MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

1280

2005 HOUSE HUMAN SERVICES

HB 1280

2005 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. **HB 1280**

House Human Services Committee

☐ Conference Committee

Hearing Date **18 January 2005**

Tape Number	Side A	Side B	Meter #
1		X	2550 - end

Committee Clerk Signature

Minutes:

Vice Chairman Kreidt opened the hearing of HB 1280.

Representative Todd Porter, District 34, introduced the bill. During the last interim, Lana Kurl from MedCenter One Health Systems approached me with a problem that they were having with State Board of Respiratory Therapy. Part of the sleep therapy and sleep apnea study is a dual roll that merges a bit from respiratory therapy and a bit from sleep therapy and they were having a little trouble with the way the board was interpreting their job. Lana is here today and after we come back from our break she will testify on it. Senator Lee is also here and has worked with Lana on an amendment to change the entire portion of section 7. It's basically a "hog house" out to a much shorter version that's acceptable to both parties and will help this particular measure go forward.

Senator Gary Lee, District 11, testified in favor of the bill if amended as proposed. **(Testimony attached.)** He submitted a proposed amendment. **(Attached.)** The amendment that you see does help both sides come to an agreement that can work for all of us.

Rep. Potter: In your testimony you said that ND needed more and better trained physicians in this field. We don't have enough. Does this bill speak to that?

Senator Lee: My understanding is there is one board certified sleep physician in Fargo, there's at least three in Bismarck, and some in the process of the credentialing system and will be certified in the future. There are not enough board certified doctors in the sleep area. We are moving in that direction. The pipeline is filling and people are coming into the field and to work in sleep medicine.

Representative Betty Grande, District 41, spoke in favor of the bill. I've had the opportunity to visit with Senator Lee about his amendments and at this point I have no opposition to them being put on. My only concern is that it should not stop the practice of various private businesses that are currently working in the state. As long as we are not looking at shutting down these particular businesses, I am in favor of the amendment.

Lana Curl, director of the Sleep Center in Bismarck, presented a power point presentation regarding the responsibility Polysomnographic Technologists (Sleep Study Technologists). **(Copy attached.)**

Rep. Kaldor: If this bill not passed, are you prohibited from practicing?

Curl: I could do most of my job but I couldn't do the sleep apnea oxygen therapy.

Steven Rixen, lobbyist for Medcenter One Health Systems, testified in favor of the bill with the amendment recommended by Senator Gary Lee. **(Testimony attached.)**

2005 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1280

House Human Services Committee

☐ Conference Committee

Hearing Date January, 24, 2005

Tape Number	Side A	Side B	Meter #
#1		x	4160 - 5348

Committee Clerk Signature

Minutes:

Chairman Price opened discussion on HB 1280

Rep. Porter: You will have physicians who are privileged by a board with in a hospital to perform and order sleep apnea studies. They will not fit into the proposed amendment by Senator Lee. You will have an ENT Dr. who is the surgeon, who will perform the surgery on the patient after the sleep apnea study, couldn't actually order the test and the polysomnograpic tech couldn't actually perform the test the way the amendment is written Basically says that the Board will determine who is privileged in sleep medicine and whoever that hospital board determines is privileged to be able to order that test.

Chairman Price: Are we limiting the free standing in Fargo/Bismarck.

Rep. Porter: No, we have taken the position in the past that we not limit individuals on a boards determination where their fence should be drawn.

Rep. Weisz: Does the all hospitals have these crediting boards to deal with this?

Rep. Porter: They have boards for everything, do be privileged, they would have gone through a peer review.

Rep. Porter: Move to amend.

Rep. Potter: Second

Voice Vote: 11 -0-0

Chairman Price: Will this amendment be favorable to everyone involved?

Rep. Porter: No, the respiratory therapist's will not be satisfied, they want sole rights to doing this. But it is interesting, in going through this bill, that most of the respiratory therapists, in order to get the instruction they need, to take this set of tests to have this certification, go to Oregon and are taught by people who have no respiratory therapist back round. They only have the polysomnographic credentials. They even invited Ms. Pearl to their convention, to teach them about the procedures, but yet they want to control it and have it as part of their package of things that they get to do.

Rep. Damschen: The amendment that we adopted, does that not require any special training for the physician, the hospital board just approves them.

Rep. Porter: That is correct, they go through the normal crediting of the hospital.

Rep. Devlin: Do pass as amended.

Rep. Potter: Second

Vote: 10-1-0

Carrier: Rep. Porter

2005 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1280

House Human Services Committee

❑ Conference Committee

Hearing Date January 25, 2005

Tape Number	Side A	Side B	Meter #
Number 1		x	4360-5384

Committee Clerk Signature

Minutes:

Chairman Price: Rep. Porter, we voted on this, but wanted you to have a chance to see the E-mail.

Rep. Porter: I did visit with him, and I don't have a problem with his suggestion. But it would definitely open up a can of worms in the process. They are right, because it does bring down that fence for the respiratory therapists because if someone is certified in a para profession that has nationally accredited standards, that they should recognize that. Currently, they were one of the lucky groups that had a board in the 80's, and now they are using it against everybody and we have seen it in here before, the power plays from this group. I think they will have a chance on the Senate side, and I feel this will probably end up being in a conference committee.

Chairman Price: That is probably true.

MR# 5387.

Proposed Amendments to House Bill NO. 1280

Page 2, line 13, replace "a polysomnographic technologist, technician, or" with "the performance of oxygen therapy or the initiation of noninvasive positive pressure ventilation by a registered polysomnographic technologist, relating to the study of sleep disorders, if such procedures are performed or initiated under the supervision of a physician who is privileged in sleep medicine at a state licensed hospital or health system or is Board-eligible or a diplomate of the American Board of sleep medicine."

Page 2, remove lines 14 through 28

Renumber accordingly

50349.0102
Title.

Prepared by the Legislative Council staff for
Senator G. Lee
January 18, 2005

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1280

Page 2, line 13, replace "a polysomnographic technologist, technician, or" with "the performance of oxygen therapy or the initiation of noninvasive positive pressure ventilation by a registered polysomnographic technologist, relating to the study of sleep disorders, if such procedures are performed or initiated under the supervision of a physician who is board-eligible in the discipline of sleep medicine or who is a diplomate of the American academy of sleep medicine and are performed at a facility accredited by a national accrediting organization acceptable to the board or otherwise accredited as acceptable to the board."

Page 2, remove lines 14 through 31

Page 3, remove lines 1 and 2

Renumber accordingly

Adopted by the Human Services Committee
January 24, 2005

VR
1/24/05

HOUSE AMENDMENTS TO HOUSE BILL NO. 1280 H.S. 1-25-05

Page 2, line 13, replace "a polysomnographic technologist, technician, or" with "the performance of oxygen therapy or the initiation of noninvasive positive pressure ventilation by a registered polysomnographic technologist, relating to the study of sleep disorders, if such procedures are performed or initiated under the supervision of a physician who is privileged in sleep medicine at a state licensed hospital or health system or is board eligible or a diplomate of the American board of sleep medicine."

Page 2, remove lines 14 through 28

Page 2, line 29, remove "d."

Renumber accordingly

Date: 1/18/05
1/24/05

Roll Call Vote #:

2005 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1280

House **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass as Amd

Motion Made By Rep Porter Seconded By Rep Potter

Representatives	Yes	No	Representatives	Yes	No
Chairman C.S. **Price**	✓		Rep.L. **Kaldor**	✓	
V Chrm.G. **Kreidt**	✓		Rep.L. **Potter**	✓	
Rep. V. **Pietsch**	✓		Rep.S. **Sandvig**	✓	
Rep.J.O. **Nelson**	✓				
Rep.W.R. **Devlin**	✓				
Rep.T. **Porter**	✓				
Rep.G. **Uglem**	AB				
Rep C. **Damschen**					
Rep.R. **Weisz**					

Total (Y) 10 **No** 1

Absent 1

Floor Assignment Rep Porter

If the vote is on an amendment, briefly indicate intent:

Misc:
1/24/05 Amd - Rep Porter 2nd Potter, vaicivati 12-0-6

REPORT OF STANDING COMMITTEE

HB 1280: Human Services Committee (Rep. Price, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (10 YEAS, 1 NAY, 1 ABSENT AND NOT VOTING). HB 1280 was placed on the Sixth order on the calendar.

Page 2, line 13, replace "a polysomnographic technologist, technician, or" with "the performance of oxygen therapy or the initiation of noninvasive positive pressure ventilation by a registered polysomnographic technologist, relating to the study of sleep disorders, if such procedures are performed or initiated under the supervision of a physician who is privileged in sleep medicine at a state licensed hospital or health system or is board eligible or a diplomate of the American board of sleep medicine."

Page 2, remove lines 14 through 28

Page 2, line 29, remove "d."

Renumber accordingly

2005 SENATE HUMAN SERVICES

HB 1280

2005 SENATE STANDING COMMITTEE MINUTES

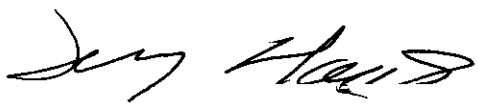
BILL/RESOLUTION NO. HB 1280

Senate Human Services Committee

❑ Conference Committee

Hearing Date March 9, 2005

Tape Number	Side A	Side B	Meter #
1		X	1960-END
2	X		1-4250

Committee Clerk Signature  CM

Minutes:

Chairman Lee opened the hearing on HB 1280, relating to the exemption of the practice of sleep therapy from the regulation of respiratory therapy. All Senators were present.

Representative Todd Porter introduced HB 1280. See written testimony.

Dr. Sue Karen Wink, an otolaryngologist, appeared in support of the bill. See written testimony.

Lana Curl, a registered sleep technologist, appeared in support of the bill. See written testimony.

Senator Dever- How many sleep clinics are in the state, and how many technologists are there?

Lana- There are ten technologists, and at least one sleep center in every large community in the state.

Senator Dever- When you referenced your visit with the attorney general, in your testimony and he advocated seeking a legislative solution, what would be the alternative?

Lana- When they asked me to come up with something legislatively, I did not hear back from the Respiratory Care society until October, and at that point I didn't have information on hand.

Senator Dever- Are there schools that specialize in sleep technology?

Lana- There are now.

Steve Vilness, appeared in support of the bill. He is a registered respiratory therapist and a registered sleep technician. It is very important to address the differences between the two practices.

Kristi Kirkeby, a registered sleep technologist and a certified respiratory therapist, appeared in support of the bill.

Chairman Lee- Are you involved with a private clinic?

Kristi- We provide services to hospitals by having a contract.

Tina Thompson, appeared in support of the bill.

Marcia Nelson, CEO of Winmar Diagnostics Sleep Wellness Center in Fargo, appeared in support of the bill. See written testimony.

Chairman Lee- What are the restrictions for practice in Minnesota?

Marcia- In Minnesota, there are not any restrictions. Respiratory Therapists are not licensed in Minnesota, they are registered by the state.

Renee Fuchs, a registered respiratory therapist, appeared in support of the bill. See written testimony.

Steve Rixen, representing Medcenter One Health Systems, appeared in support of the bill. See written testimony.

Senator Dever- Does the clinic itself require any kind of certification?

Steve- We hire qualified professionals and follow the standards.

Lana- Our job descriptions require a background in medicine. There is only one sleep lab in ND that is accredited. We have training and competencies that we have to follow.

Senator Dever- So, you are not registered by the state? Are the services reimbursable?

Lana- We are not registered by the state, and our services are reimbursable.

Debra Mills, appeared in support of the bill. She spoke on behalf of her husband who is under the care of a respiratory therapist, due to a sleep disorder. Every patient has the right to ask if the person performing the procedure is licensed.

Senator Gary Lee, appeared in opposition to the bill. See written testimony.

Dr. Sami Karaz, appeared in opposition to the bill. He is a sleep specialist at Meritcare Hospital in Fargo, and has practiced for the last 12 years. There are currently over 60 sleep disorders out there, several are interrelated with one another. Some sleep studies take place in the daytime and others at night. Sleep studies can't be independent, it involves a great deal of physiological functions. Some patients often have cardio or neurological problems. He is concerned a great deal about what the pre-study evaluation currently entails. Some of his patients have also come to him with concerns about a lack of supervision during the sleep studies. This bill does not improve the quality of care that sleep disorder patients receive.

Karla Smith, Sleep Center Coordinator for St. Alexius Medical Center appeared in opposition to the bill. See written testimony.

Senator Dever- Is every sleep technologist also a respiratory therapist?

Karla- No, that would only apply to some. There is no violation of the current law.

Dr. Will Beachey, representing the ND Society for Respiratory Care appeared in opposition to the bill. See written testimony.

Mike Runge, Director of Respiratory Therapy at St. Alexius Medical Center appeared in opposition to the bill. See written testimony.

Jutta Schmidt, a registered respiratory therapist from Minot appeared in opposition to the bill. Misinterpretation is quite evident in the bill. Someone with no formal education could be trained on the job, and then practice sleep therapy. This is a patient safety issue, several mistakes could take place.

David Peske, representing the North Dakota Medical Association appeared before the committee. There are many instances where the licensing acts call for the supervision by a physician. Our board of directors looked at this bill from that standpoint. He made a request for the committee to delete a portion of the bill between lines 16-18 on page 2 of the bill.

Chairman Lee closed the hearing on HB 1280. No action was taken.

2005 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. **HB 1280**

Senate Human Services Committee

☐ Conference Committee

Hearing Date March 22, 2005

Tape Number	Side A	Side B	Meter #
1	x		1050-5961

Committee Clerk Signature Diane Dani

Relating to the exemption of the practice of sleep therapy from the regulation of respiratory therapy.

Chairman J. Lee opens committee work on HB 1280.

(meter #867)

(meter #1050)

Senator Gary Lee - District 22 - See attachment 1 and 1A, proposed amendment. Read through the amendments.

(meter #1612)

Senator Lyson - Asked why December 31 for a date.

Senator G. Lee - He said this gives them 6 months to think about what the rules could be. By January 1st the rules should be in place.

Senator Lyson - Asked if could be September 1st.

Senator G. Lee- He said he thinks the time frame is reasonable.

Senator J. Lee - Agreed it does take time to get the rules through the system. Asked how many people are on the board now.

Senator G. Lee - Replied 7 members.
Senator J. Lee - Asked is there a provision that there would be imput by the board in the development of the rules.

Senator G. Lee - Replied it is assumed that it is part of the process of administrative rule making.

Senator J. Lee - Asked if there would be polysom tech for a 2 year period as part of the board during the time of this rule development.

Senator G. Lee - Said that isn't a part of this but he wouldn't be opposed. Maybe as a temporary solution.

Senator J. Lee - Said she was hoping something would get resolved in the national organization in the next couple of years.

Senator G. Lee - He is not opposed.

Senator Dever - Said he thinks the meat of this bill involves the right of exemption from the Respiratory Therapist Act. Asked how will this rule making process address that.

Senator G. Lee - Replied that it would be outlined in this bill that is what they would do. That is what the intent of this bill is, to allow them to get out from underneath that limitation that this

practice act prevents them from doing now. Because of those two things they can't work at night.

Senator Dever - Said they are also a respiratory therapist.

Senator G. Lee - Said some of them aren't.

Senator Warner - Is there any section of the bill that defines the make up of the board.

Senator G. Lee - Replied yes there is.

(meter #2250)

Rickson - Medcenter One- Proposed amendment, see attachment 2. He went through his amendment.

(meter #2478)

Rickson - He said he has some specific concerns with Section 7 that is proposed by Senator G. Lee.

(meter #2586)

Lana Kurl - Concerned with representation on the board and being involved in the rules process.

Senator Lyson - Asked if we were to put an amendment of Sen. G. Lee's amendments to find a place on the board these amendments could disappear.

Kurl - Said yes its a start.

Senator Lyson - Asked what the make up of the board is.

Kurl - Replied, 7 members - 2 lay persons, a physician, and 2 registered respiratory therapists, 2 cetified respiratory therapists, and a chairman..

Senator Dever - Asked if there is a state organization of polysom techs.

Kurl - Said it has been attempted but has had only one meeting. Hasn't been real supportive.

Senator Dever - Asked how many polysom techs are not respiratory therapists.

Kurl - Replied, 10 that could practice in the state if they had licensure, 40-50 that practicing.

Senator Warner - Refrerred back to subsection 7. Asked what the nature of the supervision is.

Kurl - There is no direct supervision, however the medical director is available through a phone call or emergency medicine. It would not help to use a respiratory therapist because they are not trained in sleep medicine. Direct supervision could be a physician which has worked for 20 years.

They also have a house supervisor that is available, who is a RN.

(meter #3240)

Senator Brown - Asked how much of the original bill would survive under Senator Lee's amendment.

Response - None, it is a hoghouse.

The committee discussed amendments and the supervision needed plus how the rule making would take care of most of this.

(meter #3539)

Senator Warner - Moved the amendment, 02- 03.

Senator Dever - Seconded.

Senator Warner - Asked to further amend, he has prepared an amendment which deals with Allied Health Professions. Mr. Ricksons's amendment contains a section dealing with that.

Discussed his amendment, see attachment 3.

Committee talked of combining amendments or adding a study resolution.

Senator Warner's amendment would replace one laymember of the board with a polysom tech and the board would remain the same size. Also discussed whether bringing on a polysom tech on the board temporarily until expiration of a lay person. The Respiratory Care Board members expiration dates are: Gerry Boyer 9/06, Judy Fossum 9/06, Amy Inger RT 9/06, Galen M. 9/07, Alan Nicholson RT, Chair, 9/05, Dr. Palo 9/07.

Senator J. Lee - Stated since there isn't a lay person vacancy, should they add a polysom tech temporarily to the board until an opening occurs. From that point on a polysom tech will be a member of the board, and one lay member.

(meter #5195)

Voted on Amendment 02-03, do pass.

Senator Warner move amendment

Senator Dever - seconded

Voted do pass

Senator Brown moved amended bill

Senator Dever seconded

Voted do pass amended bill

Senator Lee will carry

(meter #5742)

Prepared by the Legislative Council staff for
Senator G. Lee
March 21, 2005

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1280

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 43-42 of the North Dakota Century Code, relating to licensure of polysomnographic technologists; and to amend and reenact sections 43-42-01 and 43-42-03 of the North Dakota Century Code, relating to licensure of registered polysomnographic technologists.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 43-42-01 of the North Dakota Century Code is amended and reenacted as follows:

43-42-01. Definitions. In this chapter, unless the context otherwise requires:

1. "Board" means the state board of respiratory care.

2. "Bona fide respiratory care training program" means a program of respiratory care education which is accredited by the commission on accreditation of allied health educational programs, or the commission's successor organization.

3. "Certification examination" means the entry level examination for respiratory therapists administered by the national board for respiratory care.

4. "Certified respiratory therapist" means a person licensed by the board to practice respiratory care under the direction or supervision of a physician or registered respiratory therapist.

5. "National board for respiratory care" means the body issuing credentials for the respiratory care profession, or the board's successor organization.

6. "Polysomnography" means the practice of attending, monitoring, and recording physiologic data during sleep for the purpose of identifying and assisting in the treatment of sleep-wake disorders.

7. "Registered polysomnographic technologist" means an individual licensed by the board to practice polysomnography under supervision as prescribed by the board by rule.

8. "Registered respiratory therapist" means a person licensed by the board to practice respiratory care.

~~7.~~ 9. "Registry examination" means the advanced level examination for respiratory therapists administered by the national board for respiratory care.

~~8.~~ 10. "Respiratory care" means the health specialty involving the treatment, management, control, and care of patients with deficiencies and abnormalities of the cardiorespiratory systems. Respiratory care is implemented on an order from a licensed physician, and includes the use of medical gases, air and oxygen administering apparatuses, environmental control systems, humidification and aerosols, drugs and

medications, apparatuses for cardiorespiratory support and control, postural drainage, chest percussion and vibration and breathing exercises, pulmonary rehabilitation, assistance with cardiopulmonary resuscitation, maintenance of natural and artificial airways, and insertion of artificial airways. The term also includes testing techniques to assist in diagnosis, monitoring, treatment, and research, including the measurement of cardiorespiratory volumes, pressures and flows, and the drawing and analyzing of samples of arterial, capillary, and venous blood.

~~9.~~ 11. "Respiratory therapist" means a certified respiratory therapist or a registered respiratory therapist.

~~10.~~ 12. "Respiratory therapy" means respiratory care.

~~11.~~ 13. "Temporary respiratory therapist" means any individual who has successfully completed a bona fide respiratory care training program and is licensed by the board to practice respiratory care under the supervision or direction of either a physician, certified respiratory therapist, or registered respiratory therapist.

SECTION 2. AMENDMENT. Section 43-42-03 of the North Dakota Century Code is amended and reenacted as follows:

43-42-03. Respiratory therapist and polysomnographic technologist licensing - Fees.

1. The board shall license as a registered respiratory therapist any applicant whom the board determines to be qualified to perform the duties of a registered respiratory therapist. In making this determination, the board shall require evidence that the applicant has successfully completed a bona fide respiratory care training program and has passed the registry examination. The board shall establish fees not in excess of one hundred dollars for the issuance and renewal of a registered respiratory therapist license.

2. The board shall license as a certified respiratory therapist any applicant whom the board determines to be qualified to perform the duties of a certified respiratory therapist. In making this determination, the board shall require evidence that the applicant has successfully completed a bona fide respiratory care training program and has passed the certification examination. The board shall establish fees not in excess of seventy dollars for the issuance and renewal of a certified respiratory therapist license.

3. The board shall license as a temporary respiratory therapist any applicant whom the board determines to be qualified to perform duties as a temporary respiratory therapist. In making this determination, the board shall require evidence that the applicant has successfully completed a bona fide respiratory care training program. The board shall establish fees not in excess of seventy dollars for the issuance of a temporary respiratory therapist license.

4. The board shall license as a registered polysomnographic technologist any applicant whom the board determines to be qualified to perform the duties of a registered polysomnographic technologist. In making this determination, the board shall require evidence that the applicant has complied with the rules adopted by the board under section 3 of this Act. The board shall establish fees not in excess of seventy dollars for issuance and for renewal of a registered polysomnographic technologist license.

5. The board may assess a late fee not in excess of twenty-five dollars for all license renewal applications that are postmarked after December thirty-first of the year prior to the year of renewal.

~~5.~~ 6. The board shall refuse to license any applicant or shall suspend or revoke any license after proper notice and a hearing, if the applicant:

a. Is not qualified or competent to perform the duties of a registered respiratory therapist, a certified respiratory therapist, ~~or~~ a temporary respiratory therapist, or a registered polysomnographic technologist.

b. Has attempted to obtain or has obtained licensure under this chapter by fraud or material misrepresentation.

c. Has been found by the board to have been grossly negligent as a registered respiratory therapist, certified respiratory therapist, ~~or a~~ temporary respiratory therapist, or registered polysomnographic technologist.

d. Has engaged in conduct as a registered respiratory therapist, certified respiratory therapist, ~~or a~~ temporary respiratory therapist, or registered polysomnographic technologist which is unethical, unprofessional, or detrimental to the health of the public.

e. Has failed to demonstrate satisfactory completion of such continuing courses of study in respiratory care as the board may require.

f. Has been convicted or adjudged guilty of an offense, as defined by section 12.1-01-04, determined by the board to have a direct bearing upon that individual's ability to practice respiratory care and is not sufficiently rehabilitated as determined by the board in accordance with section 12.1-33-02.1.

g. Is habitually drunk or is addicted to the use of a controlled substance as defined in chapter 19-03.1.

h. Has been declared mentally incompetent by a court of competent jurisdiction, and who has not thereafter been lawfully declared competent.

~~6.~~ 7. The board may impose a fee on any person subject to regulation under this chapter to reimburse the board for all or part of the costs of administrative actions resulting in disciplinary action, which are not reversed on appeal, including the amount paid by the board for services from the office of administrative hearings, attorney's fees, court costs, witness fees, staff time, and other expenses.

~~7.~~ 8. Licenses issued under this chapter expire annually, but may be renewed upon application to the board and payment of the annual renewal fee established by the board. Licenses which have expired, been suspended, or been revoked may be renewed or reissued upon satisfaction of any conditions that may be established by the board, and after payment of a fee established by the board. Temporary licenses may not be renewed.

~~8.~~ 9. The board shall require as a condition of renewal and relicensure that the applicant demonstrate satisfactory completion of continuing courses of study in respiratory care.

SECTION 3. A new section to chapter 43-42 of the North Dakota Century Code is created and enacted as follows:

Polysomnography practice.

1. After December 31, 2005, a person may not practice, nor represent that the person is able to practice, polysomnography unless licensed under this chapter as a registered polysomnographic technologist. A registered polysomnographic technologist may not practice respiratory care except as may be authorized by rules adopted by the board. A registered polysomnographic technologist is limited in practice to polysomnography within the scope of practice and limitations as provided by rules adopted by the board.

2. The board shall adopt rules regulating registered polysomnographic technologists and establishing the scope of practice of a registered polysomnographic technologist. The rules may include requirements for examination requirements for licensure, education requirements for licensure, continuing courses of study in polysomnography, and student practice.

3. This section does not prohibit a respiratory therapist from practicing respiratory care."

Renumber accordingly

Date: 3-22-05
Roll Call Vote #: 1

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1280

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass amendment 0203 (plus ';' comma)

Motion Made By Sen Warner Seconded By Sen Dever

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee - Chairman	✓		Sen. John Warner	✓	
Sen. Dick Dever - Vice Chairman	✓				
Sen. Richard Brown	✓				
Sen. Stanley Lyson	✓				

Total (Yes) 5 No Ø

Absent

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Attachment 3

50349.0201
Title.

Prepared by the Legislative Council staff for
Senator Warner
March 18, 2005

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1280

Page 1, line 3, after "therapy" insert "; and to provide for a legislative council study"

Page 2, after line 23, insert:

"**SECTION 2. ALLIED HEALTH PROFESSIONS BOARD - LEGISLATIVE COUNCIL STUDY.** The legislative council shall consider studying, during the 2005-06 interim, the feasibility and desirability of creating an allied health professions board to regulate the practice of members of allied health professions such as acupuncturists and sleep therapists. The study must include consideration of the feasibility and desirability of a North Dakota allied health professions board entering joint professional licensure agreements with neighboring states. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixtieth legislative assembly."

Renumber accordingly

Date: 3-22
Roll Call Vote #: 2

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. AB 1280

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Further amend 0201 + adopt of 1 pkg ontd on

Motion Made By Sen Warner Seconded By Sen Dever

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee - Chairman	✓		Sen. John Warner	✓	
Sen. Dick Dever - Vice Chairman	✓				
Sen. Richard Brown	✓				
Sen. Stanley Lyson	✓				

Total (Yes) 5 No 0

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 3-22-05
Roll Call Vote #: 3

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB1280

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass Move Amended Bill

Motion Made By Sen Brown Seconded By Sen Dever

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee - Chairman	✓		Sen. John Warner	✓	
Sen. Dick Dever - Vice Chairman	✓				
Sen. Richard Brown	✓				
Sen. Stanley Lyson	✓				

Total (Yes) 5 No 0

Absent 1

Floor Assignment Sen. J. Lee

If the vote is on an amendment, briefly indicate intent:

Date: 3-22-05
Roll Call Vote #: 4

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1280

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Move to reconsider amendment

Motion Made By Sen Brown Seconded By Sen Dever

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee - Chairman			Sen. John Warner		
Sen. Dick Dever - Vice Chairman					
Sen. Richard Brown					
Sen. Stanley Lyson					

Total (Yes) No

Absent

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Voice.

Date: 3-22-05
Roll Call Vote #: 5

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1280

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass add emergency clause

Motion Made By Warner Seconded By D

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee - Chairman	✓		Sen. John Warner	✓	
Sen. Dick Dever - Vice Chairman	✓				
Sen. Richard Brown	✓				
Sen. Stanley Lyson	✓				

Total (Yes) 5 No Ø

Absent

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 3-22-05
Roll Call Vote #: 6

2005 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1280

Senate **Human Services** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass as amended

Motion Made By Sen Dever Seconded By Sen Lyson

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee - Chairman	✓		Sen. John Warner	✓	
Sen. Dick Dever - Vice Chairman	✓				
Sen. Richard Brown	✓				
Sen. Stanley Lyson	✓				

Total (Yes) 5 No Ø

Absent Ø

Floor Assignment Sen. J Lee

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1280, as engrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (5 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1280 was placed on the Sixth order on the calendar.

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact a new section to chapter 43-42 of the North Dakota Century Code, relating to licensure of polysomnographic technologists; to amend and reenact section 43-42-01, subsection 2 of section 43-42-02, and section 43-42-03 of the North Dakota Century Code, relating to licensure of registered polysomnographic technologists; to provide for a legislative council study; to provide an effective date; to provide an expiration date; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 43-42-01 of the North Dakota Century Code is amended and reenacted as follows:

43-42-01. Definitions. In this chapter, unless the context otherwise requires:

1. "Board" means the state board of respiratory care.

2. "Bona fide respiratory care training program" means a program of respiratory care education which is accredited by the commission on accreditation of allied health educational programs, or the commission's successor organization.

3. "Certification examination" means the entry level examination for respiratory therapists administered by the national board for respiratory care.

4. "Certified respiratory therapist" means a person licensed by the board to practice respiratory care under the direction or supervision of a physician or registered respiratory therapist.

5. "National board for respiratory care" means the body issuing credentials for the respiratory care profession, or the board's successor organization.

6. "Polysomnography" means the practice of attending, monitoring, and recording physiologic data during sleep for the purpose of identifying and assisting in the treatment of sleep-wake disorders.

7. "Registered polysomnographic technologist" means an individual licensed by the board to practice polysomnography under supervision as prescribed by the board by rule.

8. "Registered respiratory therapist" means a person licensed by the board to practice respiratory care.

~~7.~~ 9. "Registry examination" means the advanced level examination for respiratory therapists administered by the national board for respiratory care.

~~8.~~ 10. "Respiratory care" means the health specialty involving the treatment, management, control, and care of patients with deficiencies and abnormalities of the cardiorespiratory systems. Respiratory care is

implemented on an order from a licensed physician, and includes the use of medical gases, air and oxygen administering apparatuses, environmental control systems, humidification and aerosols, drugs and medications, apparatuses for cardiorespiratory support and control, postural drainage, chest percussion and vibration and breathing exercises, pulmonary rehabilitation, assistance with cardiopulmonary resuscitation, maintenance of natural and artificial airways, and insertion of artificial airways. The term also includes testing techniques to assist in diagnosis, monitoring, treatment, and research, including the measurement of cardiorespiratory volumes, pressures and flows, and the drawing and analyzing of samples of arterial, capillary, and venous blood.

~~9.~~ 11. "Respiratory therapist" means a certified respiratory therapist or a registered respiratory therapist.

~~10.~~ 12. "Respiratory therapy" means respiratory care.

~~11.~~ 13. "Temporary respiratory therapist" means any individual who has successfully completed a bona fide respiratory care training program and is licensed by the board to practice respiratory care under the supervision or direction of either a physician, certified respiratory therapist, or registered respiratory therapist.

SECTION 2. AMENDMENT. Subsection 2 of section 43-42-02 of the North Dakota Century Code is amended and reenacted as follows:

2. The board consists of ~~seven~~ eight members appointed by the governor. Four members must be respiratory therapists, chosen from a list of eight respiratory therapists supplied to the governor by the North Dakota society for respiratory care. One member must be a physician chosen from a list of two physicians supplied to the governor by the North Dakota medical association. The governor shall appoint two members to be representatives of the general public. One member must be a registered polysomnographic technologist chosen from a list of candidates recommended to the governor by the association of polysomnographic technologists. Members are appointed for terms of three years. Each member holds office until the member's successor is duly appointed and qualified. A vacancy in the office of any member may be filled for the unexpired term only. No member may serve more than two successive complete terms.

