COLORADO

Department of Regulatory Agencies

2014 Sunset Review: Respiratory Therapy Practice Act

Office of Policy, Research and Regulatory Reform
October 15, 2014

COLORADO

Department of
Regulatory Agencies

Executive Director's Office

October 15, 2014

Members of the Colorado General Assembly
c/o the Office of Legislative Legal Services
State Capitol Building
Denver, Colorado 80203

Dear Members of the General Assembly:

The mission of the Department of Regulatory Agencies (DORA) is consumer protection. As a part of the Executive Director's Office within DORA, the Office of Policy, Research and Regulatory Reform seeks to fulfill its statutorily mandated responsibility to conduct sunset reviews with a focus on protecting the health, safety and welfare of all Coloradans.

DORA has completed the evaluation of the Respiratory Therapy Practice Act. I am pleased to submit this written report, which will be the basis for my office's oral testimony before the 2015 legislative committee of reference. The report is submitted pursuant to section 24-34-104(8)(a), of the Colorado Revised Statutes (C.R.S.), which states in part:

> The department of regulatory agencies shall conduct an analysis of the performance of each division, board or agency or each function scheduled for termination under this section...
>
> The department of regulatory agencies shall submit a report and supporting materials to the office of legislative legal services no later than October 15 of the year preceding the date established for termination….

The report discusses the question of whether there is a need for the regulation provided under Article 41.5 of Title 12, C.R.S. The report also discusses the effectiveness of the Director of the Division of Professions and Occupations and staff in carrying out the intent of the statutes and makes recommendations for statutory changes in the event this regulatory program is continued by the General Assembly.

Sincerely,

Barbara J. Kelley
Executive Director

COLORADO

Department of Regulatory Agencies

2014 Sunset Review
Respiratory Therapy Practice Act

SUMMARY

What Is Regulated?
Respiratory therapists care for patients who have trouble breathing. Their patients range in age from premature infants with underdeveloped lungs, to older people with diseased lungs. They analyze breath, tissue and blood specimens to determine levels of oxygen and other gases; manage ventilators and artificial airway devices for patients who cannot breathe normally on their own; respond to urgent calls for care; and educate patients and their families about lung disease so they can maximize their recovery.

Why Is It Regulated?
One of the more important roles played by respiratory therapists is the care of patients who use ventilators to breathe. Regulation ensures that respiratory therapists meet minimum standards of competence to perform this and a multitude of other tasks safely and effectively.

Who Is Regulated?
As of September 2014, there were 2,233 actively licensed respiratory therapists.

How Is It Regulated?
The Director of the Division of Professions and Occupations (Director and Division, respectively) issues licenses to applicants who are certified or registered by the National Board for Respiratory Care (NBRC). The NBRC requires certification candidates to possess an associate's degree and pass a written, computer-based examination. Registration candidates must be certified and pass both a written, computer-based examination and a clinical simulation examination.

What Does It Cost?
In fiscal year 13-14, expenditures to oversee the program were $98,478 and there were 0.4 full-time equivalent employees associated with this program.

What Disciplinary Activity Is There?
Between fiscal years 08-09 and 12-13, the Director took 44 disciplinary actions against respiratory therapists who violated the Respiratory Therapy Practice Act (Act), including: 8 revocations, 22 stipulations, 9 letters of admonition, 4 cease and desist orders and 1 suspension.

Key Recommendations

Continue the Act for nine years, until 2024.

While an individual respiratory therapist's job duties are generally dictated by the specific facility at which that therapist works, those job duties very often entail a great deal of responsibility for maintaining patients' lives. For example, respiratory therapists monitor patients on ventilators, perform arterial blood draws and blood gas analyses to determine the amount of various gases in patients' bodies and administer therapies to help patients breathe easier through the administration of medications or the removal of mucus and other secretions that can obstruct patients' airways. Thus, the public health, safety and welfare is enhanced by the regulation of respiratory therapists by ensuring that these health care practitioners are competent. The public is further protected by the regulation of respiratory therapists in that regulation provides a mechanism by which the conduct of practitioners can be investigated and the appropriate disciplinary actions taken.

Establish failure to properly address the respiratory therapist's own physical or mental condition as grounds for discipline and grant the Director the authority to enter into confidential agreements with respiratory therapists.

Currently, a respiratory therapist can be disciplined simply for having a physical or mental condition, even if such condition is manageable. This does nothing to protect the public, and the characterization of a condition as "discipline" could be misconstrued by the public. A more enlightened approach would be to revise the grounds for discipline such that failing to accommodate such a condition is grounds for discipline. To ensure that practitioners adequately manage their conditions, the Director should be authorized to enter into confidential agreements with such licensees. These agreements would articulate the measures the licensee will take to manage the condition. If the licensee fails, the Director could then pursue discipline.

Major Contacts Made During This Review

American Lung Association in Colorado
Colorado Association of Medical Equipment Services
Colorado Department of Law
Colorado Health Care Association
Colorado Medical Society
Colorado Society of Respiratory Care
Division of Professions and Occupations
Home Care Association of Colorado

What is a Sunset Review?

A sunset review is a periodic assessment of state boards, programs, and functions to determine whether they should be continued by the legislature. Sunset reviews focus on creating the least restrictive form of regulation consistent with protecting the public. In formulating recommendations, sunset reviews consider the public's right to consistent, high quality professional or occupational services and the ability of businesses to exist and thrive in a competitive market, free from unnecessary regulation.

Sunset Reviews are prepared by:
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Background

Introduction

Enacted in 1976, Colorado's sunset law was the first of its kind in the United States. A sunset provision repeals all or part of a law after a specific date, unless the legislature affirmatively acts to extend it. During the sunset review process, the Department of Regulatory Agencies (DORA) conducts a thorough evaluation of such programs based upon specific statutory criteria[1] and solicits diverse input from a broad spectrum of stakeholders including consumers, government agencies, public advocacy groups, and professional associations.

