Submitted via email to *Karen.Wilson@ct.gov*

August 15, 2017

Karen G. Wilson, HPA
Practitioner Licensing & Investigations Section
Connecticut Department of Public Health
410 Capitol Avenue, MS#12APP
P.O, Box 340308
Hartford, CT 06134

Dear Ms. Wilson:

As the Department of Public Health (DPH) is aware, the Connecticut Society for Respiratory Care seeks to better serve the needs of the patients of Connecticut through adopting the scope of practice changes submitted and accepted by the American Association for Respiratory Care.

In addition to the named parties on the submission, the CTSRC and the Connecticut Hospital Association have worked diligently to increase support for this proposal from other stakeholders. We are requesting selection for a scope of practice review as established under Public Act 11-209.

We believe that recent and ongoing changes to healthcare delivery make it imperative that this request receive the benefit of the process during this cycle. As more and more states accept the advanced practice of Respiratory Care we believe the state of Connecticut and its patients will benefit because of the proposed changes.

We therefore respectfully submit the attached request for review under PA 11-209.

Thank you for your assistance with this request. If you have any questions Please do not hesitate to contact Dr. John J. Votto DO, FCCP Medical Director for the Connecticut Society for Respiratory Care (860) 827-1958 Ext. 4743.

Sincerely,

Jason Robert Wright MBA, ACHE, RRT

Jason Robert Wright MBA, ACHE, RRT
President

Connecticut Society for Respiratory Care

RESPIRATORY CARE SCOPE OF PRACTICE REQUEST TO THE STATE OF CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

Connecticut Society for Respiratory Care

C/O

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Background:

Respiratory Care Practitioners (RCPs) are specialized health care practitioners who most often work in the acute care hospital setting and spend much of their time within these facilities in the critical care and emergency areas. They are also members of rapid response, resuscitation and trauma teams within these facilities. In addition to the acute care setting, RCPs also work in outpatient clinics, physicians' offices, rehabilitation and long-term care facilities and in the home-health setting. RCPs work with patients of all ages from the premature newborn to the older adult. There are close to 1800 licensed RCPs in the state of Connecticut (CT).

The Connecticut Society for Respiratory Care (CTSRC) is the professional society that represents RCPs in the state. The CTSRC is a non-profit organization and chartered affiliate of the American Association for Respiratory Care (AARC). The CTSRC has served Respiratory Care Practitioners and their patients in the state of CT for over 40 years. The society is managed by a volunteer board of Respiratory Care Practitioners from throughout of the state. The mission of the CTSRC is to promote professional excellence among its members and serve as an advocate for patients and their families, the general public and Respiratory Care Practitioners in the state.

A Description of the Request:

The CTSRC is requesting changes and updates to the current scope of practice for Respiratory Care Practitioners. The reason for this request is because a significant portion of the language in the current practice act is outdated and in relation to the current trends in health care, is vague and as such is restricting the practice of Respiratory Care in our state. The practice of Respiratory Care has evolved since the current practice act was first written back in the early-mid 1990s. Over the ensuing years only minor changes in technical language were made. The last revision was made back in the mid-2000s with the addition of tuberculosis screening by way of the purified protein derivative (PPD) test and patient education for self-care procedures. The lack of clarity in the scope has, at times, presented barriers to flexible, efficient and better quality health care. For example, there have been instances over the last several years where health care facilities have inquired whether RCPs can perform procedures such as arterial line insertion[1], extracorporeal membrane oxygenation (ECMO[2]), intravenous (IV[3])/interosseous (IO)

[1] Arterial line placement is a common procedure in various critical care settings. Intra-arterial blood pressure (BP) measurement is more accurate than measurement of BP by noninvasive means, especially in the critically ill. Overall, arterial line placement is considered a safe procedure, with a rate of major complications that is below 1%.

[2] Extra corporeal membrane oxygenation-Extracorporeal membrane oxygenation (ECMO) is a treatment that uses a pump to circulate blood through an artificial lung back into the bloodstream of a very ill patient. This system provides heart-lung bypass support outside of the body. It may help support a patient who is awaiting a heart or lung transplant.

[3] Intravenous therapy is the infusion of liquid substances directly into a vein. Intravenous (IV) means "within vein". Intravenous infusions are commonly referred to as drips.

[4]insertion, injections of medications, and vaccinations[5]. Since there is not a state board of Respiratory Care, these questions were posed to the CTSRC.

While the CTSRC feels that these procedures do fall within the scope and that Respiratory Care Practitioners are by their education and training qualified to perform them, the CTSRC does not have the legal authority to interpret the scope of practice and therefore we have been hesitant to support these requests. It is the CTSRC's belief that the RCPs in the state of CT are not performing the full range of skills for which they have been educated and trained. Therefore, we are proposing changes to our scope of practice which will more clearly define the practice of Respiratory Care. Furthermore, we are proposing changes to the credentialing requirements for obtaining a license to practice respiratory care in the state of CT. We are also requesting updates to some of the technical and educational language and we are requesting an increase of our continuing education requirement from the current 6 hours to 10 hours and of the 10 hours at least 50% of these must be live programs.

The CTSRC respectfully requests these changes to the RCP scope of practice. We believe that the proposed changes will accommodate the advancements in technology and the changes in patient care that have occurred over the past 25 years and will continue to occur into the future.

See Appendix A for the proposed language changes.

Public Health and Safety Benefits

RCPs are extensively trained in the theory and practice of Respiratory Care which includes comprehensive education and training in the assessment and treatment of patients with conditions and diseases that affect the cardiopulmonary system.

