures pertinent to the State's administration, monitoring and discipline of persons or establishments possessing some form of license, registration or certification from the State to provide health care and/or environmental services. The terms *regulatory system* and *credentialing system* are interchangeable as used in the NCR project.

Credentialing – from the National Perspective:

Today, professions credentialed by states are encouraged to support nationally accepted standards and uniform definitions. This is apparent in standards of practice definitions, school curriculums, education requirements, and examinations for initial licensure.

Some professions have developed model practice acts and encourage states to adopt the model practice acts.

Many of the national reforms have been encouraged and documented by the Pew Health Professions Commission. In December 1995 the organization published *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century.* Since then, a 1998 publication, *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation,* has expanded on issues.

Created by The Pew Charitable Trusts in 1989, the Pew Health Professions Commission has developed recommendations for change in health professions education and advocated for the development of policies which respond to the nation's health care workforce needs. The Commission has initiated and sustained what many believe to be a national movement for change in the health professions education and workforce policy.

The 1995 report included ten recommendations that were a part of the orientation for the PREP Committee. From the report introduction [page vi-vii]:

> "Health care workforce regulation has developed over the last century into fifty separate state systems creating a complex and often irrational organizational patchwork. The lack of uniformity in language, laws, and regulations between the states limit effective professional practice and mobility, confuses the public, and present barriers to integrated delivery systems and the use of telemedicine and other emerging health technologies…Current statutes grant broad, near-exclusive scopes of practice to a few professions and "carved-out" scopes for the remaining professions. These laws erect unreasonable barriers to high-quality and affordable care…Perhaps most seriously, regulatory bodies are perceived as largely unaccountable to the public they serve…Finally, recent reports and incidents have raised concerns that the regulatory system may not effectively protect the public. Continuing education requirements do not guarantee continuing competence. Additionally, the complaint process is often difficult for the consumer to initiate, and many complaints go without adequate investigation. Moreover, regulatory systems, in large part, have failed to implement mechanisms to evaluate their effectiveness and correct shortcomings."

Many states have decided that now is the time to make changes, big and small, in their regulatory systems.

PREP

PREP, based on Nebraska Credentialing Reform (NCR) recommendations, has been developed for use with professions and occupations currently credentialed by the Department of Health and Human Services Regulation and Licensure. PREP's purpose is to evaluate the impact of the State regulatory process and outcomes on public protection and to consider the quality of that process. Based on existing statutes, PREP reviews the current regulation, the regulatory efficiency, the effect of regulation, and the continued need for State regulation of the profession or occupation. The final PREP report can contain recommendations for how the regulatory system can be improved and affirmations of things well done.

It is vital to PREP that the purpose of regulation is understood. The purpose of regulation is to:

- Ensure that the public is protected from unscrupulous, incompetent and unethical practitioners;
- Offer some assurance to the public that the regulated individual is competent to provide certain services in a safe and effective manner; and
- Provide a means by which individuals who fail to comply with the profession's standards can be disciplined, including the revocation of their licenses.

Quality improvement, quality assurance and continuous quality improvement are frequently used quality terms. The definition of quality used during PREP orientation is: Quality not only is efficiency, effectiveness, and the achievement of outcomes, but quality can also be defined as the best possible application of knowledge to be as successful as possible.

PREP is not a sunset. A sunset is the automatic termination of regulatory boards and agencies unless legislative action is taken to reinstate them.

All health professions and occupations must have a scope of practice. One of the goals of PREP is to evaluate effectiveness and efficiency in relation to public protection – not to evaluate the scope of practice itself. However, information provided in the scope of practice must be considered in order to evaluate the regulation of the profession or occupation. The PREP committee may note scope of practice issues in the report, but specific recommendations for changes to the scope of practice are not a part of the PREP. It is possible that one PREP recommendation may be that there should be a Change in Scope of Practice Credentialing Review.

PREP is not a Change in Scope of Practice Credentialing Review. A Change in Scope of Practice Credentialing Review is one kind of credentialing review possible under the Nebraska Regulation of Health Professions Act (Revised 1988). This is a formal process that includes an application, a public hearing and production of three reports (Technical Committee Report, Board of Health Report, Director of HHS Regulation and Licensure Report) that have recommendations and are submitted to the Legislature.

PREP is a quality improvement mechanism for the Department and is designed as a non-threatening and non-adversarial approach. A ten-member committee conducts the PREP and uses topic areas to focus the committee discussions. The product of PREP is a report from the Committee to the Department Director that is a public document and identifies recommendations and affirmations relevant to the regulatory system.

Process

PREP is divided into four broad steps.

Step 1: Selection of the profession or occupation to be evaluated.

During the fall of 2005, the Department asked members of the Nebraska Credentialing Reform (NCR) Committee to suggest professions for the next PREP review. Respiratory Care was suggested and, when the Board and Society were approached by the Department, the profession agreed to participate. On November 17, 2005, the Department sent a letter to notify interested parties that the Respiratory Care PREP Committee would soon start work. The letter included information about how interested parties could become involved.

Step 2: Appointment of PREP Committee.

On January 8, 2006, Dr. Joann Schaefer, Chief Medical Officer and the Department Director, appointed the Respiratory Care PREP Committee members. The State Board of Health and the Board of Respiratory Care Practice selected representatives to finalize the ten-member committee. All members of the committee are voting members and are expected to actively participate.

Respiratory Care PREP Committee Members

Kevin Borcher, RP, PharmD	*(related/associated professional representative)*
Mary Bunger, RN	*(related/associated professional representative)*
David Dryburgh	*(public representative)*
Frank Martin Freihaut, RRT	*(Board of Respiratory Care Practice representative)*
Jeffrey Gonzalez, RRT	*(professional representative)*
Betty Kaslon	*(public representative)*
David Montgomery	*(Department representative)*
Corrinne Pedersen	*(public representative)*
Robert Sandstrom, PhD, PT	*(State Board of Health representative)*
Marcy Wyrens, RRT	*(professional representative)*

Step 3: Evaluation of the profession or occupation by the PREP Committee.

At their January 19, 2006 meeting, the Board of Respiratory Care Practice discussed the PREP process and provided some insight about the profession and current issues. Department staff attended the meeting and summarized the significant points made by the Board. This information was shared with the PREP Committee.

Information the PREP Committee received to prepare for discussions included:

- Research material relevant to respiratory care. Sources for the research material were mostly the Internet and included such Web sites as Nebraska Health and Human Services System (www.hhs.state.ne.us/crl/rcs/resp/resp.htm), the American Association for Respiratory Care (AARC) (www.aarc.org), the National Board for Respiratory Care, Inc. (NBRC) (www.nbrc.org), and the U.S. Department of Labor, Bureau of Labor Statistics (www.bls.gov/oco/ocos084.htm) (see Attachment A). Provided by Department staff.
- Overview of the credentialing process. Provided by Diane Hansmeyer, Section Administrator for Rehabilitative Health (Respiratory Care is part of this Section) in HHS Regulation and Licensure Credentialing Division.
- Explanation of the work and responsibilities of respiratory care professionals. Provided by the respiratory care practitioners on the Committee.
- Map of Nebraska showing the distribution of LRCP by County (see Attachment B)
- Other information and/or clarification of the research material. Provided by all members of the Committee.
- Comparison chart. The chart includes information from seven states for the education requirements, examinations, renewal requirements, disciplinary actions, and a list of the respiratory titles used (see Attachment C). Provided by Department staff.
- Surveys completed by licensed respiratory care practitioners. Surveys were sent to 516 respiratory care practitioners with Nebraska mailing addresses and 38% were returned. Survey results were compiled and presented to the Committee (see Attachment D). Provided by Department staff.

The PREP Committee conducted their work in accordance with public meeting laws. Agendas for public meetings provided an opportunity for non-committee members to comment during each meeting. Throughout the course of the evaluation, notices of the Committee public meetings were posted and a list was maintained of those wanting to receive the meeting agenda or notification about the Respiratory Care PREP.

Respiratory Care PREP Committee meetings were held on:

- February 15, 2006 with 9 committee members present.
- March 29, 2006 with 8 committee members present.
- April 13, 2006 with 10 committee members present.
- May 10, 2006 with 10 committee members present.
- June 5, 2006 with 10 committee members present.
- June 26, 2006 with 10 committee members present.
- August 29, 2006 with 9 committee members present.
- February 21, 2007 with 6 committee members present.
- June 28, 2007 with 7 committee members present.

The Respiratory Care PREP Committee explored and evaluated issues using

eight topic areas as a focus for the discussions. More information on the topic areas and Committee discussions are in the "Recommendations, Affirmations, and Comments" section of this report.

The August 29, 2006 Respiratory Care PREP Committee meeting included a discussion with representatives of six Durable Medical Equipment (DME) vendors. The focus of the discussion was public safety. Committee members had requested an opportunity to dialogue with DME vendors because the Committee members had questions about respiratory care in the home and how patients are cared for and educated. The Committee members and DME vendors discussed guidelines used in supplying equipment, particularly oxygen, CPAP, BiPAP and ventilators, the role of LRCPs in the DME companies, and the statutory responsibility of the medical director for a LRCP. The Committee members received clarification about the DME approach and policies for public safety and their management of referrals to licensed practitioners. Committee members believe that in most cases, there are procedures and safeguards in place for public protection when oxygen and equipment are used in the home (when there is not a LRCP or a licensed health care provider physically present).