SECTION 3. AMENDMENT. Subsection 2 of section 43-42-02 of the North Dakota Century Code is amended and reenacted as follows:

2. The board consists of seven members appointed by the governor. Four members must be respiratory therapists, chosen from a list of eight respiratory therapists supplied to the governor by the North Dakota society for respiratory care. One member must be a physician chosen from a list of two physicians supplied to the governor by the North Dakota medical association. The governor shall appoint two members one member to be representative a representative of the general public. One member must be a registered polysomnographic technologist chosen from a list of candidates recommended to the governor by the association of polysomnographic technologists. Members are appointed for terms of three years. Each member holds office until the member's successor is duly appointed and qualified. A vacancy in the office of any member may

be filled for the unexpired term only. No member may serve more than two successive complete terms.

SECTION 4. AMENDMENT. Section 43-42-03 of the North Dakota Century Code is amended and reenacted as follows:

43-42-03. Respiratory therapist and polysomnographic technologist **licensing - Fees.**

1. The board shall license as a registered respiratory therapist any applicant whom the board determines to be qualified to perform the duties of a registered respiratory therapist. In making this determination, the board shall require evidence that the applicant has successfully completed a bona fide respiratory care training program and has passed the registry examination. The board shall establish fees not in excess of one hundred dollars for the issuance and renewal of a registered respiratory therapist license.

2. The board shall license as a certified respiratory therapist any applicant whom the board determines to be qualified to perform the duties of a certified respiratory therapist. In making this determination, the board shall require evidence that the applicant has successfully completed a bona fide respiratory care training program and has passed the certification examination. The board shall establish fees not in excess of seventy dollars for the issuance and renewal of a certified respiratory therapist license.

3. The board shall license as a temporary respiratory therapist any applicant whom the board determines to be qualified to perform duties as a temporary respiratory therapist. In making this determination, the board shall require evidence that the applicant has successfully completed a bona fide respiratory care training program. The board shall establish fees not in excess of seventy dollars for the issuance of a temporary respiratory therapist license.

4. The board shall license as a registered polysomnographic technologist any applicant whom the board determines to be qualified to perform the duties of a registered polysomnographic technologist. In making this determination, the board shall require evidence that the applicant has complied with the rules adopted by the board under section 5 of this Act. The board shall establish fees not in excess of seventy dollars for issuance and for renewal of a registered polysomnographic technologist license.

5. The board may assess a late fee not in excess of twenty-five dollars for all license renewal applications that are postmarked after December thirty-first of the year prior to the year of renewal.

~~5.~~ 6. The board shall refuse to license any applicant or shall suspend or revoke any license after proper notice and a hearing, if the applicant:

   a. Is not qualified or competent to perform the duties of a registered respiratory therapist, a certified respiratory therapist, ~~or~~ a temporary respiratory therapist, or a registered polysomnographic technologist.

   b. Has attempted to obtain or has obtained licensure under this chapter by fraud or material misrepresentation.

c. Has been found by the board to have been grossly negligent as a registered respiratory therapist, certified respiratory therapist, ~~or a~~ temporary respiratory therapist, or registered polysomnographic technologist.

d. Has engaged in conduct as a registered respiratory therapist, certified respiratory therapist, ~~or a~~ temporary respiratory therapist, or registered polysomnographic technologist which is unethical, unprofessional, or detrimental to the health of the public.

e. Has failed to demonstrate satisfactory completion of such continuing courses of study in respiratory care as the board may require.

f. Has been convicted or adjudged guilty of an offense, as defined by section 12.1-01-04, determined by the board to have a direct bearing upon that individual's ability to practice respiratory care and is not sufficiently rehabilitated as determined by the board in accordance with section 12.1-33-02.1.

g. Is habitually drunk or is addicted to the use of a controlled substance as defined in chapter 19-03.1.

h. Has been declared mentally incompetent by a court of competent jurisdiction, and who has not thereafter been lawfully declared competent.

~~6.~~ 7. The board may impose a fee on any person subject to regulation under this chapter to reimburse the board for all or part of the costs of administrative actions resulting in disciplinary action, which are not reversed on appeal, including the amount paid by the board for services from the office of administrative hearings, attorney's fees, court costs, witness fees, staff time, and other expenses.

~~7.~~ 8. Licenses issued under this chapter expire annually, but may be renewed upon application to the board and payment of the annual renewal fee established by the board. Licenses which have expired, been suspended, or been revoked may be renewed or reissued upon satisfaction of any conditions that may be established by the board, and after payment of a fee established by the board. Temporary licenses may not be renewed.

~~8.~~ 9. The board shall require as a condition of renewal and relicensure that the applicant demonstrate satisfactory completion of continuing courses of study in respiratory care.

SECTION 5. A new section to chapter 43-42 of the North Dakota Century Code is created and enacted as follows:

Polysomnography practice.

1. After December 31, 2005, a person may not practice, nor represent that the person is able to practice, polysomnography unless licensed under this chapter as a registered polysomnographic technologist. A registered polysomnographic technologist may not practice respiratory care except as may be authorized by rules adopted by the board. A registered polysomnographic technologist is limited in practice to polysomnography

within the scope of practice and limitations as provided by rules adopted by the board.

2. The board shall adopt rules regulating registered polysomnographic technologists and establishing the scope of practice of a registered polysomnographic technologist. The rules may include requirements for examination requirements for licensure, education requirements for licensure, continuing courses of study in polysomnography, and student practice.

3. This section does not prohibit a respiratory therapist from practicing respiratory care.

SECTION 6. ALLIED HEALTH PROFESSIONS BOARD - LEGISLATIVE COUNCIL STUDY. The legislative council shall consider studying, during the 2005-06 interim, the feasibility and desirability of creating an allied health professions board to regulate the practice of members of allied health professions. The study must include consideration of the feasibility and desirability of a North Dakota allied health professions board entering joint professional licensure agreements with neighboring states. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixtieth legislative assembly.

SECTION 7. EFFECTIVE DATE. Section 3 of this Act becomes effective on October 1, 2006.

SECTION 8. EXPIRATION DATE. Section 2 of this Act is effective through September 30, 2006, and after that date is ineffective.

SECTION 9. EMERGENCY. Section 2 of this Act is declared to be an emergency measure."

Renumber accordingly

2005 TESTIMONY

HB 1280

(1) HB 1280
1/18/05

Polysomnographic Technologists
(Sleep Study Technologists)

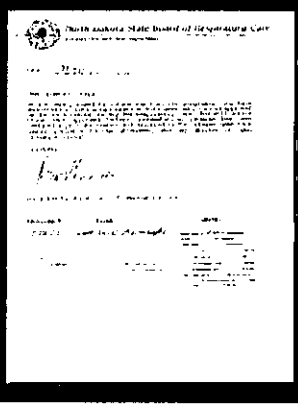
The knowledge & skills needed.
How the are applied.
How they are acquired.
Recent professional developments and why HB1280 is important.

Lana Curl

Director of Sleep Center in Bismarck
Worked in Sleep Medicine for 20 years
1997 Board Certified by the Association of Polysomnographic Technologists (RPSGT)
1986 Graduated from Anoka Vocational Technical Institute with an Electroneurodiagnostic Degree
1988 Completed Stanford University's Clinical Polysomnography course
NDBRC Approved Workshop Presenter in 2001 and 2003

Lana Curl

Workshop presenter for U. S. Senator Dorgan's Women's Health, Women's Lives Conference 2003
North Dakota DOT Wellness Clinic Screener 2004-2005
Partner of the National Sleep Foundation
Organizer of the North Dakota Sleep Professional Society 2004



Sleep Medicine

A young specialty for both physicians and technologists.

- Doctors backgrounds: Pulmonary Medicine, Neurology, ENT, and Psychology
- Sleep technologist backgrounds: respiratory therapy techs, neurodiagnostic techs,nursing, computers
- Beginning in 2003 there were accredited training programs for exclusively for sleep technologists

Sleep Medicine, Neurodiagnostics and Respiratory Therapy are now recognized as unique professional specialties.

Each specialty practitioner must master a distinct body of knowledge and skill.

Sometimes where there seems to be commonality, the application is markedly different. This was the motivating focus of HB1280.

Neurodiagnostic Technologist	Sleep Technologist	Respiratory Therapist
	diagnostic polysomnograms	
	therapeutic polysomnograms	
	multiple sleep latency tests	
	maintenance of wakefulness test	
	parasomnia studies	
	esophageal pressure monitoring	
	penile tumescence testing	
	seizure recording	
	CPAP/BiLEVEL titration	**Use very**
	Oxygen titration	**differently**
	Collect, analyze, & integrate sleep patient information	Basic overview
	Prepare & calibrate sleep equipment	
	Apply electrodes & sensors per established standards	
	Instrumentation proficiency	
	Polysomnogram procedures	
Limited	Comprehensive knowledge base of 84 sleep disorders	Limited
	Scoring of studies	
	Electrical safety	

A Closer Look

Neurodiagnostic Technologist	Sleep Technologist	Respiratory Therapist
	CPAP/BiLEVEL titration	Use very
	Oxygen titration	differently

CPAP/O2 THERAPY

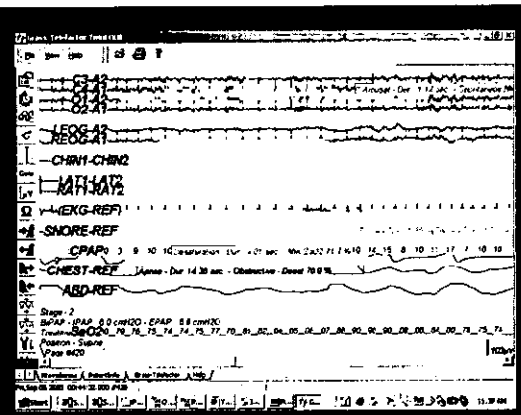
SLEEP MEDICINE	RESPIRATORY THERAPY
Upper airway obstruction problems causing sleep apnea	Pulmonary (lung) problems
Identification of proper levels for chronic management	Inpatient, often critical care, management of acute hypoxia

Sleep Center Testing

Evaluation
Monitoring & Continuous Assessment

Simultaneous Monitoring

- EKG
- EEG
- Snoring
- Movements
- Position
- Oxygen levels
- Respirations



Intra-Test Assessment/ Therapeutic Trials

Sleep Study duration 6-9 hours
Diagnostic/Therapeutic Intervention
Ongoing analysis

Post-Test Analysis

800 pages of information
Technologists score data
- Take 2-3 hours to review all the data
- Use a national standardized scoring manual
- Standardize guidelines, per Medicare and professional standards

Physician interpretation

Sleep Apnea Treatment

- CPAP/Bi-level
- Surgery
- Weight loss
- Dental appliances
- Position management
- Medications

Sleep Disorders

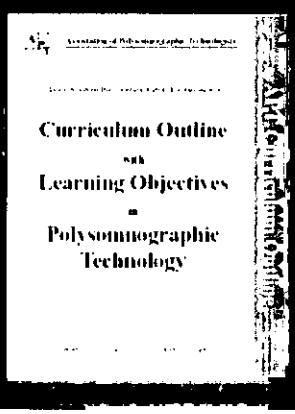
- Sleep apnea
- REM Behavior Disorders
- Nocturnal Seizures
- Narcolepsy
- Parasomnias
- Shift Work
- Insomnia

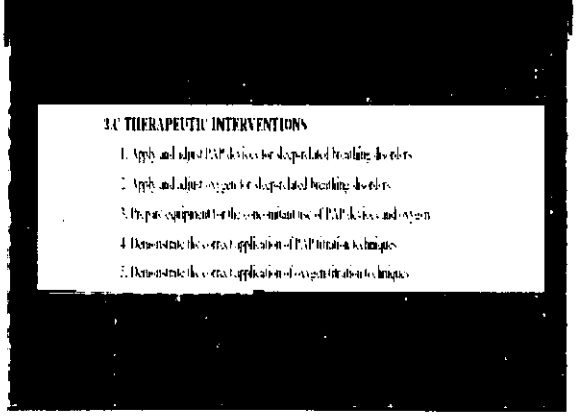
Historical Entry into the Profession

- On-the-Job Training.
- Complete education and training as a respiratory therapist or a neurodiagnostic technologist then take some additional sleep study training to cover areas not included in these programs.
- 2003 was a new beginning.

Achieved Recognition as a Unique Specialty

- April 2003 from the **Commission on Accreditation of Allied Healthcare Educational Programs**
- Created a Committee on Accreditation for Polysomnography (CoASPSG) 2004
- Approved as sponsoring organizations
  - American Academy of Sleep Medicine
  - Board of Registered Polysomnographic Technologists


Curriculum Outline
on
Learning Objectives
for
Polysomnographic
Technology


3.C THERAPEUTIC INTERVENTIONS

1. Apply and adjust PAP devices for sleep-related breathing disorders
2. Apply and adjust oxygen for sleep-related breathing disorders
3. Prepare equipment for the administration of PAP devices and oxygen
4. Demonstrate the correct application of PAP titration techniques
5. Demonstrate the correct application of oxygen titration techniques

Accredited Programs

Stand-a-lone programs

Electroneurodiagnostic or respiratory care programs that fully incorporate the sleep study CoPSG curriculum in their training

Electroneurodiagnostic programs that have add-on-programs for either neurodiagnostic technologists or respiratory therapy technologists to become trained as polysomnographic technologists

Currently, no ND colleges have this accreditation

Clinical Summary

Sleep medicine is a unique specialty

- It uses some of the knowledge and skills of neurodiagnostics and respiratory therapy.
- but often applies them quite differently
- It has its own body of knowledge

Neither a neurodiagnostic technologist nor a respiratory therapist is qualified to be a polysomnographic technologist without further training

Medicare Position

Medicare recognizes the RPSGT credential as a qualification for performing polysomnography.

Conclusion

The North Dakota State Board of Respiratory Care has asked me to seek a legislative change to address the issue of licensure

The Board desired that we ask for licensure of polysomnography techs

Exemption for RPSGTs from the NDCC Respiratory Care Act was the strongest recommendation from various representatives of the 3 branches of ND government

By virtue of knowledge, skills, training, education and experience, passing HB1280 will allow qualified RPSGTs to continue to practice their profession. Sleep Medicine is an evolving and expanding field, and it is important to recognize this aspect so ND patients are not adversely impact by restricting the availability, safety, and quality of Sleep Studies.

Discussions or Questions

Medcenter One

Members of The North Dakota State House of Representatives:

We ask for your support of House Bill 1280.

Make no mistake about this bill, it is intended to limit the practice of sleep medicine to qualified professionals. If your concern is patient safety, then vote in favor of House Bill 1280. Currently, there is nothing in statute that refers in any way to sleep medicine. If this bill fails, we revert to the status quo…where there is absolutely no mention of this specialty or those who can practice it. This exemption offers two things: 1) It recognizes in the Century Code this new and growing field of sleep medicine. 2) It provides that only qualified specialists will be allowed to practice sleep medicine. With this legislation, you can rest assured that the practice of sleep medicine will be left to professionals (Sleep Technologists or Respiratory Therapists) who will be supervised by physicians who are trained and/or privileged in sleep medicine.

Registered Polysomnographic Technologists are recognized professionals. They are specialists in sleep medicine. To protect the safety of patients in the coming years of sleep technology, we need to assure that these professionals are allowed to practice in North Dakota. This bill will simply allow these professionals to do what they are trained to do.

We hope you will follow the recommendation of the Human Services Committee and vote yes on House Bill 1280.

Thank You,

Janelle Johnson

Director of Public Policy and Community Development

Excellence • Service • Respect • Caring

Janelle Kay Johnson

Public Policy and Community Development Director

701-323-8745

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Bismarck, ND 58506-552

Telephone: 701-323-6000

Website: medcenterone.com

#2 HB 1280
1/18/05

Madam Chairman, Members of the House Human Services Committee.

I am here this morning in support for HB1280 which will enable all qualified polysomnographers to practice their profession. I think it would be helpful to you to know a bit about my clinical background and experiences.

I am a cardiothoracic surgeon who has had the good fortune of working with excellent respiratory therapists – many before their profession was recognized as a new specialty. These allied health professionals were great with ventilator and oxygen therapy for my acutely ill patients. Because I could rely on them to provide good care, I had additional time to devote to other patient care concerns. The quality of practice of many fields of medicine would be diminished with out their active participation in the health care team.

Now a new allied health profession which grew from the expanded practices of respiratory therapy technicians and neurodiagnostic technologists has matured to the point where it deserves equal recognition. This is not just my opinion. It is shared by those responsible for ensuring that qualified allied health professionals are graduated from accredited educational programs. As a result of relatively new accreditation standards, there are now 3 ways for students to complete an accredited educational program and enter the profession of polysomnography.

In April 2003, The Committee on Accreditation of Allied Health Education Programs (CAAHEP) recognized the need for having educational programs that provide training only in this field. Therefore CAAHEP, which oversees the Committee on Accreditation for Respiratory Care, created a new committee, the Committee on Accreditation of Polysomnography (CoAPSG). It mandated that by Oct 2003, the CoAPSG establish minimum standards of quality to be used in accreditation of programs that prepare individuals to enter the polysomnography technology profession. The CoAPSG was directed to incorporate the standardized educational materials for teaching and assessing polysomnography that had been developed by the Association of Polysomnographic Technologists.

Also, the 2003 accreditation standards for Respiratory Therapy programs include a Respiratory Care/Polysomnography "specialty" accreditation option for those schools that wish to graduate respiratory therapists who are qualified to practice both specialties. It states that additional units, modules and courses of instruction may be appropriate including 14 that are on focused polysomnographic technology, supplemental oxygen therapy, and positive airway pressure titration. The last two are included because use of these last two treatments in sleep medicine patients is different than it is for patients with acute respiratory failure. Finally, the 2002 accreditation standards for Neurodiagnostic Technician schools contain similar requirements for schools to have a specialization in polysomnography.

Based on my experience as a member of the Accreditation Review Committee on Education for the Physician Assistant, this doesn't mean that these additional topics are optional, but that a school may already incorporate some or all of the topics in addition to what is required for a standard respiratory therapy or neurodiagnostic program. This is like the situation where some physician's assistants programs were designed to train assistants for surgeons. When we incorporated requirements for a physician's assistant program to achieve accreditation with specialization as a surgeon's assistant, the surgical assistant programs had already incorporated many of the requirements in their curriculum.

These standards ensure that students will learn how to interpret the information appropriately depending upon whether they are providing the physician assistance in caring for a patient with acute respiratory failure or one with a chronic sleep problem.

The differences in applying standards from one situation to another can mean as much as life in one situation and death in another. [Tale of two girls.] Misapplying knowledge about how to handle acute

respiratory failure can lead to a recommendation that the patient have an unnecessary permanent tracheostomy(hole in the windpipe). This is at best a debilitating situation.

I now have executive responsibility for our sleep medicine center. We welcome respiratory therapists who are interested in becoming polysomnographers and would like to be able to welcome neurodiagnostic technologists who are similarly interested. When either of these professionals are hired, we send them for further training in polysomnography and place them in a probationary status for several months until they demonstrate, while under supervision, that they have acquired the necessary knowledge and skills to oversee sleep studies. We also require that they become Registered Polysomnographers.

HB1280 will allow us to hire a registered polysomnographer regardless of their background. I thank you for listening to my comments, and I request your support for this bill.

Judy E. Schwartz, MD, MPH, CPE
Vice President Surgical Services and Electronic Medical Record Informatics
Medcenter One Health Systems

North Dakota 59th Legislative Assembly
2005
House Bill No. 1280

January 18, 2005

Good Morning, Representatives,

My name is Will Beachey. I am on the Board of Directors for the North Dakota Society for Respiratory Care (NDSRC) as a delegate to the national organization. I am also director of the respiratory therapy educational program cosponsored by the University of Mary and St. Alexius Medical Center. On behalf of the Society, I speak in opposition to HB 1280, which would exempt polysomnography trainees with as little as six months of on-the-job experience from the Respiratory Therapy Practice Act. First, it is important to recognize that this practice act does not prevent *licensed, qualified* members of other healthcare professions from performing respiratory therapy duties—if such duties are consistent with the accepted standards of that individual's profession. The requirement for individuals to be *licensed* and *qualified* in this context can only be construed as reasonable. It is through nationally recognized educational accreditation and testing organizations, separate from professional membership organizations, that professions can legitimately claim that certain tasks and procedures are within their scope of practice. Such separate accrediting and testing organizations are clearly identified in the Respiratory Therapy Practice Act. HB 1280, however, proposes that the polysomnography scope of practice is simply the scope adopted by the Association of Polysomnographic Technologists, a professional membership association.

It is also important to recognize that the North Dakota legislature enacted the respiratory therapy licensure law because it realized the potential for great harm to its citizens if respiratory therapy practice is not regulated by the state. Part of that regulation mandates that respiratory therapists must be graduates of nationally accredited educational programs and credentialed by the nationally accredited respiratory therapy testing organization. The proposed exemption language in HB 1280, however, does not ask the state to regulate the respiratory therapy procedures that unlicensed polysomnography technicians and trainees would perform; instead, it seeks a blanket exemption from any state regulation or oversight for these individuals. HB 1280 does not propose an alternative licensure board for overseeing those who provide polysomnography services, nor does it propose a mechanism whereby they would document proficiency.

If enacted, HB 1280 would place vulnerable patients in the hands of unregulated personnel who may provide a wide range of health care services and procedures that are otherwise protected and regulated when practiced by licensed professionals. The potential for harm is not trivial. For this reason, the North Dakota Society for Respiratory Care opposes the enactment of this bill.

Respectfully submitted,

Will Beachey, PhD, RRT
North Dakota Society for Respiratory Care

HB-1280

Mr. Chairman,

Members of the House Human Services Committee,

For the record my name is Steven Rixen and I am a lobbyist for Medcenter One Health Systems. Thank you for letting me testify before you today about House Bill 1280. We are here today to urge your support for HB 1280 with the amendment recommended by Senator Gary Lee.

As Lana Curl has already demonstrated, Sleep Medicine is a relatively new and very specialized practice. We urge your support for this legislation because it will simply allow these professionals continue doing what they have been trained to do.

What I will do now is formally introduce Dr. Judy Schwarz to speak on Medcenter One Health System's behalf. She is much smarter than me, so I think it is appropriate for her to address this proposed legislation.

I will be happy to try and answer any of your questions, but I will most likely be yielding to Dr. Schwarz on the intricacies of sleep medicine.

Thank you

Steven Rixen
Medcenter One Health Systems

HB-1280 1/18/05

Mr. Chairman and Committee members my name is John Lund, I am a North Dakota licensed respiratory therapist (RRT), a registered polysomonographer (RPSGT), past President of the North Dakota Society for Respiratory Care and owner of a sleep diagnostic service, Precision Diagnostic Services in Fargo. Our company is the largest employer of Polysomnographic technologists in the state of North Dakota and the upper Midwest. I appreciate this opportunity to comment on HB 1280. As a provider of sleep diagnostic services two things are of highest importance: the first is to ensure the safety of patients being tested and the second is to ensure an appropriate diagnosis.

Polysomnograhic technology is an independent and distinct discipline. This has been substantiated with the acceptance of Polysomnographic technology into the Commission on Accreditation of Allied Health Education Programs (CAAHEP) system and with the approval of the Committee on Accreditation of Polysomnography (CoA-PSG) by CAAHEP. In addition, the Board of Registered Polysomnographic Technologists (BRPT) administers a comprehensive examination consistent with accepted credentialing standards that measures recognized competency levels for the Polysomnographic technologist.

Regarding safety related to the administration of Continuous Positive Airway Pressure I would like to share the following from The American Thoracic Society a Medical Section of the American Lung Association. In an official statement in the American Journal of Respiratory and Critical Care Medicine titled "Indications and Standards for Use of Nasal Continuous Positive Airway Pressure in Sleep Apnea Syndromes" they report that "CPAP is a safe, effective form of therapy with rare complications. There are no absolute contraindications." Although this is a relatively safe procedure it is important that only trained personnel are involved in placing and adjusting it on patients. The greater concern for the safety of patients is in the ability of the technician who may be working alone in the middle of the night with two patients to recognize uncommon life threatening events. The only way to ensure patient safety and the appropriate clinical response is to ensure that technicians are trained in healthcare and able to recognize serious events. This is an area where HB 1280 falls short in addressing, this is why we are opposed to the bill as written.

An online review yesterday of two respiratory training programs in the state reveals no mention of sleep course work. The past minutes of the North Dakota State Board of Respiratory Care reflect a manager of a respiratory care and sleep department in this state reporting his utilization of two excellent training schools that he has used to train his sleep personnel in Oregon and Atlanta. This seems appropriate for those respiratory therapists to get specialized training in sleep, because they generally don't get it in their training. What doesn't make sense is that the training program referenced in the state of Oregon has no faculty with a respiratory therapy background. Our company has a training program for sleep practitioners utilizing staff with both respiratory therapy and sleep credentials. Our program has been approved by the American Association for Respiratory Care continuing education and a citizen of the state of North Dakota could go through our program, be appropriately trained and not practice sleep in North Dakota.

The other thing that doesn't make sense is that the faculty in Oregon that is good enough to train our respiratory therapists in sleep can't practice sleep in the state North Dakota. We oppose HB 1280 as written but at the same time offer a solution which we feel will serve both professions. It is a relatively simple change. In Section 4 of this bill where it states: "This chapter does not prevent a licensed and qualified member of another health care prffoession from performing any of the duties of a registered respiratory therapist..."

We recommend changing the first sentence to read: "This chapter does not prevent a licensed ~~and~~ **OR** qualified member of another health care profession from performing any of the duties of a registered respiratory therapist...." Qualified is defined in the existing Respiratory Care Practice Act Section 105-02-01-06 (1) as "trained and possessing the credential issued by the recognized testing or certification body of the profession".

Having now had the opportunity to review Senator Gary Lee's amendment I would like to add the following to my previous testimony:
Senator Gary Lee' Proposed Amendment-

As written, this amendment is too restrictive. It will limit physicians practice, it limits health care access to the citizens of this state, and it limits our ability as a business in North Dakota. We employ more credentialed polysomnographers than all sleep practitioners combined in this state. PDS employs 15 Registered Polysomnographers of which 14 also hold a respiratory therapy credential and are licensed in this state. We still believe this bill is too restrictive. Should this amendment be made law today, there is currently only one institution in North Dakota where a Registered Polysomnographic Technologist could work. That is MeritCare in Fargo, the employer of Senator Lee.

MeritCare, in Fargo has the only American Academy of Sleep Medicine accredited facility in North Dakota. There are only five board certified sleep physicians in North Dakota and only one other who is board eligible. Three of those board certified sleep physicians are at one institution in Bismarck, one is in Fargo and one in Minot. There are only 4,000 board certified sleep physicians in the world. Also contradicting this amendment is the fact that the American Academy of Sleep Medicine, the accrediting body for sleep centers and laboratories, does not even require that technical staff in the laboratory hold the Registered Polysomnographic Technologist credential in order to attain accreditation.

We don't understand why Respiratory Care wants to regulate another profession. We oppose the amendment of Senator Lee and feel our proposed suggestion will allow qualified and credentialed sleep professions to practice in the state while ensuring the safety of North Dakota citizens without restricting access or economic activity.

Respectfully submitted,

John A. Lund, RPSGT, RRT

59th Legislative Assembly 2005
HB 1280

Dear Representatives;

I am a Registered Respiratory Therapist and the president-elect to the North Dakota Society for Respiratory Care. I am respectfully asking that you vote no on HB 1280, a bill that would allow sleep technicians to perform sleep studies exempt from the North Dakota Respiratory Therapy Licensure Law.

As a respiratory therapist, I am opposed to this bill because this will allow unlicensed and personnel not formally trained to perform diagnostic and therapeutic tests on patients and they only need to have a high school diploma or GED to perform the procedures and most importantly making them exempt from the licensure law does not protect the patient, they are not held accountable without licensure or regulated in some fashion.

I am not opposed however to the amendment proposed because the Registered Polysomnography Technologist has proven competent by gaining certification in the area of sleep and is being guided by a physician who is eligible to be certified by the American Board of Sleep Medicine and is working in a hospital setting accredited by JCAHO or the AASM.

Thank you for your time and consideration of my request.

Sincerly,

Karla Smith, RRT

Karla Smith, RRT

59th Legislative Assembly 2005
HB . 1280

Dear Representatives,

I am a physician certified by the American Board of Sleep Medicine and I respectfully ask that you vote no to HB 1280. This bill would allow sleep technicians to be exempt from the North Dakota Respiratory Therapy Licensure Law.

As a physician certified in sleep medicine, I am opposed to this bill because it will allow personnel without proper training or regulation to perform diagnostic and therapeutic testing on my patients. They would be able to apply therapy that I feel should only be applied and monitored by personnel who are competent and qualified to perform this therapy. This bill would also mandate that I or another one of my colleagues who are trained in sleep be supervising them while they tested.

I do however, approve of the amendment to the bill which would allow an RPSGT under the guidance of a physician certified in sleep in an accredited center or hospital. An RPSGT has worked in the field of sleep and has undergone training in sleep and is able to perform the duties during a sleep study and has proven competency by obtaining the RPSGT title.

I urge you to vote not to pass this bill as it is originally written but to pass with the proposed amendment. Passing the original bill would compromise the safety of patients by allowing persons not formally trained and formally proven competent performing diagnostic and therapeutic procedures on my patients. Approving the amendment would assure that the person performing the test is competent because of the title that they hold.

Thank you for considering my request.

Sincerely,

MD, FAASM.

SIRIWAN KRIENGKRAIRUT, MD, FAASM

59th Legislative Assembly 2005
HB 1280

Dear Representatives,

I am a physician certified by the American Board of Sleep Medicine and I respectfully ask that you vote no to HB 1280. This bill would allow sleep technicians to be exempt from the North Dakota Respiratory Therapy Licensure Law.

As a physician certified in sleep medicine, I am opposed to this bill because it will allow personnel without proper training or regulation to perform diagnostic and therapeutic testing on my patients. They would be able to apply therapy that I feel should only be applied and monitored by personnel who are competent and qualified to perform this therapy. This bill would also mandate that I or another one of my colleagues who are trained in sleep be supervising them while they tested.

I do however, approve of the amendment to the bill which would allow an RPSGT under the guidance of a physician certified in sleep in an accredited center or hospital. An RPSGT has worked in the field of sleep and has undergone training in sleep and is able to perform the duties during a sleep study and has proven competency by obtaining the RPSGT title.

I urge you to vote not to pass this bill as it is originally written but to pass with the proposed amendment. Passing the original bill would compromise the safety of patients by allowing persons not formally trained and formally proven competent performing diagnostic and therapeutic procedures on my patients. Approving the amendment would assure that the person performing the test is competent because of the title that they hold.

Thank you for considering my request.

Sincerely,

CHATREE WONGJIRAD, MD, FAASM

The NDSRC takes a formal statement opposing HB1280 for several important reasons:

- HB1280 provides exemption to current law that was enacted to ensure the safety of the people of North Dakota. This exemption opens many loop-holes that will surely permit unqualified individuals to provide healthcare services in an unregulated manner. The open-ended language in this proposed legislation is simply unacceptable. If enacted, this Bill would place vulnerable patients in the hands of unregulated personnel who may provide any range of healthcare services and procedures that are otherwise protected and regulated when practiced by licensed professionals.

- This Bill falls short in several key areas such as regulation, qualification, documentation of competence, and formal education - as evident in the language.

- This Bill proposed exemption: it does not ask for the State to regulate the occupation of polysomnography nor request licensure for them or even certification. Nor does it state that oversight of those providing polysomnography should be provided by an other licensed Board - in essence, they are asking for Curte Blache to provide services without being responsible to any other governing body. There will be no "watch dog" for these individuals. The claim is that they will take their ques from the APT, which is a professional membership association that represents the interest of the occupation - there is no stipulation that the Scope of Practice be based on education essentials required by accredited schools or programs. A professional membership association should not be able to declare that procedures and services are a part of a Scope of Practice just because they say so.

