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# Sunrise Analysis of a Proposal to Regulate Respiratory Care Practitioners

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A Report to the  
Governor  
and the  
Legislature of  
the State of  
Hawaii

Report No. 95-31  
December 1995



**THE AUDITOR**  
STATE OF HAWAII

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## The Office of the Auditor

The missions of the Office of the Auditor are assigned by the Hawaii State Constitution (Article VII, Section 10). The primary mission is to conduct post audits of the transactions, accounts, programs, and performance of public agencies. A supplemental mission is to conduct such other investigations and prepare such additional reports as may be directed by the Legislature.

Under its assigned missions, the office conducts the following types of examinations:

1. *Financial audits* attest to the fairness of the financial statements of agencies. They examine the adequacy of the financial records and accounting and internal controls, and they determine the legality and propriety of expenditures.
2. *Management audits*, which are also referred to as *performance audits*, examine the effectiveness of programs or the efficiency of agencies or both. These audits are also called *program audits*, when they focus on whether programs are attaining the objectives and results expected of them, and *operations audits*, when they examine how well agencies are organized and managed and how efficiently they acquire and utilize resources.
3. *Sunset evaluations* evaluate new professional and occupational licensing programs to determine whether the programs should be terminated, continued, or modified. These evaluations are conducted in accordance with criteria established by statute.
4. *Sunrise analyses* are similar to sunset evaluations, but they apply to proposed rather than existing regulatory programs. Before a new professional and occupational licensing program can be enacted, the statutes require that the measure be analyzed by the Office of the Auditor as to its probable effects.
5. *Health insurance analyses* examine bills that propose to mandate certain health insurance benefits. Such bills cannot be enacted unless they are referred to the Office of the Auditor for an assessment of the social and financial impact of the proposed measure.
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# OVERVIEW

THE AUDITOR  
STATE OF HAWAII

## Sunrise Analysis of a Proposal to Regulate Respiratory Care Practitioners

### Summary

We analyzed whether respiratory care practitioners should be regulated as proposed in House Bill No. 2240 introduced during the 1995 Regular Session. We conclude that regulation is not warranted and the proposed legislation is flawed.

Respiratory care practitioners specialize in the evaluation, treatment, and care of people with breathing disorders. They work with a wide variety of patients who suffer from conditions resulting from asthma, emphysema, heart failure, stroke, drowning, shock, and other causes.

House Bill No. 2240 proposes to regulate respiratory care practitioners with a seven-member licensing board in the Department of Commerce and Consumer Affairs. With some exceptions, unless licensed by the State, no one could lawfully practice respiratory care or use the title "respiratory care practitioner" (or the abbreviation "R.C.P.").

The Sunset Law states that professions and vocations should be regulated only when reasonably necessary to protect the health, safety, and welfare of consumers. In assessing the need for regulation, the Auditor is to give great weight to evidence of abuse. Other considerations include whether consumers are at a disadvantage in choosing or relying on providers, whether alternatives provide sufficient protection to consumers, and whether the benefits of regulation outweigh the costs.

The regulation of respiratory care practitioners is not warranted. If improperly performed, respiratory care can cause harm. However, regulation is not necessary because sufficient protections already exist. Practitioners work under the medical direction of physicians and are employed by knowledgeable health providers. Moreover, practitioners work within a framework of standards provided by several national organizations including the National Board for Respiratory Care and the American Association for Respiratory Care. Criminal laws provide additional protection.

Moreover, regulation would be costly. A start-up appropriation of nearly \$60,000 would be needed and application/license fees to support the program could run between \$500 and \$650 per person every two years. The State should not allocate its limited resources to establish regulation of respiratory care practitioners when

current protections are sufficient, regulation is duplicative, and its benefits are so uncertain. Moreover, charging fees to cover the State's costs could restrict entry into the occupation.

We presented similar arguments against regulation in our 1986 *Sunrise Analysis of a Proposal to Regulate the Practice of Respiratory Care*, Report No. 86-10. The occupation has not changed sufficiently since our previous report to justify regulation. Arguments that new technology and growth of home care justify regulation are not convincing.

House Bill No. 2240 is also flawed because the licensing board lacks a sufficient number of public members and certain licensing provisions are questionable. Furthermore, the bill would authorize the licensing board to investigate and hold hearings on violations. This conflicts with Section 26-9, HRS, under which the Department of Commerce and Consumer Affairs has these responsibilities.

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## Recommendation and Response

We recommend that House Bill No. 2240 not be enacted.

The Department of Commerce and Consumer Affairs agrees with our findings which conclude that regulation of respiratory care practitioners is not warranted. In addition, the department raises concerns about the bill's impact on other health care professionals, its grandfather provision, and its allusions to continuing education, accreditation of educational programs, and recovery fund assessment.

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Submitted by

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STATE OF HAWAII

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## Foreword

The Sunset Law, or the Hawaii Regulatory Licensing Reform Act of 1977, contains a sunrise provision that requires that measures proposing to regulate professions or vocations be referred to the State Auditor for analysis prior to enactment. The Auditor is responsible for reporting the results of the analysis to the Legislature.

