

## Compact Licensure for Respiratory Therapists

### Introduction

During the time of a national public health emergency such as the COVID-19 pandemic, many states have issued Executive Orders to lift occupational and professional statutes and regulatory restrictions with respect to licensure, renewal, and continuing education. Additional flexibilities have been added for students and retirees (in state and out-of-state) to come back into the workforce through temporary licensure. In addition, there is great flexibility among states to allow health care professionals to cross state lines under certain circumstances which improves access. It is also during the time of a public emergency or natural disaster that the AARC is asked more frequently why we do not have compact licensure for respiratory therapists like the nursing profession.

### AARC Actions Related to Compact Licensure

Because of our members interest, the AARC has actively researched compact licensure.

- We have attended webinars by the Council noted above to gain a better understanding of the complexities of the compact licensure process and continue to remain in contact with the group as a resource.
- We surveyed State Boards of Respiratory Care to determine their level of interest in compact licensure.
- We provided an overview of our findings and survey results at the spring 2021 AARC Board Meeting and additional follow-up at its 2021 summer meeting.

### Compact Licensure Process

It is important for our members to understand fully how compact licensure is initiated and implemented. There are three phases and multiple steps that must be accomplished which is why it takes several years to come to fruition. It took the nurses well over a decade to implement their compact. A multistate license is only applicable in the states that are part of the compact. A compact cannot be enacted until a minimum of 10 states join. It took the nurses over a decade to get their compact.

<b>INTERSTATE COMPACTS - DEVELOPMENT</b>		
<i>Phase I - Development</i>	<i>Phase II – Education/Enactment</i>	<i>Phase III – Transition/Operation</i>
<b>Advisory Group</b>	<b>Education</b>	<b>Transition</b>
<ul style="list-style-type: none"> <li>✓ Approximately 20 state officials. stakeholders, issue experts.</li> <li>✓ Examines issues, current policy, best practices, and alternative structures.</li> <li>✓ Recommends compact content.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Develop comprehensive legislative resource kit.</li> <li>✓ Develop informational internet site with state-by-state tracking and support documents.</li> <li>✓ “National Briefing” to educate legislators/key state officials.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Enactment threshold met.</li> <li>✓ State notification.</li> <li>✓ Interim Executive Board appointed.</li> <li>✓ Interim Committee’s establish.</li> <li>✓ Convene first Compact meeting.</li> <li>✓ Information system developed.</li> </ul>

<b>Drafting Team</b>	<b>State Support</b>	<b>Operation</b>
<ul style="list-style-type: none"> <li>✓ Composed of 5 to 8 state officials, stakeholders, and issue experts.</li> <li>✓ Crafts compact based on recommendations.</li> <li>✓ Circulates draft compact to states and stakeholder groups for comment.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Develop network of champions.</li> <li>✓ Provide on-site technical support and assistance.</li> <li>✓ Provide informational testimony support and assistance.</li> <li>✓</li> </ul>	<ul style="list-style-type: none"> <li>✓ Ongoing state control and governance.</li> <li>✓ Staff support.</li> <li>✓ Annual assessment, if needed.</li> <li>✓ Annual business meeting.</li> <li>✓ Information system oversight</li> <li>✓ Long-term upgrades.</li> </ul>
<b>Final Product</b>	<b>State Enactments</b>	
<ul style="list-style-type: none"> <li>✓ Drafting team considers comments and incorporates into compact.</li> <li>✓ Final product sent to advisory group.</li> <li>✓ Released to states for consideration.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Track and support state enactments</li> <li>✓ Prepare for transition and implementation of compact.</li> <li>✓ Provide requested support as needed.</li> </ul>	

Source: National Center for Interstate Compacts (NCIC) – The Council of State Governments

**Interstate Commission and Executive Board**

Once at least 10 states have implemented legislation to add compact licensure to their scope of practice, a compact Interstate Commission acting as a quasi-government entity must be formed, which can take up to a year. Below is an overview of the roll of the Interstate Commission.

<b>INTERSTATE COMPACTS - TYPICAL GOVERNANCE STRUCTURE</b>
✓ The commission is comprised of voting representatives from each member state and is responsible for key decisions with respect to the compact.
✓ The commission can form committees, including an executive committee that is responsible for making day-to-day decisions.
✓ Compact commissions are frequently granted the authority to hire staff, which is responsible for implementing the policies and procedures established by the commission.
✓ Commissions serve agencies of the member states and are tasked with acting on their behalf and not on the behalf of groups or organizations.