- Of great concern also is the definition of the trainee. Specifically, the statement - have completed one year of post-secondary education - in what? This definition means an individual could have a high school diploma or G.E.D. and then attend one year of college in a subject of said individual's choice with no minimum of proficient knowledge base requirement and is not legally eligible to perform procedures that require a Respiratory Therapist graduation from an accredited Respiratory Therapy educational program and the passing of a competency exam to do.

- HB1280 has many troubling loop-holes and questions as to who and what with no protection stipulated for the safety of the people of North Dakota.

For these and several other reasons that are found under careful scrutiny of this Bill it is the NDSRC's recommendation that this Bill be given a **DO NOT PASS!**

Respectfully Submitted,

Teri Ronglien

HB 1280

Chairman Price & members of the Committee, for the record, I am Gary Lee Senator, Senator from District 22.

I am here to speak in favor of the bill, if amended as proposed.

A polysomnograhic technologist performs sleep testing. HB 1280 if amended, will exempt a Registered Polysomnograhic technologist from the Respiratory Care Practice Act, if they work under the supervision of a physician board-eligible or a Diplomat of the American academy of sleep medicine and at a facility accredited by a national accrediting organization or other accrediting agency that is acceptable to the board.

I assumed State limited in function in Resp Therapy

Currently, these technologists, few in number (about 6) are not prohibited from working in ND, However they are limited in function by the Respiratory Care licensing law.

The original bill, as drafted, is overly broad, nonspecific and lacks the necessary provisions for supervision that should be required.

Sleep is an integral part of daily life. The lack of restorative sleep can have a profound effect on a person's over all health, productive capacity and general well being. Sleep medicine as a medical sub-specialiy is relatively new. Progress in the diagnosis & treatment of sleep disorders has grown up in the last 10 years in particular.

The "gold standard" for the diagnosis & treatment of sleep disorders is provided by a physician, Board Certified in Sleep Medicine, at a sleep center that is accredited by the American Academy of Sleep Medicine. This physician works with other health care professionals, not the least of which could be a polysomnograhic technologist.

There are about 7-9 facilities &/or private businesses providing some level of sleep medicine services or testing around the State. Most of these seek to provide quality work.

However, in my opinion, some have a more entrepreneurial spirit, taking advantage of the relative immaturity of the field. In these cases, inappropriate sleep studies are being generated too frequently and patients are being misdiagnosed and mistreated at a very expensive cost.

There is a need for more, high quality sleep medicine services in the State. But we first need to increase the number of qualified Doctors that have the training and expertise to provide and over see the kind of quality service these patients need, then support them with the appropriate staff. I believe we will start to see that happening over the next few years.

The amendment proposed would allow polysomonographers, with proper credential, the ability to provide services for which they have been competency tested. It outlines provisions for supervision & oversight by properly trained physicians. It would allow the growth in technologists to parallel the growth in trained physicians. This is the logical, orderly and correct way of moving forward in this field.

January 14, 2005

Honorable Legislators:

This letter is in support of HB 1280.

I am a registered sleep technologist and a registered respiratory therapist. I worked in clinical respiratory therapy for 22 years prior to making a career change to sleep medicine. I was trained on the job by a registered PSGT for three months, studied for an additional nine months, and then passed the exam to become a registered PSGT. As a respiratory therapist I needed additional training to learn and perform sleep studies.

I believe it is important to stress the difference between respiratory therapy and sleep medicine. Although both specialties use CPAP and oxygen, the application is very different. In respiratory therapy CPAP and oxygen are used mostly in acute situations decided by a physician. In sleep medicine CPAP and oxygen are used by the sleep technologist, who is trained to analyze sleep study data and use this knowledge to make the necessary decision in regards to this limited application.

I strongly encourage you to vote YES on this House Bill to ensure the quality of sleep medicine and patient care in North Dakota.

Sincerely,

Steven Vilness, RPSGT, RRT
New Salem, ND

Dear Legislators,

I am writing to provide support for bill # HB 1280.

The current guidelines that are in place for Respiratory Care Practitioners in the State of North Dakota prohibit Polysomnography Technologists in the State of North Dakota from performing within the scope of practice of their positions.

Polysomnography Technologists are experts in the field of sleep and are well trained in the application of the CPAP and bi-PAP devices that are frequently required to complete the therapeutic portion of a sleep study.

Among the staff members employed by Winmar Sleep Center in Fargo are a mix of Respiratory Care Practitioners, and Polysomnography Technologists. These two groups of employees have been proven to be equally qualified in the application of CPAP and bi-PAP.

Please consider supporting this bill that will allow Polysomnography Technologists to perform within their scope of practice.

Thank you for your consideration.

Kindest Regards,

Marcia Nelson

Marcia Nelson, CEO
Winmar Diagnostics
Sleep Wellness Center
Fargo, ND

Dear Honorable Legislators,

I am a registered sleep technologist with over six years of experience in PSG. I am writing in response to the sleep tech bill 1280. My degree is in electroneurodiagnostic technology with extensive training in EEG and also diagnostic and therapeutic PSG.

Neurodiagnostics is a strong backbone of PSG. Here are a few examples how: applying electrodes appropriately and precisely, understanding the instrumentation of the PSG recording, and being able to accurately acquire and read brain activity (or EEG) to differentiate all stages of sleep.

PSG is such a separate and distinct allied health profession. That is why knowledge, training, and experience are crucial for sleep techs no matter what background they come from.

I moved to the state of North Dakota in 1998 to advance my career in ENDT. Recently I left the state of ND to pursue other professional options in a state that doesn't have this issue.

Sincerely yours,

Kathryn Shuda

Lana Curl

From: "kristi kirkeby" <kristi.kirkeby@winmarsleep.com>
To: <lcurl@mohs.org>
Sent: Friday, January 14, 2005 1:51 PM
Subject: hb 1280

Dear Legislators, I am currently working as a registered polysomnography technician in the state of ND. Previously, I worked for 13 years as a respiratory therapy technician in 2 Fargo area hospitals. I have experience working with hospitalized patients in acute need of CPAP therapy to relieve respiratory distress. I have spent the last 10 years working with patients in the sleep lab, many of whom have been titrated on CPAP, for the treatment of Obstructive Sleep Apnea. I strongly support a measure allowing polysomnography technicians to apply CPAP to patients in the sleep lab. Patients in the lab are monitored very closely, including EEG, EOG, EMG, HR, RR, ECG, respiratory effort and flow, oxygen saturation, body position, and limb movements. During a sleep study, if a patient shows symptoms of obstructive sleep apnea, CPAP can be applied. CPAP therapy provides tremendous relief to these patients, allowing them to "really sleep", often times the same night they are diagnosed. Unlike patients being treated in a hospital setting, patients seen in the sleep lab are not suffering from acute respiratory distress. Obstructive Sleep Apnea is a chronic condition treated with CPAP therapy. Polysomnography technicians are well trained to initiate and titrate CPAP as needed to alleviate the symptoms of Obstructive Sleep Apnea.

Kristi Kirkeby CRCP, RPSGT

January 14, 2005

Honorable Legislators:

This letter is in support of HB 1280.

I am a specialist in Internal Medicine and Critical Care. I also have patients under my care that have breathing issues, such as sleep disorder breathing also known as sleep apnea. When necessary, I refer these patients to a sleep center for diagnostic and therapeutic testing. I must have faith the staff is qualified to do this testing. Although sleep technologists can come from a variety of educational backgrounds, I believe the designation of registered PSGT for the sleep technologists qualifies them to do this specialized testing.

I believe medical care in North Dakota is of the utmost importance, therefore I encourage passage of this amendment.

Sincerely,

Anthony Tello, M.D.

January 17, 2005

Honorable Legislators:

This letter is in support of HB 1280.

I am a specialist in Neurology and graduate of Standford University Sleep Course. I also have patients under my care that have sleep apnea or any of the other 88 different classification of sleep disorders. When necessary, I refer these patients to a sleep center for diagnostic and therapeutic testing. I must have faith the staff is qualified to do this testing. Although sleep technologists can come from a variety of educational backgrounds, I believe the designation of registered PSGT for the sleep technologists qualifies them to do this specialized testing.

I believe medical care in North Dakota is of the utmost importance, therefore I encourage passage of this amendment.

Sincerely,

Marco A. Benitez, M.D.

59TH LEGISLATIVE ASSEMBLY
2005

HOUSE BILL #1280
TESTIMONY IN OPPOSITION

My name is Pam Rangen. I am a licensed Registered Respiratory Therapist in the state of North Dakota. I am respectfully asking that you consider voting no on House Bill #1280, a bill that would allow exemption of polysomnographic technologists, technicians, and trainees from the North Dakota Respiratory Therapy Licensure Law. I oppose House Bill #1280 for the following reasons:

The language in House Bill #1280 does not provide a limited scope of practice for the polysomnographic technologists, technicians, and trainees. House Bill #1280 would allow individuals to provide any range of respiratory therapy services in any environment they choose without being regulated by the state of North Dakota.

This language in House Bill # 1280 will put North Dakota citizens who seek healthcare at risk. Currently the North Dakota Century Code Section 43-42-05 assures that the individuals who provide respiratory therapy services to the general public meet minimum competency requirements. The language in House Bill #1280 does not ensure this continued minimum competency requirement.

In conclusion, I believe House Bill #1280 sets a precedence in which any group of individuals wishing to practice any scope of currently regulated healthcare services the opportunity to elude the North Dakota Century Code and put citizens of North Dakota at risk. Thank you for your time and consideration of my request and I urge this committee to give House Bill #1280 a do not pass recommendation.

TESTIMONY IN SUPPORT OF HOUSE BILL

1280

TODD PORTER, STATE REPRESENTATIVE

DISTRICT 34, MANDAN

Madame Chair and members of the Senate Human Services Committee, for the record my name is Todd Porter, State Representative, District 34, Mandan.

I was asked to sponsor House Bill 1280 during the interim. This bill has a special meaning to me as a Para professional working in a medical world of "true professionals". I was told by a licensed professional that until the Legislature creates a board to license paramedics I would always be a Para professional. That licensed professional was a Respiratory Therapist.

In my job as a paramedic I answer directly to a physician. No other health care provider can give me orders. I am a physician extender working from standing and direct orders to perform the life saving tasks that I have been trained to perform. I perform the tasks of

Respiratory Therapists by administering breathing treatments and ventilating patients, I perform the tasks of Nurses by taking histories and administering intravenous medications, I perform the tasks of Nurse Anesthetists by performing advanced airway techniques, I perform the tasks of Physicians by decompressing collapsed lungs. All of these tasks are done by an individual that is not licensed and only carries the certification of a national registry from whom I took a written and practical examination upon completion of the 1000 hours of paramedic training.

If your wondering if there are any other trained personnel working inside of hospitals and clinics without a license from a state board I will tell you my radiology story. The next time you go to your clinic, ask the person taking your x-ray how many hours of training they have and if they took a test to prove their proficiencies. ND only requires 100 hours of training in order for an individual to take your skull x-ray. There are some fairly important things behind that bony structure.

A registered Polysomnographic Technologist is no different than me. They have been given specialized training in the performing and interpretation of sleep apnea tests. They have completed a national test in order to have the title of "Registered".

I will not go into the program that they complete, however I will tell you that there is not a single Respiratory Therapy Program in the state of ND that graduates individuals prepared to go to work in a sleep laboratory. Respiratory Therapy graduates must attend

the same training program and complete the same national test in order to have the expertise to work in a sleep lab.

I will also tell you that the opposition to this bill is about turf. Last evening on the news I was appalled to see a one sided "Dan Rather" type story by the local CBS affiliate talking to a Respiratory Therapist at a sleep lab. This individual claimed that no one but a Respiratory Therapist should be performing these tests in the name of patient safety.

Sounds almost like the Physical Therapist vs Chiropractor bill that we heard yesterday.

These turf battles are never about patients and rarely have anything to do with safety, however if you turn them over and look at the backside, they always have to do with job security, and money.

As you hear from individuals working in this new field of sleep apnea, I know that you will see through the boogey man and understand that by offering these individuals an opportunity to use their training under the direction of a Physician within the boundaries of a licensed health care facility you as a patient will be better served and safer.

You will now hear from Registered Polysomnographic Technologists, Physicians, and Respiratory Therapists who support this exemption within this act.

I would be more than happy to answer any questions the committee may have.

As a practicing Otolaryngologist who has cared for patients with sleep disorder for over 15 years, thank you for the opportunity to testify in support of House Bill N.1280.

The field of sleep medicine is a rapidly expanding area of medical practice which treats over eighty sleep disorders with a multidisciplinary approach. The gold standard for diagnosis is a test called the Polysomnogram. This is a complicated 6-8 hour test which monitors a patient's breathing patterns, snoring, heart rate, brain waves, blood oxygen level and stages of sleep. The test is conducted usually overnight in a certified sleep lab and generates over a thousand pages of data.

Judgments are made during the course of the test to alter the patient's sleep performance with the use of CPAP(continuous positive airway pressure) and BIPAP (bilevel positive airway pressure) trials.

The test is administered by a certified sleep technologist supervised by a physician. Registered sleep technologists have extensive training in polysomnographic technology as well a neuroanatomy, respiratory function and cardiovascular physiology. They must pass a rigorous national certification exam (pass rate <50%).

Without the untiring dedication of PSG T's to quality sleep evaluations, the accurate diagnosis of sleep disorders would be impossible.

As a physician who counts on accuracy in making surgical decision, I would greatly appreciate your support and passage of HB 1280. This bill ensures that patients of North Dakota will continue to enjoy access to quality sleep technology and health care.

Sue Karen Wink, MD
3/9/2005

Opening Statement:

Madam Chair and members of the Senate Human Services Committee. My name is Lana Curl. Thank you for allowing me to testify this morning on HB1280, which is non-partisan bill, has no appropriations attached and has no concerns with reimburse-ment. I am a Registered Polysomnographic Technologist, also known as a Registered Sleep Tech, or RPSGT. My specialty is Sleep Medicine technology. I do not practice Respiratory Therapy, Nursing or Emergency Medicine. I am representing myself today.

I have been a Sleep Technologist for 20 years. I have completed or directly supervised over 4500 Sleep Studies and have had no sentinel events or adverse outcomes. I have a degree Neurodiagnostics and am a Registered EEG Technologist. I am a graduate of Stanford University Sleep School. I took the National Polysomnography Board exam in 1997 and successfully passed on my first attempt. The pass rate is 48%. I am a recognized authority on

Sleep Medicine. I have worked with North Dakota physicians, businesses, the Department of Transportation, the local media, schools, service clubs, and was a presenter at Senator Dorgan's Women's Health, Women's Lives Conference. I have organized Sleep Medicine technology workshops in 2001 and 2003, attended by RTs who submitted the education to the ND Board of Respiratory Care for continuing education units. The Board approved my courses. They documented that I am qualified in sleep medicine.

The origin of this bill began about a year ago. I was contacted by the Board of RT, with concerns that as a RPSGT, I was performing Respiratory Therapy in my Sleep Center. We met with the AG, Wayne Stenehjem, to discuss this conflict and at that time, he said the NDCC wasn't clear on the issue and unofficially, a legislative clarification would be recommended. There is no currently language that deals with Sleep Medicine in the NDCC. He advocated that we 'play nice' and try seeking a legislative solution. I attended the next RT Board meeting.

The Board spent 1 ½ hour questioning me about Sleep Medicine, my education, qualifications and training and that of my staff. The RT Board asked if I would pursue legislation to help this matter and I said absolutely. Over the summer, I met with several Legislators, Dr. Dwelle from the Health Department, Mr. Duane Hodek from the Governor's office and various healthcare professionals. The consensus was to seek an exemption from the RT Practice Act rather than to create another Board or Commission, due to the small number of practicing Registered Sleep Technologists. We used model language and submitted the bill. Senator Gary Lee submitted an amendment prior to the House Committee testimony. At first this amendment seemed acceptable. After the committee hearing, a Representative asked if the language was ok. I explained at that time, the language was very restrictive and that in visiting with our legal staff, and physicians, we could improve on it. We submitted another amendment, with the engrossed bill passing the committee vote 10-1, and the House floor vote 81-10.

It is important to understand that Sleep Medicine Technology and Respiratory Therapy are recognized at the U.S. Department of Education, Medicare, and AASM as separate and distinct Allied Health specialties, with each having it's own core curriculum. Currently, there is no Sleep Technology schools or RT programs in ND that teach this the CoAPSG curriculum. Here is a copy of the curriculum. Historically, Sleep Technologists come from mainly either EEG or RT backgrounds. RPSGTs must complete 18 months of supervised paid training primarily in Polysomnography or 6 months of Polysomnography training with an EEG, RT, or nursing degree before they are eligible to sit for the registration exam. Without further training in Sleep Medicine, neither an EEG Technologist nor RT is qualified to perform Sleep Studies. A 3-5 day class does not constitute qualified. Please note pages 19-32 of the exam handbook, which outlines the knowledge necessary to sit for the exam. All the members of my sleep center have either 2 or 4 year allied health degrees.

The idea that RPSGTs are unsafe or unregulated or not accountable because they are not licensed by a "Board" is not accurate. RPSGT complete competencies that are required by job descriptions, privileges and administration at state licensed hospital facilities, which are overseen by the Department of Health. Sleep Technologists practice under the supervision of a physician, much like EMTs. RPSGTs are trained and educated in 88 different sleep disorders. They must prove competency in the application, equipment, indications and contraindications of CPAP and O2, as it applies to sleep-related breathing disorders only. RPSGTs and RTs have a shared commonality of these 2 areas, but the application and knowledge applied is very different. Many healthcare professions have crossover aspects.

There are no states with licensure for RPSGTs and no precedents have been established. Because Sleep Medicine is a new practice, it is not addressed in most states language. There is a National movement with an agenda for the RTs to absorb Sleep Medicine. RTs who have

no experience in Sleep Medicine testing, will testify that this is their scope of care. There are RTs in this room today who will testify that they are qualified to do sleep studies because they have a RT degree, yet have never performed a sleep study. I have sited several facts today to support the qualifications, accountability, and training of RPSGTs. I e-mailed each of you a copy of the article from the Journal of Clinical Sleep Medicine, the sleep doctor's journal, written January, 2005. It explains about the conflict clearly. I have highlighted the key points.

Closing Statement:

Sleep Medicine is a new medical frontier. Patients, doctors, businesses, researchers are just beginning to understand the importance of good sleep. I want patients to have access to quality sleep medicine. Building fences around certain specialties will limit the already suffering healthcare workforce shortage, thus preventing this access. Please do not be diverted from the

main issue of the bill. It is not about RTs, Boarded Sleep Doctors, or patient safety. This bill will allow Registered Sleep professionals to practice their field of expertise, under the supervision of a physician and clarify the NDCC language on Sleep Medicine. Most people have little knowledge about the credentials, or licensure of the staff taking care of them in a sleep center setting. However, they have trusted us to be qualified. RPGSTs are trained and qualified to do Sleep Medicine. I ask you to vote YES on this bill. Thank you. Questions?

Testimony in Favor
of HB 1280
March 9, 2005

Madame Chair and members of the Senate Human Services Committee:

My name is Kristi Kirkeby and I am here today to ask for your support for House Bill 1280. I have been a certified respiratory therapist since 1982, and a registered sleep technologist since 1997. I currently supervise 14 sleep technologists who practice in Minnesota, North Dakota and Wisconsin. If I have the choice to hire a registered respiratory therapist, or a registered polysomnography technologist to perform sleep studies, I would choose the polysomnography technologist. If I were to hire the respiratory therapist, I would have to invest in additional sleep training before they would be qualified to work in the sleep lab. The sleep technologist is already fully trained in sleep medicine.

I appreciate your careful consideration of House Bill 1280 and urge you to vote do pass which will clarify state statute and allow sleep technologists to practice their specialty in this state. I would be happy to answer any questions you may have.

Letter

HB 1280
Testimony in Support
Senate Human Services Committee
March 9, 2005

Madaam Chair and Members of the Human Services COmmittee,

I am Marcia Nelson, co-Owner and CEO of Winmar Diagnostics Sleep Wellness Center in Fargo. Winmar Diagnostics is the first free-standing sleep center in North Dakota. Winmar has been in business in North Dakota for 11 years.
In 2004, Winmar paid $83,000 in corporate taxes to the State of North Dakota.

We currently employ a staff of 35. Of the Sleep Technicians Winmar employs, 45% are Registered Sleep Techologists, 25% are Respiratory Therapists and the remainder are in the process of becoming eligible to take the national certification test.
Winmar currently has the opportunity to diagnosis and treat 250 patients per month. Our staff undergoes an intensive

training program
that requires them to be under the direct supervision of the lead polysomnography technician
for the first 6 months of employment.

Winmar Diagnostics has been uncomfortable with the current Respiratory Care Act and the fact that the
current law does not address the field of sleep technology. Since this field is not
addressed in state law, our company has struggled with whether we need to employ individuals
who are dual eligible in both respiratory therapy and sleep technology to complete studies
in North Dakota. House Bill 1280 clarifies that sleep technologists
can perform their speciality in this state exempt of the Board of Respiratory Therapy.

Our corporate headquarters is currently located in south Fargo. If Winmar Sleep Center
would relocate to the other side of the river, our company would no longer need to be concerned about
North Dakota law and its possible restrictions on our trained professionals.

HB 1280 recognizes polysomnography technologists as an

allied health group as qualified
medical professionals practicing within their scope of care.
Please support HB 1280. If you have
any questions, I will be pleased to answer them.

TESTIMONY BEFORE THE
SENATE HUMAN SERVICES COMMITTEE
REGARDING HOUSE BILL 1280
MARCH 9, 2005

Chairman Lee and members of the committee,

My name is Renee Fuchs and I am a Registered Respiratory Therapist in North Dakota. I began working in Respiratory Therapy in 1972. I have worked in many facets of the profession. Through the years I have been witness to and a part of the ever-changing profession of Respiratory Therapy. When I started my respiratory therapy training, we were known as Inhalation Therapists. In 1973, when I started my first job (in Fargo, at St. Lukes Hospitals) there were only a few Respiratory Therapists in the state. St. Lukes had opened its first training program with its first class of students. The profession was new and exciting and we were trying to convince the medical staff that Inhalation Therapists could make a difference in patient care by improving the outcome of the patients. Physicians and other medical professionals voiced concern about "oxygen jockeys" being capable of providing adequate care. Respiratory Therapy was on its first leg of its journey as an allied health profession. Over the years, Respiratory Therapy has evolved and developed into a high tech profession. My clinical experience included taking care of many critical patients and suffering from various acute and chronic diseases. I became a part of the history of the profession by seeing Licensure for Respiratory Therapy pass in the mid 1980's. During this process of licensure, we were told that licensure would ensure job security and provide quality care for our patients. During the same time period, I was witness to a new medical specialty developing. A sleep lab opened at St. Luke's Hospital in Fargo. It was very interesting to find out that

this profession actually watched people sleep at night. The lab was staffed by a polysomnographic technologist. This specialty had training in the neuro science of sleep, (EEG or brain wave recognition). Like the profession of respiratory therapy, sleep medicine has also evolved. Each profession at different rates of growth, each field becoming more and more specialized as research has become practice. There is room for both of these fields to practice. No one interfered with the evolution of Respiratory Therapy and limited the practice of its therapists. Maybe anesthesia wanted to impose restrictions on the respiratory technicians in the development of the profession, but they didn't. Sleep is now where Respiratory Therapy was. The numbers of Registered Polysomnograhic Technologists in the North Dakota are few, but they are highly qualified, and were so before Respiratory Therapy decided to question the ability of these professionals to practice in this state. Sleep technology is new and still evolving. A medical director oversees the practice of sleep medicine wherever it is practiced. Don't interfere with the evolution of this separate profession. Please support HB 1280 that recognizes respiratory therapy and sleep medicine as separate professions.

TESTIMONY BEFORE THE SENATE HUMAN SERVICES COMMITTEE
REGARDING HOUSE BILL 1280
MARCH 9, 2005

Chairman Lee, members of the committee,

My name is Steve Rixen and I am a lobbyist for Medcenter One Health Systems. I am here to today to offer our support for House Bill 1280. Dr. Judy Schwartz has administrative responsibility over our sleep lab. She testified before the House Human Services Committee on this bill. Regrettably she cannot be here today as she recently underwent a surgery that has put her out of commission for about a month. I have attached a letter that she wrote in support of this bill to my testimony. I encourage you all to read it as her qualifications allow her to speak with greater authority in a letter than I can from this podium.

This legislation will accomplish a great deal. House Bill 1280 will provide some necessary recognition of this new field, while allowing qualified professionals to do what they have been trained to do. It would in no way reduce the quality of patient care or threaten any jobs in the State of North Dakota. It will offer legislative clarification to a gray area in the Century Code while protecting those who do already practice this specialty in the state.

There are many people in the room today who, as I am sure we will all see in a few moments, are opposed to this bill. They are good people whom I respect a great deal despite our disagreements about this legislation. They do have many questions that need to be answered. So I will simply provide a little background information on some of the issues that may be raised.

Sleep technologists are qualified. An RPSG needs to pass a very difficult test to gain national certification. The national pass rate is around 50% for all candidates, including respiratory therapists and neurdiagnostic technologists. That test is administered by an organization (The Board of Registered Polysomnographic Technologist) that has been certified by the National Commission for Credentialing Agencies (The accrediting body of the National Organization for Competency Assurance; a well respected agency that uses peer review methods to assess competency of professional organizations). Among many groups accredited by the NCCA are The American Academy of Nurse Practitioners, The American Medical Technologists and the National Board of Respiratory Care...The same board that administers the test given to respiratory therapists to receive national certification. That certification is also required to become a licensed respiratory therapist in the State of North Dakota.

Going a bit further, and this is something Dr. Schwartz addresses in her letter, Sleep Technology is also recognized as a separate specialty by a the Commission on Allied Health Educational Programs or CAAHEP. This is a body within the Department of Education that accredits educational programs for allied health professions.
There is recognition of this body in the definition section of the Respiratory code. In defining a "bono fide education program", it says, "a program of respiratory care education which is accredited by the commission on accreditation of allied health

educational programs, or the commission's successor organization". The State Board of Respiratory Care thinks highly enough of CAAHEP to require that the programs that train respiratory therapist are accredited by them. CAAHEP thinks highly enough of Sleep Technologists to recognize them as a separate specialty.

I have attached a small blue card to my testimony as well as the entire litany of CAAHEP's requirements to receive this accreditation. Currently there no Universities in North Dakota requiring enough additional coursework to be accredited to train sleep technologists. Now in saying this, I must clarify that in no way am I impugning the job done by our Universities in their training of Respiratory Therapists. They are among the best in the country. I am only offering this point to show that they are training respiratory therapists...not sleep technologists.

It is true that sleep technologists do not have a license. The relatively small number of sleep technologists in the state of North Dakota makes the establishment of a licensing board impractical. Even though we know how excited the legislature would be to weigh the merits of such a board, we felt the exemption was the best way to go about this. Minnesota respiratory therapists are not required to have a have a license. Because they don't have a licensing board to issue that piece of paper, does that mean that every patient undergoing respiratory therapy at the Mayo Clinic is being treated by an unqualified person?

Currently there is nothing in law that even mentions sleep medicine. All we are seeking is a clarification that would allow sleep technologists to continue doing what they have been trained to do. There has been a very strong indication from discussions with the Board of Respiratory Care that they do not feel these professionals are qualified. We do not think that a field that has a broad understanding of only one of the aspects of this new science should be able to build a wall around sleep medicine and claim it as their specialty alone.

The physician overseeing any allied health professional, sleep technologist or respiratory therapist practicing sleep medicine, should be qualified. It has been brought to our attention that some people in the medical community are not entirely comfortable with putting a limiting physician oversight requirement in any practice act. We would not object to an amendment that would remove some of this language as long as it still provided oversight by a physician.

I know this is a great deal to digest. But just remember that Sleep technologists are professionals. They have the training. They are the gold standard of this growing specialty. We are asking nothing more than legislative clarification and recognition of all they have done to become qualified their profession. I ask for your support and urge a do pass recommendation on HB 1280.

Thank you very much. I would be happy to answer any of your questions.

Steve Rixen
Medcenter One Health Systems

February 24, 2005

Madam Chairman, Members of the Senate Human Services Committee.

Because I am having major surgery, I am unable to appear in person to testify in support of HB1280 as passed by the House. This bill will enable all qualified polysomnographers (sleep medicine technologists) to practice their profession and it keeps the determination of physician qualifications for practice in the hands of the State Board of Medical Examiners.

I am by training and experience a cardiothoracic surgeon. Currently, I am Vice President of Surgical Services and I have the executive responsibility for our sleep center. As a heart and lung surgeon I had the good fortune of working with excellent respiratory therapists – many before their profession was recognized as a specialty. These allied health professionals were great with ventilator and oxygen therapy for my acutely ill patients. Because I could rely on them to provide good care, I had additional time to devote to other patient care concerns.

Now I am anticipating a surgical procedure that could be lengthy. It could result in post-operative complications that will require respiratory therapists to become part of my healthcare team. I take comfort in knowing they will be there for me as a patient. But, I would not want a respiratory therapist who has not received additional training in polysomnography (sleep medicine) to care for me if I were undergoing a sleep evaluation. Standard respiratory therapy training does not prepare them for this task.

This is not just my opinion. It is shared by those responsible for ensuring that qualified allied health professionals are graduated from accredited educational programs. The 2003 accreditation standards for Respiratory Therapy programs include a Respiratory Care/Polysomnography "specialty" accreditation option for those schools that wish to graduate respiratory therapists who are qualified to practice both specialties. It states that additional units, modules and courses of instruction may be appropriate including 14 that are on focused polysomnographic technology, supplemental oxygen therapy, and positive airway pressure titration. The last two are included because use of these treatments in sleep medicine patients is different than it is for patients with acute respiratory failure. They must also receive education in other surgical, non-surgical and behavioral treatment options.

(Based on my experience as one of the American College of Surgeons representatives to the Accreditation Review Committee for Physician Assistants, I know that the phrase "may be appropriate" does not make these requirements optional. It merely recognizes that some programs may have added some of the requisite educational activities.)

I understand that <u>none</u> of the North Dakota Respiratory Therapy programs are accredited to graduate students prepared to enter the polysomnography (sleep medicine) profession. A graduate of these programs must take additional training to learn the necessary information.

Fortunately, there is a way to determine if they have acquired the necessary knowledge. They can become registered polysomgraphers (sleep medicine technologists). This entails first taking additional training and then passing a rigorous national examination. (The pass rate is about 50%.) This same option is available to graduates of neurodiagnostic programs.

In addition to the option for a special track for respiratory therapy schools, there are now accreditation standards for schools that want to prepare students for just a career in

polysomnography (sleep medicine). Also neurodiagnostic programs have a similar accreditation option that will allow their students to graduate with dual qualifications. (Those programs actually have to add less to their basic programs as more of what they routinely do is used in sleep medicine.)

I don't believe that there are any North Dakota schools that offer either of these programs. However, successful graduates from other states would be prohibited from practicing their profession if this bill does not pass.

Respiratory therapists who do the preliminary interpretation of sleep study data based on their limited training can lead physicians to erroneously recommend that a patient have a permanent tracheostomy. This procedure which results in a tube being put in the patient's windpipe is socially very debilitating. The patient must occlude the opening to speak and must deal with spit coming from the tube and getting on clothing. For these reasons, patients with tracheostomies frequently become social recluses. But they are also at much greater risk for pneumonia. This can result in a pre-mature death.

I understand there is some interest in amending this bill to limit the physicians who can oversee sleep medicine studies to only those who are board certified by the American Board of Sleep Medicine. While I think that will become the norm sometime in the future, now is not the time. There are physicians in several specialties that received training during their residencies in the sleep disorders that are seen by that specialty. These doctors are responsible under state law for knowing their limitations and seeking consultation when appropriate. This is no different from, for example, general surgeons in the state who perform thoracic procedures. They received training from programs that included thoracic procedures and have maintained their knowledge and skills. It would be inappropriate to limit their practice and allow only board certified thoracic surgeons to perform these operations. These general surgeons are responsible for seeking consultation when a case in beyond their ability.