This report evaluates the regulation of respiratory care practitioners as proposed in House Bill No. 2240, introduced in the Regular Session of 1995. The Legislature requested this study in House Concurrent Resolution No. 31, House Draft 1, of the session. The study presents our findings on whether the proposed regulation complies with policies in the Sunset Law and whether there is a reasonable need to regulate respiratory care practitioners to protect the health, safety, and welfare of the public. It concludes with our recommendation on whether the proposed regulation should be enacted.

We acknowledge the cooperation of the Department of Commerce and Consumer Affairs, other state officials, and organizations and individuals knowledgeable about the occupation whom we contacted during the course of our analysis.

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# Chapter 1

## Introduction

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The Sunset Law, or the Hawaii Regulatory Licensing Reform Act (Chapter 26H, Hawaii Revised Statutes), contains a sunrise provision which requires that measures proposing to regulate professions or vocations be referred to the State Auditor for analysis prior to enactment. The Auditor is to determine whether regulation is necessary to protect the health, safety, and welfare of consumers.

This report evaluates whether the regulation of respiratory care as proposed in House Bill No. 2240, introduced in the 1995 Regular Session, complies with policies for occupational regulation in the Sunset Law. The Legislature requested this study in House Concurrent Resolution No. 31, House Draft 1, of the 1995 session.

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### Background on Respiratory Care Practitioners

Respiratory care practitioners specialize in the evaluation, treatment, and care of people with breathing disorders. Practitioners work with a wide variety of patients who suffer from conditions resulting from asthma, emphysema, heart failure, stroke, drowning, shock, and other causes.

Practitioners evaluate patients by using breathing instruments to test lung capacity and by analyzing oxygen in blood samples. Treatment methods include administering oxygen and oxygen mixtures (which requires ventilator machines for patients who cannot breathe on their own) and administering aerosol medications (which the patient inhales as a mist). Practitioners also perform chest physiotherapy to remove mucus that accumulates in the lungs because of surgery or lung disease. In addition, practitioners may teach patients to use life support equipment in home care settings.

Most respiratory care practitioners work at hospitals in three distinct phases of care: diagnosis, treatment, and pulmonary rehabilitation. Nationally, about 90 percent of practitioners work at hospitals in respiratory care, anesthesiology, or pulmonary medicine departments. Home health care agencies, home medical equipment companies, clinics, and nursing homes account for most other jobs.

Employment in Hawaii generally follows the national pattern. However, home health care agencies in Hawaii are not likely to employ respiratory care practitioners because there is little third-party reimbursement available for their ongoing professional services. Most respiratory care services in home settings are provided by home medical equipment companies.

### ***Professional organizations and credentials***

The American Association for Respiratory Care is the major professional association for respiratory therapists, technicians, and others involved in pulmonary and respiratory fields. The association has over 36,000 members nationwide. It educates its members and the public, promotes understanding of the profession, and advances the art and science of respiratory care.

The association has three types of membership. Active members must meet at least one of the following criteria: (1) hold a legal credential as a respiratory care practitioner if employed in a jurisdiction that mandates legal credentials, (2) have graduated from an educational program in respiratory care accredited by an agency recognized by the American Association for Respiratory Care, or (3) hold a credential issued by the National Board for Respiratory Care. Associate members are those who hold a position related to respiratory care but do not meet the requirements of active membership. Special memberships are available, including for example people with an interest in respiratory care who do not qualify for other membership.

The National Board for Respiratory Care is a national, voluntary credentialing organization. It awards the credentials of certified respiratory therapy technician, registered respiratory therapist, perinatal/pediatric respiratory care specialist, and certified or registered pulmonary function technologist. Many practitioners hold multiple credentials.

The Hawaii Society for Respiratory Care is a chartered affiliate of the American Association for Respiratory Care and has about 180 members. The society's primary goals are education for respiratory care practitioners and professional networking.

### ***Numbers in Hawaii***

The National Board for Respiratory Care estimated in 1995 that about 414 practitioners in Hawaii hold a board credential. The Hawaii Society for Respiratory Care says there are a few additional practitioners without credentials in the state.

### ***Education***

The field of respiratory care has two levels of practitioners—the technician and the therapist. Respiratory therapy technicians are graduates of a 12- to 15-month program normally based in a vocational/technical school, community college, or hospital. Their primary job responsibility is to provide patient care at the bedside. Their duties include administering oxygen and breathing treatments, operating equipment, and conducting sterilization procedures.

Respiratory therapists are graduates of either a two-year or four-year program. In addition to general patient care activities, respiratory therapists provide leadership in diagnostic and therapeutic activities. The

two-year programs require a minimum of 62 semester hours of college credit with a concentration in science and respiratory care courses. Most two-year programs are located at community colleges and lead to an associate degree. Four-year baccalaureate degree programs provide a greater depth of science and respiratory care courses.

Graduates of technician programs may sit for the entry level examination leading to the credential of certified respiratory therapy technician. Graduates of therapist programs can gain the credential of registered respiratory therapist by passing the entry level examination and the advanced practitioner examination. Both credentialing examinations are given by the National Board for Respiratory Care.

The Joint Review Committee for Respiratory Therapy Education under the Committee on Accreditation of Allied Health Education Programs accredits respiratory care educational programs in the United States. In 1994, the joint review committee reported approximately 180 programs for technicians and another 300 programs for therapists.