Advances in technology and workforce innovations have not only changed the practice of Respiratory Care but also the traditional boundaries between professional scopes of practice and this requires flexibility and cooperation among licensed health professionals. The CTSRC agrees with others when they recommend collaboration between healthcare providers and that overlap among professions is necessary. (Changes in Healthcare Professions' Scope of Practice: Legislative Considerations, 2007) and that in certain settings and circumstances, flexibility and overlap between RCPs and other licensed healthcare professions is key to providing safe, high quality and cost-effective care for our patients.

[4] **Intraosseous** infusion (IO) is the process of injecting directly into the marrow of a bone to provide a non-collapsible entry point into the systemic venous system. This technique is used to provide fluids and medication when intravenous access is not available or not feasible.

[5] Injection is the act of putting a liquid, especially a drug, into a person's body using a needle and a syringe. Reference to medications that are explicit to the cardiopulmonary system, pneumonia vaccine, influenza vaccine, other pulmonary related medications, and PPD test for TB.

In terms of personnel availability, the changes that we are requesting will provide for a more flexible and diversified professionally licensed health care workforce which we believe will have a positive impact on public health and patient safety. We are proposing that some of these procedures such as extracorporeal life support (ECLS)/ECMO and IV/IO insertions are done by RCPs in appropriately identified settings and with the appropriate education and training and that RCPs demonstrate continuing competency in the performance of these procedures.

The CTSRC has no evidence to indicate that implementing these changes to the RCP scope of practice will harm the public in any way. We have heard repeatedly from many physicians and practitioners that they are surprised there is any uncertainty about our profession's ability to perform the additional functions requested here.

Public Access to Health Care

According to Lebuhn and Swankin (2010), "the productivity of the US healthcare system is constrained by an inability to make full and appropriate use of its professional workforce. Artificial scope of practice restrictions prevent health care professionals from performing the full range of skills for which they were trained, limit consumer access to care and choice of providers and inflate the cost of health care". In addition, they state that "there are two looming developments that will only compound the problem of healthcare workforce challenges: the aging Baby Boomers which includes a substantial number of health care workers whose retirements will only compound the problem and the increase in the number of insured Americans as a result of the healthcare reform" (Lebuhn and Swankin, 2010).

The proposed changes to the RCP's scope of practice allows for a more diversified licensed workforce with multiple professionals being able to perform or administer these particular types of procedures. While it does not necessarily increase access to health care per se, a more diversified and less restrictive professionally licensed workforce improves access to necessary therapeutic and diagnostic procedures.

State and Federal Laws Governing the Profession

Forty-nine states and the Commonwealth of Puerto Rico require licensure of RCPs. Of those states, most require that licensees obtain the certified respiratory therapist (CRT) credential through the National Board for Respiratory Care (NBRC) however several states are moving or have moved (Ohio, California, Arizona, Georgia, Oregon and New Jersey) to the more advanced registered respiratory therapist (RRT) credential. According to the AARC, "Respiratory Care Practitioners that possess the more advanced RRT credential exemplifies the dedication of a respiratory therapist to professional excellence and demonstrates a commitment to providing care at the highest level" (AARC: Guidance Document Regarding RRT Entry to Licensure, 2017). The AARC actively encourages RCPs to obtain the RRT credential. Respiratory Care Practitioners are providers within Medicare and also Medicaid.

The CRT credential is the minimum credentialing requirement to obtain a license in the state of CT. In order to obtain the credential, respiratory care graduates must take an examination that is administered by the National Board for Respiratory Care. In order to take the exam, the candidate must be a graduate of an accredited Respiratory Care educational program.

Current Regulatory Oversight of the Profession

As mentioned previously, applicants for a RCP license in CT must be graduates of an accredited Respiratory Care educational program and they must have obtained the CRT credential. In order to renew their license in CT, RCPs are required to earn a minimum of 6 hours of continuing education annually which is directly related to respiratory therapy and reflects the professional needs of the licensee in order to meet the health care needs of the public. When questions or concerns arise, you contact the Department of Public Health as they oversee all aspects of the profession, including licensure.

See Appendix D for the current practice act.

The CTSRC is requesting that the minimum requirement of the CRT credential be changed to the more advanced RRT credential. We understand the impact this change may have on the current workforce and therefore we propose that any licensed RCP that obtained their CRT credential prior to the date by which this proposal becomes law are qualified to renew their CT state license provided that they do not let their license lapse. In addition, we are proposing that Respiratory Care Practitioners applying for a CT license from out of state will be required to have the RRT credential.

See Appendix A section 20-162o for proposed language changes.

Education, Training and Examination Requirements of Respiratory Care Practitioners

All RCPs must graduate from an accredited Respiratory Care program and pass a national certification examination administered by the NBRC which is the only credentialing agency for Respiratory Care Practitioners. The current language in the Respiratory Care practice act refers to accreditation by the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs in cooperation with the Joint Review Committee for Respiratory Therapy Education. These organizations no longer accredit Respiratory Care educational programs. Currently, all Respiratory Care educational programs are accredited by the Commission on Accreditation for Respiratory Care which is also known as CoARC. As stated on its website, CoARC accredits entry into professional practice programs in respiratory care at the Associate, Baccalaureate, and Master's Degree level in the United States and its territories and its mission is to ensure that high quality educational programs prepare competent respiratory therapists for practice, education, research, and service (www.coarc.com).