As a physician, I resent the idea of an Allied Health Professional Board being allowed to decide whether or not I am qualified to practice any aspect of medicine. Our State Board of Medical Examiners has physicians who are qualified to make that determination and to take appropriate action if a physician's performance is less than acceptable. Physician practice issues must be left as their responsibility. (The proposal to limit physician practice with an amendment to this bill will not personally affect me. But, it would set an unacceptable precedent. How many other "carve-outs" would there become in other sections of the code? How will a newly licensed physician find out about them? When will they begin to conflict? Why would someone with no medical training be allowed to set standards for physicians?)

Please vote yes on engrossed bill HB 1280.

Respectfully,

Judy E. Schwartz

Judy E. Schwartz, MD, MPH, CPE, FACS, FACC

Commission on Accreditation of Allied Health Education Programs

Standards and Guidelines
for the Accreditation of Educational Programs in Polysomnographic Technology

Standards initially adopted in 2004

Adopted by the
Association of Polysomnographic Technologists
American Academy of Sleep Medicine
Board of Registered Polysomnographic Technologists
Commission on Accreditation of Allied Health Education Programs

The Commission on Accreditation of Allied Health Education Programs (CAAHEP) accredits programs upon the recommendation of the Committee on Accreditation for Polysomnographic Technology (CoA-PSG).

These accreditation **Standards** are the minimum standards of quality used in accrediting programs that prepare individuals to enter the polysomnographic technology profession. The accreditation **Standards** therefore constitute the minimum requirements to which an accredited program is held accountable.

Standards are printed in regular typeface in outline form. *Guidelines* are printed in *italic* typeface in narrative form.

Preamble

The Commission on Accreditation of Allied Health Education Program, the Association of Polysomnographic Technologists (APT), the American Academy of Sleep Medicine (AASM), and the Board of Registered Polysomnographic Technologists (BRPT) cooperate to establish, maintain and promote appropriate standards of quality for educational programs in polysomnographic technology and to provide recognition for educational programs that meet or exceed the minimum standards outlined in these accreditation Standards. Lists of accredited programs are published for the information of students, employers, educational institutions and agencies, and the public.

These standards are to be used for the development, evaluation and self-analysis of polysomnographic technology programs. On-site review teams assist in the evaluation of a program's relative compliance with the accreditation *Standards*.

Description of the Profession

Polysomnographic technologists perform sleep diagnostics working in conjunction with physicians to provide comprehensive clinical evaluations that are required for the diagnosis of sleep disorders. By applying non-invasive monitoring equipment, the technologist simultaneously monitors EEG (electroencephalography), EOG (electro-oculography), EMG (electromyography), ECG (electrocardiography), multiple breathing variables and blood oxygen levels during sleep. Interpretive knowledge is required to provide sufficient monitoring diligence to recording parameters and the clinical events observed during sleep. Technologists provide supportive services related to the ongoing treatment of sleep related problems. The professional realm of this support includes guidance on the use of devices for the treatment of breathing problems during sleep and helping individuals develop sleeping habits that promote good sleep hygiene.

I. Sponsorship

A. Sponsoring Educational Institution

A sponsoring institution must be one of the following:

1. A post-secondary academic institution accredited by an institutional accrediting agency that is recognized by the U.S. Department of Education and authorized under applicable law or other acceptable authority to provide a post-secondary program, which awards a minimum of a certificate/diploma at the completion of the program.

2. A full service sleep center or branch of the United States Armed Forces that has appropriate accreditation such as that provided by AASM.

   It is recommended that students earn an associate degree or higher either in conjunction with or prior to completion of the program.

B. Consortium Sponsor

1. A consortium sponsor is an entity consisting of two or more members that exists for the purpose of operating an educational program. In such instances, at least one of the members of the consortium must meet the requirements of a sponsoring institution as described in I,A.

2. The responsibilities of each member of the consortium must be clearly documented as a formal affiliation agreement or memorandum of understanding, which includes governance and lines of authority.

C. Responsibilities of Sponsor

The Sponsor must assure that the provisions of these **Standards** are met.

II. Program Goals

A. Program Goals and Outcomes

There must be a written statement of the program's goals and learning domains consistent with and responsive to the demonstrated needs and expectations of the various communities of interest served by the educational program. The communities of interest that are served by the program include, but are not limited to, students, graduates, faculty, sponsor administration, employers, physicians, the public, and nationally accepted standards of roles and functions

Program-specific statements of goals and learning domains provide the basis for program planning, implementation and evaluation. Such goals and learning domains must be compatible with both the mission of the sponsoring institution(s) and the expectations of the communities of interest. Goals and learning domains are based upon the substantiated needs of health care providers and employers, and the educational needs of the students served by the educational program.

Nationally accepted roles and functions in polysomnographic technology are reflected in what is being done by polysomnographic technologists in the workplace (the Board of Registered Polysomnographic Technologists (BRPT) Job Analysis) and the material covered in the appropriate national credentialing examination (s) (BRPT Examination Matrices), and the most recent version of the Association of Polysomnographic Technologists standard curriculum.

B. Appropriateness of Goals and Learning Domains

The program must regularly assess its goals and learning domains. Program personnel must identify and respond to changes in the needs and/or expectations of its communities of interest.

An advisory committee, which is representative of these communities of interest, must be designated and charged with the responsibility of meeting at least annually, to assist program and sponsor personnel in formulating and periodically revising appropriate goals and learning domains, monitoring needs and expectations, and ensuring program responsiveness to change.

C. Minimum Expectations

The program must have the following goal defining minimum expectations: "To prepare competent entry-level polysomnographic technologists in the cognitive (knowledge), psychomotor (skills), and affective (behavior) learning domains".

Programs adopting educational goals beyond entry-level competence must clearly delineate this intent and provide evidence that all students have achieved the basic competencies prior to entry into the field.

Programs are encouraged to consider preparing advanced level or specialized practitioners.

III. Resources

A. Type and Amount

Program resources must be sufficient to ensure the achievement of the program's goals and outcomes. Resources include, but are not limited to: faculty, clerical/support staff, curriculum, finances, offices, classroom/laboratory facilities, ancillary student facilities, clinical affiliations, equipment/supplies, computer resources, instructional reference materials, and faculty/staff continuing education.

Clinical affiliates should conform to professional standards of practice, standards established by the American Academy of Sleep Medicine and by other health care accrediting entities where applicable. Clinical affiliates should insure that students have appropriate access to and interaction with other related health care personnel and agencies.

Learning resources should be available to students outside of regular classroom hours, e.g. evenings and weekends. This should conform to the operational plans and standards of the participating sponsor. Instructional plans should promote student utilization of these resources.

B. Personnel

The sponsor must appoint sufficient faculty and staff with the necessary qualifications to perform the functions identified in documented job descriptions and to achieve the program's stated goals and outcomes.

1. Program Director

a. Responsibilities

The Program Director must be responsible for the continuous review, planning, development, and general effectiveness of the program. The Program Director has primary responsibility for the organization and administration of the program as well as provision of input and participation in all aspects of the program.

The Program Director should pursue ongoing formal training designed to maintain and upgrade his/her professional, instructional and administrative capabilities.

b. Qualifications

The Program Director must possess at least an associate degree, be a Registered Polysomnographic Technologist (RPSGT) and have a minimum of two years clinical experience as a practicing polysomnographic technologist.

2. Medical Director

a. Responsibilities

The Medical Director of the program must ensure that the medical components of the curriculum, both didactic and supervised clinical practice, meet current standards of medical practice.

The Medical Director must also assure physician instructional involvement in the training of polysomnographic technologists.

The Medical Director should promote the cooperation and support of practicing physicians.

b. Qualifications

The Medical Director must be a licensed physician board certified in sleep medicine.

3. Faculty and/or Clinical Instructional Staff

a. Responsibilities

In classrooms, laboratories, and all clinical facilities where a student is assigned, there must be (a) qualified individual(s) clearly designated as liaison(s) to the program to provide instruction, supervision, and timely assessments of the student's progress in meeting program requirements.

b. Qualifications

Instructors must be knowledgeable and appropriately credentialed in subject matter by virtue of training and experience, and effective in teaching assigned subjects.

C. Curriculum

The curriculum must ensure the achievement of program goals and learning domains. Instruction must be an appropriate sequence of classroom, laboratory and clinical activities. Instruction must be based on clearly written course syllabi describing learning goals, course objectives and competencies required for graduation.

The following general education requirements are suggested in order to help students achieve success with these required learning objectives:

General Education Competencies:

1. *written and oral communication*
2. *mathematics*
3. *computer skills including keyboard entry, word processing*
4. *social and behavioral sciences*
5. *critical thinking skills*
6. *evidence based scientific literature and technology assessment*

Basic Science and Technical Knowledge

1. *human anatomy and physiology, with emphasis on cardiopulmonary and neurological systems*
2. *basic physics*
3. *basic pharmacology*
4. *electricity and electronics*

Fundamentals of Patient Care Competencies

1. *medical terminology*
2. *patient care principles*
3. *ethical and medical-legal issues*
4. *infection control*
5. *Basic Cardiac Life Support (BCLS)*

Polysomnographic Technology content areas

1. *polysomnographic instrumentation*
2. *sleep/wake physiology and pathophysiology*
3. *patient and equipment preparation for polysomnography*
4. *patient monitoring*
5. *patient safety*
6. *polysomnographic procedures*
7. *therapeutic intervention*
8. *polysomnographic data analysis and reporting*
9. *professional development*

D. Resource Assessment

The program must, at least annually, assess the appropriateness and effectiveness of the resources described in these standards. The results of resource assessment must be the basis for ongoing planning and appropriate change. An action plan must be developed when deficiencies are identified in the program resources. Implementation of the action plan must be documented and results measured by ongoing resource assessment.

Other dimensions of the program may merit evaluation as well, such as the admission criteria and process, the curriculum design, and the purpose and productivity of the Advisory Committee.

Student and faculty evaluations of resources is a method for assessing resources.

The format for resource assessment documents should be:

- *Purpose statements;*
- *Measurement systems;*
- *Dates of measurement;*
- *Results;*
- *Analyses;*
- *Action plans;*
- *Follow-up.*

IV. Student and Graduate Evaluation/Assessment

A. Student Evaluation

1. Frequency and purpose

Evaluation of students must be conducted on a recurrent basis and with sufficient frequency to provide both the students and program faculty with valid and timely indications of the students' progress toward and achievement of the competencies and learning domains stated in the curriculum.

The evaluation system should provide each student and the program with a thorough analysis of the student's knowledge, performance-based strengths and areas needing improvement.

Valid means that the evaluation methods chosen are consistent with the competencies and objectives being tested, and are designed to measure stated objectives at the appropriate level of difficulty.

Methods used to evaluate clinical skills and behaviors should be consistent with stated performance expectations and designed to assess competency attainment accurately and reliably.

Students should have adequate time to correct identified deficiencies in knowledge and/or performance. Guidance should be available: to help students understand course content; to comply with program practices and policies; to provide counseling or referral for problems that may interfere with their progress through the program. Students should be eligible for all services offered by the educational institution.

2. Documentation

Records of student evaluations must be maintained in sufficient detail to document learning progress and achievements.

B. Outcomes

1. Outcomes Assessment

The program must periodically assess its effectiveness in achieving its stated goals and learning domains. The results of this evaluation must be reflected in the review and timely revision of the program.

Outcomes assessments include, but are not limited to: national credentialing examination performance, programmatic retention/attrition, graduate satisfaction, employer satisfaction, job (positive) placement, and programmatic summative measures. The program must meet the outcomes assessment thresholds.

Programmatic summative measures, if used, should contribute to assessing effectiveness in specific learning domains. "Positive Placement" means that the graduate is employed full or part-time in a related field; and/or continuing his/her education; and/or serving in the military.

In an effort to keep programmatic attrition below the established CoAPSG threshold, the program should provide objective, success-related admissions standards, and/or prerequisites, and effective methods of assessing basic academic skills for all prospective students. Prospective students should be admitted to the program after having demonstrated at least a minimum acceptable level of academic skills performance.

Programs not meeting the established "Thresholds of Success" set by the CoAPSG, will begin a dialogue with the CoAPSG to develop an appropriate plan of action to respond to the identified shortcomings.

2. Outcomes Reporting

The program must periodically submit its goal(s), learning domains, evaluation systems (including type, cut score, validity and reliability), outcomes, its analysis of the outcomes and an appropriate action plan based on the analysis.

The program should maintain records of evaluations of the effectiveness of its action plan (s).

V. Fair Practices

A. Publications and Disclosure

1. Announcements, catalogs, publications and advertising must accurately reflect the program offered.
2. At least the following must be made known to all applicants and students: the sponsor's institutional and programmatic accreditation status as well as the name, address and phone number of the accrediting agencies; admissions policies and practices; policies on advanced placement, transfer of credits, and credits for experiential learning; number of credits required for completion of the program; tuition/fees and other costs required to complete the program; policies and processes for withdrawal and for refunds of tuition/fees.
3. At least the following shall be made known to all students: academic calendar, student grievance procedure, criteria for successful completion of each segment of the curriculum and graduation, and policies and processes by which students may perform clinical work while enrolled in the program.

B. Lawful and Non-discriminatory Practices

All activities associated with the program, including student and faculty recruitment, student admission, and faculty employment practices, must be non-discriminatory and in accord with federal and state statutes, rules, and regulations. There must be a faculty grievance procedure made known to all paid faculty.

In accordance with the Americans for Disabilities Act (ADA) and other governmental regulations, technical standards that define the essential functions of polysomnographic technology may be published and used in the lawful and non-discriminatory admission of students.

C. Safeguards

The health and safety of patients, students and faculty associated with the educational activities of the students must be adequately safeguarded.

All activities required in the program must be educational and students must not be substituted for staff.

D. Student Records

Satisfactory records must be maintained for student admission, advisement, counseling and evaluation. Grades and credits for courses must be recorded on the student transcript and permanently maintained by the sponsor in a safe and accessible location.

E. Substantive Change

The sponsor must report substantive change(s) as described in Appendix A to CAAHEP/CoAPSG in a timely manner. Additional substantive changes to be reported to the CoAPSG within the time limits prescribed include:

- Vacancy in required personnel
- Significant curriculum revision(s)

F. Agreements

There must be a formal affiliation agreement or memorandum of understanding between the sponsor and all other entities that participate in the education of the students describing the relationship, role and responsibilities between the sponsor and that entity.

Appendix A
Application, Maintenance and Administration of Accreditation

A. Program and Sponsor Responsibilities

1. **Applying for Initial Accreditation**

a. The chief executive officer or an officially designated representative of the sponsor completes a "Request for Accreditation Services" form and returns it to:

Association of Polysomnographic Technologists
Attention: CoA-PSG
One Westbrook Corporate Center
Suite 920
Westchester, IL 60154

The "Request for Accreditation Services" form can be obtained from the Committee on Accreditation of Education for Polysomnographic Technologists (CoA-PSG), CAAHEP or the CAAHEP website at www.caahep.org.

Note: There is **no** CAAHEP fee when applying for accreditation services; however, individual committees on accreditation may have an application fee.

b. The program undergoes a comprehensive review, which includes a written self-study report and an on-site review.

The self-study instructions and report form are available from the CoA-PSG. The on-site review will be scheduled in cooperation with the program and once the self-study report has been completed, submitted, and accepted by the CoA-PSG.

2. Applying for Continuing Accreditation

a. Upon written notice from the CoA-PSG, the chief executive officer or an officially designated representative of the sponsor completes a "Request for Accreditation Services" form, and returns it to:

Association of Polysomnographic Technologists
Attention: CoA-PSG
One Westbrook Corporate Center
Suite 920
Westchester, IL 60154

b. The program may undergo a comprehensive review in accordance with the policies and procedures of the CoA-PSG.

If it is determined that there were significant concerns with the on-site review, the sponsor may request a second site visit with a different team.

After the on-site review team submits a report of its findings, the sponsor is provided the opportunity to comment in writing and to correct factual errors prior to the CoA-PSG forwarding a recommendation to CAAHEP.

3. Administrative Requirements for Maintaining Accreditation

a. The program must inform the CoA-PSG and CAAHEP within a reasonable period of time (as defined by the CoA-PSG and CAAHEP policies) of changes in chief executive officer, dean of health professions or equivalent position, and required program personnel.

b. The sponsor must inform CAAHEP and the CoA-PSG of its intent to transfer program sponsorship. To begin the process for a Transfer of Sponsorship, the current sponsor must submit a letter (signed by the CEO or designated individual) to CAAHEP and the CoA-PSG that it is relinquishing its sponsorship of the program. Additionally, the new sponsor must submit a "Request for Transfer of Sponsorship Services" form. The CoA-PSG has the discretion of requesting a new self-study report with or without an on-site review. Applying for a transfer of sponsorship does not guarantee that the transfer of accreditation will be granted.

c. The sponsor must promptly inform CAAHEP and the CoA-PSG of any adverse decision affecting its accreditation by recognized institutional accrediting agencies and/or state agencies (or their equivalent).

d. Comprehensive reviews are scheduled by the CoA-PSG in accordance with its policies and procedures. The time between comprehensive reviews is determined by the CoA-PSG and based on the program's on-going compliance with the **Standards**, however, all programs must undergo a comprehensive review at least once every ten years.

e. The program and the sponsor must pay CoA-PSG and CAAHEP fees within a reasonable period of time, as determined by the CoA-PSG and CAAHEP respectively.

f. The sponsor must file all reports in a timely manner (self-study report, progress reports, annual reports, etc.) in accordance with CoA-PSG policy.

g. The sponsor must agree to a reasonable on-site review date that provides sufficient time for CAAHEP to act on a CoA-PSG accreditation recommendation prior to the "next comprehensive review" period, which was designated by CAAHEP at the time of its last accreditation action, or a reasonable date otherwise designated by the CoA-PSG.

Failure to meet any of the aforementioned administrative requirements may lead to administrative probation and ultimately to the withdrawal of accreditation. CAAHEP will immediately rescind administrative probation once all administrative deficiencies have been rectified.

4. Voluntary Withdrawal of a CAAHEP- Accredited Program

Voluntary withdrawal of accreditation from CAAHEP may be requested at any time by the Chief Executive Officer or an officially designated representative of the sponsor writing to CAAHEP indicating: the last date of student enrollment, the desired effective date of the voluntary withdrawal, and the location where all records will be kept for students who have completed the program.

5. Requesting Inactive Status of a CAAHEP- Accredited Program

Inactive status may be requested from CAAHEP at any time by the Chief Executive Officer or an officially designated representative of the sponsor writing to CAAHEP indicating the desired date to become inactive. No students can be enrolled or matriculated in the program at any time during the time period in which the program is on inactive status. The maximum period for inactive status is two years. The sponsor must continue to pay all required fees to the CoA-PSG and CAAHEP to maintain its accreditation status.

To reactivate the program the Chief Executive Officer or an officially designated representative of the sponsor must notify CAAHEP of its intent to do so in writing to both CAAHEP and the CoA-PSG. The sponsor will be notified by the CoA-PSG of additional requirements, if any, that must be met to restore active status.

If the sponsor has not notified CAAHEP of its intent to re-activate a program by the end of the two-year period, CAAHEP will consider this a "Voluntary Withdrawal of Accreditation."

B. CAAHEP and Committee on Accreditation Responsibilities –Accreditation Recommendation Process

1. After a program has had the opportunity to comment in writing and to correct factual errors on the on-site review report, the CoA-PSG forwards a status of public recognition recommendation to the CAAHEP Board of Directors. The recommendation may be for any of the following statuses: initial accreditation, continuing accreditation, transfer of sponsorship, probationary accreditation, withhold accreditation, or withdraw accreditation.

   The decision of the CAAHEP Board of Directors is provided in writing to the sponsor immediately following the CAAHEP meeting at which the program was reviewed and voted upon.

2. Before the CoA-PSG forwards a recommendation to CAAHEP that a program be placed on probationary accreditation, the sponsor must have the opportunity to request reconsideration of that recommendation or to request voluntary withdrawal of accreditation. The CoA-PSG reconsideration of a recommendation for probationary accreditation must be based on conditions existing both when the committee arrived at its recommendation as well as on subsequent documented evidence of corrected deficiencies provided by the sponsor.

The CAAHEP Board of Directors' decision to confer probationary accreditation is not subject to appeal.

3. Before the CoA-PSG forwards a recommendation to CAAHEP that a program's accreditation be withdrawn or that accreditation be withheld, the sponsor must have the opportunity to request reconsideration of the recommendation, or to request voluntary withdrawal of accreditation or withdrawal of the accreditation application, whichever is applicable. The CoA-PSG reconsideration of a recommendation of withdraw or withhold accreditation must be based on conditions existing both when the [committee on accreditation] arrived at its recommendation as well as on subsequent documented evidence of corrected deficiencies provided by the sponsor.

   The CAAHEP Board of Directors' decision to withdraw or withhold accreditation may be appealed. A copy of the CAAHEP "Appeal of Adverse Accreditation Actions" is enclosed with the CAAHEP letter notifying the sponsor of either of these actions.

   At the completion of due process, when accreditation is withheld or withdrawn, the sponsor's Chief Executive Officer is provided with a statement of each deficiency. Programs are eligible to re-apply for accreditation once the sponsor believes that the program is in compliance with the accreditation **Standards**.

   Any student who completes a program that was accredited by CAAHEP at any time during his/her matriculation is deemed by CAAHEP to be a graduate of a CAAHEP-accredited program.

Dear Honorable Legislators,

I am writing in response to the PSG-sleep technologist Bill HB1280. I am a registered sleep technologist with over six years of experience performing sleep studies-PSG. My degree is in electroneurodiagnostic technology with extensive training in EEG and also performing diagnostic and therapeutic sleep studies.

Electroneurodiagnostic technology is a strong backbone of PSG. Here are a few examples how: applying electrodes appropriately and precisely to specific lobes of the brain, understanding the instrumentation of the PSG recording, and being able to accurately acquire and read brain activity or EEG to differentiate all stages of sleep.

PSG is such a separate and distinct allied health profession. That is why knowledge, training, and experience are crucial for sleep technologists no matter what background they come from.

I moved to the state of North Dakota in 1998 to advance my career. Recently I left the state of ND to pursue other professional options in a state that doesn't have this issue.

Sincerely yours,

Kathryn Shuda

March 3, 2005

Dear Editor:

As a patient with a sleep apnea, I ask everyone who reads this to ask his or her Senator to vote **YES** on **HB1280**. Passage of this bill will allow all qualified sleep technologists to continue to practice their profession in North Dakota.

I recommend that everyone having a sleep study ask if the person doing the study is a Registered Polysomnographic Technologist (RPSGT). A RPSGT has trained extensively and passed a national exam that covers all aspects of sleep medicine.

There are respiratory therapists fighting this bill. As respiratory therapists it is their belief they, and they alone, are qualified as sleep technologists. However, the respiratory therapy training program does not include sleep medicine as part of the core curriculum.

If you have a breathing disorder you certainly want a respiratory therapist involved. However, if you have a sleep disorder you definitely want to have an RPSGT on your health care team. The passage of **HB1280** will assure this.

Thank you

Loren Eikanas
Bismarck, ND
701-223-3979

HB 1280 - Polysom Tech Exemption

Madame Chair and Members of the Senate Human Services Committee, for the record I am Gary A. Lee, the Senator from District 22.

I am a Respiratory Therapist by training and Manage several Departments including a Sleep Center for MeritCare Health System. But my comments today represent my own personal views & may or may not represent the views of my employer.

This exemption for Polysomnograhic Technologists from the Respiratory Care Practice Act does nothing to promote quality sleep medicine in North Dakota.

Therefore, I am here speaking in opposition to HB 1280.

There are at least 3 reasons why I oppose this bill.

1. **It sets a double standard in licensing for the professionals providing sleep studies.**

   A. A Respiratory Therapist requires a license from the State. The Polysomnographic Technologist would be exempt. A credential doesn't confer a license.

   B. Professional licensing laws are in place to provide some assurance to the public that individuals are competent in their field. Competency is demonstrated through formal education, testing, standards & continuing education.

   C. Licensed professionals are subject to sanctions and penalties for violations of ethics, laws, and standards of practice.

   D. Legal action maybe the only alternative for patients seeking satisfaction from sub-standard service by an unlicensed individual.

2. **The request is premature.**

   A. These two groups are now collaborating at a National level, seeking common ground that will hopefully develop agreeable standards that can be used at the State level.

   B. Rather than creating exemptions and fewer safe guards for the public, this cooperation may lead to licensing standards fitting both professions and the public interest.

3. **Sleep Medicine is more than sleep studies.**

   A. Sleep medicine is a medical sub-speciality that needs to be lead by a physician formally trained in sleep.

   B. It should include a trained physician working directly with a team of professionals (i.e. PA's, nurses, therapists, technologists) to provide a diagnosis after, a complete & comprehensive examination of the patient.

   C. As written, this bill allows an unlicensed technologist to be directed & supervised by a physician that has no sleep credentials, or one that has never

been, nor intends to be located in the state. Furthermore, the out of state physician may never see or evaluate the patient directly.

D. This can & does put Technologists in the position of making decisions that are beyond the scope of their training because of absent or distant medical direction.

Currently, there are only a few Polysom Techs (2-6) State wide. Though limited somewhat in function by the Respiratory Care licensing law, they are *not* prohibited from working in ND.

Allowing these professional groups (R.T. and Polysom) time to collaborate at the national level, developing standards that are usable in a licensing law at the State level, is the more logical, orderly and correct way of moving forward in this field.

Therefore Madam Chair, I would request that a **Do Not Pass** recommendation be given to HB 1280.

I would attempt to answer any questions.

St. Alexius
Sleep Center
PrimeCare

59th Legislative Assembly
Senate Human Service Committee
HB 1280

Members of the Human Service Committee;

As the individual who overseas the sleep center in our medical center I am opposed to HB 1280 and I am asking that you vote DO NOT PASS on HB 1280. The passage of this bill would put the safety and well being of the citizens of North Dakota at risk by making certain individuals who perform sleep studies exempt from a law that was put into effect to protect the North Dakota citizens. These individuals would in effect with this bill be unlicensed and unregulated. I feel that asking to be to exempt from a law is not promoting a profession.

We believe this issue should be dealt with on a national level and is currently being collaborated on between the AASM (American Academy of Sleep Medicine) and the AARC (American Association or Respiratory Care). This would eliminate a state law on this issue.

This bill is not needed because there is no person or hospital in the state who is in violation of the current law and not passing the bill would not hinder anyone's job nor would they lose their job. I urge you to vote DO NOT PASS on HB 1280.

Thank you for your consideration of my request,

Karla Smith, RRT

Karla Smith, RRT
Sleep Center Coordinator
St. Alexius Medical Center
Bismarck ND 58502

MeritCare
meritcare.com

MeritCare Health System
720 4th St N
PO Box MC
Fargo, ND 58122
(701) 234-2000

Roger L. Gilbertson, M.D., President

59th Legislative Assembly
Senate Human Service Committee
HB 1280

Members of the Human Service Committee;

As licensed, Registered Respiratory Therapists and Registered Polysomnographic Technicians we are opposed to HB 1280 and we are asking that you vote DO NOT PASS on HB 1280. The passage of this bill would put the safety and well being of the citizens of North Dakota at risk by making certain individuals who perform sleep studies exempt from a law that was put into effect to protect North Dakota citizens. These individuals would in effect, with this bill enacted, be performing procedures while unlicensed and unregulated. We feel that by polysomnographers asking to be exempt from a law they are, in effect, not promoting their profession.

We believe this issue should be dealt with on a national level and it is currently being collaborated upon between the AASM (American Academy of Sleep Medicine) and the AARC (American Association for Respiratory Care). This collaborative effort would eliminate the need for state law on this issue.

This bill is not needed due to the fact that within current job roles, there is no person or hospital within the state that is in violation of the current law. A DO NOT PASS on this bill will not hinder anyone's job, nor would they loose their current job. We urge you to vote a DO NOT PASS on HB 1280.

Thank you for your consideration of our request,

Kimberly Gross RRT/RPSGT
Jennie Becker CRT/RPSGT
Dean Olson RRT/RPSGT
Darin Roesler RRT/RPSGT
Lisa Olson RRT/RPSGT
Jo Thorson RRT/RPSGT
Karrie Meland RRT/RPSGT

TOTAL P.02

59th Legislative Assembly
Senate Human Service Committee
HB 1280

Members of the Human Service Committee;

As the individual who overseas the sleep center in our medical center I am opposed to HB 1280 and I am asking that you vote DO NOT PASS on HB 1280. The passage of this bill would put the safety and well being of the citizens of North Dakota at risk by making certain individuals who perform sleep studies exempt from a law that was put into effect to protect the North Dakota citizens. These individuals would in effect with this bill be unlicensed and unregulated. I feel that asking to be to exempt from a law is not promoting a profession.

We believe this issue should be dealt with on a national level and is currently being collaborated on between the AASM (American Academy of Sleep Medicine) and the AARC (American Association or Respiratory Care). This would eliminate a state law on this issue.

This bill is not needed because there is no person or hospital in the state who is in violation of the current law and not passing the bill would not hinder anyone's job nor would they lose their job. I urge you to vote DO NOT PASS on HB 1280.

Lorraine Potts
Respiratory Care and Sleep Lab Manager
Mercy Medical center
Williston, ND

Lorraine Potts

Altru
Health System

59th Legislative Assembly
Senate Human Service Committee
HB 1280

Members of the Human Service Committee;

As the individual who overseas the sleep center in our medical center I am opposed to HB 1280 and I am asking that you vote DO NOT PASS on HB 1280. The passage of this bill would put the safety and well being of the citizens of North Dakota at risk by making certain individuals who perform sleep studies exempt from a law that was put into effect to protect the North Dakota citizens. These individuals would in effect with this bill be unlicensed and unregulated. I feel that asking to be to exempt from a law is not promoting a profession.

We believe this issue should be dealt with on a national level and is currently being collaborated on between the AASM (American Academy of Sleep Medicine) and the AARC (American Association or Respiratory Care). This would eliminate a state law on this issue.

This bill is not needed because there is no person or hospital in the state who is in violation of the current law and not passing the bill would not hinder anyone's job nor would they lose their job. I urge you to vote DO NOT PASS on HB 1280.

Erin M. Dionne
Respiratory Care, Pulmonary Lab, and Sleep Lab Manager
Altru Health System

59th Legislative Assembly
Senate Human Service Committee
HB 1280

Members of the Human Service Committee;

As the individual who overseas the sleep center in our medical center I am opposed to HB 1280 and I am asking that you vote DO NOT PASS on HB 1280. The passage of this bill would put the safety and well being of the citizens of North Dakota at risk by making certain individuals who perform sleep studies exempt from a law that was put into effect to protect the North Dakota citizens. These individuals would in effect with this bill be unlicensed and unregulated. I feel that asking to be to exempt from a law is not promoting a profession.

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This bill is not needed because there is no person or hospital in the state who is in violation of the current law and not passing the bill would not hinder anyone's job nor would they lose their job. I urge you to vote DO NOT PASS on HB 1280.

Thank you for your consideration of my request,

Bev Berger CRT

Bev Berger CRT
Director of Respiratory Care/EEG/ Sleep Diagnostic
30 West 7th Street
Dickinson, ND 58601

59th Legislative Assembly
Senate Human Service Committee
HB 1280

Members of the Human Service Committee;

As the individual who overseas the sleep center in our medical center I am opposed to HB 1280 and I am asking that you vote DO NOT PASS on HB 1280. The passage of this bill would put the safety and well being of the citizens of North Dakota at risk by making certain individuals who perform sleep studies exempt from a law that was put into effect to protect the North Dakota citizens. These individuals would in effect with this bill be unlicensed and unregulated. I feel that asking to be to exempt from a law is not promoting a profession.