Kapiolani Community College (KCC), on Oahu, offers the only accredited program for respiratory care training in Hawaii. Currently, KCC offers only a two-year therapist program. KCC recently terminated the technician program in the belief that the program does not provide students with enough knowledge and skill.

Those who complete KCC's 65-credit therapist course of study receive an Associate of Science degree. The program includes clinical practice courses in which students receive training at affiliated community hospitals.

### ***Regulation in other states***

Currently, 42 states regulate respiratory care practitioners. The type of regulation varies. Thirty-one states have "practice" laws (requiring a license to practice the occupation). Ten states have certification laws (protecting the use of certain titles such as respiratory therapist). One state requires simple registration.

However, the requirements for applicants are quite similar among the states. An applicant must have graduated from an approved educational institution that incorporates clinical experience and must be credentialed by passing the entry level examination of the National Board for Respiratory Care.

All of the state regulatory boards have respiratory care practitioners, physicians, and public representatives as members.

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## **Previous Sunrise Analysis**

In our *Sunrise Analysis of a Proposal to Regulate Respiratory Care Practitioners*, Report No. 86-10, we analyzed a previous proposal to regulate the practice of respiratory care. We found that the potential for practitioners harming patients was remote because practitioners work under the supervision of physicians and are employed by knowledgeable health care providers. We also pointed out that licensing of health occupations increases the cost of health care, reduces the flexibility of health care providers to utilize the most qualified personnel in a cost-effective manner, and reduces the mobility of health care workers. Private credentialing programs provided adequate indicators of the competency of respiratory care practitioners. We recommended that the proposed bill to regulate the practice not be enacted.

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## **Current Proposal to Regulate Respiratory Care Practitioners**

House Bill No. 2240 would regulate both the practice of respiratory care and the use of certain titles. With some exceptions, unless licensed by the State, no one could (1) lawfully practice respiratory care or (2) advertise or use the title “respiratory care practitioner” (or the abbreviation “R.C.P.”).

In defining “respiratory care,” the bill specifies that respiratory care be practiced under the medical direction of a licensed physician.

### ***Licensing board***

The bill would create a licensing board for respiratory care within the Department of Commerce and Consumer Affairs. The board would be composed of four licensed respiratory care practitioners, one physician, and two public members.

The board is authorized to issue, suspend, revoke, and renew licenses. The board is also authorized to do the following: set licensing standards; contract with a testing agency for testing services; recommend the denying or withdrawing of accreditation from educational programs that fail to meet standards; investigate and conduct hearings regarding violations; and adopt rules.

### ***Licensing requirements and exemptions***

License applicants must complete an accredited respiratory care educational program and pass an examination to be administered by the board at least once a year. The examination must be nationally recognized and validated as a test for respiratory care competencies.

The bill would exempt the following from regulation:

- students who practice under the supervision of a licensed respiratory care practitioner in an accredited education program;
- self-care by a patient, or gratuitous care by a friend or family member;
- respiratory care rendered in an emergency;
- “the performance of respiratory care techniques by a respiratory care practitioner through formalized or specialized training”;
- persons in military services or in federal facilities doing work within their duties;
- persons performing procedures in an examination approved by the board; and
- persons licensed to practice by another state or foreign country.

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## Objectives of the Analysis

1. Determine whether there is a reasonable need to regulate the occupation to protect the health, safety, and welfare of the public.
2. Make recommendations based on our findings.

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## Criteria for the Analysis

The Legislature established the “sunrise” criteria to ensure that regulation of an occupation takes place only for the right reason: to protect consumers. Regulation is an exercise of the State’s police powers and should not be taken lightly.

Consumers rarely initiate regulation. More often, practitioners themselves request regulation for benefits that go beyond consumer protection. They often equate licensure with professional status in seeking respect for the occupation. Through regulation, they may gain access to third-party reimbursements for their services and control entry into their field.

## *Policies and principles for regulation*

Hawaii’s sunrise law—Section 26H-6, HRS—requires the Auditor to assess legislative proposals against the regulation policies in the statute. The policies reinforce the primary purpose of consumer protection:

- the State should regulate professions and vocations only where reasonably necessary to protect consumers;
- regulation should protect the public health, safety, and welfare and not the profession;
- evidence of abuses by providers of the service shall be given great weight in determining whether a reasonable need for government intervention exists;
- regulation should protect those consumers who may be at a disadvantage in choosing or relying on the provider;
- regulation should be avoided if it artificially increases the costs of goods and services or if its costs to taxpayers outweigh its benefits to consumers; and
- regulation should not unreasonably restrict qualified persons from entry into the profession.

We were also guided by the publication *Questions a Legislator Should Ask*, published by the national Council on Licensure, Enforcement and Regulation. The primary guiding principle for legislators, according to this publication, is whether the unregulated profession presents a clear and present danger to the public's health, safety, and welfare. If it does, regulation may be necessary; if not, regulation is unnecessary and wastes taxpayers' money.<sup>1</sup>

We developed additional criteria for this review, including whether:

- the incidence or severity of harm based on documented evidence is sufficiently real or serious to warrant regulation;
- the cause of harm is the practitioner's insufficient skill or incompetence;
- the occupational skill needed to prevent harm can be defined in law and measured;
- the field is too complex for consumers to be able to choose practitioners wisely; and
- no alternatives provide sufficient protection to consumers, for example federal programs, other state laws, marketplace constraints, private action, or supervision.