According to the CoARC accreditation standards-specifically Standard IV, Section 4.03, "Curricular content in respiratory care must be periodically reviewed and revised to ensure its consistency with the competencies and duties performed by registered respiratory therapists entering the workforce, as established by the national credentialing agency through its periodic job analysis and credentialing examination specifications…These nationally accepted standards must be the basis for formulating the objectives and competencies of the program's curriculum. In addition to the annual reviews related to outcomes on the credentialing exams, an extensive review of curricular content must be conducted after any revision in the national credentialing agency content outline" (CoARC Accreditation Standards, June 2015: http://www.coarc.com/29.html). This statement indicates that all respiratory care education programs are required to educate respiratory students to the level of the registered respiratory therapist (RRT).

According to the CoARC, "Respiratory Care curricular content should reflect the current competencies and duties required of registered respiratory therapists. Respiratory therapists provide patient care which includes clinical decision-making and patient education. The Respiratory Care scope of practice includes, but is not limited to the following basic competencies:

- acquiring and evaluating clinical data;
- assessing the cardiopulmonary status of patients;
- performing and assisting in the performance of prescribed diagnostic studies such as: obtaining blood samples, blood gas analysis, pulmonary function testing, and polysomnography;
- evaluating data to assess the appropriateness of prescribed respiratory care;
- establishing therapeutic goals for patients with cardiopulmonary disease;
- participating in the development and modification of respiratory care plans;
- case management of patients with cardiopulmonary and related diseases;
- initiating prescribed respiratory care treatments, managing life support activities, evaluating and monitoring patient responses to such therapy and modifying the prescribed therapy to achieve the desired therapeutic objectives;
- initiating and conducting prescribed pulmonary rehabilitation;
- providing patient, family, and community education;
- promoting cardiopulmonary wellness, disease prevention, and disease management;
- promoting evidence-based practice by using established clinical practice guidelines and by evaluating published research for its relevance to patient care.

The CRT/RRT Combined Detailed Content Outline comparison should be used to document the comparison of each program's curriculum with the NBRC CRT and RRT content matrices." (CoARC Accreditation Standards, June 2015: http://www.coarc.com/29.html)

In addition to the credentialing examinations for Certified and Registered Respiratory Therapists (CRT/RRT), the NBRC offers several specialty examinations. The two that are most relevant to this scope of practice request are the Advanced Critical Care Specialist (ACCS) and the Neonatal Pediatric Specialist (NPS) credentialing examinations. In most cases, these credentialing examinations are voluntary, however, the content outlines contain sections on insertion, monitoring and troubleshooting procedures such as arterial lines, specialty nasogastric tubes and monitoring of ECMO.

See the content outlines for the CRT/WRRT and Clinical Simulation Exams.

Scope of Practices Changes Requested or Enacted Concerning the Profession

There have been no known scope of practice changes requested or enacted concerning Respiratory Care Practitioners and the practice of Respiratory Care in the past five years. However, the CTSRC did submit an Impact Statement in 2012 when a scope proposal was submitted by the Medical Assistants. CTSRC had representation on the review committee and fully participated in the process.

Existing Relationships

Respiratory Care Practitioners work very closely with many health care professionals including physicians, physician assistants, advanced practice nurses, registered nurses, and physical and occupational therapists as well as speech language pathologists in varied health care settings such as acute care hospitals, long term care and rehabilitative facilities, physician's offices and in the home care setting. RCPs are educated to provide varying levels of care depending on the setting in which they work and they provide care to patients across the life span who experience deficiencies and abnormalities that affect the cardiopulmonary system and the associated effects these have on the function of other bodily systems.

The Connecticut Hospital Association's comments have been supportive of the recommended changes to the scope of practice and embrace moving the profession forward to meet the growing demand for healthcare in the US. CHA is in favor of the proposed changes.

Respiratory Care Practitioners provide this care under the direction of a licensed physician in accordance with written protocols developed by physicians. Furthermore, educational programs in Respiratory Care are required through the CoARC accreditation standards to have medical direction by a qualified licensed physician. This close association with physician leaders has been an integral part of the profession since its inception.

In terms of the mid-level practitioners (APRN, PA), RCP receive orders from these professionals and work with them as members of health care teams across the continuum.

State	ECMO	Arterial Line Insertion	IV/IO	Medication Injections	Influenza and Pneumonia Vaccinations

RCPs work most closely with nurses. We compliment their profession and they ours. We are not subordinate to nurses in our practice. We are both critical members of a team of heath care professionals.

Perfusionists provide most of their patient care in the operating room therefore RCPs do not work as closely with this profession.

The CTSRC expects the implementation of this scope of practice request to enhance our professional relationships with these health care professionals and provide the flexibility and appropriate overlap that is needed in today's health care environment. The changes we are requesting are supportive in nature and in no way should be construed as replacing our fellow and respected health professionals from carrying out their customary duties and functions.

Economic Impact

The CTSRC believes, given the current economic outlook in the state of CT, these proposed changes will have a positive economic impact on health care in our state. By allowing health care facilities more flexible options in terms of staffing, these changes should increase efficiency, improve care and reduce costs.

Regional and National Trends

Below is a sample of states that allow RCPs to perform many of the procedures that we have included in our request. The CTSRC is a society run by a volunteer board and does not have the resources to investigate the practice acts of all US states that require licensure.