Sunset reviews are based on the following statutory criteria:

- Whether regulation by the agency is necessary to protect the public health, safety and welfare; whether the conditions which led to the initial regulation have changed; and whether other conditions have arisen which would warrant more, less or the same degree of regulation;
- If regulation is necessary, whether the existing statutes and regulations establish the least restrictive form of regulation consistent with the public interest, considering other available regulatory mechanisms and whether agency rules enhance the public interest and are within the scope of legislative intent;
- Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures and practices and any other circumstances, including budgetary, resource and personnel matters;
- Whether an analysis of agency operations indicates that the agency performs its statutory duties efficiently and effectively;
- Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates;
- The economic impact of regulation and, if national economic information is not available, whether the agency stimulates or restricts competition;
- Whether complaint, investigation and disciplinary procedures adequately protect the public and whether final dispositions of complaints are in the public interest or self-serving to the profession;
- Whether the scope of practice of the regulated occupation contributes to the optimum utilization of personnel and whether entry requirements encourage affirmative action;

[1] Criteria may be found at § 24-34-104, C.R.S.

- Whether the agency through its licensing or certification process imposes any disqualifications on applicants based on past criminal history and, if so, whether the disqualifications serve public safety or commercial or consumer protection interests. To assist in considering this factor, the analysis prepared pursuant to subparagraph (i) of paragraph (a) of subsection (8) of this section shall include data on the number of licenses or certifications that were denied, revoked, or suspended based on a disqualification and the basis for the disqualification; and
- Whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest.

Types of Regulation

Consistent, flexible, and fair regulatory oversight assures consumers, professionals and businesses an equitable playing field. All Coloradans share a long-term, common interest in a fair marketplace where consumers are protected. Regulation, if done appropriately, should protect consumers. If consumers are not better protected and competition is hindered, then regulation may not be the answer.

As regulatory programs relate to individual professionals, such programs typically entail the establishment of minimum standards for initial entry and continued participation in a given profession or occupation. This serves to protect the public from incompetent practitioners. Similarly, such programs provide a vehicle for limiting or removing from practice those practitioners deemed to have harmed the public.

From a practitioner perspective, regulation can lead to increased prestige and higher income. Accordingly, regulatory programs are often championed by those who will be the subject of regulation.

On the other hand, by erecting barriers to entry into a given profession or occupation, even when justified, regulation can serve to restrict the supply of practitioners. This not only limits consumer choice, but can also lead to an increase in the cost of services.

There are also several levels of regulation.

Licensure

Licensure is the most restrictive form of regulation, yet it provides the greatest level of public protection. Licensing programs typically involve the completion of a prescribed educational program (usually college level or higher) and the passage of an examination that is designed to measure a minimal level of competency. These types of programs usually entail title protection – only those individuals who are properly licensed may use a particular title(s) – and practice exclusivity – only those individuals who are properly licensed may engage in the particular practice. While these requirements can be viewed as barriers to entry, they also afford the highest level of consumer protection in that they ensure that only those who are deemed competent may practice and the public is alerted to those who may practice by the title(s) used.

Certification

Certification programs offer a level of consumer protection similar to licensing programs, but the barriers to entry are generally lower. The required educational program may be more vocational in nature, but the required examination should still measure a minimal level of competency. Additionally, certification programs typically involve a non-governmental entity that establishes the training requirements and owns and administers the examination. State certification is made conditional upon the individual practitioner obtaining and maintaining the relevant private credential. These types of programs also usually entail title protection and practice exclusivity.

While the aforementioned requirements can still be viewed as barriers to entry, they afford a level of consumer protection that is lower than a licensing program. They ensure that only those who are deemed competent may practice and the public is alerted to those who may practice by the title(s) used.

Registration

Registration programs can serve to protect the public with minimal barriers to entry. A typical registration program involves an individual satisfying certain prescribed requirements – typically non-practice related items, such as insurance or the use of a disclosure form – and the state, in turn, placing that individual on the pertinent registry. These types of programs can entail title protection and practice exclusivity. Since the barriers to entry in registration programs are relatively low, registration programs are generally best suited to those professions and occupations where the risk of public harm is relatively low, but nevertheless present. In short, registration programs serve to notify the state of which individuals are engaging in the relevant practice and to notify the public of those who may practice by the title(s) used.

Title Protection

Finally, title protection programs represent one of the lowest levels of regulation. Only those who satisfy certain prescribed requirements may use the relevant prescribed title(s). Practitioners need not register or otherwise notify the state that they are engaging in the relevant practice, and practice exclusivity does not attach. In other words, anyone may engage in the particular practice, but only those who satisfy the prescribed requirements may use the enumerated title(s). This serves to indirectly ensure a minimal level of competency – depending upon the prescribed preconditions for use of the protected title(s) – and the public is alerted to the qualifications of those who may use the particular title(s).

Licensing, certification and registration programs also typically involve some kind of mechanism for removing individuals from practice when such individuals engage in enumerated proscribed activities. This is generally not the case with title protection programs.

Regulation of Businesses

Regulatory programs involving businesses are typically in place to enhance public safety, as with a salon or pharmacy. These programs also help to ensure financial solvency and reliability of continued service for consumers, such as with a public utility, a bank or an insurance company.

Activities can involve auditing of certain capital, bookkeeping and other recordkeeping requirements, such as filing quarterly financial statements with the regulator. Other programs may require onsite examinations of financial records, safety features or service records.

Although these programs are intended to enhance public protection and reliability of service for consumers, costs of compliance are a factor. These administrative costs, if too burdensome, may be passed on to consumers.

Sunset Process

Regulatory programs scheduled for sunset review receive a comprehensive analysis. The review includes a thorough dialogue with agency officials, representatives of the regulated profession and other stakeholders. Anyone can submit input on any upcoming sunrise or sunset review via DORA's website at: www.dora.colorado.gov/opr.