We assessed the specific regulatory proposal—House Bill No. 2240—as to whether:

- the scope of practice to be regulated is clearly defined and enforceable;
- the licensing requirements are constitutional and legal, for example, no residency or citizenship requirements;
- licensing requirements, such as experience or continuing education, are directly related to preventing harm;
- provisions are not unduly restrictive nor do they violate federal anticompetition laws;
- prohibited practices are directly related to protecting the public; and
- disciplinary provisions are appropriate.

### ***Burden of proof***

The sunrise process places the burden of proof on those in the occupation to justify their request for regulation and defend their proposed legislation. We evaluate their arguments and data against the sunrise criteria.

We examine the regulatory proposal and determine whether practitioners and their professional associations have made a strong enough case for regulation. It is not enough that regulation *may* have *some* benefits. We recommend in favor of regulation only if it is *demonstrably* necessary to protect the public. We also scrutinize the language of the regulatory proposal for appropriateness.

### ***Types of regulation***

In examining the type of government regulation being proposed, we determine whether it is one of three approaches to occupational regulation:

A *licensing* law gives persons who meet certain qualifications the legal right to deliver services, that is, to practice the profession (for example, social work). Penalties may be imposed on those who practice without a license.

A *certification* law restricts the use of certain titles (for example “social worker”) to persons who meet certain qualifications, but does not bar others who do not use the title from offering such services. This is sometimes called title protection. (Government certification should not be confused with certification, or credentialing, by private organizations. For example, social workers receive accreditation from the National Association of Social Workers.)

A *registration* law simply requires practitioners to sign up with the State so that a roster or registry will exist to inform the public of the nature of their services and to enable the State to keep track of them. Registration may be mandatory or voluntary.

As part of our analysis, we assess the appropriateness of the selected approach.

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## Scope and Methodology

To accomplish the objectives of the analysis, we reviewed literature on respiratory care practitioners. We also reviewed evidence of harm to consumers.

We obtained information from national and Hawaii associations for respiratory care. We interviewed their representatives and those of other organizations: the National Board for Respiratory Care, the Joint Committee on Accreditation of Healthcare Organizations, the Joint Review Committee for Respiratory Therapy Education, the Kapiolani Community College, and employers of respiratory care practitioners. We contacted staff of the Department of Commerce and Consumer Affairs and other government agencies as deemed appropriate.

Our work was performed from August 1995 through November 1995 in accordance with generally accepted government auditing standards.

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# Chapter 2

## Findings and Recommendation

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This chapter presents our findings and recommendation on the need to regulate respiratory care practitioners. We conclude that regulation is not warranted and that House Bill No. 2240, which proposes regulation, is flawed.

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### Summary of Findings

1. Regulation of respiratory care practitioners is not warranted. Existing protections such as medical supervision and standards of private organizations make licensing unnecessary to protect consumers. Regulation would be duplicative and costly.
2. House Bill No. 2240 is flawed. The proposed regulatory board lacks sufficient public representation, there are questionable licensing provisions, and the investigative authority is inappropriate.

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### Regulation of Respiratory Care Practitioners Is Not Warranted

The Sunset Law states that professions and vocations should be regulated only when necessary to protect the health, safety, and welfare of consumers. In assessing the need for regulation, the Auditor is to give great weight to evidence of abuse. Other considerations include whether consumers are at a disadvantage in choosing or relying on providers, whether alternatives provide sufficient protection to consumers, and whether the benefits of regulation outweigh the costs.

We found that improperly performed respiratory care can cause harm. However, we also found that regulation is not necessary because sufficient protections already exist. Licensing would be duplicative and would have substantial costs. The case for regulation of respiratory care practitioners is no stronger today than it was in 1986 when we first recommended against regulation.

### *Sufficient protections already exist*

The improper practice of respiratory care can harm patients. Doctors and nurses rely on respiratory care practitioners to perform activities requiring special skill, often in emergency situations. The practitioner's negligence, poor clinical assessment, and improper use and maintenance of respiratory care equipment can result in severe damage or even death. Problems of this nature have been reported on the mainland, as have other problems such as misrepresentation of credentials, drug abuse, and sexual misconduct.

The National Board for Respiratory Care, the national voluntary credentialing agency, records 150 to 200 complaints annually. Those complaints generally fall into four categories: (1) falsification of education, (2) misrepresentation of credentials, (3) medical frauds, and (4) drug and alcohol related cases.

Nevertheless, adequate protections are already in place. Respiratory care practitioners work under the medical direction of physicians and are employed by knowledgeable health providers. Moreover, practitioners work within a framework of standards provided by several national organizations. State criminal laws provide additional protection.

### **Practitioners receive medical supervision and direction**

Respiratory care practitioners perform services that require special skills, knowledge, and judgment. However, they are not independent health care practitioners. House Bill No. 2240 recognizes this by providing that they work under the medical direction of licensed physicians.