Step 4: Preparation of a PREP Committee report.

The final report is submitted to Dr. Joann Schaefer, Chief Medical Officer and Director of the Department of Health and Human Services Regulation and Licensure, and is a public document. The Chief Medical Officer/Director may use the report to make changes in the regulatory system by adjusting administrative procedures, proposing legislative action or by proposing changes to rules and regulations. Report content may be used by anyone to initiate legislation, a Scope of Practice Credentialing Review, or other actions as they deem appropriate.

The terms "consumer" and "public" are interchangeable in the report and have been used as referenced in the research documents used by the Committee.

Status of Respiratory Care in Nebraska During the PREP Review

Demographics

In Nebraska, there are approximately 1,200 licensed respiratory care practitioners (see map, Attachment B). There are 170 LRCPs that do not have Nebraska mailing addresses.

There are about 100 new licenses for respiratory care issued each year.

Respiratory care discipline statistics during 2003 through 2005 in Nebraska are as follows:

Year	Received	Open	Investigated	Nature of Complaint	Discipline
2003	4	4	4	3=Unprofessional Conduct 1=Felony Conviction	3=Assurance of Compliance 1=Letter of Concern
2004	6	6	6	1=Unprofessional Conduct 2=Felony Conviction 2=Alcohol Abuse 1=Other	2=Assurance of Compliance 1=Revoke 1=Probation 1=Suspend License
2005	1	1	1	Unlicensed Practice	Cease & Desist

Nebraska Regulatory Background

The Department of Health and Human Services Regulation and Licensure has responsibility for credentialing health professions and occupations in the State of Nebraska. Credentialing means the totality of the process associated with obtaining state approval to provide health care services. Credentialing grants permission to use a protected title that signifies that a person is qualified to provide the service of a certain profession. Credentialing includes a license, certificate, or registration (State Statute 71-101 (9)).

The Board of Respiratory Care Practice is appointed by the State Board of Health and consists of four people: two licensed respiratory care practitioners, one physician and one public member. The Board advises the Department on all issues related to the regulation of respiratory care. Board member duties include, but are not limited to: approval of licensing examinations; recommending the issuance or denial of licenses; changes in legislation and regulation, and making recommendations on investigative and disciplinary actions.

The Legislature established licensure for respiratory care 1986 and it has been twenty years since respiratory care regulations and statutes were significantly updated. All respiratory care licenses are required to renew in even-numbered years.

A *license* grants the person a right to provide the services of the profession. This right is limited exclusively to those who have met specific requirements and educational prerequisites and who have passed some type of examination indicating that they are capable of providing services safely and effectively.

Professional practice complaints can be filed with the Department's Investigations Division. All complaints are carefully reviewed by the Department to determine if legal sufficiency exists to conduct an investigation. The Department will notify complainants of the results of the review.

Respiratory Care Background Information

The respiratory care profession is comprised of approximately 60% women and 40% men. There are approximately 133,000 respiratory care professionals in the United States with 74% working in acute care settings, 9% in durable medical equipment (DME)/home health, 7% in accredited educational programs and 10% in a variety of other settings. (American Association for Respiratory Care 2005 Human Resources Study)

The Nebraska Society for Respiratory Care (NSRC) is the State organization for the profession. The national organization, the American Association for Respiratory Care (AARC), is based in Texas. AARC publishes white papers and the Clinical Practice Guidelines that are the standard guidelines utilized by respiratory care professionals.

There are four schools with respiratory care programs in Nebraska: two have associates programs, one has a bachelors program and one has both. Nationally, the trend is to encourage every respiratory care graduate to get a baccalaureate degree. Minimum coursework for respiratory care includes two years of respiratory care classes that are very intense: heavy in sciences, computers and ethics. To better understand the intensity of respiratory care training, consider that the respiratory care course spends ten weeks going through a section on anatomy and the physiology of the pulmonary system (arterial blood gases), while for some health provider training, this section would consist of a two-hour lecture.

Forty-eight states have licensure (Hawaii and Alaska do not simply because there are few practitioners in those states). After a student has completed the basic respiratory care courses, they can sit for the Certified Respiratory Therapist (CRT) exam to get national CRT certification by the National Board of Respiratory Care (NBRC). The CRT exam assures that the student has the basic knowledge and skills needed. After six months additional training, the student is eligible to sit for two more exams: the Clinical Simulation Examination and the Written Registry Examination for Advanced Respiratory Therapists. After passing these exams, the student receives their Registered Respiratory Therapist (RRT) credential from NBRC. The RRT preparatory courses have additional physiology training, concentrate on how and why things work in the body, and increase the focus on assessment of the patient. The national trend is to encourage everyone to get the RRT; however, most states only require the CRT exam for state licensure. Nebraska's minimum requirement for licensure is the CRT. Some facilities in Nebraska have started the practice of accepting the CRT when the respiratory care professional is hired, but requiring that the person complete the RRT certification within a specified time period.

Respiratory care practitioners are employed on every floor of hospitals, including the ICU and emergency care. Many practitioners take care of people in their homes and there are growing numbers of practitioners in doctor's offices, especially those specializing in pulmonary care. Practitioners are involved on flight teams, in research, and national initiatives (i.e. the government asked the national association to provide a list of practitioners that would work in the case of a national disaster. At UNMC, where a ten-bed Biohazard unit

is set up, they have eight respiratory care practitioners who drill to work in the unit every other month. Respiratory care therapists have been active in Washington lobbying for easier access to care in the home and to make it easier for people to travel with their oxygen tanks. Respiratory care has also been involved in preparing for pandemics.)

Studies have shown that if there is a respiratory care practitioner involved with patient therapy in the home (i.e. CPAP machine, nebulizers), the patient compliance and outcomes are greatly improved. People who don't have a respiratory care practitioner involved and instead are working only with an equipment vendor can get frustrated and often won't use the machine (mask is not fitting appropriately, etc.). A national veterans' study was done that showed there were significant cost savings when veterans were sent home on oxygen with a respiratory care practitioner involved to evaluate the patient's respiratory care. The issue oftentimes is access to respiratory care practitioners in the home. [Basic Statistics About Home Care, National Association for Home Care & Hospice, Updated 2004. www.nahc.org/04HC_Stats.pdf (pg. 13b)]

Respiratory Care is a coordinated approach led by a physician to determine the presence of lung disease, the severity of lung disease, and how the disease is to be treated. Medication, technology, patient assessment, and diagnostic tests are used to treat all kinds of patients in a variety of settings. This includes the preterm infants to the geriatric patients and may be performed in acute care settings, home care, hospice, research, education and other types of settings.

A respiratory care practitioner may need to draw arterial blood to measure blood gases. They are also very involved in patient education. Respiratory care practitioners, especially in hospital settings, work closely with pharmacists. A respiratory care practitioner may be expected to provide many treatments related to blood gases, pharmacology, therapeutic gases, and mechanical ventilation. Other functions a respiratory care practitioner may be involved in includes serving as an anesthesia assistant, bronchoscopy assistant, an assistant with balloon pump, pacemakers, perfusion assistant, etc. In most facilities, if the assistance involves high technology, the respiratory care practitioner is the easiest person to have trained right away because of their technological background and experience.

Evaluation

Committee Affirmations, Recommendations, and Comments

The eight topic areas considered by the Respiratory Care PREP Committee are listed below. While there are eight topic areas, they do not "stand alone". Something can be identified under one topic area yet may also be a part of other topic areas. Affirmations, recommendations, and comments are listed with the first appropriate topic area.

*Topic Area **I** Considered*

I. Qualifications to obtain and maintain the credential.

- **Qualifications – standard for entry:** A regulatory system outcome is that the qualifications for the credential are sufficient to ensure the public/consumer that the respiratory care practitioner can safely perform the work identified in the scope of practice. The standards for entry should be appropriate to protect the public/consumer and be job-related. The education and training required should prepare the respiratory care practitioner for actual work. The process for validating qualification requirements for the respiratory care practitioner should be sufficient and efficient.
- **Qualifications – measure for maintaining:** A regulatory system outcome is that the profession has established requirements to ensure that the respiratory care practitioner demonstrates continued competency. The measure for maintaining a credential should demonstrate continued competency. Sufficient opportunities for continuing competency should be available, varied and appropriate for the practice of respiratory care. The regulatory system and processes should consider how changes in the practice of respiratory care (new technology, new procedures) impact on continued competency.
- **Qualifications – practitioner mobility:** A regulatory system outcome is that the practice of respiratory care has processes in place to ensure public/consumer protection while supporting interstate mobility of respiratory care practitioners. Considerations are the affect of Nebraska regulation on the respiratory care practitioner's ability to change practice settings to another state or from another state. Differences from state to state in respiratory care requirements for education, initial licensure and continued competency can create a system where practitioner mobility is complicated and discouraged.