Source: National Council for Interstate Compacts (NCIC) – The Council of State Governments

In developing various health care compacts, the physicians' compact was led by the Federation of State Medical Boards; the nurses' compact by the National Council of State Boards of Nursing; the EMTs' compact by the Interstate Commission for EMS Personnel Practice Members; the Physical Therapists' compact by the Federation of State Boards of Physical Therapy. There is no similar oversight in the respiratory care profession. The National Board of Respiratory Care does not have jurisdiction over state boards as do these other entities. Their purpose is to recognize the national credentials as the basis for awarding a respiratory therapist license and to allow the State Boards to use the exams for licensure-only purposes where and when needed.

To give you an idea of how an Interstate Commission works, we researched the physical therapists' compact. For example, the Physical Therapy Board in each member state that is part of the compact selects a delegate to the Commission who must be a member of that board and one of the following: a physical therapist, a physical therapists assistant, a public member, or a board administrator. The Commission then elects a 7-member Executive Board from the Compact Commission delegates to represent all the member states. Representatives from the American Physical Therapy Association (APTA) and the Federation of State Boards of Physical Therapy (FSBPT) serve as non-voting ex-officio members.

**Challenges to Compact Licensure for Respiratory Therapists**

We understand the desire of respiratory therapists to travel more easily among states to provide their expertise where needed; however, challenges for the respiratory care profession include the following:

- Compact licensure can only be successful if State Boards of Respiratory Care are willing to put in the time, money, and work to make it happen. A survey conducted by the AARC in spring of 2021 asked states to weigh in on five key questions. Twenty-four states responded with 21 states answering most all questions.

Questions	Yes	No
Do we need compact licensure to allow RTs to move more freely among states?	33%	67%
Does your state have a reciprocity clause?	55%	45%
Has your State Society expressed an interest in compact licensure?	10%	90%
Should AARC pursue compact licensure as a priority for the profession?	33%	67%
Would your state be willing to open the RT practice act to include compact licensure?	55%	45%

- In addition to specific questions, states were given an opportunity to express any concerns they had with compact licensure.
  - Responses centered on loss of state control, the licensure process, and costs; duplication and added burden; lack of resources; variation in continuing education requirements; background check requirements and time involved to implement; and risk to state licensing boards.
- States are responsible for forming an Interstate Commission to provide oversight that requires promulgating uniform rules that have the effect of law and are binding on all states that are part of the compact.
  - An Executive Committee and the hiring of additional staff are needed to provide day-to-day operational tasks, hold business meetings, etc. That is not the role of the AARC or the NBRC.
- A data system must be established as a repository of information about licenses, CEUs, exams, fingerprinting, criminal background checks, adverse actions, etc. According to the NCIC, this can cost anywhere from \$500,000 to \$1 million dollars with additional funds needed to maintain it.

- States may accept appropriate donations and grants of money, equipment, supplies and other materials and services to offset the costs provided there is no appearance of impropriety or conflict of interest.
- The scopes of practice for RTs vary considerably among states.
  - Seven states require the RRT as the minimum credential for entry to licensure. Three additional states are in the process of moving to RRT or already have introduced legislation.
  - A handful of states require dual licensure for CRTs and RRTs making the situation more complex.
  - Continuing education hours and content vary, and some states do not require the RT to have any CEUs to renew their license.
- The respiratory care profession does not have an overarching Federation or Council like the PTs or nurses.
  - Some Respiratory Care Boards are independent, some are part of the state's Medical Board, and others are part of the State Regulatory agency.
- A multi-compact license only allows the RT to work among the states who have agreed to join the compact.
- Each state who wants to form the compact must develop its own legislation and be willing to open the RT practice act to add compact licensure. Most important is finding a sponsor for the legislation and support from stakeholders.
- Interstate compacts can have a financial and administrative impact on state boards which are often reasons for nonsupport - fear of lost revenue being one of the primary reasons. Delegation of state regulatory authority is another key concern.

### **Conclusion**

Considering activities underway to meet the objectives of the Association's six Horizon Goals, its priority to move the profession forward to require a RRT credential and a bachelor's degree as entry level for licensure, and to advance the profession by developing an advanced practice respiratory therapist credential, the AARC Board of Directors concluded that compact licensure is not a priority for the Association at this time.