The regulatory functions of the Director of the Division of Professions and Occupations (Director and Division, respectively) as enumerated in Article 41.5 of Title 12, Colorado Revised Statutes (C.R.S.), shall terminate on July 1, 2015, unless continued by the General Assembly. During the year prior to this date, it is the duty of DORA to conduct an analysis and evaluation of the administration of the Respiratory Therapy Practice Act by the Director pursuant to section 24-34-104, C.R.S.

The purpose of this review is to determine whether the currently prescribed regulation of respiratory therapists should be continued for the protection of the public and to evaluate the performance of the Director. During this review, the Director must demonstrate that the regulation serves to protect the public health, safety or welfare, and that the regulation is the least restrictive regulation consistent with protecting the public. DORA's findings and recommendations are submitted via this report to the Office of Legislative Legal Services.

Methodology

As part of this review, DORA staff interviewed Division staff; reviewed Division records, including complaint files and disciplinary actions; interviewed officials with professional associations, health care providers and representatives of various hospitals; and reviewed Colorado statutes and the Director's rules.

Profile of the Profession

In very general terms, respiratory therapists care for patients who have trouble breathing. Their patients range in age from premature infants with underdeveloped lungs, to older people with diseased lungs.

Respiratory therapists typically:[2]

- Interview and examine patients with breathing or cardiopulmonary disorders;
- Consult with physicians to develop patient treatment plans;
- Perform diagnostic tests such as measuring lung capacity;
- Treat patients, using a variety of methods, including chest physiotherapy and aerosol medications; and
- Monitor and record the progress of treatment.

They may also:[3]

- Analyze breath, tissue and blood specimens to determine levels of oxygen and other gases;
- Manage ventilators and artificial airway devices for patients who cannot breath normally on their own;
- Respond to urgent calls for care; and
- Educate patients and their families about lung disease so they can maximize their recovery.

[2] U.S. Bureau of Labor Statistics. *Respiratory Therapists*. Retrieved November 20, 2013, from http://stats.bls.gov/ooh/healthcare/print/respiratory-therapists.htm
[3] American Association of Respiratory Care. *What RTs Do*. Retrieved June 17, 2014, from www.aarc.org/career/be_an_rt/what_rts_do.cfm

The day-to-day functions of any individual respiratory therapist are dictated, in large part, by the facility in which that therapist works. For example:[4]

- In a hospital, a respiratory therapist may provide treatments to patients;
- In an intensive or critical care unit, a respiratory therapist may manage the ventilators that keep the critically ill or injured alive;
- In sleep laboratories, a respiratory therapist may help to diagnose sleep disorders, such as sleep apnea;
- In patients' homes, a respiratory therapist may provide regular check-ups to ensure that patients have what they need in order to stay out of the hospital; and
- In case management programs, a respiratory therapist may help to devise long-term care plans for patients.

In some facilities, particularly in smaller or rural facilities where there may be only one respiratory therapist on duty at any given time, the respiratory therapist may be required to perform all of these functions, in addition to any other functions that may be necessary.

In other, typically larger urban facilities, where there may be multiple respiratory therapists on duty at any given time, the therapists may have an opportunity to specialize, or they may rotate throughout the facility's various departments.

In short, respiratory therapists are considered an integral part of the health care delivery team, and they are relied upon heavily by both the medical and nursing staffs.

All states, except Alaska, regulate respiratory therapists to one degree or another.[5]

In general, to become a respiratory therapist, an individual must complete an education program accredited by the Commission on Accreditation for Respiratory Care (CoARC). Colorado is home to four such programs:[6]

- Concorde Career College—Denver;
- Pickens Technical College in Aurora;
- Pima Medical Institute—Denver; and
- Pueblo Community College.

[4] American Association of Respiratory Care. *Where RTs Work*. Retrieved June 17, 2014, from www.aarc.org/career/be_an_rt/where_rts_work.cfm
[5] American Association of Respiratory Care. *State Licensure Contacts*. Retrieved on June 17, 2014, from www.aarc.org/advocacy/state/licensure_matrix.html
[6] Commission on Accreditation for Respiratory Care. *Find a CoARC-Accredited Respiratory Care Program*. Retrieved June 18, 2014, from www.coarc.com/36.html

Many individuals seeking to become respiratory therapists pursue the credentials offered by the National Board for Respiratory Care (NBRC), which offers the entry level Certified Respiratory Therapist (CRT) credential and the Registered Respiratory Therapist (RRT) credential.

To obtain the CRT, a candidate must pass the NBRC's Entry-Level CRT Examination. The examination consists of 160 computer-based, multiple-choice questions that must be completed within three hours. In general, to sit for the examination, a candidate must be at least 18 years old and:

- Possess an associate's degree from a CoARC-accredited program; or
- Have completed the science, general academic and respiratory therapy coursework required of a CoARC-accredited baccalaureate degree program.[7]

The NBRC utilizes its Registry Examination System to issue the RRT credential. Candidates must pass both the Written Registry Examination for Advanced Respiratory Therapists and the Clinical Simulation Examination.[8]

To sit for the Written Registry Examination, a candidate must hold the CRT credential. This examination consists of 115 computer-based, multiple-choice questions that must be completed within two hours.[9]

The Clinical Simulation Examination consists of 12 separate patient management problems, which are designed to simulate reality and be relevant to the clinical practice of respiratory care. Candidates have four hours to complete this examination.[10]

[7] *Candidate Handbook & Application*, National Board for Respiratory Care (2014), p. 3.
[8] *Candidate Handbook & Application*, National Board for Respiratory Care (2014), p. 3.
[9] *Candidate Handbook & Application*, National Board for Respiratory Care (2014), p. 3.
[10] *Candidate Handbook & Application*, National Board for Respiratory Care (2014), p. 3.