Tennessee	X				X
California	X	X	X	X	X
Wisconsin	X	X			
Ohio	X				X
Nebraska	X				X
North Carolina	X	X	X	X	X
Massachusetts	X				
Vermont	X	X	X	X	X
New York		X	X	X	
Florida		X	X	X	

The American Association for Respiratory Care (AARC) advocates for RCPs to perform the procedures that we are requesting to add to our scope of practice. In addition to the AARC position, the Extracorporeal Life Support Organization (ELSO) recommends that the educational qualifications for an ECMO specialist include, in addition to nurses and perfusionists, registered respiratory therapists (RRT) (ELSO Guidelines for Training and Continuing Education of ECMO Specialists, 2010).

See Appendix B – AARC Position Statements

Health Care Professions That May Be Affected by the Request

The health care professions that may be directly affected by the request include physicians, registered nurses, mid-level practitioners, and perfusionists. The CTSRC believes that the impact of these changes to these professions will be minimal. The goal is to clarify the language thereby allowing for a health care facility to have the option to designate the performance of these procedures to the RCP provided that they delineate the setting in which the task will be performed and provide the appropriate education and training to the RCP and that the RCP can demonstrate continued competence in performing these procedures.

As mentioned previously in this request, it is the CTSRC's belief that these procedures have always fallen within the respiratory care scope of practice but due to the vagueness or lack of clarity in the practice act there have been instances where individuals outside the profession have interpreted the scope of practice differently from the way in which respiratory care professionals interpret it. In several instances over the past few years, health care facilities reached out to the CTSRC directly or through the CT Hospital Association (CHA) to ascertain whether we can provide some of these services. The CHA is aware of our efforts and has shown a particular interest in advancing the role of RCPs as ECMO Specialists in the critical care settings. The following is a synopsis of the impact on the other health professions:

Nurses:
Nurses perform injections, vaccinations, insertion of IV catheters and insertion of nasogastric tubes. RCPs would share these responsibilities in designated circumstances and settings such as outpatient, rehabilitation and long term care, physicians' practices and medical evacuation and transport.

With advances in mechanical ventilation, there are ventilators that require the insertion of a specialized nasogastric (NG) tube. This tube is designed to sense movements of the diaphragm. In addition to these specialized tubes and in specific health care settings, RCPs insert NG tubes for the purpose of measuring esophageal pressures and motility

Physicians, Physician Assistant and Advanced Practice Nurses:
These professionals are typically responsible for the insertion of arterial line catheters. RCPs have a long history of inserting arterial lines in many states including CT. At one hospital in CT, RCPs were inserting arterial lines for over 20 years without incident. This practice was abandoned following a state inspection where the inspectors felt that it did not fall within the Respiratory Care scope of practice. The CTSRC believes that it was, in part, due to the vagueness of the language in the current scope of practice that lead to this change.

Perfusionists:
Perfusionists in many hospitals are also the ECMO Specialists. There primary work place is in the operating room managing cardiopulmonary bypass. We are proposing that RCPs work as ECMO specialists in the adult, pediatric and neonatal intensive care units.

Practicing to the Full Extent and Training of a Respiratory Care Practitioner

In summary and as describe above in previous sections, the CTSRC believes that the current scope of practice is outdated and restricts RCPs from practicing to the full extent of their education and training and in accordance with advancing technology. Moreover, it is our belief that by allowing health care facilities greater flexibility to effectively utilize their licensed health care personnel, patients will be safer and the quality, and efficiency of care improved.

Appendix A: Proposed Language Changes to the Respiratory Care Scope of Practice

CONNECTICUT GENERAL STATUTES
CHAPTER 381a
RESPIRATORY CARE PRACTITIONERS

Section 20-162n. Definitions. As used in subsection (c) of section 19a-14 and sections 20-162n to 20-162q, inclusive:
(a) "Commissioner" means the Commissioner of Public Health;

(b) "Respiratory care" means health care under the direction of a physician licensed pursuant to chapter 370 and in accordance with written protocols developed by said physician, employed in the therapy, management, rehabilitation, diagnostic evaluation and care of patients with deficiencies and abnormalities that affect the cardiopulmonary system and associated aspects of other system functions and that includes the following: (1) The therapeutic and diagnostic use of medical gases, administering apparatus, humidification and aerosols, administration of drugs and medications used to treat the cardiorespiratory systems, ventilator assistance and ventilatory control, postural drainage, chest physiotherapy and breathing exercises, respiratory rehabilitation, cardiopulmonary resuscitation and maintenance of natural airways as well as the insertion and maintenance of artificial airways, (2) the specific testing techniques employed in respiratory therapy to assist in diagnosis, monitoring, treatment and research, including the measurement of ventilatory volumes, pressures and flows, specimen collection of blood and other materials, pulmonary function testing and hemodynamic and other related physiological monitoring of cardiopulmonary systems including the percutaneous insertion and monitoring and maintenance of arterial catheters and the monitoring and maintenance of other cardiovascular indwelling catheters including central venous and pulmonary artery catheters, (3) performance of purified protein derivative test to identify exposure to tuberculosis, ~~and~~ (4) patient education in self-care procedures as part of the ongoing program of respiratory care of such patient. (5) the administration of influenza and pneumonia vaccinations, (6) with the appropriate training and in appropriately identified health care settings such as medical evacuation/transport, outpatient bronchoscopy and long term care and rehabilitation facilities, the insertion of intravenous and intraosseous catheters (7) the insertion of nasogastric tubes including those used for the purpose of sensing diaphragmatic movements and (8) with appropriate training and in appropriately identified health care settings such as adult, pediatric and neonatal intensive care units, the monitoring and maintenance of all forms of extracorporeal life support (ECLS), including but not limit to extracorporeal membrane extracorporeal membrane oxygenation (ECMO) and extracorporeal carbon dioxide removal ($ECCO_2R$). The practice of respiratory therapy is not limited to the hospital setting;

(c) "Respiratory care practitioner" means a person who is licensed to practice respiratory care in this state pursuant to section 20-162o and who may transcribe and implement written and verbal orders for respiratory care which are issued by a physician licensed pursuant to chapter 370, or a physician assistant licensed pursuant to chapter 370 or an advanced practice registered nurse licensed pursuant to chapter 378 who is functioning within the person's respective scope of practice.