*Topic Area **I** Discussion*

Licensure requires graduation from an accredited program. The Commission on Accreditation of Allied Health Education Programs (CAAHEP) in collaboration with the Committee on Accreditation for Respiratory Care (CoARC) accredits the Respiratory Care education programs.

Nebraska's minimum entry level requirements include the applicant passing the Certified Respiratory Therapist (CRT) examination which is a national computer-based comprehensive examination with a time limit. This examination is recognized by all states. The NBRC sets a national score; however, some states have put a passing score in statute that may not be the same as the current national passing score. Nebraska uses the same passing score that the national exam accepts.

The title used for the respiratory care professional is different from state to state (see Attachment C). Nebraska uses Licensed Respiratory Care Practitioner or LRCP.

Licensure renewal is required in even-numbered years. Respiratory Care has not yet gone to on-line renewal but will do so in the future. The 2006 renewal period instigated major changes in continuing competency. Licensure renewal will include attestation for Continuing Education (CE) instead of pre-approval for CE. Pre-approval for CE was a process where the CE provider needed to apply for and receive certification that the education was pre-approved and would count toward required CE hours. Attestation is when the licensee must attest on their application for renewal that they have completed the required CE during the preceding 24-month period. Twenty CEs are required for renewal, and the Board has clearly defined and published what is needed and acceptable for CE attestation. Nevertheless, there is some uncertainty and concern among LRCPs about how the Board will interpret and apply the regulations in this first year without pre-approval for CE. There will be random audits of CE attestation during LRCP renewal.

Options for continuing competency include opportunities provided by the Nebraska Society for Respiratory Care at their annual meeting; hour-long seminars provided by hospitals and universities; web-based training, and trainings offered by private vendors. The Board recognizes that certain national specialty certification examinations (page 32 of the Respiratory Care Rules and Regulations) can count as ten contact hours for CE.

The State of Nebraska has "endorsement" not "reciprocity". True reciprocity means that if the practitioner has a license in another state s/he will get a license in Nebraska. Endorsement means that the practitioner must meet the Nebraska licensure requirements (i.e. if Nebraska has a higher passing score requirement, then the applicant must have the highest of the two scores). One area where the Department has sometimes had difficulties when it comes to mobility is with people who train in respiratory care in the military because that training may not be in an accredited program. Some branches of the military have made changes to better ensure that their programs are accredited so that people can come out of the military and go to work in Nebraska and other states.

While the CRT certification by NBRC is the standard for entry-level qualification in the United States, there is national discussion about eliminating the CRT and using the RRT for the entry-level standard. Part of the rationale for eliminating the CRT credential is that at the national level, respiratory care would like to raise the education level to associates and bachelors degrees versus what is out there now, which are the certificate and associates levels. Also, the RRT has demonstrated clinical competency at a higher level by virtue of the additional two exams.

Everyone who goes through the respiratory care program has to meet the entry level scope of practice. Like other professions (pharmacy, nursing, etc.), respiratory care practitioners all have the same basic training and it becomes the responsibility of the facility or employer to determine their competency related to specific practices. The Joint Commission on Accreditation of Healthcare Organizations, JCAHO, requires that all hospital employees be competent, qualified, trained and oriented properly to their job.

Access to services in the rural areas of the state may be a concern when considering moving from CRT to RRT as the entry-level requirement. This may put more people at

risk since LRCPs are scarce in the rural areas and raising the entry-level requirements would eliminate many rural practitioners. This would result in the necessity of respiratory care services being done by other trained licensed professionals (pharmacist, nurses, etc.). While these trained licensed professionals can provide respiratory care services when the LRCP is not available, they do not have the same specialized training as the LRCP with the CRT certification.

Respiratory care does not require a jurisprudence exam. This exam is a good method to assure the practitioner understands Nebraska's requirements, rules and regulations.

While continuing competency currently includes only continuing education, the Committee spent considerable time discussing some renewal requirement for number of practice hours. As an example, Nursing requires twenty hours of CE in two years and 500 hours of practice in the past five years. If the license is inactive over five years, the applicant must take a refresher course.

Since the passage of the CRT is required and the accrediting body does not recognize any foreign schools, licensure of foreign-trained professionals is problematic. Respiratory care practitioners are not the same in other countries because in most countries the practitioner does not have the luxury of just practicing in respiratory care – they are a nurse, physician, etc. People who practice respiratory care in another country and want to practice in the United States would have to pass the CRT test. The national association has an international fellowship program and is exploring the foreign-training area.

Mobility from profession to profession is possible. A LRCP could get additional training to become a Physician's Assistant (PA), Certified Registered Nurse Anesthetist (CRNA), Registered Nurse (RN), and other professionals. The EMT can train to become an EMT-P, and then get the education to become a LRCP. The respiratory care educational courses support obtaining additional skills, wearing more than one hat.

The teamwork approach to medical care is where the person who is best qualified is performing the task and minimum standards allow flexibility to meet the needs of the patient. The teamwork approach recognizes that health professionals have some crossover and can cover some of the basics in other professional scopes of practice. Students in health profession educational programs are trained in silos – where explanations are this is "my" job and that is "your" job. Changing the educational environment to recognize that professional crossover can occur is a struggle.

*Topic Area **I** Response*

Affirmation #1: The public is protected by the current State regulation practice of using the national Certified Respiratory Therapist (CRT) examination given by the National Board of Respiratory Care (NBRC) as an entry level test for basic competency.

Affirmation #2: The title Licensed Respiratory Care Practitioner (LRCP) should be continued in Nebraska. Different credentials are used by respiratory care practitioners in other states and this can be confusing. However, until there is agreement on one title that will be recognized and used by all states, Nebraska should keep LRCP and encourage the LRCPs to also use specialty initials based on NBRC examinations.

Affirmation #3: Ten hours can be earned toward continuing competency requirements for license renewal when the LRCP passes nationally recognized specialty certification examinations related to an area of specialty practice in the field of respiratory care. Specialty certification is identified in the rules and regulations as an option to meet continuing competency requirements. This option encourages LRCPs to pursue advanced certification and increase competency.

Recommendation #1: Consider options to improve regulation by making changes in the continuing competency requirements for respiratory care licensure renewal:

a. A major change in continuing competency requirements was made during the 2006 renewal period (attestation instead of pre-approval). The Board and Department staff should evaluate the impact of this change.
b. Coordination among the Board, the Nebraska Society for Respiratory Care, and the Department is needed to facilitate better communication between vendors of continuing education programs and LRCPs. The question "Does the continuing education program meet the continuing competency requirements for renewal of an LRCP license?" should have a clear answer.
c. Specialty certifications should be evaluated by the Board. While the NBRC sponsored specialty examinations have established requirements that increase competency, this may or may not be the case for all specialty certifications. Specialty certifications that increase the competency of a practitioner should be recognized. When appropriate, rules and regulations should state that the specialty certification will qualify as ten contact hours toward continuing education requirements for renewal of a license. (Example: The asthma specialty certification for LRCP is not by NBRC sponsored examination. Instead the examination is sponsored by the National Asthma Educator Certification Board. There are established requirements that increase competency and so it should be an option for continuing competency.)
d. Establish that passing the national registered respiratory therapists (RRT) examination offered by the National Board of Respiratory Care (NBRC) during the 24 month renewal period will qualify as contact hours toward the continuing education requirements for renewal of a license. The number of contact hours would be determined by the Board. The intent is to encourage RRT certification in the State. (The entry-level of CRT is all that is required to be credentialed as a LRCP in Nebraska.)
e. Add a license renewal requirement for 500 practice hours during the previous five years through a process modeled after that used by the nursing profession. This would involve developing a mechanism for this change in renewal requirements

and considerations include:

- Issuance of a temporary license
- Refresher course requirement if not enough practice hours
- Determine appropriate supervision
- Evaluate and develop alternatives to passing the RRT exam within five years

Recommendation #2: The Nebraska Society for Respiratory Care and the Board should explore establishing Registered Respiratory Therapist (RRT) qualifications for Nebraska credentialing. Exploration should include:

a. At a minimum, monitor the direction of national requirements for respiratory care, and if the national entry-level standard for respiratory care changes from CRT to RRT, the Nebraska entry-level requirements should change accordingly;
b. Consider implementing two levels of Nebraska respiratory care credentialing based on entry-level requirements. One level would be based on achieving the CRT national certification and the second level would be based on achieving the RRT national certification;
c. Consider making Nebraska's entry-level requirement the RRT and establish a grandfather process for current CRTs;
d. Consider options for students from other states with respiratory care education programs offering only CRT; and
e. Consider a temporary license for CRT.

Recommendation #3: Establish the use of a jurisprudence examination as part of the requirements for initial licensure. Future options for continuing competency requirements may include adding the jurisprudence exam as an element for license renewal. (Jurisprudence means the science or philosophy of law, in this case the Nebraska laws for the practice of respiratory care therapy.)