Legal Framework

History of Regulation

Sunrise applications requesting the licensure of respiratory therapists were submitted to the Department of Regulatory Agencies (DORA) in 1986, 1993, 1995 and 1999. Only the 1999 report recommended in favor of regulating respiratory therapists, based on the potential for harm.

House Bill 00-1294 created the Respiratory Therapy Practice Act (Act) and provided for the licensure of respiratory therapists by the Director of what is now the Division of Professions and Occupations (Director and Division, respectively). The Act creates a director model program, vesting in the Director, all licensing, disciplinary and policy-making authority.

The Act was almost immediately amended by Senate Bill 01-11, which, among other things, authorized the Director to seek an injunction against anyone violating the Act, and clarifying that the Act does not prohibit the practice of pulmonary function technologists, pulmonary function technologist students, sleep technology students and certain other unlicensed individuals.

In 2004, the Director was authorized to issue letters of admonition to licensees found to have violated the Act.

2004 also saw the first sunset review of the Act. That review recommended that the Act be repealed due, in part, to the fact that even in those instances when licensees were disciplined, no physical harm to consumers was involved.

The General Assembly disagreed with this recommendation and passed Senate Bill 05-147, which not only continued the Act for 10 years, but also clarified when licensees can be disciplined for the excessive use or abuse of alcohol and drugs; mandated that the Director take disciplinary action against those licensees found to have falsified or repeatedly made incorrect essential entries on patient records and for practicing beyond the scope of the licensee's competence; and clarified that the Act does not prohibit the practice of sleep technologists (and renamed these practitioners "polysomnographic technologists").

Finally, House Bill 06-1264 amended several practice acts administered by the Division, including the Act, to, among other things, authorize the Director to issue confidential letters of concern and cease and desist orders.

Respiratory Therapy Practice Act

The Act defines respiratory therapy as:

> providing therapy, management, rehabilitation, support services for diagnostic evaluation, and care of patients with deficiencies and abnormalities which affect the pulmonary system under the direction of a medical director.[11]

A medical director is a licensed physician who holds the title of "medical director" in any inpatient or outpatient facility, department or home care agency, and who is responsible for the quality, safety and appropriateness of the respiratory therapy provided.[12]

The Act specifically does not prohibit:[13]

- Self-therapy or gratuitous therapy by a friend or family member;
- Any service provided during an emergency;
- Respiratory therapy services rendered in the course of assigned duties of those serving in the military or working in federal facilities;
- Respiratory therapy services rendered in the course of assigned duties of those delivering oxygen supplies, including the inspection and maintenance of associated apparatus;
- The instruction or training of people to administer emergency oxygen during an aquatic emergency;
- The practice of respiratory therapy by:
  - Students enrolled in respiratory therapy education programs;
  - Students enrolled in programs of study that lead to certification or registration as pulmonary function technologists or polysomnographic technologists;
  - Certified or registered pulmonary function technologists or polysomnographic technologists; or
  - Unlicensed individuals so long as the procedures performed are not invasive, do not require an assessment and are performed under the supervision of a licensed respiratory therapist.

In order to practice respiratory therapy in this state, one must be licensed as a respiratory therapist,[14] and only licensed respiratory therapists may use the titles "licensed respiratory therapist" and "L.R.T."[15]

[11] § 12-41.5-103(6), C.R.S.
[12] § 12-41.5-103(4), C.R.S.
[13] § 12-41.5-110(2), C.R.S.
[14] § 12-41.5-112(2), C.R.S.
[15] § 12-41.5-104, C.R.S.

To obtain a license, an applicant must be 1) certified or registered by the National Board for Respiratory Care,[16] or 2) licensed by another state or other nation and possess qualifications that are substantially equivalent to those required for licensure by this state.[17]

The Director may deny, revoke, suspend or refuse to renew a license, place on probation a licensee, or issue a letter of admonition to a licensee if such person:[18]

- Has procured or attempted to procure a license by fraud, deceit, misrepresentation, misleading omission or material misstatement of fact;
- Has willfully or negligently acted in a manner inconsistent with the health or safety of people under his or her care;
- Has had a license to practice respiratory therapy or any other health care occupation suspended, revoked or otherwise subjected to discipline in any jurisdiction;
- Has practiced respiratory therapy in a manner that failed to meet generally accepted standards of practice;
- Has negligently or willfully violated any order or rule of the Director;
- Excessively or habitually uses or abuses alcohol or habit-forming drugs or habitually uses a controlled substance;
- Has a physical or mental disability that renders him or her unable to practice respiratory therapy with reasonable skill and safety and that may endanger the health or safety of people under his or her care;
- Has committed a fraudulent insurance act;
- Has willfully and repeatedly ordered and performed, without justification, demonstrably unnecessary laboratory tests or studies;
- Has administered treatment that is demonstrably unnecessary and without clinical justification;
- Has failed to obtain consultations or perform referrals when failing to do so is inconsistent with the standard of care for the profession;
- Has ordered or performed, without clinical justification, a service, procedure or treatment that is contrary to recognized standards of the practice of respiratory therapy;
- Has practiced without possessing a valid license, or while his or her license was suspended, revoked or expired;
- Has sold, fraudulently obtained or furnished a license to practice respiratory therapy, or has aided or abetted such activity;
- Has failed to notify the Director of the suspension, probation or revocation of any of the person's past or currently held licenses, certificates or registrations required to practice respiratory therapy in this or any other jurisdiction;
- Has knowingly employed any person who is not licensed in the practice of respiratory therapy in the capacity of a respiratory therapist; or

[16] § 12-41.5-106(2)(b), C.R.S.
[17] § 12-41.5-106(2)(a), C.R.S.
[18] § 12-41.5-109(2), C.R.S.