We believe this issue should be dealt with on a national level and is currently being collaborated on between the AASM (American Academy of Sleep Medicine) and the AARC (American Association or Respiratory Care). This would eliminate a state law on this issue.

This bill is not needed because there is no person or hospital in the state who is in violation of the current law and not passing the bill would not hinder anyone's job nor would they lose their job. I urge you to vote DO NOT PASS on HB 1280.

C Kelly

Chris Kelly, RRT, RPSgT
Cardiopulmonary Services Coordinator
Trinity Health
Minot, ND 58701

North Dakota 59th Legislative Assembly
2005
House Bill No. 1280

March 9, 2005

Good Morning, Senators:

My name is Will Beachey. I am on the Board of Directors for the North Dakota Society for Respiratory Care (NDSRC). On behalf of the Society, I speak in opposition to HB 1280, which would *exempt* unlicensed polysomnographic personnel from the respiratory therapy practice act. The North Dakota legislature enacted the respiratory therapy licensure law because it recognized the potential for harm that could come to its citizens from unregulated practice. It is important to recognize that the respiratory therapy practice act does not prevent *licensed, qualified* members of other healthcare professions from performing respiratory therapy duties—if such duties are consistent with the accepted standards of that individual's profession. That such individuals should be licensed is consistent and reasonable; even as it is in the interest of the state to regulate the acts of respiratory therapists, so also is it in the state's interest to regulate any group that would practice respiratory therapy. However, HB 1280 seeks to *exempt* polysomnography personnel from the respiratory therapy practice act and allow them to perform respiratory therapy procedures, unregulated.

The respiratory therapy practice act mandates that to practice in North Dakota, respiratory therapists must (1) be graduates of nationally accredited educational programs, (2) be credentialed by the nationally accredited respiratory therapy testing organization, and (3) meet annual continuing education requirements. HB 1280 seeks a blanket exemption from the respiratory therapy practice act for polysomnography personnel; it does not suggest alternate state regulation for these individuals, requiring only that they function under physician oversight. Physician oversight does not substitute for state regulatory oversight any more than it does for respiratory therapists, who also function under physician oversight, but must be licensed. In fact, most licensed healthcare personnel function under physician oversight. Proponents of HB 1280 have argued paradoxically that patient safety is somehow protected by specifically naming registered polysomnographic technologists as exempt from the respiratory therapy practice act. ***It cannot be construed that exempting unlicensed personnel from a practice act protects patient safety.*** Exemption is not only a patient safety concern, it is philosophically unsound. If respiratory therapists must be licensed to perform procedures that a polysomnographic technologist wants to perform, it follows that the polysomnographic technologist should also be licensed. Under the proposed exemption, if an incompetent respiratory therapist harms a patient, the state can suspend or revoke the license, preventing the individual from practicing. But if a registered polysomnographic technologist is similarly incompetent, there is no license to suspend or revoke and no basis for state imposed sanctions.

If enacted, HB 1280 would place vulnerable patients in the hands of unregulated personnel who may provide a wide range of health care services and procedures that are otherwise protected and regulated when practiced by licensed professionals. For this reason, the North Dakota Society for Respiratory Care opposes the enactment of this bill.

Respectfully submitted,

Will Beachey, PhD, RRT
North Dakota Society for Respiratory Care

2005 NORTH DAKOTA 59TH LEGISLATIVE ASSEMBLY
HOUSE BILL #1280

March 9, 2005

Good morning Chairman Lee and members of the Senate Human Services Committee:

My name is Mike Runge. I am the Director of Respiratory Therapy at St. Alexius Medical Center, and I am responsible for the Sleep Center at St. Alexius Medical Center. On behalf of the North Dakota Society of Respiratory Care, I would like to speak in **"OPPOSITION OF HB 1280,"** which would exempt Registered Polysomnographers from North Dakota State Law. I have personally been a Respiratory Therapist for 25 years and Sleep Medicine was established well before my time.

The American Association for Respiratory Care and the American Academy of Sleep Medicine have been collaborating on issues for over 10 years as evident by the AARC-APT Clinical Practice Guidelines for Polysomnography, which was released back in 1995 as a joint statement between the two organizations.

In a background information letter (see handout) from Sam Giordano, Executive Director of the American Association for Respiratory Care, to Jerry Barret, the Executive Director of the American Academy of Sleep Medicine, it identifies multiple issues that the two organizations are trying to collaborate on. One of the most recent issues that the organizations collaborated on is outlined on Page 2, No. 4 of this background information document where the American Association for Respiratory Care worked with the American Academy of Sleep Medicine to help the sleep community achieve their Committee on Accreditation for Polysomnographic Technologists Education Programs. As stated in the outline, the American Association for Respiratory Care was the only organization to offer verbal comments in support of this application.

April 2003 Salary, Demographics, and Educational Needs Survey Report conducted by the sleep community, it indicated that a majority of hospital-based sleep disorder centers were organized under a Respiratory Therapy Department (43%). Typical respondents held the RPSGT (73%) or RCP, CRT, or RRT credentials (50%) and approximately one-third (34.2%) held both the RPSGT and a Respiratory Care credential. The study also indicated that most respondents indicated that they received their initial training as polysomnographer technologist on-the-job (70%) followed by those who took a 1 to 2 week training course (21%). Clearly, this indicated how Respiratory Therapists are involved in Sleep Medicine.

Currently, there is no hospital or individual in violation of the current Respiratory Care Practice Act. The one or two Registered Polysomnographers who this Bill is addressing, are currently practicing within the limits of the current Respiratory Care Practice Act and are not violating the law. As stated in the letter by Janelle Johnson, Director of Public Policy and Community Development for MedCenter 1, that was handed out to the members of the North Dakota State House of Representatives, it states that "if this Bill fails, we revert to the status quo...where there is absolutely no mention of this speciality or those who can practice it." "Revert to status quo...tells me that no jobs are threaten if this Bill is not passed. In our opinion, an exemption from a state law does not make a profession legitimate. It also states that if your concern is patient safety, then an exemption from state law is a favorable decision. We highly disagree with this statement because if a Registered Polysomnographer injuries a patient, they have no accountability according to state law because they would be exempt from the Practice Act.

Every hospital in North Dakota uses Respiratory Therapists to perform Sleep testing, including MedCenter 1, and a significant number of those Respiratory Therapists are dual-credentialed as RPSGT's. Would these dual-credentialed Respiratory Therapists, now be exempt from their own Respiratory Care Practice Act if this bill passes?

In conclusion, I believe this issue of RPSGT/Respiratory Therapist is being collaborated on between the American Association of Respiratory Care and the American Academy of Sleep Medicine and we should allow the two professional organizations to work this out on a National level and not involve the State's Practice Acts.

Thank you for your time and consideration.

Section 2. Amendment. Section 43-42-02 of the North Dakota Century Code is amended an reenacted as follows:

1. The state board of respiratory care is responsible for the enforcement and administration of this chapter and for the adoption of any rules necessary to govern the practice of respiratory care in this state.

2. The board consists of seven members appointed by the governor. Four members must be respiratory therapists, chosen from a list of eight respiratory therapists supplied to the governor by the North Dakota society for respiratory care. One member must be a physician chosen from a list of two physicians supplied to the governor by the North Dakota medical association. The governor shall appoint two members to be representatives of the general public. Before the expiration of one public member on September 30, 2006, an additional member of the board shall be added, consisting of one registered polysomnographic technologist chosen from a list of members of the American Polysomnographic Technologists. At the expiration of the representative of the public on September 30, 2006, the board shall consist of one member to be a representatives of the general public. One member must be a registered polysomnographic technologist chosen from a list of members of the American Polysomnographic Technologists. Members are appointed for terms of three years. Each member holds office until the member's successor is duly appointed and qualified. A vacancy in the office of any member may be filled for the unexpired term only. No member may serve more than two successive complete terms.

3. The board shall annually select a chairman from among its members. The board shall meet at least twice each year and also shall meet upon the call of the chairman.

Lee, Judy E.

From: Dwellekimbo@aol.com
Sent: Monday, March 14, 2005 7:22 PM
To: Lee, Judy E.; Smith, Arvy J.
Subject: Re: HB 1280

Dear Judy:
Thanks for the note and opportunity to respond.
Certification / registration / licensure etc. exists to protect the public from inappropriate practices often in a proactive way. To adequately supervise and regulate this process demands at least some expertise in the field particularly when national standards and certifications are still being debated. Unfortunately the Health Department has no expertise related to sleep technology. Just having a consultant available to review retroactive professional complaints seems superficial and inadequate in proactively protecting the public.
I have discussed this situation with some of the sleep technology tech folks in the past and suggested, what I think would be the best option, that they (even the few that exist in the state) organize and develop a self certification / regulation program based on criteria they establish (ie passing a national exam of their choosing, evidence of minimal clinical experience, etc.). They could consider contracting with an existing professional clinical licensing board (nursing, board of medical examiners, etc.) that understands general principles of professional certification and licensure to provide the minimal administrative and clerical coverage needed. Some yearly dues system would likely be necessary to offset the minimal administrative impact of this small "board". This situation will likely be repeated several times in the future as emerging new clinical specialties arise and a "board support" mechanism for these small specialties would be helpful.
I am not aware of other situations where a technical professional field of clinical practice is certified, licensed, or regulated by those not engaged in that field.
Just some initial thoughts.
I would be happy to discuss this with you further if desired.
Whatever you decide the Health Department will do it's best to help make this work.
Thanks!
Terry

3/15/05

American Academy of Sleep Medicine

March 14, 2005

Hon. Judy Lee
Senator 13th District
State Capitol
600 East Boulevard
Bismarck, ND 58505

Dear Senator Lee,

House Bill 1280, a bill to amend the Respiratory Care Practice Act, provides a limited exemption for the practice of polysomnographic technology. The current language of the bill, adopted by the House Human Services Committee and currently being considered by the Senate, severely limits the scope of practice for polysomnographic technologists, technicians and trainees (PsgTs).

HB 1280, as originally introduced on January 10, provided exemption language endorsed by the American Academy of Sleep Medicine (AASM). The original bill allowed PsgTs the unfettered right to practice within the scope of their profession as long as the activities practiced were performed under the direction of a physician who has training in sleep medicine. Training in sleep medicine indicates two tracks, physicians board-certified in sleep medicine; and physicians who are board-certified in pulmonary medicine and qualified to treat patients with sleep related breathing disorders. The AASM accredits Sleep Disorder Centers, which are full service sleep medicine facilities and require a board-certified individual be on staff. The AASM also accredits Sleep Disorder Breathing Laboratories, requiring a physician board-certified in pulmonary medicine be on staff. The American Thoracic Society and the American College of Chest Physicians have recently entered into a cooperative tri-society agreement with the AASM to ensure that the right to practice polysomnographic technology is not infringed upon by other professions, including respiratory care.

The amendment adopted by the House Human Service committee on January 24, currently the language being considered in the Senate, severely limits the scope of practice for the profession. In limiting the practice of polysomnographic technology to only those who are registered PsgTs under the under the supervision of a physician who is privileged in sleep medicine at a state licensed hospital or health system or is board eligible or a Diplomate of the American Board of Sleep Medicine puts an undue strain on the profession within the state of North Dakota and will effectively limit patient access to quality sleep medicine care. This is a tremendous disservice to the citizens of North Dakota. We strongly believe that PsgTs working under the direction of a board-certified Pulmonologist in an AASM Accredited Sleep Disorder Breathing Laboratory, at a minimum be added to the exemption language.

One Westbrook Corporate Center, Suite 920, Westchester, IL 60154
Phone: 708/492-0930, Fax: 708/492-0943, Email: aasm@aasmnet.org
www.aasmnet.org

The AASM is opposed to the current exemption language and urges the North Dakota legislature to include the original polysomnographic technology exemption language in HB 1280.

North Dakota is a geographically large state with a population dispersed between urban and rural areas. To afford the citizens of North Dakota with the best possible access to sleep medicine care we strongly urge you to consider remaining with the original language in HB 1280.

If you have any questions regarding this position or to request further information regarding the profession of polysomnographic technology and sleep medicine contact AASM Executive Director Jerome A. Barrett at (708) 492-0930.

Sincerely,

Michael J. Sateia, MD
President

Vote **YES** on HB 1280

Ensure qualified allied healthcare professionals are allowed to practice their profession.

Sleep medicine and respiratory care are unique allied health care professions.

Sleep Technologists registered by the Board of Registered Polysomnography Technologists:

1. Have taken additional training after completing respiratory therapy or neurodiagnostic schooling
2. Have passed a rigorous national examination (pass rate = 50%)

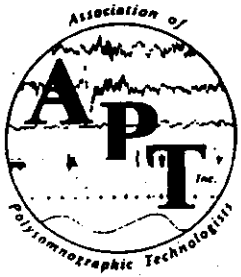
Vote **YES** on HB 1280

Ensure qualified allied healthcare professionals are allowed to practice their profession

North Dakota Respiratory Therapy Schools are NOT accredited to prepare students to enter the profession of polysomnography (sleep medicine).

The Committee on Accreditation for Respiratory Care requires these additional units, modules and courses of instruction for a Respiratory Care/Polysomnography (sleep medicine) "specialty" accreditation option:

1. Focused study in 14 sleep medicine (polysomnography) technology areas;
2. Training in the use of supplemental oxygen therapy for sleep patients;
3. Training in the use of Positive Airway Pressure titration for sleep patients; and
4. Study regarding other surgical, non-surgical and behavioral treatment modalities.



SALARY, DEMOGRAPHIC, AND EDUCATIONAL NEEDS SURVEY REPORT

April 2003

where . . .

Quality is a result, not an objective.

CONFIDENTIAL

Executive Summary

Planning for an updated survey study began in 2002. The study was concluded in 2003. Similar studies were conducted in 1992, 1996, and 1999. The APT conducted this study to identify: 1) polysomnographic practice environments, 2) technologists' characteristics, 3) typical compensation and benefits, and 4) the educational background and needs of technologists. This report summarizes steps taken to distribute surveys and analyze responses. APT survey results are intended to guide APT leaders as they plan future programs and guide those who determine technologists' salaries and benefits.

Four thousand five hundred seventy-eight surveys were mailed to technologists, centers, and laboratories in 2002. For the purpose of this report and to be consistent with the survey, the term *center* will be used to represent both centers and laboratories. Subsamples who received the survey included 2,608 APT members and 1,970 laboratories served by a sleep equipment manufacturer. The study sample returned 894 usable surveys for a response rate of 19.5% as of February 6, 2003.

Typical respondents spent most of their time in hospital-based sleep disorders centers organized under a respiratory care department (43%) or a separate sleep disorders department (42%). Of those who worked in hospital centers, typical respondents worked 38 hours/week. One-half of respondents work in an unaccredited center (50%), while 44% work in centers with full (38%) or lab (6%) accreditation, and 11% work in centers with pending accreditation. Clinical practice was the primary source of support for most respondents' salaries. Research activities were again a minor source of salary support compared to past studies.

Labs in which respondents worked typically performed 22 sleep studies per week. Approximately 2 MSLT procedures were performed each week, compared to zero MWT procedures. Approximately 97% of respondents indicated they performed sleep studies on geriatric patients and 99% performed studies on adults. About 62% of respondents indicated they performed sleep studies on adolescents. About 40% conducted studies on pediatric patients and about 8% of respondents conducted studies on neonates. Only 6% of respondents reported their center performed in-home studies and 9% reported performing remote studies. Data were most frequently acquired for polysomnography using only digital amplifiers (71%), followed by a mix of analog and digital amplifiers (24%), and only analog amplifiers (5%). This reflects a trend toward use of more digital amplifiers compared to past studies.

Most respondents were female (59%) and were APT members (78%). Typical respondents held the RPSGT (73%) or RCP, CRT, or RRT credentials (50%), and approximately one-third (34.2%) held both the RPSGT and a respiratory care credential.

Respondents most frequently reported the highest educational level they had achieved was an Associates (38%) or a Baccalaureate degree (22%). Most respondents

indicated they received their initial training as a polysomnographic technologist on-the-job (70%) followed by those who took a one to two week training course (21%). Most respondents indicated their primary job title was "Staff Technologist" (31%) or "Coordinator/Lead Technologist " (25%). In their primary job, respondents spent most of their time performing duties associated with polysomnographic technologists and managers. Typical respondents had worked 6 to 9 years for their primary employer.

Reported average salary for all respondents increased by 14% compared to 1999 to $1,719 for a two-week period. Mean two-week compensation also increased from 1999 levels for respondents with the following job functions:

- Staff Technologists by 15.7% to $1,492
- Coordinator/Lead Technologists by 12.3% to $1,654
- Directors/Supervisors by 10.7% to $1,964

Respondents with the RPSGT credential typically earned $200 more over a two-week period than those without the RPSGT credential. The salary differential between respondents with and without the RPSGT credential was more than it was in 1999 when the differential was $165.

Respondents who held a specialty credential in EEG, electrophysiology, or pulmonary function, in addition to the RPSGT, earned a premium of about $97 more per two-week period than those who only held the RPSGT. This is slightly less than in 1999, when the premium was $115. Respondents with a nursing credential and the RPSGT did not earn a premium, as opposed to 1999 when respondents with such dual credentialing earned a $55 premium. It was also clear such dual-credentialed respondents were rare within this sample. Respondents with a general respiratory care credential and the RPSGT occurred with much greater frequency, but did not earn a premium, which was similar to 1999 results.

Education was moot as an explanation for salary variation because variation in education was accounted for by variation in job function. Experience, age, job function, and RPSGT credential were statistically significant factors associated with salary.

Schemes for deriving a two-week salary commensurate with study results are offered in the report. A simple method is offered for generating an initial salary figure an employer could then choose to refine based on regional variation and credentials beyond the RPSGT.

The average number of overtime hours worked in a two-week period was 8.1, which was a slight decrease from 1999 when the average overtime value was 8.8 hours. The average shift differential was $2.08/hour, which was a 20% increase from 1999. The majority of those who received differential pay worked the night shift (82%).

Only 20% of respondents reported holding a second polysomnography job, most commonly as a "Staff Technologist." Respondents who held a second job, spent most of their time performing sleep/wake center technologist activities and had typically worked for their employer for 2 - 4 years.

Respondents reported a typical secondary salary of $560 for a two-week period, a slight decrease from 1999. Respondents with second jobs typically did not work overtime hours and did not receive a shift differential.

Those who reported they were eligible for paid days off indicated they typically earned 8-9 sick days, 7-8 paid holidays, 13-14 paid vacation days, or 14-15 days of paid time-off. There was a negative trend in paid days off compared to 1999, but 2002 levels were similar to 1996 levels.

More than two-thirds of respondents reported their employer paid at least some expenses associated with continuing education activities (i.e., meeting registration and hotel/travel expenses). Only about one-third of employers paid direct costs for their technologists to become credentialed or to join a professional association. Most respondents received some employer support for medical (80%), dental (75%), family medical (67%), and optical (53%) insurance. Approximately 77% received some support for their retirement, 7% received some support for childcare, and 12% received support for health club memberships.

Regarding educational needs, respondents felt they would benefit most from additional education/instruction related to the following tasks:

- utilizing sleep resources
- marketing the sleep program and engaging in strategic planning
- developing competencies for staff, policies, and procedures
- creating sleep awareness, working with news media, and advocating for sleep
- engaging in public education

Respondents felt least proficient in their mastery of neurophysiology and sleep center management.

This survey was supported in part by a postage and mailing grant from RESPIRONICS.
The APT Demographic, Salary, and Educational Needs survey is conducted as a service to its members by the APT approximately every three years and the summary is distributed without charge to all current members. The 80+ page full report is available through the APT (913-541-1991) at a nominal cost and provides a detailed breakdown of survey information by regions, credentials, full vs. part time, job title, etc. It provides detailed statistics extremely valuable to human resource departments and sleep center administrators for salary and job title comparisons. The next survey should be conducted in 2005.

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TO: Jerry Barrett
Executive Director
American Academy of Sleep Medicine

FROM: Sam P. Giordano, MBA, RRT, FAARC
Executive Director
American Association for Respiratory Care

RE: **BACKGROUND INFORMATION**

DATE: April 22, 2004

I thought that it might be helpful to provide some background information about the AARC's activities as they relate to sleep diagnostics and treatment.

1. As you may know, respiratory therapists have been involved in sleep diagnostics and treatment for the last several decades. This involvement was prior to any efforts to gain licensure for respiratory therapists. On a personal note, I organized and directed a sleep lab in the late 70's at St. Luke's Hospital in Kansas City, Missouri.

2. When I was President of the AARC in 1980, I undertook development of a licensure effort which included creating a Model Licensure Act. The act included a general scope of practice which included sleep diagnostics. I mention this only to point out that AARC did not recently add the sleep aspect to the respiratory therapy scope of practice.

   I would also point out that our Model Licensure Act is considered non-restrictive. Our model language contains words to the effect that the Practice Act will not work to restrict other licensed persons from providing parts of the RT scope of practice if deemed appropriate by the Licensure Board. We also included language that would allow the Licensure Board to consider requests from other disciplines to practice all our parts of the RT scope of practice provided that the petitioners document their competency using the method that is considered equivalent to that used by the Licensure Board.

3. AARC has welcomed collaboration and partnership with the sleep community for over a decade. We collaborated with APT to develop a joint clinical practice guideline which was published several years ago. There were regularly scheduled meetings between ASET, APT, ERPT, and AARC for several years. The purpose of these meetings is to assure that all the groups were on the same page. During that time, the AARC indicated that it would support recognition of persons holding the RPSGT credential for the purposes of a limited license or limited exemption under respiratory practice acts with the qualification that the examination be accredited by NCCA.

   AARC did honor its commitment as evidenced by the guidance statement it issued in May of 2003.

4. AARC was delighted to be included in meetings in recent years with ASET, APT, ERPT, CAAHEP, and CoARC. The purpose of the meeting was to discuss formation of the Committee on Accreditation for Polysomnographic Technologist education programs. There was a point of disagreement with AARC and APT regarding the recognition of the polysomnographic technologist as a separate profession. AARC opposed the recognition on the basis that the request did not meet CAAHEP criteria for professional recognition. However, AARC worked with CAAHEP to develop a revision to the policy which would permit CoA recognition by CAAHEP for a separate discipline. We supported the revision which was subsequently passed by the CAAHEP Board of Directors last April. I also was in attendance at the meeting to offer personal comments in support of the application for a Polysom CoA. AARC was the only organization to offer verbal comments in support of this application. I might add that it was a bit embarrassing to learn that among the items contained in the application was a statement made by AASM's Executive Committee dated 1998 which contained the generalization that all respiratory therapists were not qualified to provide sleep diagnostics and treatment without additional post graduate education. Nonetheless, we continue to support the development of the CoA. Indeed, we met at our expense with BRPT, ASET and APT to assist them in getting their CoA off the ground. Rich Walker, the Executive Director of the Committee on Accreditation of Respiratory Care (CoARC) contributed as well.

5. I sent a letter out to all of our state societies encouraging them to support the recognition of the RPSGT, CPFT, and RPFT credentials. As an equivalent competency documentation instrument (albeit with a narrower scope) for the purposes of gaining recognition, under their respective state laws.

6. Even though we wish it were otherwise, AARC is not immune to the political forces that exist in every organization. That said, AARC still holds the position that persons with the RPSGT credential should be recognized under state law to provide the scope of services residing within the test matrix. The state societies are independent corporations and do not always follow either our Model Licensure Act or our directives. Add to that the fact that the state Licensure Boards will often march to a different drummer as well. AARC did send the guidance statement to all state Licensure Boards and all state societies.

7. Approximately a year ago last February, David Shelledy, AARC's President at the time and I met with Roseanne Zumstein, the APT President and APT's Executive Secretary here in Dallas. We agreed that in order to clear the air and create a better working relationship between our respective organizations that it would be beneficial to develop a letter describing mutual respect for one another's roles within the context of sleep medicine. The draft was to be originated by APT, but was not developed. Instead, we read another attack on AARC calling into question its intentions and actions. At that time, Jerry, given the fact that many of our members and our elected leaders are aware of these statements from APT, we feel that for whatever reason, there has not been a good faith effort to discuss issues of mutual concern. That's why through our Board of Medical Advisors we want to open a dialogue with AASM. As you may have noticed, we have never responded to any negative messages in kind. Frankly, even though AARC isn't perfect, we do a pretty good job of staying on the high road, biting our tongue, and continuing to find a way to solve the problems.

I hope that the foregoing backgrounder proves useful to you and your team. Please don't think we want to re-open any negatives, I simply don't know how much of this information you have. We are looking forward to a congenial and constructive meeting. Thanks, again, for all your help.

Reprinted from RESPIRATORY CARE [Respir Care 1995;40(12):1336-1343]

AARC-APT Clinical Practice Guideline

Polysomnography

This Guideline was developed jointly by the AARC Cardiopulmonary Diagnostics CPG Focus Group and representatives of the Association of Polysomnography Technologists (APT). Both groups have approved its content.

PSG 1.0 PROCEDURE:

Polysomnography

PSG 2.0 DESCRIPTION/DEFINITION:

Polysomnography refers to the collective process of monitoring and recording physiologic data during sleep. The specific variables monitored during center-based polysomnographic evaluation of sleep-related respiratory disturbances are listed.[1,2] Home-based polysomnography[3] and unattended monitoring systems are not addressed in this guideline.

The variables monitored and recorded during polysomnography include but are not limited to:[4,5]

2.1 global neural electroencephalographic activity (EEG) from electrodes placed on the patient's scalp;
2.2 eye movements (electro-oculogram, or EOG) from electrodes placed near the outer canthus of each eye;
2.3 submental electromyographic activity (EMG) from electrodes placed over the mentalis, submentalis muscle, and/or masseter regions;
2.4 rhythm electrocardiogram (ECG) with two or three chest leads;
2.5 respiratory effort, by chest-wall and abdominal movement via strain gauges, piezoelectric belts, inductive plethysmography, impedance or inductance pneumography, endoesophageal pressure, or by intercostal EMG;
2.6 nasal and/or oral airflow via thermistor or pneumotachograph;
2.7 oxygen saturation (S_{pO_2}) via pulse oximetry;
2.8 body position via mercury switches or by direct observation;
2.9 limb movements (arms and legs) via EMG;[6]
2.10 recordings of or vibration (frequency and/or volume) may be recorded;[7]
2.11 end-tidal CO_2, transcutaneous CO_2, esophageal pH, penile tumescence, and bipolar EEG are beyond the scope and intent of this guideline.

PSG 3.0 SETTING:

Center-based polysomnography is performed within specialized hospital sleep laboratories,[1] appropriately equipped hospital rooms, or stand-alone sleep centers, with a qualified technician in constant attendance.[8]

PSG 4.0 INDICATIONS:

Polysomnography *may be* indicated in patients[9-12]

4.1 with COPD whose awake P_{aO_2} is > 55 torr but whose illness is complicated by pulmonary hypertension, right heart failure, polycythemia, or excessive daytime sleepiness;
4.2 with restrictive ventilatory impairment secondary to chest-wall and neuromuscular disturbances whose illness is complicated by chronic hypoventilation, polycythemia, pulmonary hypertension, disturbed sleep, morning headaches, or daytime somnolence and fatigue;
4.3 with disturbances in respiratory control whose awake P_{aCO_2} is > 45 torr or whose illness is complicated by pulmonary hypertension, polycythemia, disturbed sleep, morning headaches, or daytime somnolence and fatigue;
4.4 with nocturnal cyclic brady- or tachyar-

rhythmias, nocturnal abnormalities of atrioventricular conduction, or ventricular ectopy that appear to increase in frequency during sleep;
4.5 with excessive daytime sleepiness or insomnia;
4.6 with snoring associated with observed apneas and/or excessive daytime sleepiness;
4.7 with other symptoms of sleep-disordered breathing as described in International Classification of Sleep Disorders;[6]
4.8 with symptoms of sleep disorders described in the International Classification of Sleep Disorders.[6]

PSG 5.0 CONTRAINDICATIONS:

There are no absolute contraindications to polysomnography when indications are clearly established. However, risk-benefit ratios should be assessed if medically unstable inpatients are to be transferred from the clinical setting to a sleep laboratory for overnight polysomnography.

PSG 6.0 PRECAUTIONS/COMPLICATIONS:

6.1 Skin irritation may occur as a result of the adhesive used to attach electrodes to the patient.
6.2 At the conclusion of the study, adhesive remover is used to dissolve adhesive on the patient's skin. Adhesive removers (eg, acetone) should only be used in well-ventilated areas.
6.3 The integrity of polysomnographic equipment's electrical isolation must be certified by engineering or biomedical personnel qualified to make such assessment.
6.4 The adhesive used to attach EEG electrodes, (eg, collodion) should not be used to attach electrodes near the patient's eyes and should always be used in well-ventilated areas.
6.5 Due to the high flammability of collodion and acetone, they should be used with caution, especially in those patients who require supplemental oxygen.
6.6 Collodion should be used with caution in those patients with reactive airways disease and in small infants.
6.7 Patients with parasomnias or seizures may be at risk for injury related to movements during sleep. Institution-specific policies and guidelines describing personnel responsibilities and appropriate responses should be developed.

PSG 7.0 DEVICE LIMITATIONS/VALIDATION OF RESULTS:

Due to the nature of the various physiologic variables that are examined during polysomnography, a variety of devices are attached to the patient, and the output of these devices is interfaced with a standard polysomnographic recorder; consequently, the potential exists for several individual device limitations, rather than any one specific limitation to polysomnography.

7.1 Records of EEG, EOG, and EMG activity. These variables are monitored by gluing or taping, small metal-disk electrodes to the patient.[13] The low impedance limit is 1,000 ohms (1 K), and, in the routine diagnostic polysomnogram recorded at 10-15 mm/s using referential EEG channels, an impedance ≤ 10,000 ohms (10 K) is acceptable for all channels.[14-16] Slightly higher impedances are acceptable for limb EMG.[17] However, a maximum impedance of 5,000 ohms (5 K) is recommended for bipolar EEG channels frequently used in extended polysomnography montages when seizure activity is suspected.[18] Limitations associated with EEG, EOG, and EMG monitoring include:

- **7.1.1** displacement of the electrode from the subject's skin causes a reduction, or complete loss, of the signal;
- **7.1.2** failure to properly prepare the skin or drying of the transduction gel inside of the electrode obscures the signal's characteristics;
- **7.1.3** artifactual signals can obscure actual physiologic signals;
- **7.1.4** environmental electrical noise can obscure actual physiologic signals.

7.2 Record of ECG activity. Rhythm ECGs are typically obtained by using two of the described EEG electrodes. Recording a modified Lead-II (right shoulder and left leg) or precordial lead (MCL) is sufficient. Limitations associated with rhythm ECGs obtained during polysomnography include:

- **7.2.1** The recording paper speed used during polysomnography may be slower than that used by cardiac monitors and recorders. This or improper filtering tech-

niques may obscure P-wave or QRS-complex wave morphology.[5]

7.2.2 Other limitations can be the same as described in Section 7.1.

7.3 Record of chest-wall and abdominal movement. A variety of devices exist for measuring chest-wall and abdominal movement including mercury strain gauges, piezoelectric belts, inductance, and impedance pneumography.[1]

7.3.1 Mercury strain gauges are placed on or around the chest or abdomen. Limitations of strain gauges include:[19]

7.3.1.1 The quality and interpretability of the respiratory signal is affected (1) if the gauge slips from its original position and (2) if the patient changes position.

7.3.1.2 Calibration of strain gauges is difficult; consequently, the displayed data are more qualitative than quantitative.

7.3.1.3 The mercury in the Silastic tubing can develop bubbles that can affect signal integrity.

7.3.2 Piezoelectric belts are placed around the chest and/or abdomen. Limitations of piezoelectric belts include:

7.3.2.1 The quality and interpretability of the respiratory signal is affected if belts slip out of their original position.

7.3.2.2 Belts are generally not calibrated; consequently, the displayed data are more qualitative than quantitative.

7.3.3 Inductance plethysmography is accomplished by placing elastic belts around the abdomen and chest of the patient. Limitations of inductance plethysmography include:[20]

7.3.3.1 The slipping of a belt from its original position affects the calibration, and, consequently, the quality and interpretability of the respiratory signal.