Section 20-162o. Application. Qualifications. Fees. Regulations. (a) Each person seeking licensure as a respiratory care practitioner shall make application on forms prescribed by the commissioner, pay an application fee of one hundred ninety dollars and present to the commissioner satisfactory evidence that (1) s/he has successfully completed an educational program for respiratory therapists or respiratory therapy technicians which, at the time of his/her completion, was accredited by the Committee on

Allied Health Education and Accreditation, or the Commission on Accreditation of Allied Health Education Programs, in cooperation with the Joint Review Committee for Respiratory Therapy Education, or was recognized by the Joint Review Committee for Respiratory Therapy Education or accredited by the Commission on the Accreditation for Respiratory Care, (2) s/he is currently credentialed as a Registered Respiratory Therapist as demonstrated by achieving passing scores on the required examinations ~~passed the entry level or advanced practitioner respiratory care examination~~ administered by the National Board for Respiratory Care, Inc. or obtained the CRT credential by successfully passing the required examination administered by the National Board not later than December 31, 2018 ~~and (3) he is currently credentialed by the National Board for Respiratory Care as a certified respiratory therapy technician or registered respiratory therapist.~~

~~(b) Notwithstanding the provisions of subsection (a) of this section, the department may issue a license as a respiratory care practitioner to a person who (1) was credentialed by the National Board for Respiratory Care as a certified respiratory therapy technician not later than June 30, 1978, or as a registered respiratory therapist not later than June 30, 1971, and (2) meets the requirements of subdivisions (2) and (3) of subsection (a) of this section. Each person seeking licensure pursuant to this subsection shall make application on forms prescribed by the commissioner, pay an application fee of one hundred ninety dollars and present to the commissioner satisfactory evidence of his credentialing by said board.~~

(c) Notwithstanding the provisions of subsection (a) of this section, the department may issue a license as a respiratory care practitioner to a person who (1) has been registered as a respiratory therapist by the Canadian Society of Respiratory Therapists, (2) has passed the clinical simulation examination of the National Board for Respiratory Care and (3) is currently credentialed by said board as a registered respiratory therapist. Each person seeking licensure pursuant to this subsection shall make application on forms prescribed by the commissioner, pay an application fee of one hundred ninety dollars and present to the commissioner satisfactory evidence of his credentialing by said society and said board.

(d) The department may, upon receipt of an application for respiratory care licensure, accompanied by the licensure application fee of one hundred ninety dollars, issue a temporary permit to a person who has completed an educational program in respiratory care which satisfies the requirements of subdivision (2) of subsection (a) of this section. Such temporary permit shall authorize the permittee to practice as a respiratory care practitioner under the supervision of a person licensed pursuant to this section. Such practice shall be limited to those settings where the licensed supervisor is physically present on the premises and is immediately available to render assistance and supervision as needed, to the permittee. Such temporary permit shall be valid from the date of issuance of same until the date of issuance of the results of the first examinations administered pursuant to subdivision (1) of subsection (a) of this section, following the permittee's completion of said educational program in respiratory care. Such permit shall remain valid for each person who passes said examination until the permittee receives their license from the department. Such permit shall become void and shall not be reissued in the event that the permittee fails to pass said examinations. No permit shall be issued to any person who has previously failed said examinations or who is the subject of an unresolved complaint or pending professional disciplinary action. Violation of the restrictions on practice set forth in this section may constitute a basis for denial of licensure as a respiratory care practitioner.

~~(e) Notwithstanding the provisions of subsection (a) of this section, from July 1, 1995, until July 1, 1996, a person seeking licensure pursuant to this section may present to the department satisfactory evidence that he has, from July 1, 1980, until July 1, 1995, practiced as a respiratory care practitioner for at least ten years and has been determined eligible by the National Board for Respiratory Care, Inc. to sit for the examination required pursuant to subdivision (2) of subsection (a) of this section, provided any license issued pursuant to this subsection shall become void on October 1, 1997, unless the person has, on or~~

~~before that date, presented to the department satisfactory evidence that he has met the requirements of subdivisions (2) and (3) of subsection (a) of this section.~~

(f) Licenses shall be renewed annually in accordance with the provisions of section 19a-88. The fee for renewal shall be one hundred dollars.

(g) no license shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint in this or any other state or territory.

(h) The commissioner may adopt regulations in accordance with the provisions of chapter 54 to administer provisions of sections
20-162n to 20-162q, inclusive.