- Has been convicted of or entered and had accepted by a court a plea of guilty or *nolo contendere* to any crime that relates to such person's employment as a respiratory therapist or to any felony.

Furthermore, the Director must discipline a licensee who has falsified or repeatedly made incorrect essential entries or repeatedly failed to make essential entries on patient records, or who has practiced outside of or beyond the person's area of training, experience or competence.[19]

The Director may issue a letter of admonition if an investigation discloses an instance of misconduct that does not warrant formal action but that should not be dismissed.[20]

Additionally, the Director may issue a confidential letter of concern when an investigation discloses an instance of conduct that does not warrant formal action and should be dismissed, but the Director has noticed indications of possible errant conduct that could lead to serious consequences if not corrected.[21]

[19] § 12-41.5-109(2.5), C.R.S.
[20] § 12-41.5-109(11), C.R.S.
[21] § 12-41.5-109(11.5), C.R.S.

Program Description and Administration

The Director of the Division of Professions and Occupations (Director and Division, respectively) is vested with the authority to regulate respiratory therapists.

Table 1 illustrates, for the five fiscal years indicated, the expenditures and staff associated with the regulation of respiratory therapists.

Table 1
Agency Fiscal Information

Fiscal Year	Total Program Expenditure	Full-Time Equivalent Employees
08-09	$84,763	0.25
09-10	$103,574	0.45
10-11	$119,652	0.45
11-12	$110,789	0.50
12-13	$80,523	0.56

For fiscal year 13-14, 0.40 full-time equivalent (FTE) employees staffed the office:

- General Professional V (Program Director) = 0.20 FTE: this individual makes initial recommendations on all cases and applications (in terms of disciplinary actions or dismissals for complaints, and acceptance or denial of applications for licensure) to the Division's Deputy Director, before an ultimate recommendation is made to the Director. This individual is responsible for ensuring that all applications, complaints and Colorado Open Records Act (CORA) requests are timely handled.
- Technician IV = 0.10 FTE: this individual receives and processes all complaints and applications and prepares them for the Program Director's review. This individual also gathers information regarding CORA requests and prepares correspondence for the Program Director's signature.
- Administrative Assistant III = 0.10 FTE: this individual receives and processes all complaints and applications and prepares them for the Program Director's review. This individual also gathers information regarding CORA requests and prepares correspondence for the Program Director's signature.

The FTE listed in Table 1 do not include employees in the Division's centralized offices, which provide management, licensing, administrative, technical and investigative support to the office. However, the cost of those central services FTE is reflected in the Total Program Expenditures column of Table 1.

Expenditures were relatively high in fiscal years 09-10 through 11-12 due to higher than normal legal services expenditures.

The office is cash-funded by the fees paid by respiratory therapist applicants and licensees. Table 2 illustrates, for the five fiscal years indicated, the fees associated with the regulation of respiratory therapists.

Table 2
Fees

Fiscal Year	Original	Endorsement	Renewal	Reinstatement
08-09	$85	$60	$58	$73
09-10	$85	$85	Not Applicable	$73
10-11	$85	$85	$66	$89
11-12	$85	$85	Not Applicable	$89
12-13	$162	$162	$96	$114

Respiratory therapist licenses are valid for two years and are subject to renewal by August 31 of odd-numbered fiscal years. Thus, no renewal fees were charged during fiscal years 09-10 and 11-12.

Two factors explain the substantial fee increase in fiscal year 12-13. First, legal services expenditures were relatively high in fiscal years 09-10 through 11-12. As a result, by fiscal year 12-13, the then current fees were insufficient to adequately fund the office.

Second, fees are based on estimates from prior years. The number of new and renewal licenses in prior years did not increase at the rate estimated, resulting in the fee increase in fiscal year 12-13 to cover the shortfall.

Licensing

There are two primary avenues by which an individual can obtain a respiratory therapy license in Colorado. The first, often referred to as "original" is for those candidates seeking their first respiratory therapist license (i.e., they hold no similar license in any other jurisdiction).

These individuals must complete the required application and pay the fee for an original license (see Table 2). Additionally, they must request the National Board for Respiratory Care forward confirmation of having obtained either the Certified Respiratory Therapist (CRT) or Registered Respiratory Therapist (RRT) credential. Office staff does not track which credential an individual applicant possess. As a result, it is not possible to report the number of original licenses issued to CRTs or RRTs here.

The second route to licensure is by endorsement. This option is available to those respiratory therapists who hold a license that is in good standing that was issued by another jurisdiction, the requirements of which are substantially similar to Colorado's.

Table 3 illustrates, for the five fiscal years indicated, the number of new licenses issued, the number of licenses renewed and the total number of active licenses at the end of each fiscal year.

Table 3
Licensing Information

Fiscal Year	New Licenses Issued					
	Original	Endorsement	Total New Licenses	Renewal	Reinstatement	Active Licenses as of June 30
08-09	75	118	193	2,076	39	2,360
09-10	105	106	211	0	26	2,594
10-11	109	103	212	2,178	23	2,458
11-12	116	109	225	0	21	2,702
12-13	118	98	216	2,247	30	2,549

Complaints/Disciplinary Actions

Consumers, employers, other licensees and the Director can file a complaint against a licensed respiratory therapist or anyone who may have violated the Act.

Office staff reviews incoming complaints to determine whether they might constitute a violation of the Act. If so, office staff notifies the respiratory therapist being complained against of the complaint and allows the respiratory therapist 30 days to respond to the allegations. When the response is received, staff forwards the complaint and response, as well as a preliminary recommendation for how the case should be handled, to the Director. Staff might recommend dismissing the case, forwarding the complaint to the Division's Office of Investigations (OI) or forwarding the case to the Attorney General's Office for the commencement of disciplinary action. Generally, if staff recommends disciplinary action, the case will first be referred to the Division's expedited settlement process (ESP).

Table 4 illustrates, for the five fiscal years indicated, the number and nature of complaints received.