In Hawaii, about 90 percent of respiratory care practitioners work at hospitals where they are supervised within a professional hierarchy and system of controls. Most hospitals have medical directors and supervisors under the medical directors who oversee therapists and technicians. A qualified physician, usually a pulmonologist or anesthesiologist, supervises respiratory care. While any physician can order treatments, the medical director of a respiratory care department sets standards and guidelines for practitioners to use in evaluating the appropriateness of these orders.

Other respiratory care practitioners who work outside hospitals in home care settings receive indirect medical supervision. Nationally and in Hawaii, these practitioners generally are employed by home medical equipment suppliers. These companies rent and sell equipment for home use. They employ respiratory care practitioners on a full-time, per-diem, or per-patient-visit basis. The cost of their professional services is included in the overhead.

Respiratory care practitioners receive medical direction when they take prescriptions from physicians for respiratory care equipment. Practitioners deliver and set up the equipment, train patients and caregivers in its use, and explain potential problems and solutions. They visit homes periodically to maintain and clean equipment, clinically assess patients' condition, or both. The supply companies usually have an emergency service system.

Although physicians do not accompany respiratory care practitioners to homes and do not directly supervise them, the companies we contacted confirmed that practitioners' services are provided only on the basis of

physicians' prescriptions. Practitioners communicate with physicians on an "as needed" basis and are expected to be able to evaluate whether physicians' prescriptions make sense and to clinically assess patients.

The American Association for Respiratory Care, the main professional association, strongly supports medical direction. Its position statements and Guidelines and Standards require medical direction by a qualified physician. The National Board for Respiratory Care also emphasizes that services are only by the order of physicians, regardless of work setting.

In theory, the risk of harm to the public increases when respiratory care services are administered in a home setting. Proponents of regulation argue that practitioners are on their own without strict supervision in these settings and that patients are increasingly vulnerable to harm since home health care has grown.

However, we found no documented cases of patient harm in home settings in Hawaii. The home medical equipment companies we contacted reported few complaints. In a 1993 sunrise review, the Colorado Department of Regulatory Agencies reported that proponents of regulation presented no evidence that home respiratory care therapy had resulted in harm to Colorado citizens.<sup>1</sup>

### **Practitioners are employed by knowledgeable health care providers**

Respiratory care practitioners are not employed by patients directly. The hospitals and home medical equipment companies that employ them are the buyers of these services, and they are sophisticated and knowledgeable consumers. They are responsible for establishing and maintaining standards for the protection of patients.

### **A network of private organizations sets standards**

In recommending against regulation of respiratory therapists, the Colorado sunrise review pointed out that the respiratory therapy profession "is privately regulated by a web of private agencies which promulgate standards of practice and care for the profession, accredit the health care institutions in which they practice, and certify their competence as practitioners through an examination and credentialing process."<sup>2</sup> We agree. The following are the key elements of this private system of controls:

First, most hospital and home care employers require that applicants for their respiratory care positions have a professional credential from the National Board for Respiratory Care, or be eligible for it. Nationally, in 1992, about 78 percent of practitioners working for hospital respiratory

care departments had a board credential. Most respiratory care practitioners in Hawaii are credentialed and thus are subject to the board's ethical and judicial policies.

Obtaining credentials from the national board requires passing examinations designed to ensure uniform minimal competency. Also, the board investigates written complaints and takes action against applicants and members. Possible actions include written admonishment, formal censure, removal from eligibility for board examinations, deletion from the board directory, disqualification from recredentialing programs, and suspension from credentialing and examinations.

Second, 44 percent of the credentialed respiratory care practitioners in Hawaii are members of the American Association for Respiratory Care and are bound by its professional standards and code of ethics. The association's judicial committee has investigated alleged violations of the code, held formal hearings, and taken disciplinary action against its members.

The association has also adopted 36 clinical practice guidelines to help practitioners deliver appropriate care, including home care. Another 13 guidelines are scheduled to be released in the future.

Third, hospitals must conform to standards set by the Joint Commission on Accreditation of Healthcare Organizations in order to qualify for federal Medicare reimbursement. These standards apply to inpatient, outpatient, and home care services provided by hospitals. Medicare also requires home medical equipment companies to follow joint commission standards.

To meet standards, both hospital and home care employers must establish policies and procedures for supervising and evaluating the performance, competencies, and skills of respiratory care practitioners, and must be diligent in hiring. While recent standards focus on outcomes and do not specifically require medical supervision as did earlier standards, the employers we contacted still seem to follow the earlier supervision standards.

### **Background can be checked**

Hospitals, home medical equipment companies, and other employers are responsible for verifying the credentials of job applicants before they are hired or put to work in patient care. Misrepresenting credentials by respiratory care practitioners is a commonly reported abuse.

It is fairly easy to check credentials. The national board will answer inquiries and verify credentials by phone free of charge to any interested

party. The board also publishes an annual directory of all credentialed practitioners and sends it to licensing agencies, schools, and hospitals. College credentials can be verified by contacting the colleges directly.