*Topic Area **II** Considered*

II. Balance among quality and access to care and cost containment. A regulatory system outcome is that quality of care, access to care and cost containment are balanced in the interest of public/consumer protection. These are factors in regulatory system decisions. For example, if a system is focusing on *quality* of service, it may limit *access* to services or the *cost* of the services may increase to the point of limiting access by the consumer. The goal is to balance the three factors so the consumer is protected and the State has quality respiratory care that is accessible.

*Topic Area **II** Discussion*

Respiratory care practitioners work using protocols, and there is an abundance of research about the value of protocols. A protocol gives the respiratory care practitioner

the direction to set a plan of care (the physician gives the respiratory care practitioner the right to do what is needed based on assessment, and that is the future of respiratory care). Interaction with the physician occurs if there are questions or difficulties. Use of protocols is often specific and facility-driven. The national organization continues to advocate protocols.

There is still the issue of rural areas where the respiratory care practitioner is not available. In the urban world where you have respiratory care practitioners, you have better patient outcomes because they have the tools. That is part of the reason why when the respiratory care law was written years ago, it was written so that trained and licensed nurses, pharmacists, or physical therapists could provide needed respiratory care services. There seems to be a general policy among the boards and regulatory processes in Nebraska that, in terms of scope of practice, other professions can do things because they can meet minimum standards. That policy allows crossover between professions. Providers in the community can decide who provides the service without the government's overreaching intervention.

There are all kinds of therapeutic modalities in Omaha but some of these modalities are not available in the rural parts of the state. Good care is provided in the rural areas; however, the variety of modalities simply may not be available. Some of the concern about respiratory care services is probably directed to home care.

Other licensed providers can do specific tasks. For example, EMT-Paramedics (EMT-P) are trained in patient stabilization and transportation. The respiratory care professional is trained in patient stabilization and in ongoing disease management. There is a difference. The EMT-P has the training so that appropriate respiratory care access is there for emergency care. The law was changed a few years ago allowing paramedics to continue care in the hospital or health clinic to assure that hospitals and health clinics had enough help when there are emergency transportations and when there are staff shortages. The actual wording in rules and regulations (172 NAC 11-006.07) is: "An emergency medical technician-intermediate or an emergency medical technician-paramedic may volunteer or be employed at a hospital or a health clinic to perform activities within his/her scope of practice within such hospital or health clinic under the supervision of a registered nurse, a physician assistant or a physician." The gray area is that it does not define initial stabilization versus ongoing disease management. (The EMT-P needs to go into the Emergency Department and sometimes continues into the Intensive Care Unit.) The concern is that some hospitals and health clinics may be tempted to use the EMT-P to handle ongoing disease management instead of handing the patient off to the LRCP or RN or another health professional.

<u>*Topic Area **II** Response*</u>

Affirmation #4: The Board of Respiratory Care Practice (Board) has worked hard to assure regulations are in place that allow the public to receive needed respiratory care services. Essential to this effort has been the provision of flexibility in statute and regulations so there is access to quality services by the patient in a manner that is best for

the patient. The Board:

a. Recognizes that the rural areas of the State do not have the number of respiratory care practitioners necessary to provide support, so other appropriately trained licensed health care professionals must fulfill those needs.
b. Encourages minimum standards that allow for flexibility to meet the needs of the patient by recognizing other professions have some training in areas where there is crossover with respiratory care practitioners. Appropriately trained health care professionals can therefore handle some of the respiratory care basics when necessary as outlined in statute.

Affirmation #5: Respiratory Care Practitioners have historically recognized a concern about access to respiratory care services in Nebraska. The respiratory care statutes were written to exempt nurses, pharmacists, physical therapists and other licensed professionals acting within their scope of practice to allow more access to respiratory care services when a respiratory care practitioner is not available.

Comment: The delivery of respiratory care in Nebraska may not be the same throughout the State. There exists a difference in care mainly because some areas of the State lack numbers of patients needing respiratory care and numbers of LRCPs to provide services.

*Topic Area **III** Considered*

III. Relationship factors promoting public protection (internal/external communication and interrelationship with other professions, the public, the Department, boards). A regulatory system outcome is that the profession demonstrates positive relationships with the public and collegiality with other professions and organizations – with the focus always on public protection. This topic area looks at the need to work together for public protection in the regulatory system. Communication, interaction and interrelationships with the Department, other boards, associations (state and national), other professional associations and the public are a necessary part of a quality regulatory system.

*Topic Area **III** Discussion*

According to the professional representatives, about 40% of the practitioners in Nebraska belong to the national association. There appears to be a need for more education about what the benefits are if you belong to the national association. Benefits include continuing education, representation in legislative issues, and access to the AARC Clinical Practice Guidelines.

Communication with doctors, nurses, and physical therapists was discussed. A key point was that perhaps educational programs should emphasize how to interact/communicate with someone in another discipline so that communication is better.

The board recently has had discussion about providing some kind of education (brochure,

electronic media) to the public so that they know what a respiratory care practitioner does.

Most interactions with other boards are situational (not routine). There is a greater need for the process to come together for mutual agreement on regulatory issues. The Department staff does this informally; however, the process should be formalized. While there is an annual All Boards Meeting to bring board members together, once a year is not often enough and the meeting is not always well-attended with representation from all boards. There needs to be more communication about the boards to the public.

The Nebraska Society for Respiratory Care provides a newsletter to members. While it is a cost concern, it may be beneficial for some communication with all licensed respiratory care practitioners either through a newsletter or a Web site.

Communication with the public regarding things like durable medical equipment and sleep labs is essential. The public often assumes, incorrectly, that anyone involved with these services is a licensed professional knowledgeable about respiratory care services.

*Topic Area **III** Responses*

Affirmation #6: In general, the Board and LRCPs have established good working relationships with other health professions and work to promote public safety.

Affirmation #7: The credentialing support provided for the Board and profession is excellent. Department administration and staff are available to advise and suggest options. The value of an assistant attorney general assigned to the Board by the Office of the Attorney General is recognized.

Recommendation #4: Consider steps to enhance and encourage communication with the public:

a. Pursue recent discussions about improved communication to the public. [Example: The board has discussed making educational information (brochures, electronic media) available to provide the public with a better understanding about the role of a respiratory care practitioner in health care.]
b. Pursue communication (brochures, electronic media) to explain the role of respiratory care in relation to sleep labs and the provision of certain durable medical equipment related to respiratory care.
c. Because of the increased reports regarding unlicensed respiratory care practice, consider a special education effort for health care providers and providers in the home who are not required to be credentialed.
d. Encourage communication about the role of the Board and the role of public membership on the Board. The goal is to improve understanding of the State regulatory system, and improve recruitment for boards.

Comment: These communication concepts would be valuable Department-wide for all health professions: What do you expect from your health provider? What services

does the profession provide? What is the role of the Board? Brochures and other information available through the various health care settings (i.e. doctor's offices, health clinics) would be beneficial.

Recommendation #5: Consider steps to enhance and encourage communication within the profession and with other professions:

a. Consider utilizing the Nebraska Society for Respiratory Care (NSRC) as a conduit for improved communication about Respiratory Care State regulations, especially when changes are implemented.
b. NSRC could encourage membership in the State Society by offering society-sponsored socialization that includes education about the Society, State regulations and licensure to students in the State's respiratory care educational programs.
c. NSRC could distribute a flyer to all respiratory care students and LRCPs once a year with State society membership information (including the Web site). Consider distributing NSRC information about current professional issues, discipline and mandatory reporting concerns on a regular basis (i.e. newsletter, Web site, electronic media).
d. Encourage respiratory care educational programs to include discussion of the importance for interaction and communication with health professionals in other disciplines. Recognize that support for a teamwork approach can start in the educational program and carry through to professional practice and should be encouraged as a part of the education programs for all health professions.
e. Encourage more communication to licensed respiratory care practitioners about the Board role. The goal is to improve understanding of the State's regulatory system and improve recruitment for boards.

Topic Area ***IV*** *Considered*

IV. Licensure issues, denials, and disciplinary processes. A regulatory system outcome is that the profession has fair and efficient processes in place to protect the public from unsafe, incompetent or substandard care or services.

- Applications for licenses (initial or reinstatement) should contain information required to make an informed decision. The process should support public safety and protection.
- The disciplinary process should be supportive of public safety and protection. Information for filing a complaint should be easily accessible to the public and appropriate information on disciplinary actions should be available to the public. The Board of Respiratory Care Practice should be aware of and be able to carry out its role in the disciplinary process.
- The appropriate level of confidentiality related to these processes should be maintained.

*Topic Area **IV** Discussion*

The Committee discussed criminal background checks. The Respiratory Care credentialing process does not routinely include criminal background checks. The board can check or ask questions if the applicant has identified something on an application so, while routine criminal background checks are not done, there are occasional searches of the Nebraska Justice database. Most of the respiratory care training programs in Nebraska are requiring criminal background checks.