Table 4
Complaint Information

Nature of Complaints	FY 08-09	FY 09-10	FY 10-11	FY 11-12	FY 12-13
Discipline in another state	3	0	0	1	0
Failure to meet generally accepted standards of practice	6	4	6	4	6
Practicing without a license	2	0	0	0	0
Practicing on an expired or lapsed license	0	2	2	0	0
Falsifying patient records	1	0	0	0	0
Failure to document treatment(s)	0	0	0	0	0
Sexual assault	0	0	0	0	0
Failure to comply with Director order or stipulation/final agency order	0	1	0	0	0
Felony conviction (other than sexual assault)	2	3	1	1	0
Misdemeanor convictions (DUI/DWAI)	0	0	0	0	0
Other	10	3	2	2	0
TOTAL	**24**	**13**	**11**	**8**	**6**

By far, most complaints involve allegations of failing to meet generally accepted standards of practice. This is fairly typical of health care-related professions.

The "Other" category generally includes individuals who lied on their license applications, renewal applications or reinstatement applications.

Section 24-34-104(9)(b)(VIII.5), Colorado Revised Statutes, requires the Department of Regulatory Agencies (DORA) to determine whether the agency under review, through its licensing processes, imposes any disqualifications on applicants or licensees based on past criminal history, and if so, whether the disqualifications serve public safety or commercial or consumer protection interests.

Pursuant to this directive, DORA staff reviewed four case files involving complaints of criminal activity. In only one such instance did the Director deny a license to an applicant. In that case, the applicant made his application while still on parole for the attempted murder of his then-wife. The Director denied the application, finding that insufficient time had elapsed to show that the applicant had been rehabilitated.

Whether a complaint is referred to OI or ESP is a good indicator of whether a particular complaint has validity. Cases referred to OI are those in which office staff or the Director believes that additional information is necessary to determine how to proceed on the case. Table 5 illustrates, for the five years indicated, the number of cases referred to and completed by OI.

Table 5
Complaints Investigated

Fiscal Year	July 1 through June 30		
	Carried Over From Previous Year	Received	Investigated
08-09	0	10	7
09-10	3	3	6
10-11	0	5	2
11-12	3	4	7
12-13	0	4	4

Though the numbers fluctuate somewhat from year to year, on average, approximately half of all the complaints are referred to OI for investigation and most seem to be completed during the fiscal year in which they were referred.

When a case is referred to ESP, the Director provides general parameters within which staff is authorized to settle a case. These could include agreements to obtain continuing education in certain subject areas, such as record keeping, and agreements to complete drug or alcohol abuse therapy. Table 6 illustrates, for the five fiscal years indicated, the number of cases referred to ESP and the number of cases settled.

Table 6
Expedited Settlement Process

Fiscal Year		July 1 through June 30		
	Carried Over From Previous Year	Received	Completed	Settled
08-09	1	8	9	7
09-10	0	9	8	7
10-11	1	2	3	2
11-12	0	7	6	6
12-13	2	5	6	6

The vast majority of cases referred to ESP settle.

Importantly, the cases illustrated in Tables 5 and 6 are not mutually exclusive. Some of the cases referred to OI and included in Table 5 may well have then been referred to ESP and included in Table 6.

Table 7 illustrates, for the five fiscal years indicated, the total number of final agency actions taken, and the nature of those actions.

Table 7
Final Agency Actions

Type of Action	FY 08-09	FY 09-10	FY 10-11	FY 11-12	FY 12-13
Revocations	2	3	1	2	0
Suspensions	0	0	0	0	1
Revocation/suspensions held in abeyance or stayed	0	0	0	0	0
Stipulations	7	5	1	2	7
Letters of admonition	3	1	2	1	2
Other - cease and desist	1	2	0	0	1
TOTAL DISCIPLINARY ACTIONS	**13**	**11**	**4**	**5**	**11**
Dismiss	6	4	4	3	0
Letters of concern	0	0	2	1	1
TOTAL DISMISSALS	**6**	**4**	**6**	**4**	**1**

Consistent with the data reported in Table 6, most cases are resolved by a stipulation, though the Director issues a few letters of admonition.

Overall, roughly two-thirds of all complaints result in some form of disciplinary action, indicating that violations of the Act do, indeed, occur.

Analysis and Recommendations

Recommendation 1 – Continue the Respiratory Therapy Practice Act for nine years, until 2024.

The Respiratory Therapy Practice Act (Act) authorizes the Director of the Division of Professions and Occupations (Director and Division, respectively), within the Department of Regulatory Agencies (DORA) to license and discipline respiratory therapists. The Act establishes the initial qualifications that an applicant must possess prior to licensure, and it delineates several acts and omissions that, when performed by a licensed respiratory therapist, justify the Director disciplining a license. Thus, the Act establishes a fairly traditional regulatory framework that 1) seeks to ensure minimal competency at the time of licensure, and 2) provides mechanisms to discipline practitioners when that competency is subsequently found to be subpar.

The first sunset criterion asks whether regulation is necessary to protect the public health, safety and welfare. This question can be analyzed both in qualitative and quantitative terms.

A qualitative analysis can be performed by examining the role of respiratory therapists in today's health care delivery system. As part of this sunset review, a representative of DORA "shadowed" several respiratory therapists in a variety of departments at two separate facilities. These observations served to illuminate the knowledge and skills possessed by respiratory therapists, the degree to which they practice independently, and the degree to which other health care practitioners consult with, and even defer to them.

By far, one of the more important roles played by respiratory therapists is the care of patients who use ventilators to breathe. This requires the respiratory therapist to monitor patients to ensure that, among other things:

- Oxygen levels are within prescribed parameters;
- The rate at which oxygen is flowing is appropriate to ensure that the lungs do not over or under inflate;
- The ventilator tube is properly positioned and clear; and
- The patient's airway is clear and unobstructed by, for example, mucus.