Practitioners' work experience can also be verified. Proponents of regulation claim that hospitals are reluctant to share information on former employees with prospective employers. However, a prominent health official informed us that contacting previous employers works and is the best way to determine whether the person is a good practitioner.

Proponents of regulation also claim that patients in home care settings cannot check practitioners' background and may be victimized by unprofessional, unethical, or incompetent practices. However, patients do not hire practitioners. Home medical equipment companies employ practitioners and are responsible for checking qualifications and competency. Companies obtain customers (patients) through hospitals and physician referrals.

Diligent hiring practices, such as reference and credential checks, should effectively prevent the hiring of a practitioner with an unsatisfactory work record or dangerous conduct report.

### **Protections from drug abuse and sexual misconduct exist**

Substance abuse and sexual misconduct appear to be significant problems in the profession today. However, state occupational regulation is not necessary to deal with these problems.

The national board is empowered to suspend or revoke credentials upon conviction of certain crimes. The board also provides information regarding a practitioner's criminal record to current and potential employers upon request. Furthermore, Hawaii's penal code provides penalties upon conviction of sexual misconduct or substance abuse.

### ***Regulation would be duplicative and costly***

The Sunset Law requires that regulation be avoided if its benefits to consumers are outweighed by its cost to taxpayers and if it unreasonably restricts entry into the occupation. The proposed regulation of respiratory care practitioners appears unacceptable under this requirement. Regulation would duplicate standards that already exist in the private sector and it would be costly.

The Department of Commerce and Consumer Affairs has informed us that it would need a general fund appropriation of \$59,716 to start up the program and prepare for implementation. Once the start-up period has elapsed, the program must become self-sustaining. The department estimates that \$97,555 a year would be needed to cover personnel and

operations. Section 26-9(1), HRS, authorizes the department to assess fees on applicants and licensees so long as the fees bear a reasonable relationship to the cost of services provided.

We provided the department with our estimate that as many as 450 respiratory care practitioners might initially obtain licenses, and perhaps 30 applicants would apply in each subsequent year. The department says that it would rely on the initial group of 450 to bear the \$195,110 cost of the program for two fiscal years (\$97,555 times 2). To fully recover this cost, each applicant/licensee would be assessed an initial application/license fee of \$434. An additional fee of \$70 to support the department's Compliance Resolution Fund would bring the total fee to \$504. Examination fees could make the fee even higher. We also note that fees could be higher if fewer practitioners choose to become licensed.

Furthermore, the department says it might require the regulated group to "reimburse" the general fund for the \$59,716 start-up appropriation, which would add \$133 to the initial application/license fee for each of the 450 applicants. This would bring the total fee to \$637 at a minimum.

The department calculates that license renewal fees would be in the same range, but slightly lower if the pool of licensees increases slightly as we estimated. However, licensees might have to bear additional costs for renewal to satisfy continuing education requirements, which the bill authorizes the board to adopt.

We believe the State should not allocate its limited resources to establish regulation of respiratory care practitioners when current protections are sufficient, regulation is duplicative, and its benefits are so uncertain. Moreover, charging fees to cover the State's costs could restrict entry into the occupation.

***Situation has changed little since previous report***

We presented similar arguments against regulation in our 1986 *Sunrise Analysis of a Proposal to Regulate the Practice of Respiratory Care*, Report No. 86-10. The occupation has not changed enough since our previous report to justify regulation. For example, the arguments that new technology and growth of home care justify regulation are not convincing.

**New technology is not a reason for regulation**

Some respiratory care practitioners point out that technological advances during the past decade have affected their scope of practice. They believe that the new technology requires greater skill, which in turn increases the need for regulation. However, none of the proponents of this view provided us with conclusive evidence to support this point.

Hawaii's State Council on Vocational Education has issued a report on respiratory care listing the following examples of new technological developments between 1982 and 1992: (1) microprocessor intensive care unit ventilators, (2) nasal continuous positive airway pressure, (3) pulse oximetry, (4) high flow oxygen blenders, (5) transtracheal oxygen therapy, (6) metabolic carts for nutritional and respiratory monitoring, and (7) hyperbaric oxygen therapy.<sup>3</sup>

However, we found no evidence that these technological advances increased the possibility of harm to the public. Indeed, advanced technology may have *eased* the work of practitioners in assessing, monitoring, and treating patients. For example, pulse oximetry allows continuous patient monitoring and adjustment of therapy without requiring the practitioner to continually draw blood samples.

The Joint Review Committee for Respiratory Therapy Education accredits respiratory care educational programs in the United States, and assures that the educational programs comply with the standards adopted by the Committee on Accreditation of Allied Health Education Programs. The review committee and the colleges that educate respiratory care practitioners are responsible for upgrading curriculum content to ensure that graduates have adequate knowledge and skill to handle high tech equipment and medication. Similarly, employers such as hospitals and home medical equipment companies should provide practitioners with adequate training to update their knowledge.

### **Home care employment is constant**

As another reason for regulation, proponents point to the growth of home care and its increased use of respiratory care practitioners under limited supervision. Cost containment, hospital downsizing, managed care, and technological advances are driving today's growing home care market. National data do suggest that respiratory care practitioners are increasingly working in home care.