The Board was seeing a huge increase in misdemeanors (alcohol-related, MIP, DUI, controlled substances) for new applicants and felt that they needed help in deciding what was significant concerning licensure. To streamline their evaluation process they developed conviction guidelines, which were adopted by the Board on November 10, 2005. When respiratory care receives an application with something that requires checking (Licensee Assistance Program [LAP] evaluations are ordered under certain circumstances), it slows the process down tremendously because there are only so many LAP evaluation slots available. It can take up to eight weeks to get someone through the LAP program.

Over the history of respiratory care licensure, the Board has spent significant time interpreting the scope of practice and issuing board opinions. Staff can refer to these opinions to answer questions consistently.

Discussion about fees to cover costs of regulation indicated that, for respiratory care, the fees are adequate. However, if background check requirements change, there may need to be fee changes.

By statute, there are 150 days to process an application. Usually the Department staff can handle an application within a day. If there are questions or follow-up, then it would take more time.

It was noted that there are probably not as many complaints received as there should be because people do not understand (the process/mandatory reporting). During the committee discussion the opinion was expressed that delays in investigations are mostly because investigators or assistant attorneys general leave and their cases are passed on to someone else.

*Topic Area **IV** Response*

See other topic areas

*Topic Area **V** Considered*

V. Regulatory structure for the profession or occupation. The regulatory system should undergo periodic evaluation to assess that the regulatory processes are effective, efficient, and of high quality in support of public protection.

*Topic Area **V** Discussion*

The Board of Respiratory Care Practice does an amazing amount of work. Public members of the Board have been involved and are an asset. The LRCP representatives have mostly been from the metro areas, and the addition of an LRCP from a non-metro area would be valuable. There was discussion about adding another LRCP to the Board and encouraging that the three LRCPs come from different areas – i.e. hospitals, educator/schools, other (physician's office/DME, etc.).

The Board currently has two scheduled meetings annually and should probably have four meetings (once a quarter). Scheduling quarterly meetings would be better because they could address disciplinary and credentialing issues in a timelier manner.

*Topic Area **V** Response*

Recommendation #6: Consider adding another LRCP to the Board along with an additional public member for a six member board. Diverse LRCP representation, in both the area of expertise and geographic locations, would be beneficial to the Board. LRCPs from outside the Lincoln and Omaha geographic areas and LRCPs with experience representing the varied scopes of practice for respiratory care (hospital, education, home care) should be encouraged to apply for Board membership. The Board should communicate with the State Board of Health to explain the importance of having LRCPs on the Board that represent professional and geographic diversity.

Recommendation #7: Clarify the practice overlap area related to EMT-P and continued care in the hospital. There is a difference between stabilization/transportation and ongoing disease management, and that should be understood.

Recommendation #8: There is a need for more communication among the boards. Consider a process for reaching mutual agreement on regulatory issues that affect more than one board (e.g. boards – nursing, respiratory care – considering an issue that impacts both). The Department has an informal process; however, most interactions with other boards are situational, not routine, and some routine interaction may be beneficial.

*Topic Area **VI** Considered*

VI. Evaluate if there are other means to ensure public protection in lieu of State government regulation. A regulatory system outcome should result in the assurance that there is a mechanism in place to protect the public adequately. The questions that should be answered are whether the current method of credentialing is the most effective method to protect the public and whether regulation imposes unnecessary barriers to the optimum utilization of personnel.

*Topic Area **VI** Discussion*

Most often, the public receiving respiratory care services will not be able to distinguish whether the service is meeting minimum standards. The concern that this may cause harm is one of the major reasons for credentialing respiratory care.

The regulatory system does not pose unnecessary burdens because respiratory care allows other professions with similar competencies to do the same work.

*Topic Area **VI** Response*

See other topic areas.

*Topic Area **VII** Considered*

VII. Consider trends/future of the profession – are current statutes, rules and regulations appropriate/adequate/flexible? A regulatory system outcome is that there is the flexibility to adequately protect the public without inhibiting the profession's ability to provide the best possible options as newly developed procedures and technology improvements become available.

*Topic Area **VII** Discussion*

The Practice Act should be reviewed. The current scope of practice could be made clearer. The Board has issued more than 20 opinions because of the vagueness of the scope of practice and because of the constant advances in technology.

States are not consistent about health practice issue decisions. Some states have respiratory care practitioners doing things like moderate sedation (moderate sedation/analgesia; conscious sedation). In other states it is a physician, a physician assistant, a nurse practitioner or someone working under the direction of the physician. Regardless of the credential, the practitioner would need to be able to work with the IV push because all of the moderate sedation is given intravenously. Since it is not specified in the statute, this is a gray area.

In the future, respiratory care practitioners will likely become more of a physician extender – they will be allowed to do more varied things that are not covered in their current scope of practice. Given the continuing shortage of health care professionals, practitioners will tend to move naturally into other areas.

The practice has changed. The current scope of practice does speak to what practitioners are doing. However, concerns have been expressed that there is some risk when things are not clearly stated in the scope of practice. There is a need to look at potential changes in the scope of practice over the next 20 years.

*Topic Area **VII** Response*

Recommendation #9: Update the Respiratory Care Practitioner statutes since there has been little statutory change in twenty years of technical advances in the profession. Such work would include considerations about anticipated future changes in practice, the appropriateness of current statutes, and any professional boundary issues that need clarification.

*Topic Area **VIII** Considered*

VIII. Other.

*Topic Area **VIII** Discussion*

The public does not see the difference among licensed health care practitioners. For many, anyone delivering oxygen or working with oxygen is a LRCP.

Durable Medical Equipment (DME) providers and sleep labs are not State-regulated. During discussions, concern was expressed about public protection. The Committee does not encourage unnecessary regulation; however, discussion about methods to protect the public from harm with regard to CPAP and oxygen use would be beneficial. At a minimum, perhaps some kind of disclosure requirements could be standardized where the information is explained and handed to the patient when oxygen is delivered by DME providers or used at a sleep lab.

While DMEs must meet Medicare/Medicaid program requirements to be reimbursed by those programs, the DME providers do not get Medicare/Medicaid reimbursement for LRCP services (as defined in LRCP statutes) unless the provider meets the State licensure requirement. It is possible that the DME companies may not understand the Nebraska Respiratory Care Statutes.

For sleep labs, the concern is CPAP and oxygen because the non-invasive tests use ventilation, oxygen, etc. The people who come into sleep clinics usually have co-morbidity problems and have greater risks for complications.

*Topic Area **VIII** Response*

Affirmation #8: Durable Medical Equipment (DME) providers supply necessary services. **Most** are using appropriate personnel if they are providing respiratory care.

Comment: The importance of following existing respiratory care statutes when providing respiratory care services in order to protect the public from harm is recognized by most DME providers. Statutes pertaining to the practice of respiratory care require that if a practitioner is providing respiratory care, he/she is a LRCP or an appropriately trained licensed professional.

Recommendation #10: Conduct a study of sleep labs and sleep clinics in relation to respiratory care regulation. The qualifications of the people providing patient care in the lab/clinic are important and some may not have appropriate training. This creates a potential for harm to the public.

Recommendation #11: Conduct a study of Durable Medical Equipment (DME) and the provision of services by the DME industry. Encourage the DME industry to continue efforts to ensure that appropriate standards are in place within their profession. The potential for harm to the public exists especially since the DME industry often comes in contact with vulnerable members of the community.

a. Areas to explore include:
    - Educating providers and the public about requirements that must be met for public safety. Of special concern is the potential harm that exists when oxygen or other respiratory care services are provided by unregulated personnel in relation to DME. Collaboration with the respiratory care providers, Society and Board on this issue is encouraged.
    - Develop information handouts to increase public awareness. It is especially important that the public be given information when receiving equipment since this can be a confusing and stressful period. Important information should include: clarification about the roles and responsibilities of various personnel (pharmacist, DME driver, LRCP); easy-to-read information about essential patient care considerations while using the equipment; and who to contact for answers to questions. (When oxygen is provided, a licensed and appropriately trained provider must be consulted with patient care and use questions.)
    - Develop guidelines that can be followed by all DME providers. This could include what kind of information should be given to patients and their families.
b. The Department should make an effort to communicate the DME discussion held with the Respiratory Care PREP Committee to DME providers.

Comment: While most DME providers (see Affirmation #8) are doing everything right to supply needed services, there are some providers that may not understand and/or completely comply with the existing statutes. The intent of Recommendation #11 is not to impose some kind of new regulation on DME providers but to encourage DME providers to look at their practices and see what can be done to help assure public safety.

General Comments

Scope of Practice: All health professions and occupations must have a scope of practice. One of the goals of PREP is to evaluate effectiveness and efficiency in relation to public protection – not to evaluate the profession or occupation scope of practice itself. However, information provided in the scope of practice must be considered in order to evaluate the regulation of the profession or occupation. The PREP Committee may note scope of practice issues in its report, but specific recommendations for changes to the scope of practice are not a part of the PREP. It is possible that one PREP recommendation may be that there should be a Scope of Practice credentialing review.

The Committee acknowledges that the Board is working on and will continue to work on many of the issues identified here. The Committee encourages the communication between boards so that as one discovers something that works, other boards are informed.