Depending upon the situation, the respiratory therapist may make any necessary adjustments independently, or the therapist may consult with the patient's physician. Indeed, this later occurrence was observed by a representative of DORA. The physician at issue clearly respected the respiratory therapist's level of knowledge and gave his recommendations serious consideration.

While an individual respiratory therapist's job duties are generally dictated by the specific facility at which that therapist works, those job duties very often entail a great deal of responsibility for maintaining patients' lives. For example, respiratory therapists monitor patients on ventilators, perform arterial blood draws and blood gas analyses to determine the amount of various gasses in patients' bodies and administer therapies to help patients breathe easier through the administration of medications or the removal of mucus and other secretions that can obstruct patients' airways.

Thus, from a qualitative perspective, the public health, safety and welfare is enhanced by the regulation of respiratory therapists by ensuring that these health care practitioners are competent.

A quantitative analysis can be performed by examining complaint and disciplinary data.

As Table 4 on page 15 illustrates, the Director receives relatively few complaints pertaining to respiratory therapists, but most of the complaints that are received contain allegations of failing to meet generally accepted standards of practice. In other words, most complaints involve an issue of competency.

Finally, the data in Table 7 on page 17 illustrate that, for the five-year period between fiscal years 08-09 and 12-13, the Director saw fit to revoke the licenses of eight respiratory therapists. This indicates that the severity of the violations at issue was particularly high.

Thus, from a quantitative perspective, the public health, safety and welfare is enhanced by the regulation of respiratory therapists by providing a mechanism by which the conduct of respiratory therapists can be investigated and the appropriate disciplinary actions can be taken.

Because this sunset review identified remarkably few substantive issues with respect to the way in which respiratory therapists are regulated, a nine year continuation is justified.

For all of these reasons, the General Assembly should continue the Act and the regulation of respiratory therapists for nine years, until 2024.

Recommendation 2 – Authorize the Director to impose discipline on licensees who fail to respond to a 30-day letter.

When the Director receives a complaint against a respiratory therapist, staff sends a copy of the complaint to the licensee, who has 30 days to respond to the complaint in writing. Not only does failing to respond to a complaint create an administrative delay and hinder the investigative process, it also poses a potential threat to the public: each day that an unsafe respiratory therapist continues to work puts the public at risk. While there may be extenuating circumstances that prevent a licensee from responding promptly, the Director should have the authority to discipline a licensee for failing to respond.

As part of this sunset review, a representative of DORA reviewed 30 case files involving allegations of impropriety perpetrated by respiratory therapists. Four of those files substantiate the fact that, on occasion, respiratory therapists do, indeed, fail to respond to 30-day letters.

Other health professionals—including physicians,[22] nurses,[23] chiropractors,[24] physical therapists,[25] and dentists[26]—are subject to discipline for failing to respond to a 30-day letter.

Therefore, the General Assembly should authorize the Director to impose discipline for failing to respond to a 30-day letter.

Recommendation 3 – Authorize the Director to order physical and mental evaluations of licensees.

The Director has the authority to discipline a respiratory therapist who has:[27]

> a physical or mental disability that renders him or her unable to practice respiratory therapy with reasonable skill and safety and that may endanger the health or safety of persons under his or her care.

This authority is logical, given that a licensee's mental and physical health are key components in a licensee's ability to provide an appropriate standard of care.

However, the Director lacks the authority to order a respiratory therapist to submit to a physical or mental health evaluation in order to determine whether the licensee's physical or mental health poses a risk to patients.

The General Assembly has granted similar authority to the Director and regulatory boards with respect to the regulation of other health care providers. The practice acts governing the following professions all grant this authority to the relevant regulator:

- Massage therapists;[28]
- Mental health providers;[29]
- Occupational therapists and occupational therapy assistants;[30] and
- Physicians and physician assistants.[31]

[22] § 12-36-117(1)(gg), C.R.S.
[23] § 12-38-117(1)(u), C.R.S.
[24] § 12-33-117(1)(ff), C.R.S.
[25] § 12-41-115(1)(w), C.R.S.
[26] § 12-35-129(1)(jj), C.R.S.
[27] § 12-41.5-109(2)(i), C.R.S.
[28] § 12-35.5-114, C.R.S.
[29] § 12-43-224(2)(d), C.R.S.
[30] § 12-40.5-114, C.R.S.
[31] § 12-36-118(9)(a), C.R.S.

This list is not exhaustive, but it provides an overview of the wide array of health care providers that are subject to similar requirements.

The need for this authority was highlighted when, during the course of this sunset review, a representative of DORA examined various complaint and disciplinary files. In one case, a licensee was applying for reinstatement of a Colorado license. The applicant's license in another state had been disciplined for substance abuse. The Director ordered the applicant to submit to a mental health evaluation to determine the status of the applicant's substance abuse problem. Although the Director lacked explicit authority to do this, the applicant did not challenge the order and the reinstatement application lapsed. Regardless, this was an instance in which the Director's ability to order such an evaluation could have been critical to protecting patients.

In a second case, a licensee had three drug/alcohol-related driving convictions over a 10-year period. Since the Director lacked the authority to order a mental health evaluation, this respiratory therapist continued to practice, thereby potentially placing patients at risk, until other conduct forced this licensee out of practice.

Since the Director lacks the authority to order physical and mental health evaluations, and since there have been instances in which this authority could have protected patients, the General Assembly should grant the Director this authority.

Recommendation 4 – Authorize the Director to refuse to issue a license within two years of a license revocation or surrender.

Most health care professionals who have had their licenses revoked, or who have surrendered their licenses in lieu of revocation, must wait two years to reapply for licensure. These professionals include dentists, midwives, nurses, podiatrists, physical therapists and pharmacists. Requiring individuals to wait a specified period before reapplying enhances public protection by assuring they possess minimal competency when they re-enter the workforce. Given the severity of the violations that result in revocation or surrender of a license, and the amount of time and resources it takes to process revocations and surrenders, two years is an appropriate waiting period.