However, as described earlier, only about 10 percent of respiratory care practitioners in Hawaii work in home settings. This is a small increase since our 1986 sunrise report, when the figure was 9 percent. As we noted above, most respiratory care at home is provided through home medical equipment companies where sufficient protections exist for consumers. We found no evidence of consumer harm in this sector.

## **Proposed Legislation Is Flawed**

### ***Profession dominates licensing board***

House Bill No. 2240 is flawed by its bias against the public, questionable licensing provisions, and inappropriate investigative authority.

The principal function of occupational regulatory boards is to safeguard consumers by establishing, monitoring, and enforcing standards for the profession. State boards are not intended to be advocacy groups for professions.

House Bill No. 2240 requires a seven-member board for respiratory care. Four of the seven may be licensed respiratory care practitioners; only two of the seven must be public members. The board must also include one physician.

The purpose of placing public members on licensing boards is to introduce impartial viewpoints and ensure that the broad public interest is considered in the board's deliberations. The Institute of Medicine, a national organization, recommends that at least half of the members of licensing boards for the allied health professions be drawn from outside the profession. House Bill No. 2240 does not require an adequate mix.

### ***Grandfather clause is unfair and restrictive***

The bill has a "grandfather" clause that would allow those who have practiced respiratory care for at least four consecutive years preceding the bill's effective date, to waive the usual licensing requirements. These applicants would not have to complete the accredited educational program and pass the licensing examination required of subsequent applicants.

The grandfather provision is inconsistent with the purpose of licensing which is to ensure that *all* licensees meet a minimum level of competency. The provision also discriminates in favor of current practitioners and could unreasonably restrict new applicants.

### ***Licensing board is allowed to set passing score***

The bill allows the licensing board to set the passing score for the licensing examination. However, the board's score might not verify occupational competency.

Eligible applicants may simultaneously attempt the examination for certification by the National Board for Respiratory Care and licensing by the State without paying an additional fee. National board certification requires applicants to attain the national board's minimum score. However, the national board also allows states to set their own score for licensure. House Bill No. 2240 takes this approach.

It is conceivable that Hawaii's passing score would not be high enough for national board certification. Yet the national board's passing score is supposed to confirm basic competency. Hawaii's score might not.

***Number of examinations is restrictive***

The bill also does not specify the number of licensing examinations to be offered each year. It simply requires that an examination be conducted "at least once a year" and "as the board deems necessary." Allowing only one examination annually would unreasonably restrict entry into the profession.

***Licensing by endorsement is unclear and restrictive***

The bill's requirements for licensure by endorsement are unclear and restrictive.

The endorsement provision is confusing in its language and organization, leaving it open to more than one interpretation. The bill could mean that this form of licensure is available to applicants who meet three criteria: (1) they are licensed by another state and have qualifications equivalent to those required in Hawaii; (2) they are credentialed as certified respiratory therapy technicians or registered respiratory therapists by the National Board for Respiratory Care; and (3) they have practiced respiratory care for four years immediately preceding their application for licensure in Hawaii. However, the bill could also mean that applicants who meet only the first criterion *and* applicants who meet only the second and third criteria could be licensed by endorsement.

The first interpretation would be restrictive because it would rule out persons whose basic competency had been established by licensure but who lacked other credentials and experience.

***Investigative authority is inappropriate***

The bill would authorize the licensing board to investigate and hold hearings on violations of the law. This authorization conflicts with Section 26-9, HRS, under which the Department of Commerce and Consumer Affairs has these responsibilities. The investigatory power is currently delegated to the department's Regulated Industries Complaints Office.

**Conclusion**

Although the potential for harm exists in the practice of respiratory care, we conclude that regulation is unnecessary. Existing protections such as medical supervision and standards of private organizations are sufficient to protect consumers. Regulation would be duplicative, costly, and would restrict entry into the profession.

We also conclude that House Bill No. 2240 is flawed. The proposed licensing board would favor the profession over the public. Also, several of the licensing provisions are questionable. Finally, the bill authorizes the licensing board to investigate complaints against licensees, which conflicts with existing Hawaii law.

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## **Recommendation**

We recommend that House Bill No. 2240 not be enacted.

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## Notes

### Chapter 1

1. Benjamin Shimberg and Doug Roederer, *Questions a Legislator Should Ask*, Second Edition, The Council on Licensure, Enforcement and Regulation, Lexington, Kentucky, 1994, p. 24.

### Chapter 2

1. Colorado, Department of Regulatory Agencies, Office of Policy and Research, *Sunrise Review on Respiratory Therapists*, Denver, Colorado, June 1993, p. 2.
2. *Ibid.*, p. 2.
3. Michael Casey, *Research Report: Respiratory Care Practitioners: A Needs Assessment*, State Council on Vocational Education, Commission on Employment and Human Resources, State of Hawaii, Honolulu, Hawaii, June 1992, pp. 19-20.



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## Response of the Affected Agency

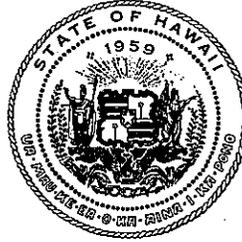
### Comments on Agency Response

We transmitted a draft of this report to the Department of Commerce and Consumer Affairs on November 28, 1995. A copy of the transmittal letter to the department is included as Attachment 1. The department's response is included as Attachment 2.