ATTACHMENTS

From: Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2006-07 Edition*, Respiratory Therapists, on the Internet at **http://www.bls.gov/oco/ocos084.htm** (visited *March 30, 2007*).

Occupational Outlook Handbook, 2006-07 Edition

U.S. Department of Labor | Bureau of Labor Statistics | Bulletin 2600

Respiratory Therapists

Significant Points

- Job opportunities will be very good, especially for therapists with cardiopulmonary care skills or experience working with infants.
- All States (except Alaska and Hawaii), the District of Columbia, and Puerto Rico require respiratory therapists to obtain a license.
- Hospitals will continue to employ the vast majority of respiratory therapists, but a growing number of therapists will work in other settings.

Nature of the Work

Respiratory therapists and *respiratory therapy technicians*—also known as respiratory care practitioners—evaluate, treat, and care for patients with breathing or other cardiopulmonary disorders. Practicing under the direction of a physician, respiratory therapists assume primary responsibility for all respiratory care therapeutic treatments and diagnostic procedures, including the supervision of respiratory therapy technicians. Respiratory therapy technicians follow specific, well-defined respiratory care procedures under the direction of respiratory therapists and physicians. In clinical practice, many of the daily duties of therapists and technicians overlap; furthermore, the two have the same education and training requirements. However, therapists generally have greater responsibility than technicians. For example, respiratory therapists will consult with physicians and other health care staff to help develop and modify individual patient care plans. Respiratory therapists also are more likely to provide complex therapy requiring considerable independent judgment, such as caring for patients on life support in intensive-care units of hospitals. In this *Handbook* statement, the term *respiratory therapists* includes both respiratory therapists and respiratory therapy technicians.

Respiratory therapists evaluate and treat all types of patients, ranging from premature infants whose lungs are not fully developed to elderly people whose lungs are diseased. Respiratory therapists provide temporary relief to patients with chronic asthma or emphysema, as well as emergency care to patients who are victims of a heart attack, stroke, drowning, or shock.

To evaluate patients, respiratory therapists interview them, perform limited physical examinations, and conduct diagnostic tests. For example, respiratory therapists test patients' breathing capacity and determine the concentration of oxygen and other gases in patients' blood. They also measure patients' pH, which indicates the acidity or alkalinity of the blood. To evaluate a patient's lung capacity, respiratory therapists have the patient breathe into an instrument that measures the volume and flow of oxygen during inhalation and exhalation. By comparing the reading with the norm for the patient's age, height, weight, and sex, respiratory therapists can provide information that helps determine whether the patient has any lung deficiencies. To analyze oxygen, carbon dioxide, and pH levels, therapists draw an arterial blood sample, place it in a blood gas analyzer, and relay the results to a physician, who then may make treatment decisions.

To treat patients, respiratory therapists use oxygen or oxygen mixtures, chest physiotherapy, and aerosol medications. When a patient has difficulty getting enough oxygen into his or her blood, therapists increase the patient's concentration of oxygen by placing an oxygen mask or nasal cannula on the patient and set the oxygen flow at the level prescribed by a physician. Therapists also connect patients who cannot breathe on their own to ventilators that deliver pressurized oxygen into the lungs. The therapists insert a tube into the patient's trachea, or windpipe; connect the tube to the ventilator; and set the rate, volume, and oxygen concentration of the oxygen mixture entering the patient's lungs.

Therapists perform regular assessments of patients and equipment. If the patient appears to be having difficulty breathing or if the oxygen, carbon dioxide, or pH level of the blood is abnormal, therapists change the ventilator setting according to the doctor's orders or check the equipment for mechanical problems. In home care, therapists teach patients and their families to use ventilators and other life-support systems. In addition, therapists visit patients several times a month to inspect and clean equipment and to ensure its proper use. Therapists also make emergency visits if equipment problems arise.

Respiratory therapists perform chest physiotherapy on patients to remove mucus from their lungs and make it easier for them to breathe. For example, during surgery, anesthesia depresses respiration, so chest physiotherapy may be prescribed to help get the patient's lungs back to normal and to prevent congestion. Chest physiotherapy also helps patients suffering from lung diseases, such as cystic fibrosis, that cause mucus to collect in the lungs. Therapists place patients in positions that help drain mucus, and then vibrate the patients' rib cages and instruct the patients to cough.

Respiratory therapists also administer aerosols—liquid medications suspended in a gas that forms a mist which is inhaled—and teach patients how to inhale the aerosol properly to ensure its effectiveness.

In some hospitals, therapists perform tasks that fall outside their traditional role. Therapists' tasks are expanding into areas such as pulmonary rehabilitation, smoking cessation counseling, disease prevention, case management, and polysomnography—the diagnosis of breathing disorders during sleep, such as apnea. Respiratory therapists also increasingly treat critical care patients, either as part of surface and air transport teams or as part of rapid-response teams in hospitals.

Working Conditions

Respiratory therapists generally work between 35 and 40 hours a week. Because hospitals operate around the clock, therapists may work evenings, nights, or weekends. They spend long periods standing and walking between patients' rooms. In an emergency, therapists work under a great deal of stress. Respiratory therapists employed in home health care must travel frequently to the homes of patients.

Respiratory therapists are trained to work with hazardous gases stored under pressure. Adherence to safety precautions and regular maintenance and testing of equipment minimize the risk of injury. As in many other health occupations, respiratory therapists run the risk of catching an infectious disease, but carefully following proper procedures minimizes this risk.

Training, Other Qualifications, and Advancement

Formal training is necessary for entry into this field. Training is offered at the postsecondary level by colleges and universities, medical schools, vocational-technical institutes, and the Armed Forces. An associate's degree is required for entry into the field. Most programs award associate's or bachelor's degrees and prepare graduates for jobs as advanced respiratory therapists. A limited number of associate's degree programs lead to jobs as entry-level respiratory therapists. According to the Commission on Accreditation of Allied Health Education Programs (CAAHEP), 51 entry-level and 329 advanced respiratory therapy programs were accredited in the United States, including Puerto Rico, in 2005.

Among the areas of study in respiratory therapy are human anatomy and physiology, pathophysiology, chemistry, physics, microbiology, pharmacology, and mathematics. Other courses deal with therapeutic and diagnostic procedures and tests, equipment, patient assessment, cardiopulmonary resuscitation, the

application of clinical practice guidelines, patient care outside of hospitals, cardiac and pulmonary rehabilitation, respiratory health promotion and disease prevention, and medical recordkeeping and reimbursement.

The National Board for Respiratory Care (NBRC) offers certification and registration to graduates of programs accredited by CAAHEP or the Committee on Accreditation for Respiratory Care (CoARC). Two credentials are awarded to respiratory therapists who satisfy the requirements: Registered Respiratory Therapist (RRT) and Certified Respiratory Therapist (CRT). Graduates from accredited entry-level or advanced-level programs in respiratory therapy may take the CRT examination. CRTs who were graduated from advanced-level programs and who meet additional experience requirements can take two separate examinations leading to the award of the RRT credential.

All States (except Alaska and Hawaii), the District of Columbia, and Puerto Rico require respiratory therapists to obtain a license. Passing the CRT exam qualifies respiratory therapists for State licenses. Also, most employers require respiratory therapists to maintain a cardiopulmonary resuscitation (CPR) certification. Supervisory positions and intensive-care specialties usually require the RRT or at least RRT eligibility.

Therapists should be sensitive to patients' physical and psychological needs. Respiratory care practitioners must pay attention to detail, follow instructions, and work as part of a team. In addition, operating advanced equipment requires proficiency with computers.

High school students interested in a career in respiratory care should take courses in health, biology, mathematics, chemistry, and physics. Respiratory care involves basic mathematical problem solving and an understanding of chemical and physical principles. For example, respiratory care workers must be able to compute dosages of medication and calculate gas concentrations.

Respiratory therapists advance in clinical practice by moving from general care to the care of critically ill patients who have significant problems in other organ systems, such as the heart or kidneys. Respiratory therapists, especially those with bachelor's or master's degrees, also may advance to supervisory or managerial positions in a respiratory therapy department. Respiratory therapists in home health care and equipment rental firms may become branch managers. Some respiratory therapists advance by moving into teaching positions.

Employment

Respiratory therapists held about 118,000 jobs in 2004. More than 4 out of 5 jobs were in hospital departments of respiratory care, anesthesiology, or pulmonary medicine. Most of the remaining jobs were in offices of physicians or other health practitioners, consumer-goods rental firms that supply respiratory equipment for home use, nursing care facilities, and home health care services. Holding a second job is relatively common for respiratory therapists. About 13 percent held another job, compared with 5 percent of workers in all occupations.

Job Outlook

Job opportunities are expected to be very good, especially for respiratory therapists with cardiopulmonary care skills or experience working with infants. Employment of respiratory therapists is expected to increase faster than average for all occupations through the year 2014, because of substantial growth in the numbers of the middle-aged and elderly population—a development that will heighten the incidence of cardiopulmonary disease—and because of the expanding role of respiratory therapists in the early detection of pulmonary disorders, case management, disease prevention, and emergency care.