The General Assembly should establish a two-year waiting period for respiratory therapists who have had their licenses revoked, or who have surrendered their licenses in lieu of disciplinary action.

Recommendation 5 – Establish failure to properly address the respiratory therapist's own physical or mental condition as grounds for discipline and grant the Director the authority to enter into confidential agreements with respiratory therapists.

One of the Director's critical responsibilities is to take disciplinary action against respiratory therapists who pose a threat to the patients under their care. The Director may take disciplinary action against any respiratory therapist who has:[32]

> a physical or mental disability that renders him or her unable to practice respiratory therapy with reasonable skill and safety and that may endanger the health or safety of persons under his or her care.

The intent of this provision is clear: to protect the public from unsafe practitioners. But in many cases, respiratory therapists with such conditions could continue to practice safely, under certain defined circumstances. For example, a respiratory therapist with a spinal injury could continue to diagnose and evaluate patients, but might have to delegate certain manual therapies to another practitioner. A respiratory therapist with bipolar disorder might be able to treat patients safely provided he or she takes the proper medication.

Under the current system, however, even a practitioner who is able to accommodate any physical or mental condition he or she has may be subject to discipline simply by virtue of having such a condition. This is typically accomplished by way of entering into a stipulation that limits the respiratory therapist's practice. Such a stipulation is public discipline.

Thus, the licensee is able to continue to practice, but his or her condition is made public and he or she has been disciplined. Being injured in a car accident, suffering a stroke or receiving a diagnosis of bipolar disorder is fundamentally different from committing an act that constitutes grounds for discipline under the Act. While these conditions might temporarily or permanently affect a respiratory therapist's ability to treat patients, it seems unjust for a respiratory therapist who successfully manages bipolar disorder with medication to be included in the same category as a respiratory therapist who has sexually assaulted a patient.

Current law presents respiratory therapists who have a physical or mental condition that might affect their practice with a stark choice: violate the law by continuing to practice without disclosing the condition, stop practicing entirely or enter into a public disciplinary order.

Disciplining a respiratory therapist for having a physical or mental condition does nothing to protect the public and unjustly punishes the therapist. A more enlightened approach would be to revise the grounds for discipline such that failing to accommodate a physical or mental condition is grounds for discipline.

[32] § 12-41.5-109(2)(i), C.R.S.

To ensure that practitioners adequately manage their conditions, the Director should be authorized to enter into confidential agreements with such licensees. These agreements would articulate the measures the licensee will take to manage the condition. If the licensee fails, the Director could then pursue discipline.

This approach protects the public by ensuring that respiratory therapists are safe to practice, and it protects the licensee from unnecessary discipline and unnecessarily publicizing the licensee's condition.

Therefore, the General Assembly should establish failure to properly address the respiratory therapist's own physical or mental condition as grounds for discipline and grant the Director the authority to enter into confidential agreements with respiratory therapists.

Recommendation 6 – Authorize the Director to transmit letters of admonition to licensees by means other than certified mail.

Section 12-41.5-109(11)(b), Colorado Revised Statutes (C.R.S.), requires the Director to send letters of admonition to respiratory therapists via certified mail. While this delivery method allows the Director to verify that a delivery attempt was made, it does not guarantee that the addressee actually receives the letter. The addressee can decline to sign for or pick up the letter, and then claim he or she never received it. This defeats the purpose of sending the letter by certified mail.

Certified mail also costs more than first-class mail.

Repealing the requirement that letters of admonition be sent via certified mail would save money and streamline the administrative process without compromising the Director's enforcement authority. Therefore, the General Assembly should repeal the requirement that letters of admonition be sent by certified mail.

Recommendation 7 – Repeal the name "National Board for Respiratory Care" from the Act.

The National Board for Respiratory Care (NBRC) is the private body that issues the credentials upon which the Act's licensing qualifications rest. One must be credentialed by the NBRC to receive a Colorado license.

Thus, on the one hand, it seems logical that the NBRC be referenced by name in the Act. However, in general, practice acts refrain from naming specific private entities, and instead empower the regulatory authority, whether it be a board or the Director, to select the entity upon which to rely.

This is advantageous for several reasons. First, if the NBRC were to change its name, the Act would be out of date and the Director, technically, would not be able to license respiratory therapists until the Act were amended to contain the correct name.

Next, as a private entity, the NBRC is free to change its credentialing standards at any time. This could have the effect of making it unnecessarily difficult to obtain a Colorado license, or it could make a Colorado license meaningless if the standards were lowered too far.

Additionally, at some point in the future, a competing organization could come into existence, the standards of which might more appropriately address the needs of Colorado. Naming the NBRC in the Act would require the General Assembly to amend the Act to adopt a different, potentially more appropriate, licensing standard.

Therefore, the General Assembly should amend the Act to repeal all references to the NBRC, and instead authorize the Director to select the credentialing body upon which to base licensure in Colorado.

Recommendation 8 – Make technical changes to the Act.

As with any law that has been in existence for many years, the Act contains instances of obsolete, duplicative and confusing language. The Act should be revised to reflect current terminology and administrative practices. These changes are technical in nature, meaning that they have no substantive impact on the practice of respiratory therapy.

The General Assembly should make the following technical changes:

- **Section 12-41.5-106(1), C.R.S.** Repeal the word "written" so that applicants for licensure need only submit evidence of possessing the necessary national credential, not necessarily written evidence of such.

- **Sections 12-41.5-109(5.5)(b)(II), 12-41.5-109(5.5)(b)(III) and 12-41.5-109(17), C.R.S.** Change references to the "board" to the "Director" since there is no regulatory board associated with the regulation of respiratory therapists.