7.3.3.2 Calibration of inductance plethysmography is difficult in morbidly obese people, and, consequently, the data are more qualitative than quantitative.

7.3.3.3 The thin wires on the surface of inductance plethysmography belts are easily broken with a consequent loss of the monitored signal.

7.3.4 Impedance pneumography uses 2 or 3 electrodes attached to the patient in a configuration similar to that of a 3-lead ECG. Limitations of impedance pneumography include:[21]

7.3.4.1 The technique provides only a qualitative indication of chest-wall movement. There is no direct relationship to the volume of air within the chest.

7.3.4.2 Because impedance pneumography displays only global chest-wall movement, obstructive apneic events cannot be clearly differentiated from central or mixed apneic events in the absence of airflow measures.

7.3.4.3 No standards exist for the frequency response, precision, and reliability of signal reproductions that represent changes in thoracic impedance.

7.3.4.4 Signal degradation can occur with changes in body position.

7.3.4.5 Impedance pneumography is susceptible to cardiogenic artifact.

7.4 Record of intercostal muscle activity. Intercostal EMG is monitored by gluing or taping small metal-disk electrodes to the patient's intercostal spaces. When these electrodes are placed near the insertion of the diaphragm, they can monitor EMG activity from both the diaphragm and intercostal muscles. Limitations of intercostal EMG recording are the same as those listed in Section 7.1.

7.5 Record of esophageal pressure changes:

7.5.1 Esophageal pressures are monitored via esophageal balloons or liquid-filled catheters, which are attached to pressure transducers and signal amplifiers. Esophageal balloons are inflated with air or liquid, whereas liquid-filled catheters are filled with water or saline. They are inserted into the nares, through the nasopharynx, and into the esophagus to monitor changes in intrathoracic pressures occurring with inspiration and expiration.[22]

7.5.2 An esophageal balloon consists of a catheter attached to an air-filled balloon, which is inserted into the esophagus. Problems with esophageal balloons include:

7.5.2.1 inadvertent tracheal intubation;
7.5.2.2 nasal trauma or irritation;
7.5.2.3 inadequate filling rendering the pressure measurements inaccurate;
7.5.2.4 patient discomfort to a degree sufficient to alter sleep staging;
7.5.2.5 patient movement's altering the position of the catheter, and, thereby affecting the accuracy of the pressure measurements.

7.5.3 Liquid-filled catheters are similar to esophageal balloons. Limitations include:

7.5.3.1 air bubbles in the tubing can alter the characteristics of the pressure transmission through the tubing and cause the pressure readings to be inaccurate;
7.5.3.2 inadvertent tracheal intubation can give rise to irritation or aspiration of a catheter's contents into the lungs;
7.5.3.3 patient movement can alter the position of the catheter, thereby affecting the accuracy of the pressure measurements.

7.6 Record of airflow

7.6.1 Thermistors and thermocouples can provide information about the presence or absence of airflow based on temperature differences between inhaled and exhaled air. The devices incorporate small wiry sensors that can be taped below the patient's nostril and next to the mouth. Limitations include:[23]

7.6.1.1 the devices cannot be calibrated and, therefore, provide only qualitative information;
7.6.1.2 the collection of moisture on a sensor can affect its ability to detect temperature changes and affect signal integrity;
7.6.1.3 dislodgment from the subject results in partial or complete loss of the signal.

7.6.2 Pneumotachometers/pneumotachographs: Pneumotachography is used when quantitation of airflow and volume are necessary. Limitations of pneumotachography include:[24]

7.6.2.1 The patient's nose and mouth must be securely covered (leak free) by a face mask with the pneumotachometer attached to it;
7.6.2.2 The pneumotachometer and face mask are obtrusive and cumbersome and may not be tolerated by the patient and, therefore, may not be suitable for routine polysomnography;
7.6.2.3 Pneumotachography requires calibration at different air flows, and the amplifiers need to be calibrated frequently to ensure linearity.

7.6.3 Recording of tracheal sounds audible via microphone is inexpensive and can be used to quantitate snoring.[7]

7.7 Recording of oxygen saturation (S_{pO_2}). Pulse oximetry transmits two wavelengths of light through a pulsatile vascular bed to measure arterial oxygen saturation. Many factors can affect device accuracy and these have been well described.[25-29] With respect to polysomnography, limitations of pulse oximetry include:

7.7.1 During apneic events, the pulse oximeter may alarm and awaken the patient. Therefore, during polysomnography, it is important that the audible low-oxygen-saturation alarm be disabled. Alarms should be disabled only if a qualified technician is in constant attendance, monitoring the physiologic signals, and able to intervene if clinically indicated.
7.7.2 Not all pulse oximeters have an analog output that can be interfaced with the polygraph recorder.
7.7.3 Pulse oximetry does not reflect total gas exchange (cannot detect changes in P_{aCO_2}).
7.7.4 The polygraph amplifier requires calibration to ensure that the oximeter recording is linear and displayed within institutional requirements (ie, each drop in S_{pO_2} causes a 1-mm pen deflection).
7.7.5 Lengthy signal averaging in some older pulse oximeters may produce imprecise values during acute events such as apnea.[29]

PSG 8.0 ASSESSMENT OF NEED:

In those patients who are suspected of sleep-related respiratory disturbances, periodic-limb-movement

disorder, or other sleep disorders described within The International Classification of Sleep Disorders, Diagnostic and Coding Manual,[6] polysomnography is used to assess and quantify the presence and severity of such disturbances and their effect on oxygenation, cardiac status, and sleep continuity.

PSG 9.0 ASSESSMENT OF TEST QUALITY:

9.1 With respect to sleep-related respiratory disturbances, polysomnography should either confirm or eliminate a diagnosis.

9.2 Documentation of findings, suggested therapeutic intervention, and/or other clinical decisions resulting from polysomnography should be noted in the patient's chart.

9.3 Each laboratory should devise and implement indicators of quality assurance with respect to equipment calibration and maintenance, patient preparation and monitoring, scoring methodology, and intertechnician scoring variances.

PSG 10.0 RESOURCES:

10.1 Equipment:

10.1.1 A polygraph recorder capable of recording a minimum of 10 channels of high-frequency physiologic data. The data should be recorded on strip-chart paper, in ink (or by inkless pens writing on heat-sensitive paper) at a paper speeds from 10-30 mm/s. The polygraph may also be interfaced with an analog or digital storage device (cassette tape, optical disk) that has the ability to store and to print all raw data collected during the study.[30] The polygraph should be equipped with both alternating (AC) and direct-current (DC) bioamplifiers, with user-selectable electrical filters and sensitivities.

10.1.2 To record EEG and EOG, the polysomnographic recorder should have the sensitivity to give a pen deflection of 5.0-10.0 mm for a 50 μV signal. A calibration signal of 50 μV/cm is most common. It is essential that the recorder be calibrated prior to the study because changes in signal amplitude are one criterion for scoring the study.[13]

10.1.3 When recording EMGs, a pen deflection of 2 μV/mm is common; however, the absolute magnitude of the amplitude is irrelevant. Rather, the emphasis is placed upon relative changes in the EMG amplitude.[13]

10.1.4 EEG and EOG signals are amplified with an AC amplifier. The high-frequency-filter setting should be $\geq$ 30-35 Hz with a low-frequency-filter setting of $\leq$ 0.3 Hz.[13]

10.1.5 The EMG signal is also amplified with an AC amplifier. A high-frequency-filter setting of 70-120 Hz and a low-frequency-filter setting $\geq$ 5 Hz are suggested.[13]

10.1.6 To record the rhythm ECGs, two additional EEG electrodes are configured for Leads I, II, III, or MCL. No particular emphasis need be placed on signal amplitude provided the signal is large enough to be discernible.

10.1.7 Output from respiratory effort and airflow-sensing devices and oxygen-saturation data are directed to the recorder and displayed with the other data.

10.1.8 Body position may be determined with mercury switches, with output signal directed to the recorder and displayed with the other data. If body position is monitored by direct observation, the patient's position should be noted at the beginning of the recording and whenever changes in position occur.

10.2 Personnel qualifications:

Level-I personnel are designated as those with at least a high school education but without formal credentialing in polysomnographic technology and with no professional credentialing or licensing. Level-I personnel can be described as those who meet minimal job requirements and have received on-the-job polysomnographic training. Both Level-I and Level-II personnel should work under the direction of a physician specifically trained in the diagnosis and treatment of sleep disorders. Any personnel responsible for observing the patient should hold a current course-completion care in cardiopulmonary resuscitation (CPR) at, at least, the basic life support (BCLS) level and be competent to perform cardiac defibrillation.[31]

10.2.1 Level-I personnel:

10.2.1.1 may perform polysomnography;

10.2.1.2 need to be proficient in patient preparation, sensor application, and operation of the polysomnograph;[2]

10.2.1.3 should be familiar with operating principles and basic troubleshooting of the equipment listed in Section 7.0.

10.2.1.4 have an appreciation for the scoring and interpretation of polysomnograms and their use in the diagnosis of patients with sleep disorders;

10.2.1.5 have effective patient assessment and communication skills relative to recognizing and reporting adverse patient conditions (ie, a decline in the patient's clinical condition).

10.2.2 Level-II personnel

10.2.2.1 should have the knowledge and demonstrated ability to perform Level-I responsibilities, ***and***

10.2.2.2 should be either credentialed or licensed as a Registered Polysomnographic Technician (RPSGT), a Registered Electroencephalographic Technologist (REEGT), Respiratory Care Practitioners (CRTT or RRT), or a Registered Nurse (RN);

10.2.2.3 must demonstrate the ability to score polysomnographic recordings and have an understanding of interpretative methods.

10.2.2.4 should have documented ability to recognize the patterns of polysomnographic variables as they are monitored and recorded enabling the practitioner to differentiate among technical difficulties and occult pathophysiology during polysomnography;

10.2.2.5 should display a proficiency in interpreting respiratory variables affected by initiation of continuous positive or bi-level positive airway pressure or nocturnal ventilatory support and should demonstrate knowledge of normative ranges for such variables as those measured during the monitoring of arterial blood gas, end-tidal CO_2, oxygen saturation, respiratory movement, and airflow;[32]

10.2.2.6 should be able to initiate and titrate supportive therapy for sleep-related respiratory disorders;[32]

10.2.2.7 should be able to assess the patient's response to therapy;

10.2.2.8 should be able to recommend modifications to prescribed therapy, as appropriate;

10.2.2.9 should be familiar with operating principles, interface techniques, data acquisition, scoring, and reporting for other than cardiopulmonary-based studies, such as penile tumescence and seizure disorders.

PSG 11.0 MONITORING:

11.1 During polysomnography, the patient variables to be monitored are those listed in Section 2.2. Intervention is required if the physiologic signals are lost due to problems with instrumentation or become obscured by artifact.

11.2 Infrared or low-light videocameras and recording equipment should permit visualization of the patient, by the technician, throughout the procedure.[30]

11.3 Patients undergoing polysomnography are being evaluated for the presence of a chronic disease; therefore, their clinical status is unlikely to deteriorate acutely. However, the center-based polysomnographic studies described in this guideline require the presence of a technician throughout the study. Therefore, the technician should intervene if an acute change in physiologic status occurs and communicate these changes to appropriate medical personnel.

PSG 12.0 FREQUENCY:

12.1 A second polysomnographic study may be indicated

12.1.1 if the first study is technically inadequate due to equipment failure;

12.1.2 if the subject could not sleep or slept for an insufficient amount of time to allow a clinical diagnosis;

12.1.3 if initiation of therapy or confirma-

tion of the efficacy of prescribed therapy is needed.

PSG 13.0 INFECTION CONTROL:

Practitioners should exercise Universal Precautions and precautions for prevention of the spread of tuberculosis as appropriate.[33,34]

13.1 Nondisposable patient use items (eg, pneumotachometers, face masks, electrodes) should undergo cleaning and sterilization procedures as recommended by the manufacturer. If sterilization is not feasible, then high-level disinfection is warranted.

13.2 The syringe and flat-tipped needle used to inject transduction gel into the EEG, EOG, and EMG electrodes should be discarded after use.

13.3 With respect to body-position sensors, inductance and impedance pneumography, abdominal or thoracic strain gauges, or piezoelectric belts, no special precautions are generally required. Gas sterilization may be used if the sensors or belts become contaminated with body fluids.

13.4 Some thermistors are equipped with disposable sensors. If nondisposable sensors are used, they should be cleaned and subjected to high-level disinfection after use.

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Lyson, Stanley

From: Potts, Lori [LoriPotts@CatholicHealth.net]
Sent: Friday, March 04, 2005 1:20 PM
To: Lyson, Stanley
Cc: mrunge@primecare.org
Subject: Sleep-1280

59th Legislative Assembly
Senate Human Service Committee
HB 1280

Senator Lyson,

As the individual who overseas the sleep center in our medical center I am opposed to HB 1280 and I am asking that you vote DO NOT PASS on HB 1280. The passage of this bill would put the safety and well being of the citizens of North Dakota at risk by making certain individuals who perform sleep studies exempt from a law that was put into effect to protect the North Dakota citizens. These individuals would in effect with this bill be unlicensed and unregulated. I feel that asking to be to exempt from a law is not promoting a profession.

We believe this issue should be dealt with on a national level and is currently being collaborated on between the AASM (American Academy of Sleep Medicine) and the AARC (American Association or Respiratory Care). This would eliminate a state law on this issue.

This bill is not needed because there is no person or hospital in the state who is in violation of the current law and not passing the bill would not hinder anyone's job nor would they lose their job. I urge you to vote DO NOT PASS on HB 1280.

Lorraine Potts
Respiratory Care and Sleep Lab Manager
Mercy Medical center
Williston, ND

North Dakota State Board of Respiratory Care

Box 2223 • Bismarck, North Dakota 58502

Date 09/17/01

Dear Sponsor: Steve.

We are very pleased to inform you that the program(s) you have submitted for Continuing Education Units have been granted approval by the North Dakota Society for Respiratory Care. You will notice below, each approved lecture, presentation, program has been assigned a provider number and allotted CEU's. Please make this number available to the attendees, who may utilize it upon licensure renewal.

Sincerely,

Brian Mehl BS RRT

North Dakota State Board of Respiratory Care

PROVIDER #	TITLE	CEU(s)
R00155T	Schloff Viral Polysomnography	2.0

BRPT™ Candidate Handbook 2005

for Polysomnographic Technologists

RPSGT™

Registered Polysomnographic Technologist

Examination Dates

June 11, 2005

December 10, 2005

Application Deadlines

March 11, 2005

September 9, 2005

PREFACE

2005 will be another active year marked by far-reaching change for the Board of Registered Polysomnographic Technologists (BRPT™). Following reflection on the first 25 years of BRPT™ history, the Board is poised to move forward with a strategic plan that will continue to improve the examination and the application process. A banquet celebrating the 25th anniversary of the BRPT™ held during the APSS meeting in Philadelphia allowed an opportunity to gather together influential voices over the history of the organization, and to listen to those voices regarding the direction of the RPSGT™ examination.

As the number of RPSGT's™ surpassed 7000 following the December 2004 exam, we find that registered technologists are expanding the role of the technologist in the field of Sleep Medicine. During the past year the BRPT™ performed a new role delineation survey. The goal of this survey was to evaluate the current role of the technologist. The process initiated with a meeting of a group of practitioners representing a diverse cross-section of geographic areas, experience levels and job descriptions. James Penny PhD, the Psychometrician charged with oversight of the RPSGT™ exam led the group. The purpose of this group was to determine the major domains of practice that represent the job of the polysomnographic technologist, the tasks necessary in that domain, and the knowledge, skills and abilities necessary to perform the task. A group of exam development committee members reviewed this work and made minor modifications prior to mailing to a large group of practitioners who reviewed the tasks to determine how important each task was, how critical they were and how frequent each task was performed. These ratings determined the content outline that will provide the structure of the RPSGT™ exam for the next several years.

To respond to communications from technologists regarding expanding services, the BRPT™ recruited the expertise of a Certified Management Consultant with extensive experience in certification to assess viability. A focus group was convened to include input from various stakeholders into the process. Subsequent telephone contacts with representatives from sleep organizations preceded an on-line survey. Though the results of the survey gave only limited support for expanding certification options, there was strong support for expanding and improving services to candidates and certificants. Some of the enhancements to be enabled that are consistent with the current BRPT™ strategic plan include a doubling of testing sites for 2005, development of an on-line application process, a faster turn-around time for score reports and improvements to the web site that include a streamlined reference list and shopping cart access to these references. Development of a study guide and practice exam will be complete early in 2005 to facilitate the BRPT™ goal of improving the pass rate of candidates for the RPSGT™ exam.

The BRPT™ insider was successfully launched to improve communication to certificants. Further enhancements to facilitate communication are planned for 2005. Eligibility requirements were modified to facilitate a pathway to certification for holders of certifications in recognized specialty fields, and graduates from educational programs with endorsement in polysomnography accredited by the Commission on the Accreditation of Allied Health Programs (CAAHEP). A task force will be convened to evaluate recertification options, and assure that the BRPT™ recertification program meets current standards and the needs of certificants. Continued support of legislative issues at the state level, and a presence of the BRPT at relevant conferences will endeavor to enhance the value of the RPSGT™ credential. Ongoing judiciary process and examination development activities assure that the strength developed over the last 25 years will allow the BRPT™ to continue to meet and exceed standards in certification as we begin the next 25 years.

Mark A. DiPhillipo
President, Board of Registered Polysomnographic Technologists

TABLE OF CONTENTS

INTRODUCTION

The RPSGT™ Examination assesses the professional competence of practitioners performing polysomnography and associated therapeutic interventions. The BRPT™ credentialing program is accredited by the National Commission of Certifying Agencies (NCCA).

Successful achievement of a passing score on the examination is required for an individual to earn the Registered Polysomnographic Technologist (RPSGT™) credential. Each candidate must demonstrate competence in all technical aspects of polysomnography commensurate with the standards established by the Board of Registered Polysomnographic Technologists (BRPT™) for effective and safe patient care. **All candidates and RPSGT™ certificants are required to observe the BRPT™ Standards of Conduct.**

The BRPT™ performs a role delineation survey, or "job analysis" of the profession, on a five-year cycle to ensure that examination development reflects current practices in the field. Geographically diverse survey respondents determine the role of Polysomnographic Technologists in terms of tasks required for competent job performance. Survey results provide contemporary information to delineate the appropriate content, scope and complexity for the RPSGT™ examination. Using educationally sound systematic test development procedures, the BRPT™ Examination Development Committee (EDC) has written the RPSGT™ examination to meet the specifications for testing as derived from the role delineation study. Current exam content is based on a role delineation survey completed in 2004.

The BRPT™ has developed this candidate handbook to describe all aspects of the credentialing process and assist you in preparing for the examination. This handbook contains an overview of examination content, admission policies, rules for taking the examination, an examination application, suggested study resources and pertinent facts concerning administrative policies governing the examination. It also describes the content and procedures for all parts of the examination process. Sample questions are provided to help you become more familiar with the types of questions appearing on the comprehensive multiple-choice examination. ***(NOTE: The BRPT will offer in early 2005 a comprehensive RPSGT™ Study Guide as well as online practice examinations, both available through www.brpt.org.)***

All candidate inquiries will be handled through the BRPT™ Management Office at Association Management Group, located in McLean, Virginia. The BRPT Management Office is the main point of contact for candidates regarding all aspects of the testing procedure as well as general information. All Inquiries should be directed to:

BRPT Management Office
8201 Greensboro Drive, Suite 300
McLean, VA 22102

Telephone: (703) 610-9020
Fax: (703) 610-9005
e-mail: info@brpt.org
web site: www.brpt.org

BRPT™ MISSION STATEMENT

The Board of Registered Polysomnographic Technologists (BRPT)™ administers a comprehensive examination, consistent with accepted credentialing standards, that measures acceptable competency levels for polysomnographic technologists.

BRPT™ VISION STATEMENT

The Board of Registered Polysomnographic Technologists™ promotes national and international acceptance of the RPSGT credential as the professional standard for polysomnographic technologists.

STATEMENT OF NONDISCRIMINATION

The BRPT™ does not discriminate among applicants on the basis of age, gender, race, religion, national origin, disability, marital status or sexual orientation.

ADMINISTRATIVE POLICIES AND RULES FOR EXAMINATION

EXAMINATION OVERVIEW

The RPSGT™ examination is developed and administered in accordance with the 1999 "Standards for Educational and Psychological Testing" (American Education Research Association, American Psychological association, and National Council on Measurement in Education) as well as the 1978 "Uniform Guidelines on Employee Selection Procedures" (Equal Employment Opportunity Commission, et al). The exam consists of 200 multiple-choice items. The test presents each question with four response alternatives (A, B, C, and D). One of these represents the single best response, and credit is granted only for selection of this response. Candidates are permitted four hours to complete this test.

ELIGIBILITY REQUIREMENTS

In order for candidates to sit for the RPSGT™ examination, they must satisfy the following eligibility criteria: **SECTION I --**

1. Complete a minimum of *18 months*** *of paid clinical experience* * where duties performed are primarily polysomnography;

OR

Complete a minimum of *6 months* **of paid clinical experience* * where duties performed are primarily polysomnography **AND** provide proof of credentialing **(national registry NOT state license)** in a health-related field accepted by the BRPT (e.g., nursing, respiratory care, electroneurodiagnostics, or national EMT-P.) **Applicants MUST submit a copy of a certificate or official correspondence from the credentialing agency with the application if mailed, or in the case of online applications, forwarded to complete eligibility.**

OR

Successfully complete a program with special recognition in polysomnography , as accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP). See page 38 for currently approved programs. **An official transcript documenting graduation from a qualified program must be submitted with the application if mailed, or in the case of online applications, forwarded to complete eligibility.**

AND

2. **Be currently (and as of the date of the examination) certified in Basic Cardiac Life Support** (BCLS), Cardiopulmonary Resuscitation (CPR) or its equivalent (international only). A copy of current BCLS card, or the equivalent, must be enclosed with the application. BCLS certification submitted must still be valid at the time that the application is filed **and at the time of examination.**

AND

3. **Follow the BRPT™ Standards of Conduct.**
   The BRPT randomly audits candidate eligibility and may request physical documentation of clinical experience. The signatory of the experience verification section on the application is responsible for verifying any experience the candidate may have had with a previous employer.

Eligibility for the RPSGT™ examination and maintenance of the RPSGT™ credential once achieved, requires adherence to the BRPT™ Standards of Conduct. RPSGT™ candidates are required to sign a statement on the application form that they understand violations of the BRPT Standards of Conduct may result in loss of eligibility to sit for the RPSGT™ examination, or the suspension or revocation of the RPSGT™ credential.

STANDARDS OF CONDUCT FOR REGISTERED POLYSOMNOGRAPHIC TECHNOLOGISTS™

PREAMBLE

The Board of Registered Polysomnographic Technologists (BRPT)™ is a nonprofit corporation that provides board certification and re-certification for Polysomnographic Technologists. The BRPT™ is an independent organization, governed by a Board of Directors including a diverse group of experts in polysomnographic technology. The Board is international in scope and blends both technologists and physicians for the purpose of establishing rigorous standards that have a basis in a real world practice.

The BRPT™ seeks to encourage, establish and maintain the highest standards, traditions and principles of polysomnographic technology. Individuals who hold the RPSGT™ credential should recognize their responsibilities, not only to their patients, but also to society, to other health care professionals and to themselves. All candidates for BRPT™ registration, and all Registered Polysomnographic Technologists (RPSGT™), shall abide by the BRPT™ Standards of Conduct and all other BRPT™ rules, policies and procedures. Individuals who fail to meet these requirements may have their credential suspended or revoked or be declared ineligible for certification by examination. The BRPT™ does not warrant the job performance of any individual.

STANDARDS OF CONDUCT

Registered Polysomnographic Technologists™, as health care professionals, must strive as individuals and as a group to maintain the highest of professional and ethical standards. The following statements are standards to guide those individuals holding the RPSGT™ credential in their professional activities.

Registered Polysomnographic Technologists™ and RPSGT™ Candidates shall:

- Do everything within their scope of authority to ensure that currently accepted professional standards are complied with in the department in which they work.
- Keep the health and safety of the patient in mind at all times and act in the best interest of the patient.
- Provide care without discrimination on any basis, respecting the rights and dignity of all individuals.
- Respect and protect the legal and personal rights of the patients that they treat.
- Comply with governmental rules and regulations that relate to and govern their scope and standards of practice.
- Divulge no confidential information regarding any patient or family unless disclosure is required for responsible performance of duty, or required by law.
- Refuse to participate in unethical or illegal acts; and refuse to conceal illegal, unethical or incompetent acts of others.
- Avoid any form of conduct that creates an impermissible conflict of interest, following the principles of ethical business behavior.

- Refuse primary responsibility for interpretation of polysomnographic procedures, provided, however, that individuals who are licensed or otherwise authorized by practice standards to provide interpretation are excluded from this standard.
- Actively maintain and continually improve their professional competence, and represent it accurately.
- Demonstrate behavior that reflects integrity, supports objectivity, and maintains a positive public image of the profession and its professionals.
- Maintain RPSGT™ registration as defined by the BRPT.

All Candidates will be governed by the policies current at the time of their application for the exam. Eligibility for the RPSGT™ may be suspended or revoked for any of the following:

- Obtaining or attempting to obtain credentialing by fraud, deception or artifice.
- Knowingly assisting another person or other persons in obtaining, or attempting to obtain credentialing by fraud, deception or artifice.
- Illegal use of an RPSGT™ certificate or falsification of credentials.
- Unauthorized possession and/or distribution of any official testing or examination materials.
- Violation of the BRPT™ Standards of Conduct.

APPLICATION PROCEDURES

To apply for the RPSGT™, you **must** complete an examination application for the **current** year, **including all documentation verifying eligibility requirements and correct examination fees**. NEW IN 2005: RPSGT™ candidates in early 2005 will now have the option of **ONLINE APPLICATIONS** at www.brpt.org for the RPSGT™ examination using any major credit card. The mail in option is still available as another option. To obtain a **current** application form, go to www.brpt.org and print the application and/or Candidate Handbook for free or please mail a $10 money order to the BRPT™ office for a pre-printed application package. (Include name, address, day time phone # and e-mail address.)

BRPT Application Processing Department
8201 Greensboro Drive, Suite 300
McLean, VA 22102

Telephone: (703) 610-9020
Fax: (703) 610-9005
e-mail: info@brpt.org
web site: www.brpt.org

Examination Fees

The examination fee for **online** applications must be paid by any major credit card at the time the application is submitted. Examination fees for mailed applications must be paid by certified check, cashier's check or money order. Any other form of payment will be returned and the application will not be processed. (**Note: Personal checks are not accepted.**)

Type of Payment	Credit Card	Certified Check, Cashier's check, Or Money Order
RPSGT™ Exam Fee	$300.00 (U.S.)	300.00 (U.S.)

Examination Application and Related Postmark Deadlines

Applications and other requests outlined below must be sent by mail; **all deadlines refer to USPS POSTMARK, or recorded date entered into UPS, FED EX or other national carriers system. EXCEPTION; ONLINE APPLICATIONS must be processed AND supporting documentation received by the application deadline date.** The table below gives important deadline dates.

RPSGT™ Administration	1. Application Deadline	2. Supplemental Test Center Request**	3. Change of Test Center	4. Postponement within 1 year: Transfer of Fees*	5. Withdrawal: Refund of Fees
June 11, 2005	March 11, 2005	Feb. 25, 2005	April 8, 2005	April 8, 2005 * $40.00 (U.S.) transfer fee must be included with request	By Apr. 29, 2005 for a full refund of fees * By May 13, 2005 for 50% refund of fees * NOTE: After May 13, 2005: No refund of fees shall be issued. * Less a $25.00 (U.S.) processing fee.
Dec. 10, 2005	Sept. 9, 2005	August 26, 2005	October 5, 2005	Oct. 5 2005 * $40.00 (U.S.) transfer fee must be included with request	By Oct. 27, 2005 for a full refund of fees * By Nov. 10, 2005 for a 50% refund of fees * NOTE: AFTER Nov. 10, 2004: No refund of fees shall be issued. * Less a $25.00 (U.S.) processing fee.

****Supplemental test center request requires a minimum of 12 candidates, unless special arrangements have been made with the BRPT office.**

1. Application Deadline:

Mailed applications must be postmarked from an official government post office, or recorded in the delivery system of UPS, FEDEX, or other similar national carrier on or before the application deadline to be accepted. ONLINE APPLIATIONS must be entered and the mailed documentation received in the BRPT office on or before the application deadline as indicated above. Candidates will not be considered for admission to the examination until the examination application is complete and all required documentation is received. Upon receipt of a mailed application the BRPT™ management office will issue a postcard to the applicant indicating the application has been received. Note that receipt of postcard acknowledgment does not mean that the application is complete or correct, only that it has been received. ONLINE APPLICATIONS are confirmed at the time of electronic processing. Candidates will receive notice of acceptance to sit for the examination and information regarding the specific location of exam administration approximately four weeks prior to the examination date.

2. Procedure for Requesting Supplemental Test Sites:

Supplemental test centers may be requested if **twelve (12) or more candidates** can be guaranteed to attempt the examination at the site. Parties interested in arranging a supplemental site should contact the BRPT™ management office. Supplemental site arrangements must be requested in writing and postmarked on or before the Supplemental Test Center Request Deadline (see previous table). **No requests for a supplemental test site will be taken over the telephone.**

Requests should include a contact person's name, address, phone number and a list of a minimum of 12 candidates. Specific arrangements for test site facilities will be made by the BRPT™. The BRPT reserves the right to cancel or deny supplemental test center sites as deemed necessary. **Test site additions or cancellations for each administration will be published on the BRPT™ website at www.brpt.org. NOTE: "In order for the supplemental test site to be formally approved, a minimum of 12 candidates requesting the supplemental site must have applications with payment submitted no later than the regular application deadline. A site test code for a requested supplemental test site will not be issued until after the site is formally approved. Candidates requesting supplemental test sites must also list an alternative test site from the established test sites on page 9 in the event the supplemental test site is not approved.**

3. Changing Test Center:

To change your original test center request, The BRPT™ Management Office must receive your request in writing, postmarked no later than **45 business days** prior to the examination date (see previous table for exact dates). **No requests for a change of test center will be taken over the telephone.**

4. Examination Postponements with Transfer of Fees:

A candidate may postpone their examination and transfer examination fees to another test date within the next 12 months only. Requests must be submitted in writing to the BRPT™ Management Office, postmarked at least 45 **business** days prior to the examination date (see previous table for exact dates). **No requests for postponement will be taken over the telephone.** A candidate who postpones an examination will be charged a $40.00 (U.S.) fee to cover the cost of rescheduling the examination and forwarding all documentation to the next administration. **Include the $40 exam postponement fee (check or money order payable to the BRPT™) with your request.** Postponement requests sent without this transfer fee cannot be processed. Requests for postponement postmarked ***after*** the deadline will not be accepted. A candidate may only postpone an examination once without forfeiting the total examination fee.

5. Withdrawal from an Examination and Refund of Fees:

Candidates submitting written requests for withdrawal from an examination, postmarked no later than 30 **business** days prior to the scheduled examination are eligible to receive full reimbursement of application fees, less a $25.00 (U.S.) processing fee per application. Candidates requesting withdrawal from examination in writing, postmarked no later than 20 **business** days prior to the scheduled examination, are eligible to receive reimbursement for one-half of the application fee, less a $25.00 (U.S.) processing fee per application. **Requests for withdrawal made later than 20 business days prior to the exam date will receive no refund.** The BRPT™, however, may consider unusual circumstances when provided with supportive documentation that is sent within 20 **business** days after the examination date. (See additional information under Candidate Grievances).