Older Americans suffer most from respiratory ailments and cardiopulmonary diseases such as pneumonia, chronic bronchitis, emphysema, and heart disease. As their numbers increase, the need for respiratory therapists will increase as well. In addition, advances in inhalable medications and in the treatment of lung transplant patients, heart attack and accident victims, and premature infants (many of whom are dependent on a ventilator during part of their treatment) will increase the demand for the services of respiratory care

practitioners.

Although hospitals will continue to employ the vast majority of therapists, a growing number can expect to work outside of hospitals in home health care services, offices of physicians or other health practitioners, or consumer-goods rental firms.

Earnings

Median annual earnings of respiratory therapists were $43,140 in May 2004. The middle 50 percent earned between $37,650 and $50,860. The lowest 10 percent earned less than $32,220, and the highest 10 percent earned more than $57,580. In general medical and surgical hospitals, median annual earnings of respiratory therapists were $43,140 in May 2004.

Median annual earnings of respiratory therapy technicians were $36,740 in May 2004. The middle 50 percent earned between $30,490 and $43,830. The lowest 10 percent earned less than $24,640, and the highest 10 percent earned more than $52,280. Median annual earnings of respiratory therapy technicians employed in general medical and surgical hospitals were $36,990 in May 2004.

Related Occupations

Under the supervision of a physician, respiratory therapists administer respiratory care and life support to patients with heart and lung difficulties. Other workers who care for, treat, or train people to improve their physical condition include registered nurses, occupational therapists, physical therapists, and radiation therapists.

Sources of Additional Information

Disclaimer:

Links to non-BLS Internet sites are provided for your convenience and do not constitute an endorsement.

Information concerning a career in respiratory care is available from:

- American Association for Respiratory Care, 9425 N. MacArthur Blvd., Suite 100, Irving, TX 75063-4706. Internet: http://www.aarc.org

For a list of accredited educational programs for respiratory care practitioners, contact either of the following organizations:

- Commission on Accreditation for Allied Health Education Programs, 35 East Wacker Dr., Suite 1970., Chicago, IL 60601. Internet: http://www.caahep.org

Information on gaining credentials in respiratory care and a list of State licensing agencies can be obtained from:

- National Board for Respiratory Care, Inc., 8310 Nieman Rd., Lenexa, KS 66214-1579. Internet: http://www.nbrc.org

OOH ONET Codes

29-1126.00, 29-2054.00

Suggested citation: Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2006-07 Edition*, Respiratory Therapists, on the Internet at **http://www.bls.gov/oco/ocos084.htm** (visited *March 30, 2007*).

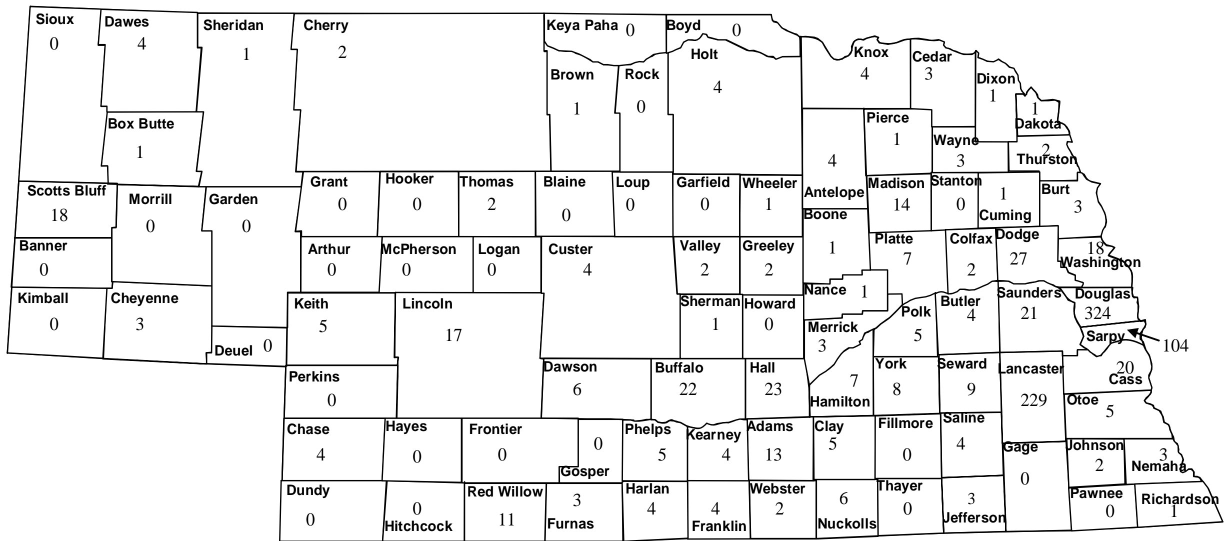
Last Modified Date: August 4, 2006

Source: Bureau of Labor Statistics

ATTACHMENT B

Nebraska Respiratory Care

1,195 licensed Respiratory Care Practitioners - distribution by counties



Respiratory Care Licenses with non-Nebraska mailing addresses: 170

Updated January 2006

Respiratory Care Requirements

STATE	*INITIAL LICENSURE REQUIREMENTS*			*RENEWAL REQUIREMENTS*		DISCIPLINARY ACTIONS				
	Education Requirements	**Examinations**	**Reciprocity/ Endorsement**	**Licensure Term**	**CEs Rquired**	**2001**	**2002**	**2003**	**2004**	**2005**
Kansas	Complete an education program in respiratory therapy approved by the board. Accreditation by CoARC may be considered by the board	NBRC Exam.	Reciprocity	Annual	12 CEs	2	4	2	4	5
Iowa	Complete a respiratory care education program from an accredited school/program for training respiratory therapists	The exam required by the board shall be the NBRC Exam or the State Clinical Exam admin. by the NBRC	Both Reciprocity and Endorsement	Biennial in even numbered year	24 CEs	0	0	1	0	5
Minnesota	Complete a respiratory therapy training program accredited by CAAHEP with recommendation from the JRCRTE	NBRC Exam.	Reciprocity	Annual	24 CEs every two years					
Virginia	Graduate of an accredited educational program for respiratory care practitioners; or Hold current credentialing as a CRT or a RRT from the NBRC. Accredited educational program means a program accredited by CoARC or any other agency approved by the NBRC for its entry level certification exam.	NBRC Exam.	Reciprocity	Biennial in odd-numbered year	20 CEs for bienniu m CEs			2		
Colorado	Graduates of programs accredited by CAAHEP and CoARC	NBRC Exam. CRT exam is the standard. May obtain the RRT credential, also.	Reciprocity	Biennially		4	10	8	18	
Missouri	Respiratory Care educational program accredited by CAAHEP, or programs supported by JRCRTE	NBRC must verify applicant's credentials	Reciprocity	Biennially	24 hours of approve d CEs					
Texas	Completed an approved four-year high school course of study or the equivalent as determined by the appropriate educational agency; and A respiratory care education program approved by the Department (CAAHEP; COARC; CAHEA)	NBRC Exam. Credentialed by NBRC as CRT, CRTT, or RRT	Reciprocity	Biennially on or before the last day of the practition er's birth month	12 hours of CEs during each renewal year	3	27	23	7	5
Nebraska	Completion of an approved training program	NBRC Exam	Reciprocity	June 1 of even numbered year	20 hours of CEs during each renewal period					2

KEY:

AARC - The American Association for Respiratory Care
CAAHEP – The Commission on Accreditation of Allied Health Education Programs
CAHEA – The Committee on Allied Health Education and Accreditation of the American Medical Association
CoARC – The Committee on Accreditation for Respiratory Care
JRCRTE – The Joint Review Committee for Respiratory Therapy Education
NBRC – National Board for Respiratory Care, Inc.