Section 20-162p. Disciplinary action. Grounds. The commissioner may take any action set forth in section 19a-17 if the license holder fails to conform to the accepted standards of the respiratory care profession, including, but not limited to, the following: Conviction of a felony, fraud or deceit in the practice of respiratory care; illegal conduct; negligent, incompetent or wrongful conduct in professional activities; emotional disorder or mental illness; physical illness, including, but not limited to, deterioration through the aging process; abuse or excessive use of drugs, including alcohol, narcotics or chemicals; willful falsification of entries in any hospital, patient or other record pertaining to respiratory care; misrepresentation or concealment of a material fact in the obtaining or reinstatement of a respiratory care practitioner license; failure to comply with the continuing education requirements set forth in Section 12 of Public Act 06-195; or violation of any provisions of sections 20-162n to 20-162q, inclusive, or any regulation adopted pursuant to said section 20-162o. The Commissioner of Public Health may order a license holder to submit to a reasonable physical or mental examination if his physical or mental capacity to practice safely is the subject of an investigation. Said commissioner may petition the superior court for the judicial district of Hartford-New Britain to enforce such order or any action taken pursuant to section 19a-17. Notice of any contemplated action under said section, of the cause therefore and the date of hearing thereon shall be given and an opportunity for hearing afforded as provided in regulations adopted by the commissioner.

Section 20-162q. License required. Use of title. Exempt activities. (a) No person shall engage in the practice of respiratory care as defined in section 20-162n, unless he is licensed under section 20-162o. (b) No person, unless licensed under section 20-162o, shall (1) use the title "respiratory care practitioner" authorized in sections 20-162n to 20-162q, inclusive, or any initials associated with such title, or (2) advertise services under the description of a "respiratory care practitioner", as defined in section 20-162n. (c) Nothing in sections 20-162n to 20-162p, inclusive, or this section shall be construed to require licensure as a respiratory care practitioner for the performance of the following: (1) Private care in a home environment by a family member or a live-in companion, provided said person does not hold himself out as a respiratory care practitioner or as being able to practice respiratory care and does not receive compensation for such care and is acting pursuant to the instructions of a respiratory care practitioner licensed pursuant to section 20-162o; (2) pulmonary function testing services performed by a person who is credentialed on or before October 1, 1997, by the National Board for Respiratory Care as a certified pulmonary function technologist or a registered pulmonary function technologist; (3) respiratory care services performed in the course of the interstate transport of a patient by any person legally authorized to perform such services outside of this state, provided such services may not be rendered for more than two calendar days in any calendar year; (4) emergency cardiopulmonary resuscitation provided to a person who requires such emergency measures; (5) services performed by a person enrolled in an

educational program satisfying the requirements of subdivision (1) of subsection (a) of section 20-162o, provided such services are a required component of such person's course of study in such program and are rendered under the direct and immediate supervision of a respiratory care practitioner licensed pursuant to said section 20-162o, and provided such person is designated by a title which clearly indicates his status as a student; (6) services performed by a person licensed in this state and functioning within the scope of such license; or (7) services performed in a youth camp, provided the person performing such respiratory care services is licensed as a respiratory care practitioner in another state whose requirements for licensure are equivalent to or greater than those required in this state and such services are provided for a period not to exceed two weeks in any calendar year.

Sec. 20-162r. Continuing education. Definitions. Minimum requirements. Records. Exemptions. Waivers and extensions. Reinstatement of void licenses. (a) As used in this section:

(1) "Commissioner" means the Commissioner of Public Health;

(2) "Contact hour" means a minimum of fifty minutes of continuing education activity;

(3) "Department" means the Department of Public Health;

(4) "Licensee" means any person who receives a license from the department pursuant to this chapter; and

(5) "Registration period" means the one-year period for which a license renewed in accordance with section 19a-88 is current and valid.

(b) Except as otherwise provided in this section, for registration periods beginning on and after ~~October 1, 2007~~ January 1, 2019 a licensee applying for license renewal shall earn a minimum of ~~six~~ ten hours of continuing education within the preceding registration period. Such continuing education shall (1) be directly related to respiratory therapy; ~~and~~ (2) reflect the professional needs of the licensee in order to meet the health care needs of the public and (3) include at a minimum that at least half (5) of the continuing education hours are live and provide opportunities for interaction (i.e. conference attendance, real-time webinars). Qualifying continuing education activities include, but are not limited to, courses, including on-line courses, offered or approved by the American Association for Respiratory Care, regionally accredited institutions of higher education, or a state or local health department.

(c) Each licensee applying for license renewal pursuant to section 19a-88 shall sign a statement attesting that he or she has maintained credentialing as a respiratory therapist, issued by the National Board for Respiratory Care, or has satisfied the continuing education requirements of subsection (b) of this section on a form prescribed by the department. Each licensee shall retain credentialing records, or records of attendance or certificates of completion that demonstrate compliance with the continuing education requirements of said subsection (b) for a minimum of five years following the year in which the licensee was recredentialed or in which the continuing education activities were completed and shall submit such records to the department for inspection not later than forty-five days after a request by the department for such records.