6. Auditing of Applications:

The BRPT™ has a policy of auditing applications on a random basis, or where eligibility appears questionable to verify the applicant's eligibility to sit for the exam. A candidates whose application is being audited will be notified in writing by the BRPT™ and given a reasonable time frame to provide the additional documentation required. If a candidate does not respond by the deadline, or does not provide the required documentation within the given time frame, the candidate will be declared ineligible and application fee will be returned less a processing fee of $40.00. If the audit cannot be concluded prior to the examination date, the score report will be withheld until documentation is provided and application fees will not be refunded.

NOTE: Examination applications, as well as any requests for site changes, site additions, examination postponement or withdrawal must be submitted in writing to the BRPT Management Office, 8201 Greensboro Drive, Suite 300, McLean, VA 22102, with associated fees as described above.

Special Examination Accommodations

The BRPT™ complies with the Americans with Disabilities Act (ADA) and is interested in ensuring that no individual is deprived of the opportunity to take the examinations solely by reason of a disability as defined under the ADA. Forms for requesting special accommodations and documentation of disability-related needs are included on pages 40-41. Applicants requiring special accommodations must complete both forms and submit them with their application postmarked by the application deadline as specified on page 6. Requests for special testing accommodations require documentation of a formally diagnosed and qualified disability by a qualified professional who has provided evaluation or treatment for the candidate. **Requests without proper documentation or arriving past the application deadline will not be considered.**

Standard Testing Centers

Test centers have been selected to provide the greatest accessibility to the most candidates. Additional test centers may be requested, as previously described in the section, **Procedure for Requesting Supplemental Test Sites.** A list of test centers for each examination administration follows. **Use the test center codes included in this list to complete section 11 of the application.** Supplemental sites updates will be listed on the BRPT™ web site at www.brpt.org The exact location of the testing center in each city may change with different test administrations, depending on the availability and/or the number of candidates admitted. Candidates will be advised on the exact location of the assigned test center on the admission letter that is sent from Castle Worldwide, Inc., four weeks prior to the test date.

2005 RPSGT Examination Table of Established Test Centers

SITE CODE	SITE—STATE	SITE--CITY	JUNE 11	DECEMBER 10
001	ALABAMA	BIRMINGHAM		X
002	ARIZONA	PHOENIX		X
035	ARIZONA	TUCSON	X	
032	ARKANSAS	LITTLE ROCK		X
003	CALIFORNIA	LOS ANGELES	X	
054	CALIFORNIA	OAKLAND	X	
004	CALIFORNIA	SACRAMENTO	X	
012	CALIFORNIA	SAN DIEGO		X
005	CALIFORNIA	SAN FRANCISCO		X
006	COLORADO	DENVER	X	
105	FLORIDA	JACKSONVILLE	X	
101	FLORIDA	MIAMI		X
008	FLORIDA	ORLANDO		X
016	FLORIDA	TAMPA	X	X
009	GEORGIA	ATLANTA	X	X
106	GEORGIA	MACON	X	
109	GEORGIA	SAVANNAH		X
010	ILLIONIS	CHICAGO	X	X
147	ILLIONIS	SPRINGFIELD	X	
153	INDIANA	INDIANAPOLIS	X	
021	KENTUCKY	LOUISVILLE		X
034	LOUISIANA	NEW ORLEANS		X

225	MARYLAND	BALTIMORE	X	
011	MASSACHUSETTES	BOSTON	X	X
401	MASSACHUSETTES	SPRINGFIELD		X
013	MICHIGAN	DETROIT	X	X
240	MICHIGAN	LANSING		X
014	MINNESOTA	MINNEAPOLIS	X	X
025	MISSOURI	KANSAS CITY	X	X
015	MISSOURI	ST. LOUIS	X	X
281	NEBRASKA	OMAHA		X
310	NEW HAMPSHIRE	MANCHESTER	X	
026	NEW MEXICO	ALBUQUERQUE	X	
017	NEW YORK	ALBANY	X	
332	NEW YORK	BUFFALO	X	
018	NEW YORK	NEW YORK	X	X
337	NEW YORK	SYRACUSE		X
043	NORTH CAROLINA	CHARLOTTE	X	
019	NORTH CAROLINA	RALEIGH		X
020	OHIO	CINCINNATI	X	X
031	OHIO	CLEVELAND		X
362	OHIO	COLUMBUS	X	
374	OKLAHOMA	OKLAHOMA CITY		X
022	OREGON	PORTLAND	X	X
024	PENNSYLVANIA	PHILADELPHIA		X
023	PENNSYLVANIA	PITTSBURGH	X	X
413	SOUTH CAROLINA	COLUMBIA		X
033	TENNESSEE	KNOXVILLE	X	
027	TEXAS	DALLAS	X	X
028	TEXAS	HOUSTON		X
444	TEXAS	SAN ANTONIO	X	
029	UTAH	SALT LAKE CITY	X	
474	VIRGINIA	NORFOLK		X
030	WASHINGTON	SEATTLE	X	X
487	WEST VIRGINIA	CHARLESTON		X
491	WISCONSIN	MILWAUKEE	X	
302	QUEENSLAND, AUSTRALIA	BRISBANE		X
200	CHINA	HONG KONG	X	
202	VICTORIA, AUSTRALIA	MELBOURNE	X	
403	JAPAN	NAGOYA	X	
402	JAPAN	OSAKA		X
102	ONTARIO, CANADA	TORONTO	X	X
100	BRITISH COLUMBIA, CANADA	VANCOUVER	X	

ACCEPTANCE FOR EXAMINATION:

If your application is accepted, an admission letter showing the exact reporting location of the test center will be mailed to you from Castle Worldwide, Inc. **approximately four weeks before the test.** If you do not receive an admission letter one week preceding the examination, call the BRPT™ Management Office at **(703) 610-9020** or e-mail at **info@brpt.org.**

If your application is not accepted, a letter of explanation will be mailed to you no later than four weeks before the test date. **Please be sure to include all required documentation with your application to avoid having your application denied.**

NOTE: Applicants are strongly encouraged to make sure they know the exact location and physically drive to the exam site prior to the examination date to prevent getting lost and arriving late. In addition it is strongly recommended that you allow extra time for arrival in the event of unforeseen circumstances such as a traffic delay, flat tire, etc. Late arrivals will NOT be admitted.

IMPORTANT: The mailing address you provide on your application will be used to mail your admission letter and test results, unless you indicate a change of address no later than 30 business days prior to examination. If you have a change of address after that time, leave a forwarding address with your post office to ensure that the mail will be forwarded to your new address.
Contact the BRPT™ Management Office as soon as possible with your new contact information.

ON THE DAY OF THE EXAMINATION:

Candidates should report to the test center on the day of examination as instructed on their admission letter. Seating of candidates, distribution of test materials and testing instructions will occur prior to the start of the examination; therefore, the total amount of time required for the examination procedure may exceed four hours and candidates should be at the test site 30 minutes prior to the scheduled start time. **Examinations start at 8:00 a.m. with recommended arrival no later than 7:30 a.m. (unless otherwise noted on your admission ticket)**

- Take your admission letter to the test center. You will be required to show your admission letter to the supervisor to gain admission to the test center.

- You must present a legal document bearing your picture and signature, such as a current driver's license, government issued identification card, or a notarized photograph bearing your signature in order to gain admission to the test center. PROPER IDENTIFICATION MUST BE PROVIDED TO GAIN ADMISSION TO THE TEST CENTER.
  Please note: **Employment and Student I.D. cards are not acceptable.**

- Report to the test center no later than the time indicated on your admission letter. Anyone who arrives after testing begins **WILL NOT BE ADMITTED.**

- You should bring two sharpened #2 pencils with you to the examination. Pencils and erasers may not be available at the test center.

- You may wish to take your watch to the examination to help pace yourself on the test. The test center supervisor will keep the official time and ensure that you are given the proper amount of time for the test.

- **NONE of the following are permitted in the examination room or center:**
  - books, slide rules, papers, dictionaries or other reference materials
  - electronic devices, including telephones, signaling devices such as pagers, cell phones, alarms, or recording / playback devices of any kind.
  - calculators (other than those provided by BRPT™)

- No test materials, documents or memoranda of any kind are to be taken from the examination room.

- Questions concerning the content of the examination will not be answered during the test. Listen carefully to the instructions given by the supervisor and read all directions thoroughly.

- The supervisor may dismiss a candidate from the test for any of the following reasons;
  - If the candidate's admission to the test in unauthorized;

- If a candidate creates a disturbance or gives or receives help;
- If a candidate attempts to remove test materials or notes from the testing room;
- If a candidate attempts to take the test for someone else.
- If a candidate has in his/her possession any item excluded from the test center as specified above.
- If candidate exhibits behavior consistent with memorization of exam items.

Hazardous Weather

In the event of hazardous weather, or any other unforeseen emergencies occurring on the day of an examination, the BRPT™ and the testing agency will determine whether circumstances warrant the cancellation, and subsequent rescheduling, of an examination at a particular test center. The test will not be rescheduled if the proctor and a majority of the candidates arrive at the test center. Every effort will be made to keep test centers open. Candidates may contact the testing agency at (919) 572-6880 (24 hrs per day) prior to the examination to determine if any test centers have been closed. Cancellation information will also be reported to area radio and television stations as feasible. Every attempt will be made to administer all examinations as scheduled; however, should an examination be cancelled at a test center, all scheduled candidates will receive notification following the examination date regarding rescheduling.

Test Security

All examination materials are the property of BRPT™. Removal of test booklets or other material from the examination room by unauthorized persons is prohibited, and each candidate must return all test materials, including calculators, to the test supervisor at the conclusion of the examination. Copyrights for the RPSGT™ examination are owned by BRPT™. Any attempt to reproduce all or part of the examination is prohibited by law unless written permission is obtained from the BRPT™. To protect the security of the examinations and maintain the validity of test scores, candidates will be required to sign the following Notice and Agreement before they are allowed to open the test booklet:

NOTICE AND AGREEMENT: You may not have any person, whether paid or unpaid, take the examination on your behalf. In addition, you may not share any portion of this examination, by any means including memorization, with anyone. If you fail to comply with these restrictions, the Board of Registered Polysomnographic Technologists™ will void your test results, and you may be subject to legal action.

TEST SCORING AND SCORE REPORTING:

Item Analysis

Following the administration of each RPSGT™ examination and prior to final scoring of an examination, members of the Examination Development Committee (EDC) evaluate the performance of items on the examination. Any item that does not demonstrate sound psychometric characteristics is closely examined to determine whether it is in any way flawed. If content experts agree that an item is flawed, appropriate adjustment to the test scoring is made.

Equating and Passing Score

To ensure the integrity and security of the test, every form of the RPSGT™ examination consists of a unique combination of items. Thus no two versions of the RPSGT™ examination are identical. Although different forms of the examination conform to the same content outline and are built to be similar in terms of their difficulty level, they are not precisely equivalent with respect to test difficulty. The BRPT™ uses equating procedures for determining the passing score for each RPSGT™

examination to ensure that candidates of comparable proficiency will be equally likely to pass the examination regardless of minor fluctuations in overall difficulty level across administrations of the RPSGT™ examination. Equating is a statistical process that adjusts the minimum passing score for each form of the RPSGT™ examination to compensate for any fluctuations in difficulty level across the different examination forms. Note that this process is not dependent upon the performance of individual candidates from a particular test group. The passing score is determined by a pre-set criteria-based performance standard.

Raw and Scaled Scores

The BRPT™ provides RPSGT™ candidates with information on their performance on the test both in terms of raw scores and scaled scores. The raw score is the number of test questions answered correctly. The minimum raw passing score may differ from one administration to the next because of variations in difficulty level of the examination forms. After equating procedures are completed, raw scores are mathematically converted to scaled scores that can range from 200 to 500 and the scaled score of 350 always represents the minimum passing score. Scaled scores are equivalent for all administrations. Scaled scores are not "number correct" or "percent correct" scores.

Score Processing

Score processing is more than a simple process of scanning answer sheets, calculating a score and printing a score report. There are several system checks and routines in place that must be run in order to produce accurate score reports. When examination materials are returned from test sites (domestic and international), the answer sheets are scanned and any answer sheet with questionable marks is flagged. A preliminary analysis of test item characteristics is produced and members of the Examination Development Committee (EDC) review questionable items. This review permits the EDC to make adjustments to scoring if there are any flawed test items. A final scoring key is produced and all answer sheets are scored. Equating procedures are performed and sample score reports are reviewed to make sure that all information reported (e.g. total scores, sub scores and text of the report) is accurate. Score reports are then printed, prepared for distribution, and mailed.

Score Reporting

Test results will be mailed to all examinees approximately 20-business days (approximately 4 weeks) following the examination. **No results will be provided prior to this mailing, and results will never be provided over the telephone.**

In the event that an irregularity is discovered during the examination or during audits of candidate eligibility, or as directed by judiciary inquiry, test scores for the candidate in question may be withheld pending results of a judiciary investigation.

Cancellation of Scores:

The BRPT™ is concerned with reporting only valid scores. On rare occasions, circumstances may make test scores invalid. The BRPT™ reserves the right to cancel or withhold test scores if there is any reason to question their validity. Scores declared invalid and cancelled may be grouped into two categories.

- Doubts may be raised about the validity of candidates' scores because of suspected misconduct; in such circumstances, candidates should cooperate in the investigation of their scores. Such candidates will be notified of procedures to ensure fair treatment.

- Some scores may be rendered invalid due to circumstances beyond candidates' control, such as faulty test materials or mistiming. In this event, retesting will be arranged.

In addition to the reasons listed above, the BRPT™ may cancel or invalidate examination results if, upon investigation, violation of BRPT™ policies outlined in this publication have been committed.

Candidate Grievances:

Disagreement with test results or complaints concerning application or testing procedures must be made in writing to the BRPT Executive Director at, 8201 Greensboro Drive, Suite 300, McLean, VA 22102. **Grievances concerning a specific exam administration must be submitted to the BRPT™ within 40 business days of that exam administration.** The BRPT™ secretary will inform the complainant in writing of the Board's decision. This process will take approximately, but not limited to, three months.

Requests for Manual Scoring of Answer Sheets:

Candidates who receive a failing score may request a manual scoring of their answer sheet. Requests should be submitted by using the online form at www.brpt.org with credit card payment or submitted in writing and mailed to the BRPT Management Office with a $25.00 fee (money order or certified check) made payable to the BRPT. Upon receipt of a written request and appropriate fee, the candidate's answer sheet will be manually re-scored. Requests for manual scoring of answer sheets must be received in the BRPT Management Office no later than 60 **business** days following the examination administration. Requests received later than that will not be honored. Request for manual scoring will be processed within 30 days after receipt of request and appropriate fee.

To ensure correct reporting of results, CASTLE Worldwide, Inc. performs general quality assurance procedures prior to mailing test results. The procedures include manually scoring a random sample of answer sheets from candidates who score within one unit of passing. Thus, it is extremely unlikely that manual re-scoring will result in a change in examination results.

BRPT™ Certificates:

In addition to test score results, successful candidates will receive a certificate to document that they have earned the RPSGT™ credential. Certificates will be mailed to successful candidates within six weeks of the examination.

Candidates must make sure that the name printed on the examination application is correct. The name on the application and admission ticket will be used on the certificate. Candidates are asked to make any corrections (e.g. minor spelling errors, incorrect middle initial) to their name on their admission tickets and give it to the test site supervisor on the day of examination.

Corrections (e.g. name changes) to certificates after their initial printing or replacements of lost or damaged certificates are available from the BRPT™ Management Office. Requests for corrected or replacement certificates may be made using the online form and major credit card, or submitted in writing with a $25 fee payable to BRPT in the form of certified check, money order or major credit card.

NAME/ADDRESS CHANGES:

Candidates who have a change in their mailing address must notify BRPT™ in writing to ensure that admission tickets, score reports and certificates are sent to the correct address and received in a timely manner. Change of address requests should be mailed to BRPT™ Management Office or submitted by e-mail to info@brpt.org.

The BRPT™ issues certificates to successful candidates in their legal name. Candidates who legally change their name must notify the BRPT™ in writing. Name change requests should be

mailed to the BRPT™ Management Office. Please note that a notarized copy of official or certified documentation supporting the request (e.g. a notarized copy of a marriage certificate) must be included with the request. Requests received without official documentation will not be processed. A $25.00 (U.S.) fee is required for additional/new certificates. These duplicate or replacement certificates can be ordered online at www.brpt.org with a major credit card, or by certified check, money order payable to BRPT™ and mailed to the BRPT™ Management Office.

Re-Examination:

Candidates who do not pass an examination, or who fail to appear for a scheduled examination, may be admitted to a future examination. Certificants may not retake the RPSGT™ except as specified by the BRPT™ re-certification policy. All candidates must complete another application form and pay the appropriate fee by the established application postmark deadline for the examination. Candidates must also meet all eligibility requirements in effect at the time of subsequent application.

Verification of Credentials:

Individuals or institutions may request written verification of an individual's registry number from the BRPT™ Management Office. Also there is a searchable RPSGT™ directory located at www.brpt.org. Requests may be made to the BRPT™ Management Office in writing, by telephone or email.

Duplicate or Replacement Certificates:

If a certificate is lost or damaged, a $25 fee must accompany the written request for replacement, and sent to the BRPT™ Management Office.

NEW IN 2005 - Optional Custom Framed Certificates:

Optional Custom Framed Certificates for an additional charge are available through the BRPT™ by going to the www.brpt.org website.

NEW IN 2005 - RPSGT™ Custom Imprinted Items:

The RPSGT™ Logo has been updated and custom imprinted apparel, business cards and other items will be added to the BRPT www.brpt.org website store in 2005. Check it out!

Disciplinary Action:

The BRPT™ has established a judiciary process designed to identify violations of the Standards of Conduct for Registered Polysomnographic Technologists™ and to determine appropriate disciplinary action. (See page 5). RPSGT™ candidates and Registered Polysomnographic Technologists™ alleged to have committed a violation of BRPT™ policies are given an opportunity to refute the allegations before the Judiciary Committee takes any action. Procedures for filing a complaint and the judiciary process for responding to complaints or allegations may be requested from the BRPT™ Management Office or viewed on the BRPT™ website (www.brpt.org).

Recertification:

Note: ***The recertification and CEU guidelines below are those in effect at the present time. The BRPT Board has commissioned a task force to study and make recommendations to the Board regarding recertification and CEU guidelines, which MAY include allowing multiple "pathways" for recertifying other than retaking the examination and for obtaining CEU's, as well as possibly modifying the time frame of 10 years. Check back on the BRPT website www.brpt.org or in the BRPT INSIDER electronic newsletter during 2005 for updates.***

Candidates taking and passing the RPSGT™ examination will be issued a time-limited credential that is valid for ten years beginning on the date of the examination. Recertification must be completed before the expiration date of the credential, or the credential will expire, the registry number of the individual will be retired and the individual's name will be removed from the list of Registered Polysomnographic Technologists. Individuals whose credential has expired will no longer have the right to use the designation "RPSGT™". If the requirements for recertification are completed successfully prior to the expiration date, the credential and existing registry number of the individual will be renewed for a 10-year period commencing on the date that requirements for re-certification are fulfilled.

The process of recertification consists of two components:

- RPSGT™ certificants must demonstrate that they have participated in continuing education relevant to the field of polysomnographic technology
- Candidates for recertification must meet recertification requirements as noted in the BRPT™/RPSGT™ Recertification Policies and Procedures at the time of recertification.

Certificants are not eligible to recertify prior to a minimum of seven years following their most recent certification or recertification (three years prior to expiration of their credential). Individuals may attempt the recertification examination a maximum of three times before the RPSGT™ credential expires. Failure to pass the recertification examination within three attempts will result in expiration of the certificant's credential and retirement of their registry number on its expiration date. Certificants whose credential has expired are eligible to apply for the examination as a new candidate if all eligibility requirements are met at the time of the application.

The RPSGT™ certificant is responsible for maintaining valid credentials. BRPT™ has no obligation to notify certificants of the impending expiration of the certificant's RPSGT™ status.

Continuing Education

The BRPT™ strongly encourages RPSGT™ certificants to maintain and improve their knowledge and skill through continuing education. It is **suggested** that individuals participate in a minimum of six hours of continuing education annually. **Individuals who wish to complete recertification of the RPSGT™ credential will be required to document credit for 18 hours of continuing education within 36 months of application for retesting. Content of continuing education programs should be relevant to one of the content domains of the RPSGT™ Content Outline.**

All Credits granted for continuing education by the Association of Polysomnographic Technologists (CEC's) are accepted. Continuing education credits granted by other organizations must be specifically for polysomnography-related program content. When the polysomnography-related content is part of a broader program including non-relevant content, credits are accepted in proportion to polysomnography-related content. For example, if 6 credits are granted for a full day's program with a total of 6 contact hours that includes 1 hour of polysomnography-related content, then only one credit will be accepted by the BRPT™. Documentation of program content is required in such cases.

RPSGT™ certificants are required to complete a BRPT™ Continuing Education Documentation Form (available online at www.brpt.org) when applying for recertification. The BRPT™ will randomly select applications for audit of continuing education documentation. Candidates who provide fraudulent information are subject to disciplinary action including loss of eligibility for recertification and revocation of the RPSGT™ credential.

Recertification Testing

Candidates for recertification of the RPSGT™ credential must pass the RPSGT™ examination prior to the expiration date of their current certification. The content of the exam will be based on the current role delineation survey conducted by the BRPT™.

Voluntary Recertification for "Grandfathered Certificants"

Individuals who earned the RPSGT™ credential prior to June 2002 ("Grandfathered Certificants") are not required to recertify; however, they may participate in voluntary recertification once every ten years. Grandfathered certificants are required to meet the continuing education requirement and are subject to the same policies applicable to all certificants prior to sitting for the recertification examination. Grandfathered certificants who successfully recertify will receive a new certificate noting recertification. Their original registry number will be maintained. Failing the voluntary recertification examination will not result in loss of the RPSGT™ credential for Grandfathered certificants.

SECTION 2

Preparation for the Examination:

The study recommendations described here may be helpful as you prepare for the examination. Try to be objective about your abilities when you are deciding how best to proceed with your study.

- Determine how you study best. Some individuals seem to learn faster by hearing information, while others need to see it written or illustrated, and still some others prefer to discuss material with colleagues. A combination of these alternatives may produce the most effective study for you. If you had success in lecture courses with little outside review, it may be that you need to HEAR information for best retention. If you find that you prefer to READ material, then you might consider jotting down important information on 3 x 5 cards and refresh your memory by periodically reviewing the cards. This is especially effective if you write the material thoughtfully and concisely, allowing for study through both writing and reading. Additionally, you may wish to organize a study group and find a study partner.

- Once you decide on a study approach, focus on that preference and use the other methods to supplement it.

- Plan your study-schedule in advance of the examination and allow sufficient time for meaningful, organized study. Find a quiet place to study where you will not be interrupted.

- Plan to arrive at the site of the examination the night before the test, unless you live in the locale of the test center (i.e., no more than one hour driving distance), and get a good night's rest. Candidates should actually go to the physical exam site prior to the examination to ensure exactly where to go on the day of the exam and allow extra time for unforeseen events such as traffic, flat tires, etc. Eat a well-balanced meal prior to reporting to the test center on the day of the examination, but limit the amount of stimulants you ingest (e.g., caffeine).

The following information is primarily presented to familiarize you with the directions for taking the examination.

Read and follow all instructions carefully.

- The examination will be timed. Bring a watch (NO watches with alarms, please) to the test center and set it to correspond to the official time used by the supervisor. Placing your watch in full view can help your concentration since a quick time check is readily accomplished.

- For best results, pace yourself by periodically checking your progress. This will allow you to make necessary adjustments. Remember, the more questions you answer, the better your chance of achieving a passing score. If you are unsure of a response, eliminate as many options as possible and choose an option from those that remain.

- Be sure to record an answer for each question, even if you are not sure the answer is correct. You can note the questions you wish to consider in the test booklet and return to them later. All questions are of equal weight. Avoid leaving any questions unanswered; marking an answer to all questions will maximize your chances of passing and prevent miss-marking your answer sheet. There is no penalty for guessing and each item counts one point.

Bring with you two sharpened #2 soft lead pencils with erasers. **ONLY #2 PENCILS CAN BE USED TO COMPLETE THE ANSWER SHEET. CALCULATORS WILL BE PROVIDED AT THE TEST SITE.**

RPSGT™ Examination Content Outline

To prepare yourself in an informed and organized manner, you should know what to expect from the actual examination in terms of the content areas and performance levels tested. As described in the INTRODUCTION to this handbook, an international role delineation survey was conducted to determine appropriate content for the RPSGT™ examination, in accordance with the 1999 "Standards for Educational and Psychological Testing" (American Education Research Association, American Psychological Association, and National Council on Measurement in Education) as well as the 1978 "Uniform Guidelines on Employee Selection Procedures" (Equal Employment Opportunity Commission, et al.).

The participants in the job analysis study constituted an internationally representative group of practitioners involved in polysomnographic technology. Survey participants using scales of task criticality and frequency, as defined in the role delineation survey, rated the job responsibility domains and task descriptions. Knowledge, skills and abilities that are fundamental to the performance of each task are represented by the knowledge/skills/abilities (KSA) Statements listed in the content outline.

The results of the role delineation survey were used to construct the Content Outline that defines the content of the RPSGT™ examination. Five domains are identified in the Content Outline. Domains are principal areas of responsibility or activity comprising the job or occupation under consideration. These are the major headings in the Content Outline and may include a brief behavioral description of the domain. Each domain has one or more task statements associated with it. Task statements define a specific, goal-directed set of activities having a common objective. Each task statement has associated with it several KSA statements that define the basic knowledge and skill base required for and individual to perform the task. Knowledge statements define organized bodies of information, usually of a factual or procedural nature, which if applied, make performance of the task possible. Skill statements define proficient manual, verbal, or mental manipulation of data, people or things. Skills embody observable, quantifiable, and measurable

performance parameters. The Content Outline that follows defines domains from which exam questions may be drawn.

RPSGT™ Examination Content Outline

DOMAIN I: ANALYSIS OF PRE-TESTING INFORMATION	CLASSIFICATION 010000
Task 1. Assess the physician's polysomnography request in order to determine its completeness and appropriateness to ensure valid data collection.	*010100*

Knowledge of:

1. Clinical reasoning
2. Signs and symptoms of sleep disorders
3. Medical terminology
4. Drug effects and interactions
5. Medical, neurological, and psychiatric disorders
6. PSG protocols and procedures

Skill in:

7. Assessing the testing request to verify the test specifications

Task 2. Assess the patient's history to determine if special testing requirements are necessary (e.g., special bed, ancillary equipment).	*010200*

Knowledge of:

1. Clinical reasoning
2. Signs and symptoms of sleep disorders
3. Drug effects and interactions
4. Medical, neurological, and psychiatric disorders
5. Physical and neurological disabilities
6. PSG protocols and procedures
7. Medical terminology

Skill in:

8. Selecting the appropriate special equipment
9. Selecting the special electrode placement and montage
10. Identifying the specific needs that are appropriate for the age, mental, and physical status of the patient.

Task 3. Review the patient's medical history and interview the patient to anticipate the nature and likelihood for medical intervention.	*010300*

Knowledge of:

1. Clinical reasoning
2. Signs and symptoms of sleep disorders
3. Medical terminology
4. Drug effects and interactions
5. Medical, neurological, and psychiatric disorders
6. PSG protocols and procedures

7. Sleep pathophysiology

Skill in:

8. Recognizing the indications for medical intervention
9. Anticipating the likelihood for medical intervention
10. Identifying the specific medication and equipment needs
11. Assessing the patient's emotional and psychological statuses
12. Recognizing recent changes in the patient's emotional and psychological statuses
13. Recognizing external factors that affect testing
14. Documenting findings
15. Obtaining informed consent

Task 4. Inventory the supplies provided to ensure the requirements of the study are met. 010400

Knowledge of:

1. Clinical research protocols
2. Patient safety requirements
3. PSG protocols and procedures
4. Manufacturer-specific operating procedures
5. Clinical reasoning

Skill in:

6. Meeting the specific needs of the patient
7. Identifying special equipment needs

Task 5. Select indicated ancillary equipment in order to optimize data collection. 010500

Knowledge of:

1. Manufacturer-specific operating procedures
2. PSG protocols and procedures
3. Physician's orders
4. Clinical reasoning

Skill in:

5. Operating the study equipment
6. Interpreting the physician's orders
7. Interfacing with ancillary equipment

DOMAIN II: STUDY PERFORMANCE 020000

Task 1. Choose the montage and channel parameters on the recording equipment in order to collect data properly. 020100

Knowledge of:

1. PSG protocols and procedures
2. PSG–specific equipment and related operating procedures
3. Electrophysiology
4. Computer operations
5. Signs and symptoms of sleep disorders

6. Medical, neurological, and psychiatric disorders

Skill in:

7. Following laboratory protocols
8. Clinical reasoning
9. Using computers
10. Using scientific reasoning
11. Selecting proper settings
12. Verifying montage parameters

Task 2. Calibrate the recording equipment to assure proper functioning (e.g., polysomnograph, ancillary devices) before, during, and after testing. *020200*

Knowledge of:

1. PSG-specific equipment operating and calibration procedures
2. Scientific methodology
3. Basic math
4. Electrophysiology
5. Computer operations

Skill in:

6. Using scientific reasoning
7. Using computers
8. Recognizing and visually discriminating appropriate waveforms from instrument artifact
9. Adjusting the recorder settings

Task 3. Explain to the patient the testing procedures and possible interventions that might occur in order to prepare him or her for testing. *020300*

Knowledge of:

1. PSG protocols and procedures
2. Signs and symptoms of sleep disorders
3. Age-specific guidelines
4. Patient assessment techniques
5. Mental and emotional health issues
6. Cultural diversity issues
7. BRPT Standards of Conduct
8. Medical terminology

Skill in:

9. Assessing the patient's mental, emotional, and physical condition
10. Communicating instructions and procedures clearly
11. Recognizing and addressing the barriers to effective communication
12. Coaching cooperative behavior
13. Behaving in an ethical manner
14. Addressing factors that may hinder optimal data collection

Task 4: Determine the placement site and properly apply the sensors according to established guidelines in order to consistently record quality data. *020400*

Knowledge of:

1. PSG protocols and procedures
2. Patient assessment techniques
3. Clinical reasoning
4. International 10-20 electrode placement system
5. Gross anatomy
6. Electrophysiology
7. Basic math
8. EEG recording principles
9. Mental and emotional health issues
10. BRPT Standards of Conduct
11. Standard precaution safety guidelines
12. Hazardous substances
13. Biopotential recording techniques

Skill in:

14. Calculating percentages
15. Using fine motor skills
16. Coordinating eye and hand movements
17. Assessing the patient's mental, emotional, and physical condition
18. Coaching cooperative behavior
19. Behaving in an ethical manner
20. Applying and securing recording equipment

Task 5: Acquire, verify, and document physiological calibrations in order to demonstrate accurate patient data collection. *020500*

Knowledge of:

1. PSG protocols and procedures
2. Clinical reasoning
3. PSG-specific equipment operating and calibration procedures
4. Electrophysiology
5. Computer operations
6. Age-specific guidelines
7. Patient assessment techniques
8. Biopotential recording techniques

Skill in:

9. Recognizing and visually discriminating appropriate waveforms from instrument artifact
10. Using fine motor skills
11. Coordinating eye and hand movements
12. Communicating instructions and procedures clearly
13. Recognizing and addressing the barriers to effective communication
14. Coaching cooperative behavior
15. Using computers

16. Recognizing and correcting instrument malfunction signal artifact

Task 6. Recognize and document relevant data (e.g., lights off and lights on, body position, artifacts, life-threatening events, cardiac/EEG abnormalities, respiratory disturbances) throughout the recording process in order to assist in data analysis. *020600*

Knowledge of:

1. Signs and symptoms of sleep disorders
2. Clinical reasoning
3. Scientific methodology
4. PSG protocols and procedures
5. PSG-specific equipment operating procedures
6. Emergency protocols
7. Electrophysiology
8. Cardio-pulmonary anatomy and physiology
9. Neurological anatomy and physiology
10. Computer operations
11. Medications and their effects on sleep
12. Medical terminology
13. Biopotential recording techniques
14. Psychological anatomy and physiology
15. Waveform pattern recognition

Skill in:

16. Communicating instructions and procedures clearly
17. Recognizing and visually discriminating appropriate waveforms from instrument artifact
18. Using computers

Task 7. Differentiate true physiologic data from recording artifacts, and correct artifacts when appropriate, in order to optimize data collection. *020700*

Knowledge of:

1. Signs and symptoms of sleep disorders
2. Clinical reasoning
3. Scientific reasoning
4. PSG protocols and procedures
5. PSG-specific equipment operating procedures
6. Electrophysiology
7. Cardio-pulmonary anatomy and physiology
8. Neurological anatomy and physiology
9. Waveform pattern recognition
10. Psychological anatomy and physiology
11. Computer operations

Skill in:

12. Recognizing and visually discriminating appropriate waveforms from instrument artifact
13. Using computers

14. Making appropriate alternations to recording parameters
15. Replacing equipment
16. Documenting actions

Task 8. Recognize the need for interventions (e.g. PAP, O_2 titration, CPR) and perform them according to established guidelines in order to provide appropriate patient care. *020800*

Knowledge of:

1. Emergency protocols
2. PSG protocols and procedures
3. PSG-specific equipment operating procedures
4. Clinical reasoning
5. Signs and symptoms of sleep disorders
6. Abnormal electrophysiology
7. Cardio-pulmonary anatomy and physiology
8. Neurological anatomy and physiology
9. Medical terminology
10. BRPT Standards of Conduct
11. Signs and symptoms of seizures
12. Epileptogenic EEG activities
13. Appropriate sleep disorder treatment protocols
14. Computer operations
15. Patient assessment techniques
16. CPR standards and techniques

Skill in:

17. Recognizing and responding to clinically significant events and emergency situations
18. Following laboratory protocols
19. Conducting medical procedures
20. Communicating instructions and procedures clearly
21. Recognizing and addressing the barriers to effective communication
22. Coaching cooperative behavior
23. Behaving in an ethical manner
23. Titrating PAP/O_2
24. Recognizing and responding to seizures
25. Recognizing and responding to untoward effects of supplemental O_2
26. Performing CPR
27. Applying CPAP interfaces and interventional equipment
28. Administering supplemental O_2
29. Identifying a patient's response to intervention
30. Documenting changes to the recordings for scoring and interpretation

Task 9. Summarize PSG and clinical observations in order to assist data interpretation. *020900*

Knowledge of:

1. Signs and symptoms of sleep disorders
2. PSG protocols and procedures
3. Clinical reasoning
4. Electrophysiology
5. Cardio-pulmonary anatomy and physiology
6. Neurological anatomy and physiology
7. Scientific methodology
8. Charting techniques
9. Medical terminology
11. Computer operations

Skill in:

12. Communicating instructions and procedures clearly
13. Recognizing and visually discriminating appropriate waveforms from instrument artifact
14. Using computers

Task 10. Apply standard precautions throughout the patient's evaluation in order to prevent the spread of infection to patients and staff. 021000

Knowledge of:

1. Standard precautions
2. Clinical reasoning
3. Cardio-pulmonary anatomy and physiology
4. Neurological anatomy and physiology
5. BRPT Standards of Conduct
6. Cultural diversity issues
7. Medical disorders

Skill in:

8. Following laboratory protocols
9. Following standard precaution protocols
10. Using fine motor skills
11. Using eye-hand coordination
12. Assessing the patient's ability to comply with procedures
13. Communicating instructions and procedures clearly
14. Coaching cooperative behavior
15. Behaving in an ethical manner

DOMAIN III. SCORING 030000

Task 1. Identify appropriate documents and data for use in analysis. 030100

Knowledge of:

1. Progress and observation notes
2. Sleep questionnaires
3. Patient history
4. Physician's orders
5. Signs and symptoms of sleep disorders
6. Medical, neurological, and psychiatric disorders

Skill in:

7. Reviewing the monitoring technologist's summary
8. Reviewing technical data/observation sheets
9. Reviewing the patient satisfaction survey
10. Reviewing the pre-sleep and post-sleep questionnaires
11. Reviewing the post-PAP comments
12. Reviewing the MSLT/MWT questionnaires
13. Reviewing the patient's history and physical examination documents
14. Verifying compliance with physician orders

Task 2: Score sleep stages and arousals in order to facilitate interpretation *030200*

Knowledge of:

1. Adult guidelines for sleep stage scoring
2. Pediatric guidelines for sleep stage scoring
3. Infant guidelines for sleep stage staging
4. AASM clinical practice parameters
5. Sleep pathophysiology
6. Signs and symptoms of sleep disorders
7. Laboratory-specific scoring protocols and procedures
8. Medications and their effects on sleep
9. Sleep stage definitions
10. Arousal definitions

Skill in:

11. Identifying sleep stages (e.g., wake, 1, 2, 3, 4)
12. Identifying REM sleep (e.g., beginning and end)
13. Identifying arousals
14. Identifying body movements and movement time
15. Identifying wake, active wake, active sleep, indeterminate sleep, and quiet sleep
16. Recognizing EEG waveforms and morphology
17. Recognizing and visually discriminating appropriate waveforms from instrument artifact

Task 3: Score respiratory events in order to facilitate interpretation *030300*

Knowledge of:

1. AASM clinical practice parameters
2. Sleep pathophysiology
3. Signs and symptoms of sleep disorders
4. Laboratory-specific scoring protocols and procedures
5. Medications and their effects on sleep and breathing
6. Breathing event definitions

Skill in:

7. Documenting SaO_2 and CO_2 changes, e.g. end tidal, transcutaneous
8. Identifying arousals related to respiratory events
9. Identifying snoring and esophageal pressure changes
10. Identifying Cheyne Stokes respiration

11. Identifying sleep apnea in adult, pediatric, and infant patients
12. Identifying sleep hypopnea in adult, pediatric, and infant patients
13. Identifying respiratory effort-related arousals in adult, pediatric, and infant patients
14. Identifying periodic breathing in adult, pediatric, and infant patients

Task 4: Score movement events in order to facilitate interpretation. *030400*

Knowledge of:

1. AASM clinical practice parameters
2. Sleep pathophysiology
3. Signs and symptoms of sleep disorders
4. Laboratory-specific scoring protocols and procedures
5. Breathing event definitions

Skill in:

6. Identifying limb movements (e.g., periodic, restless legs, fragmentary myoclonus)
7. Identifying body movements
8. Identifying arousals related to movement events
9. Identifying bruxism

Task 5: Score miscellaneous events in order to facilitate interpretation. *030500*

Knowledge of:

1. AASM clinical practice parameters
2. Sleep pathophysiology
3. Signs and symptoms of sleep disorders
4. Laboratory-specific scoring protocols and procedures
5. Biopotential recording techniques
6. Signs and symptoms of seizures
7. Epileptogenic EEG activities
8. Abnormal electrophysiology

Skill in:

9. Recognizing abnormal EEG activity (e.g., nocturnal seizures, alpha intrusion, alpha-delta)
10. Recognizing arrhythmias
11. Recognizing normal ECG rhythms
12. Recognizing body position changes
13. Identifying polygraphic patterns related to unusual behaviors
14. Documenting technologist interventions (e.g., PAP titration, O_2 administration)
15. Identifying polysomnographic patterns related to therapeutic intervention
16. Identifying changes in esophageal pH
17. Identifying polysomnographic patterns related to bruxism

Task 6: Generate and validate a report of the scoring of objective and subjective data in order to summarize the polysomnographic *030600*

procedure.

Knowledge of:

1. AASM clinical practice parameters
2. Sleep pathophysiology
3. Signs and symptoms of sleep disorders
4. Laboratory-specific scoring protocols and procedures
5. PSG protocols and procedures
6. Basic math
7. Clinical reasoning
8. Computer operations

Skill in:

9. Documenting behaviors during the study (e,g., parasommias, cataplexy, tech/patient interaction)
10. Documenting CPAP tolerance issues
11. Documenting abnormal EEG activity (e.g., nocturnal seizures, alpha intrusion, alpha-delta)
12. Documenting excessive spindles and presence of excessive beta
13. Documenting REM abnormalities (e.g., density, rebound, latency)
14. Documenting SaO_2 (e.g., nadir, average, range)
15. Calculating sleep latencies (e,g., persistent and REM)
16. Calculating conditions (e.g., total sleep time, total time in bed, sleep efficiency)
17. Calculating apnea index, apnea/hypopnea index, arousal index, PLM index
18. Reporting abnormal EEG activity, arrhythmias, and normal rhythms
19. Reporting bruxism
20. Calculating snore arousal index (e.g. RERAS)
21. Reporting body movements
22. Calculating sleep stage percentages
23. Calculating wake after sleep onset
24. Reporting artifacts, adverse events, parental/guardian behavior
25. Reporting technical problems, errors, and resolutions
26. Reporting critical events to the proper authorities for patient safety and follow-up care
27. Generating the final technical report
28. Generating histograms
29. Generating MSLT/MWT report (e.g. mean sleep latency, REM sleep latency)
30. Summarizing therapeutic intervention

Task 7. Use acceptable methods to archive data in order to ensure long-term storage and accessibility. *030700*

Knowledge of:

1. Archive, storage, and accessibility regulations and procedures

Skill in:

2. Archiving information to acceptable storage media
3. Verifying the successful transfer of data to the storage media
4. Labeling the storage media for identification and retrieval
5. Storing media, both analog and digital, in appropriate environment
6. Using computers
7. Behaving in an ethical manner

DOMAIN IV. PATIENT SUPPORT AND EDUCATION ACTIVITIES 040000

Task 1. Coordinate PAP orders with home healthcare provider to facilitate appropriate treatment. *040100*

Knowledge of:

1. PAP setup
2. Manufacturer-specific operating procedures
3. Regulatory therapy guidelines
4. Interface devices

Skill in:

5. Following physician's orders for the patient to receive appropriate equipment
6. Educating the patient on PAP setup and application
7. Communicating instructions and procedures clearly

Task 2. Suggest solutions to patients who have problems with PAP equipment to maximize PAP benefits. *040200*

Knowledge of:

1. PAP tolerance and compliance
2. Mental and emotional health issues
3. Cultural diversity issues
4. Age-specific guidelines
5. Clinical reasoning

Skill in:

6. Addressing PAP interface problems
7. Addressing PAP use issues (e.g., congestion, pressure sores, pressure complaints)
8. Suggesting methods to improve long-term compliance
9. Applying procedural procedures

Task 3. Work under the direction of a physician to provide information to the patient regarding his or her treatment. *040300*

Knowledge of:

1. Treatment protocols
2. Outcome expectations
3. Common misunderstandings by patients
4. Mental and emotional health issues
5. Cultural diversity issues
6. Age-specific guidelines

7. Clinical reasoning
8. Signs and symptoms of sleep disorders
9. BRPT Standards of Conduct

Skill in:

10. Following the physician's orders
11. Anticipating patient behaviors
12. Behaving in an ethical manner
13. Coaching cooperative behaviors

Task 4. Provide information to the public regarding sleep disorders medicine in order to facilitate awareness. 040400

Knowledge of:

1. Community's awareness of sleep disorders
2. Signs and symptoms of sleep disorders
3. Regulatory issues
4. Age-specific guidelines
5. Cultural diversity issues
6. PSG protocols and procedures

Skill in:

7. Planning in-service events in the work facility
8. Participating in community health fairs
9. Presenting topics on sleep-related disorders to the public
10. Participating in patient support group activities
11. Providing literature on sleep disorders and related health issues to patients
12. Communicating instructions and procedures clearly
13. Communicating medical information in laymen's terms
14. Behaving in an ethical manner

DOMAIN V. SITE MANAGEMENT 050000

Task 1. Inspect PSG and ancillary equipment based on accepted standards in order to assure proper operation and safety. 050100

Knowledge of:

1. Electrical safety
2. Computer operations
3. Standard precaution safety guidelines
4. Manufacturer-specific operating procedures
5. PSG protocols and procedures

Skill in:

6. Recognizing artifacts
7. Troubleshooting equipment problems
8. Correcting equipment-related problems
9. Calibrating recording equipment
10. Recognizing unsafe practices and procedures

Task 2. Apply cleaning and sterilization procedures on reusable laboratory 050200

equipment based on established precautions in order to assure patient safety and infection control.

Knowledge of:

1. Infection control and precautions
2. Proper storage and disposal of toxic agents
3. Hazardous substances

Skill in:

4. Ensuring a safe environment
5. Performing cleaning and sterilization

Task 3. Follow laboratory policies in order to respond appropriately to hazardous situations (e.g., fire, spills, weather, earthquake). *050300*

Knowledge of:

1. Emergency protocols and equipment
2. Emergency response system

Skill in:

3. Following established emergency procedures
4. Ensuring proper functioning of emergency equipment

Task 4. Follow laboratory standards in order to assess quality assurance (e.g., inter-scorer reliability, multidisciplinary patient case review). *050400*

Knowledge of:

1. Rationale for importance of quality assurance
2. Sleep pathophysiology
3. Medications and their effects on sleep
4. Signs and symptoms of sleep disorders
5. Laboratory-specific quality assurance procedures

Skill in:

6. Applying procedural protocols

Task 5. Maintain patient records using government and industry regulations in order to allow appropriate access and protect confidentiality. *050500*

Knowledge of:

1. Government and industry regulations

Skill in:

2. Archiving information to acceptable storage media
3. Following confidentiality regulations
4. Behaving in an ethical manner

Examination Specifications

RPSGT test specifications were developed by combining the importance, criticality and frequency data obtained from the Role Delineation study conducted in 2004. The resulting data were converted to percentages in the final phase of the study, and the percentages were used to determine the number of questions related to each domain and task that should appear on the multiple-choice RPSGT examination. The test specifications in the table below list how many questions are included in each Domain and Task and the percentage of the test included in each Domain.

Domains/Tasks	% of Exam	# of Items
DOMAIN I: ANALYSIS OF PRE-TESTING INFORMATION	**7.5%**	**15**
Task 1: *Assess the physician's polysomnography request in order to determine its completeness and appropriateness to ensure valid data collection.*		3
Task 2: *Assess the patient's history to determine if special testing requirements are necessary (e.g., special bed, ancillary equipment).*		4
Task 3: *Review the patient's medical history and interview the patient to anticipate the nature and likelihood for medical intervention.*		4
Task 4: *Inventory the supplies provided to ensure the requirements of the study are met.*		2
Task 5: *Select indicated ancillary equipment in order to optimize data collection.*		2
DOMAIN II: STUDY PERFORMANCE	**50%**	**100**
Task 1: *Choose the montage and channel parameters on the recording equipment in order to collect data properly.*		8
Task 2: *Calibrate the recording equipment to assure proper functioning (e.g., polysomnograph, ancillary devices) before, during, and after testing.*		9
Task 3: *Explain to the patient the testing procedures and possible interventions that might occur in order to prepare him or her for testing.*		8
Task 4: *Determine the placement site and properly apply the sensors according to established guidelines in order to consistently record quality data.*		9
Task 5: *Acquire, verify, and document physiological calibrations in order to demonstrate accurate patient data collection.*		8
Task 6: *Recognize and document relevant data (e.g., light off and lights on, body position, artifacts, life-threatening events, cardiac/EEG abnormalities, respiratory disturbances) throughout the recording process in order to assist in data analysis.*		12
Task 7: *Differentiate true physiologic data from recording artifacts and correct artifacts when appropriate, in order to optimize data collection*		10
Task 8: *Recognize the need for interventions (e.g. PAP, O_2 titration, CPR) and perform them according to established guidelines in order to provide appropriate patient care.*		14
Task 9: *Summarize PSG and clinical observations in order to assist data interpretation.*		9
Task 10: *Apply standard precautions throughout the patient's evaluation in order to prevent the spread of infection to patients and staff.*		13
DOMAIN III. SCORING	**29%**	**58**
Task 1: *Identify appropriate documents and data for use in analysis.*		8
Task 2: *Score sleep stages and arousals in order to facilitate interpretation.*		9
Task 3: *Score respiratory events in order to facilitate interpretation.*		10
Task 4: *Score movement events in order to facilitate interpretation.*		9

Task 5: *Score miscellaneous events in order to facilitate interpretation.*		8
Task 6: *Generate and validate a report of the scoring of objective and subjective data in order to summarize the polysomnographic procedure.*		8
Task 7: *Use of acceptable methods to archive data in order to ensure long-term storage and accessibility.*		6
DOMAIN IV: PATIENT SUPPORT AND EDUCATION ACTIVITIES	**8%**	**16**
Task 1: *Coordinate PAP orders with home healthcare provider to facilitate appropriate treatment.*		4
Task 2: *Suggest solutions to patients who have problems with PAP equipment to maximize PAP benefits.*		5
Domains/Tasks	**% of Exam**	**# of Items**
Task 3: *Work under the direction of a physician to provide information to the patient regarding his or her treatment.*		5
Task 4: *Provide information to the public regarding sleep disorders medicine in order to facilitate awareness.*		2
DOMAIN V: SITE MANAGEMENT	**5.5%**	**11**
Task 1: *Inspect PSG and ancillary equipment based on accepted standards in order to assure proper operation and safety.*		3
Task 2: *Apply cleaning and sterilization procedures on reusable laboratory equipment based on established precautions in order to assure patient safety and infection control.*		3
Task 3: *Follow laboratory policies in order to respond appropriately to hazardous situations (e.g., fire, spills, weather, earthquake).*		2
Task 4: *Follow laboratory standards in order to assess quality assurance (e.g., inter-scorer reliability, multidisciplinary patient case review).*		1
Task 5: *Maintain patient records using government and industry regulations in order to allow appropriate access and protect confidentiality.*		2

Abbreviations

Certain abbreviations have been used in the test specifications that may appear in the test. Some of these abbreviations and their meaning are listed below.

CO_2	Carbon dioxide
cm H_2O	Centimeters of Water Pressure
EEG	Electroencephalogram
EKG	Electrocardiogram
EMG	Electromyogram
EOG	Electro-oculogram
FIO_2	Fractional inspired oxygen
HFF	High frequency filter
Hz	Hertz (cycles per second)
LFF	Low frequency filter
LO	Lights out
MSLT	Multiple sleep latency test
MV	Millivolt
MV/cm	Millivolts per centimeter

MWT	Maintenance of Wakefulness Test
CPAP	Nasal continuous positive airway pressure
O_2	Oxygen
PAP	Positive airway pressure (CPAP or Bi-Level)
PLMS	Periodic limb movements in sleep
PSG	Polysomnogram
PAC	Premature atrial contraction
PVC	Premature ventricular contraction
REM	Rapid eye movement
SpO_2	Oxygen saturation measured by pulse oximeter
SOREM	Sleep onset REM
TC	Time constant
*u*V	Microvolt
*u*V/mm	Microvolts per millimeter
EDS	Excessive Daytime Sleepiness
SOB	Shortness of Breath
EPAP	Expiratory Positive Airway Pressure
IPAP	Inspiratory Positive Airway Pressure

Sample Questions

All test items are multiple-choice questions of equal weight with respect to scoring. Candidates are expected to select the one response that BEST answers the question (or completes the sentence). However, there are three distinct question formats, as described below.

1. ***Positively worded – one best response:***

   Most items are presented in this format. The stem is positively worded and four options (A, B, C, D) follow. You are to select the one best option as your answer.

2. ***Negatively worded – all of the following EXCEPT:***

   A small portion of items are presented in this format. The stem is negatively worded such as "All of the following are true EXCEPT" and four options (A, B, C, D) follow. You are to select the one best EXCEPTION as your answer.

3. Multiple true/false – statement/phrase combinations:

   A small portion of items are in this format. The stem is followed by three to five Roman numeral numbered statements or phrases (i.e., I, II, III, etc.). These are followed by four combination options (A, B, C, and D). You are to select the one best COMBINATION response as your answer.

The sample multiple-choice questions that follow demonstrate the formats described above. The sample questions are not intended to be difficult, nor do they necessarily reflect the degree of difficulty of the test. The correct answer is shown in the Answer Key.

The complexity level for each question is also noted, and you can see how questions are linked to the test specifications by content category. " For example the sample item 2 Content Category is designated as 04-04-02. Look on the detailed content outline to relate this: first look under Domain 4, Patient Support and Education Activities, then under Task 04, Provide information to the public regarding sleep disorders medicine in order to facilitate awareness and finally under Knowledge of: statement 02 applies, Signs and symptoms of sleep disorders."

1) Which of the following actions should be taken to avoid ground loops?

A. Have all electrical wires lie flat against the patient's body.
B. Properly apply electrodes to achieve sufficiently low electrode/skin resistance.
C. Apply more than one ground to the patient.
D. Ensure the equipment is connected to a common ground point.

2) Poor sleep hygiene would include all of the following **EXCEPT:**

A. Having a regular bedtime.
B. Eating a large meal before bedtime.
C. Consuming alcohol.
D. Exercising strenuously before bedtime.

3) Sleep onset REM can be suggestive of which of the following?

I. Prior sleep deprivation
II. Withdrawal from REM suppressing drugs
III. REM sleep behavior disorder

A. I only
B. I and II only
C. II and III only
D. I, II, and III

4) In order to assure that the digital readout is correct on an NCPAP unit, the pressure can best be verified by using a

A. Water column manometer.
B. DC amplifier.
C. Sphygmomanometer.
D. Pressure transducer.

5) Which of the following demonstrates central sleep apnea?

A. Cessation of nasal/oral airflow with continued respiratory effort
B. Initial cessation of nasal/oral airflow and respiratory effort followed by continuation of respiratory effort
C. Simultaneous cessation of airflow and respiratory effort
D. Partial decrease in nasal/oral airflow and respiratory effort.

Answer Key

Item	Correct Answer	DOMAIN	TASK	Complexity Level
1.	D	5	01	Application
2.	A	4	04	Recall
3.	B	2	06	Application
4.	A	2	02	Recall
5.	C	3	03	Recall

SUGGESTED READINGS

This list is provided as a reference to identify appropriate resource material, which may useful in preparation for the CRE. This list is not intended to be inclusive of all potentially useful resources nor does inclusion on this list constitute an endorsement by the BRPT or any officers or representatives of the BRPT. To assist with location of the listed publications, the web address of the publisher has been listed when available.

The BRPT does not endorse any particular book as being completely accurate and we recommend that applicants utilize multiple resources in the process of preparation for the exam.

RPSGT EXAMINATION PRIMARY REFERENCES

The following texts are provided by BRPT™ as suggested primary reference materials to assist applicants for the Registered Polysomnographic Technologist (RPSGT™) credential in preparation for the RPSGT™ Examination.

The BRPT™ presents this list in the sincere hope that it will serve to enhance the knowledge and skill level of those desiring to demonstrate professional competence in the field of sleep technology. We encourage you to use these references as just one "tool" in your journey towards achieving the RPSGT™ designation.

This list is not intended to be inclusive of all potentially useful resources nor does inclusion on this list constitute an endorsement by the BRPT™ or any officers or representatives of the BRPT™. The BRPT™ does not endorse any particular book as being completely accurate and we recommend that applicants utilize multiple resources in the process of preparation for the exam.

Links to purchase these materials directly from this page are provided for your convenience, but you are in no way required to obtain the references from this site.

Good luck in your preparation!

NOTE: Please click on the links below to check availability from Amazon or Alibris

Principles and Practice Of Sleep Medicine- Third Edition, Kryger, Roth, Dement, 2000

Sleep Disorders Medicine Basic Science, Technical Considerations and Clinical Aspects - Second Edition, Chokroverty, 1999

The International Classification of Sleep Disorders: Diagnostic & Coding Manual, ASDA, 1997

Sleep Medicine Pearls, Berry, 1999

Sleep Medicine, Lee-Chiong, Et Al. 2002

Atlas of Sleep Medicine, Shepard, 1991

Fundamentals of EEG Technology- Volume 1, Tyner, Knott, Mayer, 1983

Fundamentals of EEG Technology-Volume 2, Tyner, Knott, Mayer, 1989

The Only EKG Book You'll Ever Need- Third Edition, Thaler, 1999

A Manual of Standardized Terminology, Techniques and Scoring System for the Sleep Stages of Human Subjects, Rechtschaffen & Kales, 1968

Principals and Practice of Sleep Medicine in the Child, Ferber, Kryger, 2000

Egan's Fundamentals of Respiratory Care, Egan, Scanlan, Wilkins, Stoller, 8th ed, 2003

A Manual Of Standardized Terminology, Technology, and Standardized Criteria for Scoring Stages of Sleep and Wakefulness in Newborn Infants, Anders, Parmalee and Emde, 1971

Pulmonary Pathophysiology: The Essentials, Sixth Edition, John B. West

OTHER PRIMARY REFERENCE MATERIALS:

ASDA/AASM Published standards on issues such as Guidelines for the MSLT, scoring limb movements, breathing disorders definitions and measurement, EEG arousal scoring, etc.

AASM Clinical Practice Parameters from the Standards of Practice Committee

NOTE: Further reference resources and other helpful study information can be found in the new RPSGT Study Guide (available online at www.brpt.org in early 2005).

Commission on Accreditation of Allied Health Programs (CAAHEP) Accredited Electroneurodiagnostic Technology Programs with Polysomnographic Endorsement

Program Code Number

Crozer-Chester Medical Center — 001
School of Clinical Neurophysiology
One Medical Center Blvd. • Upland, PA 19013 • (610) 447-2691
Program Director: Kellee Trice, R.EEG/EP.T., RPSGT
Medical Director: Lawrence Green, M.D.
kellee.trice@crozer.org

Erwin Technical Center — 002

School of Electroneurodiagnostic Technology
2010 E. Hillsborough Avenue • Tampa, FL 33610 • (813) 231-1800 ext. 2441
Program Director: Henry Coet, III, R.EEG.T
Medical Director: David Dillenback, M.D.
coet@ popmail.firn.edu

Labouré College 003
Electroneurodiagnostic Technology Program
2120 Dorchester Avenue • Boston, MA 02124 • (617) 296-8300 ext. 4043
Program Director: Jean Farley, MA, R.EEG.T.
Jwilskiing@beld.net

Mayo School of Health Sciences 004
Clinical Neurophysiology Technology Program
Siebens 1016
200 1st St. SW • Rochester, MN 55905 • (507) 284-1255
Program Director: Jan Buss, R.ED.T
Medical Director: Michael Siber, M.D.
buss.Jan@mayo.edu

Orange Coast College
Neurodiagnostic Technologist Program 005
2701 Fairview Road • P.O. Box 5005
Costa Mesa, CA 92628-5005 • (714) 432-5591
Program Director: Walt Bancozi, R.EEG/EP.T., CNIM, RPSGT
Medical Director: Hugh McIntyre, M.D.
wbanoczi@cccd.edu

Western Wisconsin Technical College 006
Electroneurodiagnostic Technology Program
304 North 6th St. • P.O. Box 908
LaCrosse, WI 54602-0908 • (608) 785-9253
Program Director: Clayton Pollert, R.EEG.T.
Medical Director: Greg Fischer, M.D.
pollertc@wwtc.edu

Scott Community College 007
Electroneurodiagnostic Program
500 Belmont Rd., Bettendorf, IA 52722
Program Director: Amber Timmerman, R.EE/EP.T., RPSGT
atimmerman@eicc.edu

Kirkwood Community College 008
Electroneurodiagnostic Tech Program
6301 Kirkwood Blvd. SW/PO Box 2068
Cedar Rapids, IA- 52406-9973
Rebecca Meng
(319) 356-8768

NOTE: The above are based on the latest information available to the BRPT. For updates check the http://www.caahep.org/caahep/ website. (The Commission on Accreditation of Allied Health Education Programs - CAAHEP).

REQUEST FOR SPECIAL EXAMINATION ACCOMMODATIONS

If you have a disability covered by a national Disabilities Program (e.g. Americans with Disabilities Act), and you wish to request accommodation for a qualified disability, please **complete this form and the Documentation of Disability-related Needs on the reverse side** so your request can be processed efficiently. The information you provide and any documentation regarding your disability and your need for accommodation in testing will be treated with strict confidentiality.

Applicant Information Social Security # __ __ __ - __ __ - __ __ __ __

Last Name First Name Middle Name

Address (line 1)

Address (line 2)

City State Zip Code

Special Accommodations
I request special accommodations (please indicate in the table below), for the (date of exam) administration of the Comprehensive Registry Examination for Polysomnographic Technologists. **I understand that the BRPT may require a fee to defray the costs of these accommodations.**

Please provide (check all that apply):

- Accessible testing site
- Special seating
- Large print test (specify point size)
- Reader
- Circle answers in test booklet
- Extended testing time (time and a half)
- Separate testing area
- Other special accommodations (please specify

Applicant's signature Date

Return this form with your examination application to the BRPT Management office. This request will not be processed if it is not accompanied by a properly completed "Documentation of Disability-Related Needs" form (see next page)

Documentation of Disability-Related Needs

This section must be completed by a licensed health care provider who has been personally involved in the diagnosis or treatment of the disability for which you are requesting accommodation, OR an educational or testing professional who has previously provided you with testing accommodations similar to those requested.

Professional Documentation

I have known _____ since ____/____
Test Applicant Date

In my capacity as a _____
Professional Title

The applicant has discussed with me the nature of the test to be administered. It is my opinion that because of this applicant's disability described below, he/she should be accommodated by providing the special arrangements listed on the reverse side.

Comments:

Signed:

Title:

Date:

License #

(if applicable):

Return this form with your examination application to the BRPT Management Office. Please call the BRPT Management Office at **(703) 610-9020**, if you have any questions about procedures in completing this application.

The Board of Registered Polysomnographic Technologists
8201 Greensboro Drive, Suite 300 • McLean, VA 22102
(703) 610-9020 • (703) 610-9005 fax
info@brpt.org • e-mailwww.brpt.org

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Attachment 1A

HB 1280 Amendments - 3/21/05
Gary A. Lee, Senator District 22

The Amendments proposed for HB 1280 will meet many of the requests and needs of both sides of this issue.

Amendment Merits:

- Supports Registered Polysomnographers ability to practice their profession in a manner for which they have been trained.
- Combines under one licensing board two professional groups providing the same service.
- Recognizes the uniqueness of each group.
- Allows Polysomnograhers input into rules that determine their scope of practice under the Board.
- Offers oversight, rules of conduct and penalties.
- Provides greater protections for the public.
- Promotes at least a temporary solution until the Polysomn numbers grow and/or the National Organizations find an alternative.
- Seeks a method of collaboration and cooperation in the spirit of compromise.

Attachment 2

Proposed Amendments to House Bill 1280

Page 1, Line 3, after the word "therapy" insert, "and to provide for a legislative council study of licensure of polysomnographic technologists and other allied professions"

Page 2, line 16, delete, "privileged in sleep medicine at a state licensed hospital or health system or is board eligible or a diplomate of the American board of sleep medicine"

Page 2, line 16, after the word "initiated" insert, "in a state licensed hospital or health system"

Page 2, line 16, after the word "is" insert "licensed by the North Dakota board of Medical Examiners."

Page 2, line 24, insert, "**SECTION 2. STATE LICENSING OF POLYSOMNOGRAPHIC TECHNOLOGIST AND OTHER ALLIED HEALTH PROFESSIONS - LEGISLATIVE COUNCIL STUDY.** The legislative council shall consider studying, during the 2005-06 interim, the feasibility of establishing a licensing board for polysomnographic technologists through options that may include but are not limited to: modifying the structure of the board of respiratory care to represent both polysomnographic technology and respiratory therapy specialties in a fair and cooperative manner; creating a new allied health professional board that would license and regulate allied health professionals not already overseen by a state board, as well as the possibility of multi-state joint licensure and regulation program. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixtieth legislative assembly."

Renumber Accordingly

Medcenter One 3/22/05