The department agrees with our findings which conclude that regulation of respiratory care practitioners is not warranted. In addition, the department raises concerns about the bill's impact on other health care professionals, its grandfather provision, and its allusions to continuing education, accreditation of educational programs, and recovery fund assessment.

ATTACHMENT 1

STATE OF HAWAII  
OFFICE OF THE AUDITOR  
465 S. King Street, Room 500  
Honolulu, Hawaii 96813-2917



MARION M. HIGA  
State Auditor

(808) 587-0800  
FAX: (808) 587-0830

November 28, 1995

*COPY*

The Honorable Kathryn S. Matayoshi, Director  
Department of Commerce and Consumer Affairs  
Kamamalu Building  
1010 Richards Street  
Honolulu, Hawaii 96813

Dear Ms. Matayoshi:

Enclosed for your information are three copies, numbered 6 to 8 of our draft report, *Sunrise Analysis of a Proposal to Regulate Respiratory Care Practitioners*. We ask that you telephone us by Thursday, November 30, 1995, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Tuesday, December 12, 1995

The Governor and presiding officers of the two houses of the Legislature have also been provided copies of this draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Marion M. Higa'.

Marion M. Higa  
State Auditor

Enclosures

BENJAMIN J. CAYETANO  
GOVERNOR



KATHRYN S. MATAYOSHI  
DIRECTOR

NOE NOE TOM  
LICENSING ADMINISTRATOR

STATE OF HAWAII  
PROFESSIONAL & VOCATIONAL LICENSING DIVISION  
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS  
P. O. BOX 3469  
HONOLULU, HAWAII 96801

*December 12, 1995*

*Ms. Marion M. Higa  
State Auditor  
Office of the Auditor  
465 South King Street, Room 500  
Honolulu, HI 96813-2917*

RECEIVED  
DEC 12 8 47 AM '95  
OFC. OF THE AUDITOR  
STATE OF HAWAII

*Dear Ms. Higa:*

*Thank you for the opportunity to comment on the draft report, **Sunrise Analysis of a Proposal to Regulate Respiratory Care Practitioners.***

*We are in agreement with the findings in your report which conclude that regulation of respiratory care practitioners is not warranted.*

*We also reviewed the proposed legislation (H.B. 2240), to determine whether it is a fair, equitable and implementable proposal which is consistent with other departmental regulatory programs. We raise the following additional concerns:*

1. *The impact of the bill is to require those who "practice" and those using the "title" of respiratory care practitioner, to be licensed. To determine if a person is "practicing" respiratory care we would rely on the definition for the "practice of respiratory care", provided in the bill. The definition describes tasks which many other health care professionals would also perform within their own scope of practice. No "exemption to licensing" is provided for other health care professionals with possible overlapping practices. Thus, these professionals would be required to seek additional licensure as respiratory care practitioners. That being the case, until licensure is obtained, the other health care practitioners may be precluded from doing tasks which under normal circumstances they could perform, but because of the overlap with the "practice of respiratory care" they now could not. Further, due to licensing requirements specific concentration on respiratory care experience and/or education it is highly probable other health care professionals would not qualify for licensure.*

*Addressing overlapping professionals and ensuring there is no adverse impact to their continued practice is lacking in the bill. Should there continue to be intentions to require licensure of those who "practice" respiratory care then major strides must be made to ensure other health professionals are treated fairly and equitably with regard to licensure.*

2. *In the section which covers "Exemptions" (§ -21) there is a paragraph ((6)) which may be intended to address overlapping professions. The language though, is far from being clear as to who is meant to be covered by the exemption. If we interpret this exemption to apply to overlapping professionals, then the exemption is to be provided only after checking that the person has passed an exam, the substance of which appears to be subject to approval by the Board. No other regulatory program/board has such language. Further, we would have serious concern with the Board's ability to evaluate the subject matter of any exam being that they would have no exam expertise.*
3. *The bill uses the effective date of the Act to establish two (2) groups of applicants, those applying for licensure pre-Act date, and those applying post-Act date. (The intent is to set up a framework for grandfathered applicants.) Using the effective date of an Act is not a logical or practical approach to start a licensure program because statutory responsibility for, and implementation of the licensing program would not commence until after the effective date of the Act. Licensing is not done retrospectively.*
4. *We strongly support your position against grandfathering. We believe that minimum qualifications should not be compromised.*
5. *There are portions in the bill which allude to "continuing education", "accreditation of educational programs" and a "recovery fund assessment". However, no where else in the bill is it specified that these are to be statutorily required. The danger with this scenario is that it will be possible for the Board to decide to impose this upon applicants and/or licensees by simply adopting administrative rules. These substantive issues should receive legislative scrutiny. Therefore, the bill needs to be corrected to either create provisions which would make these statutory requirements or delete completely such issues from the bill.*

*Ms. Marion M. Higa  
December 12, 1995  
Page 3*

*We appreciate the opportunity to provide our input on the substantive provisions for regulation. We hope it will add to the evaluation process.*

*Very truly yours,*



**KATHRYN S. MATAYOSHI**  
*Director*