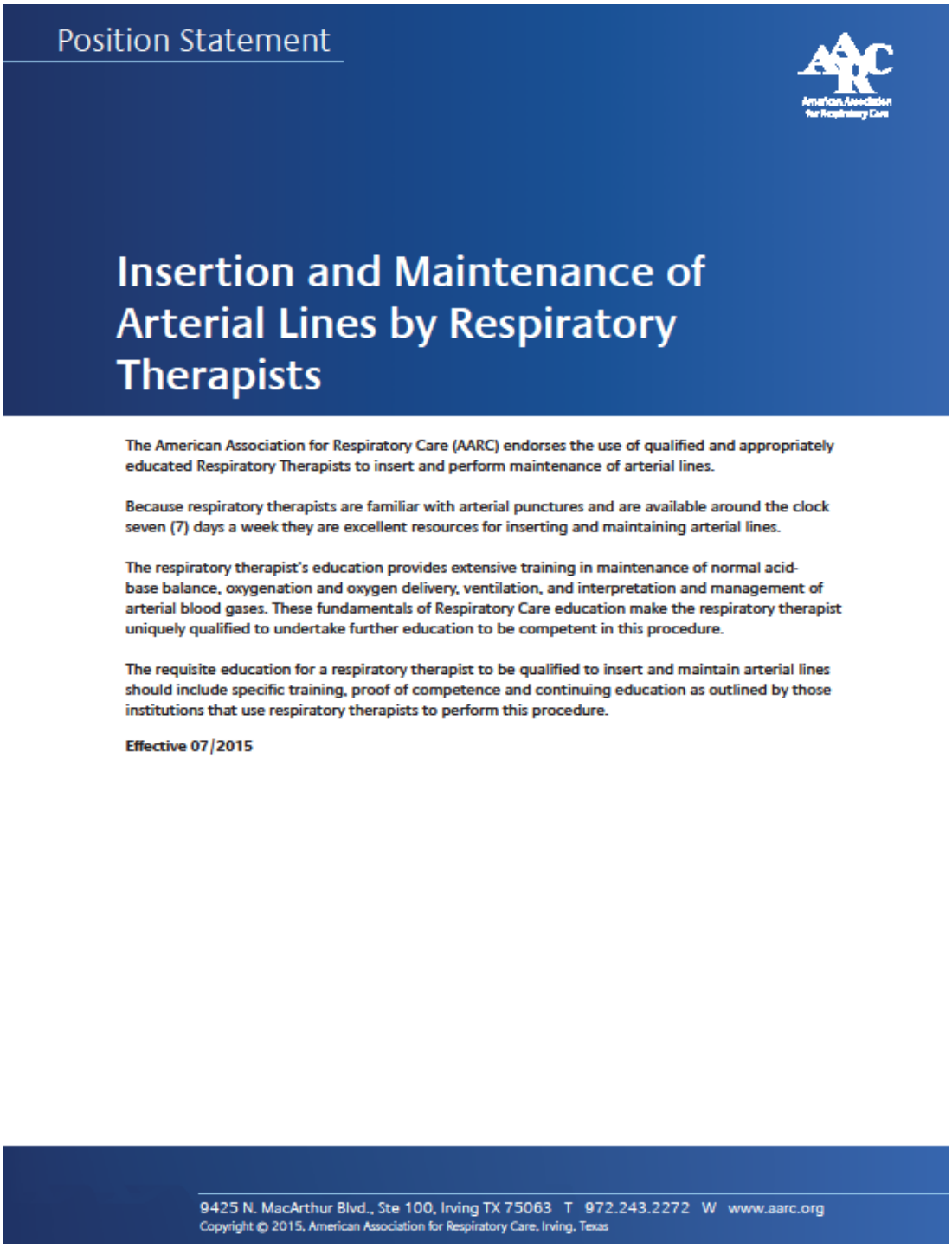
(d) A licensee applying for the first time for license renewal pursuant to section 19a-88 is exempt from the continuing education requirements of this section.

(e) In individual cases involving medical disability or illness, the commissioner may, in the commissioner's discretion, grant a waiver of the continuing education requirements or an extension of time within which to fulfill the continuing education requirements of this section to any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the department, along with a certification by a licensed physician of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except that the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension.

(f) Any licensee whose license has become void pursuant to section 19a-88 and who applies to the department for reinstatement of such license pursuant to section 19a-14 shall submit evidence documenting successful completion of ~~six~~ ten contact hours of qualifying continuing education within the one-year period immediately preceding application for reinstatement.

Appendix B: American Association for Respiratory Care Position Statements

Arterial Line Insertion by Respiratory Care Practitioners:



Position Statement

Insertion and Maintenance of Arterial Lines by Respiratory Therapists

The American Association for Respiratory Care (AARC) endorses the use of qualified and appropriately educated Respiratory Therapists to insert and perform maintenance of arterial lines.

Because respiratory therapists are familiar with arterial punctures and are available around the clock seven (7) days a week they are excellent resources for inserting and maintaining arterial lines.

The respiratory therapist's education provides extensive training in maintenance of normal acid-base balance, oxygenation and oxygen delivery, ventilation, and interpretation and management of arterial blood gases. These fundamentals of Respiratory Care education make the respiratory therapist uniquely qualified to undertake further education to be competent in this procedure.

The requisite education for a respiratory therapist to be qualified to insert and maintain arterial lines should include specific training, proof of competence and continuing education as outlined by those institutions that use respiratory therapists to perform this procedure.

Effective 07/2015

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Position Statement

Insertion and Maintenance of Vascular Catheters by Respiratory Therapists

The American Association for Respiratory Care (AARC) endorses the use of qualified and appropriately educated Respiratory Therapists to insert and perform maintenance of vascular catheters.

Vascular access catheters (VAC) are important instruments in the care of acute and critically ill, and those with chronic illnesses.

Increasing needs for more timely VAC insertion as well as the need to manage adverse events of mal-positioned catheters, pneumothorax, pulsatile blood flow, and daily site maintenance provides impetus for respiratory therapists to perform these tasks. Because respiratory therapists are available around the clock seven (7) days a week they are excellent resources for inserting and maintaining vascular access devices.