STATE'S TITLES:

KANSAS

Respiratory Therapy Licensure
Licensed Respiratory Therapist
CRTT – Certified Respiratory Therapy Technician
RRT – Registered Respiratory Therapist
RCP – Respiratory Care Practitioner

IOWA

Respiratory Care Practitioners (Licensure)
RT - Licensee – Any person licensed to practice as a Respiratory Therapist

MINNESOTA

Respiratory Care Practitioner Licensure and Registration
MRRCP - Minnesota Registered Respiratory Care Practitioner
RRCP - Registered Respiratory Care Practitioner
RCP (R.C.P.) - Respiratory Care Practitioner
RT – Respiratory Therapist
RTT; RCP – Respiratory Therapy (or care) Technician
IT – Inhalation Therapist
ITT – Inhalation Therapy Technician

VIRGINIA

Respiratory Care Practitioner Licensure
CRT – Certified Respiratory Therapist
RRT – Registered Respiratory Therapist

COLORADO

Respiratory Therapy Licensure/Practice
CRT – Certified Respiratory Therapist
RRT – Registered Respiratory Therapist

MISSOURI

Respiratory Care Practice Act
CRT – Certified Respiratory Therapist
RRT – Registered Respiratory Therapist

TEXAS

Respiratory Care Practitioner Certification
Respiratory Therapist – Certified to Practice Respiratory Care
RCP – Respiratory Care Practitioner
CRT – Certified Respiratory Practitioner
CRTT – Certified Respiratory Therapy Technician
RRT – Registered Respiratory Therapist

NEBRASKA

Respiratory Care Practitioner

ATTACHMENT D

Results from 2006 Licensed Respiratory Care Practitioner Surveys

Surveys were mailed to 516 LRCPs with Nebraska addresses (33% of the total LRCPs in Nebraska) and 194 completed surveys were returned (38% return rate). Some interesting survey results include:

- The LRCPs were asked if respiratory care services are of the same quality (question #8) and accessible (question #9) in different locations of the State. Responses indicated that at least 33% of the LRCPs did not think respiratory care services were of the same quality and accessible in all parts of Nebraska. During Committee discussion, it was stated that there are all kinds of therapeutic modalities in Omaha and Lincoln but that some of these modalities are not available in the rural parts of the State.
- Survey questions #16 to #21 responses indicate that many LRCPs are unaware of how the regulatory system works. This is a constant educational issue (How decisions are made; Discipline process; Role of the Board).
- Survey questions #22 and #23 asked if the regulation or practice boundaries limit the LRCPs or other professionals from providing services for which they are qualified by training. Responses indicate that 33% believe regulation does limit the LRCPs and other practitioners from providing services they are qualified to provide.

Detailed results follow.

SCALE – Circle your answer **5=Strongly agree; 4=Agree; 3=Neutral; 2=Disagree; 1=Strongly disagree** **N/A = Not Applicable or Do Not Know**						
1. Respiratory care licensure requirements are related to respiratory care jobs.	5 **40.2%**	4 **47.4%**	3 **8.8%**	2 **2.1%**	1 0.5%	N/A **1.0%**
2. The process for getting a license or renewing a license is easy to understand.	5 **29.4%**	4 **42.8%**	3 **18.0%**	2 **7.7%**	1 **1.0%**	N/A **1.0%**
3. The process for getting a license or renewing a license is efficient. **a. 0.5% did not answer**	5 **29.4%**	4 **47.9%**	3 **13.4%**	2 **7.2%**	1 **0.5%**	N/A **1.0%**
4. The education/training required to practice prepares the practitioner for independent decision making.	5 **23.7%**	4 **4.1%**	3 **3.9%**	2 6 **.7%**	1 **0.5%**	N/A **1.0%**
5. The education/training required to practice prepares the practitioner to educate the public regarding prevention and self-protection. **0.5% did not answer**	5 **16.5%**	4 **56.2%**	3 **21.1%**	2 **4.1%**	1 **1.0%**	N/A **0.5%**
6. Respiratory Care continuing competency requirements for renewing a license are appropriate to assure competency.	5 **24.7%**	4 **54.6%**	3 **3.4%**	2 **6.2%**	1 **1.0%**	N/A **0%**
7. There are sufficient opportunities for continuing competency. **1.5% did not answer**	5 **24.2%**	4 **45.4%**	3 **15.5%**	2 **12.4%**	1 **0.5%**	N/A **0.5%**
8. In different locations of the State, respiratory care services are of the same quality.	5 **2.6%**	4 **15.0%**	3 **30.9%**	2 **25.3%**	1 **8.2%**	N/A **18.0%**
9. In different locations of the State, the public's access to respiratory care services is the same. **1.0% did not answer**	5 **1.0%**	4 **6.2%**	3 **29.9%**	2 **29.4%**	1 **15.0%**	N/A 17.5%

SCALE – Circle your answer 5=Strongly agree; 4=Agree; 3=Neutral; 2=Disagree; 1=Strongly disagree N/A = Not Applicable or Do Not Know						
10. How important to public safety is the regulation (licensure) of respiratory care? *(5=very important; 4= important; 3= neutral; 2=somewhat important; 1=not important; and N/A=do not know.)* **0.5% did not answer**	5 **63.4%**	4 **29.4%**	3 **3.6%**	2 **1.5%**	1 **0.5%**	N/A **1.0%**
11. The Nebraska Society for Respiratory Care and/or the American Association for Respiratory Care have established guidelines for good respiratory care practice that the public can find and use. **1.5% did not answer**	5 **22.7%**	4 **40.2%**	3 **22.2%**	2 **4.6%**	1 **1.0%**	N/A **7.7%**
12. Most respiratory care practitioners use easily understood and common language when communicating with the patient.	5 **21.1%**	4 **57.2%**	3 **16.5%**	2 **2.1%**	1 **0%**	N/A **3.1%**
13. As a respiratory care practitioner, I routinely participate in dialogues or partnerships with other health professionals to identify and solve problems and improve patient care.	5 **46.4%**	4 **44.3%**	3 **6.7%**	2 **0.5%**	1 **0%**	N/A **2.1%**
14. As a respiratory care practitioner, when I need to refer a patient to other services I know the referral process and can be reasonably sure the patient will have access to the needed services. **3.6% did not answer**	5 **15.0%**	4 **49.5%**	3 **20.1%**	2 **6.7%**	1 **1.5%**	N/A **3.6%**
15. Respiratory Care practitioners support community health efforts.	5 **27.8%**	4 **50.0%**	3 **15.0%**	2 **2.6%**	1 **0%**	N/A **1.5%**
16. Respiratory care licensure discipline decisions are made by a. Nebraska Respiratory Care Society/Association (a) **TOTAL= 4.6%** b. Board of Respiratory Care (b) **TOTAL= 24.7%** c. The Department of Health and Human Services (c) **TOTAL= 29.9%** d. Other: ______ State Hlth Dept ________ (d) **TOTAL= 1.0%** e. Do Not Know (e) **TOTAL= 22.2%** checked multiple answers **TOTAL= 9.8%** **Did not answer = 7.7%**						
17. Information about <u>how</u> to file a complaint about a health professional is easily accessible to the public or a practitioner. **3.5% did not answer**	5 **6.2%**	4 **28.4%**	3 **30.4%**	2 **15.5%**	1 **2.1%**	N/A **13.9%**
18. Information about <u>where</u> to file a complaint about a health professional is easily accessible to the public or a practitioner. **8.2% did not answer**	5 **5.7%**	4 **24.7%**	3 **28.9%**	2 **16.5%**	1 **2.6%**	N/A **13.4%**
19. Appropriate information on disciplinary actions is available to the public. **5.7% did not answer**	5 **7.7%**	4 **24.7%**	3 **30.9%**	2 **11.3%**	1 **3.1%**	N/A **16.5%**

SCALE – Circle your answer 5=Strongly agree; 4=Agree; 3=Neutral; 2=Disagree; 1=Strongly disagree N/A = Not Applicable or Do Not Know						
20. The Board of Respiratory Care is appointed by the: a. Governor (a) **TOTAL= 1.5%** b. Respiratory Care Practitioners (b) **TOTAL= 18.0%** c. Nebraska Society for Resp. Care (c) **TOTAL= 11.9%** d. State Board of Health (d) **TOTAL= 7.7%** e. Department of H & H S (e) **TOTAL= 13.9%** f. Do Not Know (f) **TOTAL= 37.6%** checked multiple answers **TOTAL= 2.0%** **Did not answer = 7.2%**						
21. I know about the Board of Respiratory Care and am confident I understand the Board's duties and responsibilities. **3.6% did not answer**	5 **4.6%**	4 **19.6%**	3 **39.2%**	2 **23.2%**	1 **3.6%**	N/A **6.2%**
22. Regulation of respiratory care limits individuals from other professions or occupations from providing services for which they are qualified by training and experience. **3.1% did not answer**	5 **8.2%**	4 **25.3%**	3 **23.2%**	2 **20.1%**	1 **11.9%**	N/A **8.2%**
23. Regulation of respiratory care limits individuals from the respiratory care profession from providing services for which they are qualified by training. **4.1% did not answer**	5 **11.3%**	4 **22.2%**	3 **20.6%**	2 **22.2%**	1 **10.8%**	N/A **8.8%**
24. Respiratory Care Practitioners are frequently denied third party reimbursement. **1.0% did not answer**	5 **18.0%**	4 **20.1%**	3 **25.8%**	2 **4.6%**	1 **1.0%**	N/A **29.4%**
25. Respiratory care licensure information is readily available on the Web **3.6% did not answer**	5 **24.7%**	4 **36.6%**	3 **18.0%**	2 **2.6%**	1 **0.5%**	N/A **13.9%**
26. Additional comments: On File and Available Upon Request						

ACRONYMS

AARC = American Association of Respiratory Care

Board = Board of Respiratory Care Practice

CE = Continuing Education

CPAP = Continuous Positive Airway Pressure

CRT = Certified Respiratory Therapist

Department = Department of Health and Human Services
Regulation and Licensure

DME = Durable Medical Equipment

EMT-P = Emergency Medical Technician-Paramedic

LRCP = Licensed Respiratory Care Practitioner

NBRC = National Board of Respiratory Care, Inc.

PREP = Periodic Regulatory Evaluation Process

RRT = Registered Respiratory Therapist