The respiratory therapist's education provides extensive training in cardiorespiratory anatomy, physiology and pathophysiology. These fundamentals of Respiratory Care education make the respiratory therapist uniquely qualified to undertake further education to be competent in this procedure.

The requisite education for a respiratory therapist to be qualified to insert and maintain VACs should include specific training, proof of competence and continuing education as outlined by those institutions that use respiratory therapists to perform this procedure.

Effective 07/2015

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Position Statement

Respiratory Therapists as Extracorporeal Membrane Oxygenation (ECMO) Specialists

The American Association for Respiratory Care endorses the use of qualified and appropriately educated Respiratory Therapists as Extracorporeal Membrane Oxygenation (ECMO) Specialists.

ECMO is a modified cardiopulmonary bypass technique used for the treatment of life threatening cardiac or respiratory failure. An ECMO Specialist is the technical specialist educated to manage the ECMO system including blood pump, tubing, artificial oxygenator, and related equipment. The ECMO Specialist, under qualified medical direction and supervision, is also educated to be responsible for the clinical needs of the patient on ECMO which can include: (1) maintenance of normal acid-base balance, oxygenation, and ventilation, (2) administration of blood and blood by-products, (3) medication delivery, and (4) maintenance of appropriate anticoagulation.

The Respiratory Therapist's education provides extensive training in maintenance of normal acid-base balance; oxygenation and oxygen delivery; ventilation; and cardiorespiratory anatomy, physiology, and pathophysiology. These fundamentals of Respiratory Care education make the Respiratory Therapist uniquely qualified to undertake further education as an ECMO Specialist. Additionally the Respiratory Therapist's ability to function in multiple clinical settings among all age groups enhances his/her value as an ECMO Specialist, allowing for care of all patient populations in a variety of critical care environments.

The requisite qualifications for educating a Respiratory Therapist to be an ECMO Specialist should include: (1) the successful completion of an accredited respiratory care educational program, (2) an earned Registered Respiratory Therapist (RRT) credential from the National Board for Respiratory Care (NBRC), (3) a state license (where required), and (4) clinical experience in critical care. Education as an ECMO Specialist should be in accordance with the Extracorporeal Life Support Organization's (ELSO) document entitled "Guidelines for Training and Continuing Education of ECMO Specialists."

Effective 8/3/98
Revised 07/07
Reviewed 07/13

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Appendix C: AARC Issue Statement on the RRT Credential

Issue Paper

RRT Credential

This paper presents the reasons respiratory therapists should obtain the Registered Respiratory Therapist credential

With several developments over the history of the respiratory therapy profession, the education and credentialing processes have evolved to having two basic credentials for respiratory therapists. The Certified Respiratory Therapist (Entry Level) credential (CRT) has been adopted by most states as the minimum level of competency a therapist must demonstrate to obtain recognition by the government of that state as a licensed (certified or registered) respiratory care practitioner. The Registered Respiratory Therapist (Advanced) credential (RRT) has become the credential for advanced-level respiratory therapists. The selection of the CRT as the demonstrated competence needed for state recognition, coupled with a common lack of differential in responsibility and pay between therapists holding the CRT and RRT credentials, has led to decreased numbers of respiratory therapists obtaining the RRT credential. This paper presents the reasons respiratory therapists should obtain the Registered Respiratory Therapist credential.

Respiratory therapists who complete advanced-level respiratory therapy programs have completed education and training that provides them with knowledge and clinical expertise at a level above those needed by the Entry Level Practitioner. The written and clinical simulation components of the RRT exam are the only examination system that documents attainment of the additional knowledge. A graduate of an advanced-level program who does not complete the examinations to earn the RRT credential has not documented that he or she had actually acquired the knowledge and skills necessary to practice as an advanced-level respiratory therapist. This situation is similar to a physician who completes a residency program in a medical specialty and lists his/her credentials as Board Eligible in Internal Medicine rather than completing certification and listing him/herself as Board Certified, one would correctly question the professional commitment of both the Board Eligible physician and Registry Eligible respiratory therapist. Confusion for consumers and regulators arises when a person completes the training and education but does not complete the credentialing process to demonstrate achievement of the competency.

Possessing the RRT credential exemplifies the dedication of a respiratory therapist to professional excellence. A therapist who achieves the RRT credential has demonstrated a commitment to providing care at the highest possible level. Respiratory therapists are more readily able to achieve autonomy in their practice

Respiratory therapist who complete advanced-level respiratory therapy programs have completed education and training that provides them with knowledge and clinical expertise at a level above those needed by the Entry Level Practitioner.

of respiratory care when they have achieved the RRT credential. Medical Directors of respiratory care departments and other medical staff recognize the higher level of knowledge and clinical expertise of the RRT compared to the CRT. Accordingly, they will be more receptive to therapists utilizing protocols in the care of patients if there is an assurance of the level of knowledge and skill conveyed by possession of the RRT credential. A respiratory therapist with education at the advanced-level who has not achieved the RRT credential has not demonstrated he or she has the patient assessment and evaluation skills necessary for determining the needs of the patient or the knowledge to follow the protocol to determine the appropriate intensity of care needed by the patient. A respiratory care department director will more easily make the case that therapists are able to implement care using respiratory therapy protocols if the therapists are credentialed at the highest level available.

The RRT credential is the credential that demonstrates respiratory therapists have parity with other credentialed

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Appendix D: Current Practice Act

To open the document, click on it and then double click

Respiratory Care Practitioner Practice Act

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