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Respiratory Therapist Scope of Practice Regulations

Ethan Kelley
West Virginia University
Joana Da Silva-Gonzalez
West Virginia University
Xavier Fankhouser
West Virginia University
Haoyu Wang
hw00052@mix.wvu.edu
West Virginia University
Alicia Plemmons
West Virginia University

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Abstract

Respiratory therapists are healthcare providers focused on the management of breathing and cardiopulmonary disorders. They are responsible for a wide range of services, including managing mechanical ventilators, educating patients, and performing a wide variety of diagnostic tests. Yet, their state-by-state regulatory structure has not been documented in the health economics literature. This study introduces a new dataset tracking the state-level differences in the regulatory structure for nine tasks and duties common for respiratory therapists. This data is provided to aid future research efforts of health policy and cardiopulmonary health.

Keywords: Respiratory Therapy, Data, Supervision Requirements, Scope of Practice **JEL Codes**: J44, I18, L51

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1 Introduction

State scope of practice (SOP) laws define which clinical services healthcare professionals can legally provide, influencing how healthcare is organized across the United States. While much is known about non-physician primary care providers, such as nurse practitioners and physician assistants, there is limited information about how respiratory therapist regulations may affect patient outcomes, hospital quality, and healthcare access.

Respiratory therapists (RTs) are healthcare professionals who specialize in caring for patients with disorders and abnormalities of the cardiopulmonary system across a wide range of patient populations and healthcare settings. They most commonly practice under the general direction of a physician and carry out orders from licensed independent practitioners, such as physicians, physician assistants, and nurse practitioners, in accordance

with state SOP and licensure laws. The requirements for becoming a respiratory therapist vary across states, as do the tasks and services RTs are legally allowed to provide to patients. However, there is no standardized, dataset that systematically documents state-level differences in authorization requirements, physician supervision, and professional independence.

This paper introduces a new dataset of respiratory therapist SOP laws for all 50 U.S. states and the District of Columbia. This dataset records the state-level variation of legal authority of RTs across major areas such as application of therapeutics to respiratory care, patient assessment, and performance and collection of diagnostic information as of early 2026.[1] In addition of describing the construction of the dataset, this paper also discusses its potential applications for future research. The dataset provides a valuable resource for researchers interested in healthcare workforce regulation, access to care, and healthcare delivery. The remainder of the paper is organized as follows. Section 2 reviews the related literature on SOP regulations and respiratory therapy. Section 3 describes the data collection process and the construction of the dataset. Section 4 summarizes state-level variation in respiratory therapist SOP laws. Section 5 discusses potential applications of the dataset for future research. Section 6 concludes.

2 Literature

The title respiratory therapist represents more than a type of care, but also a classification of occupational license within healthcare. Occupational licenses are a strict legal requirement, determined by the state legislature, of completing specific education, experience, examinations, payment of fees, and displays of good moral character in order to provide a service for pay (Kleiner, 2000). While in the overall labor force only 23 percent of jobs require an occupational license, this percentage is much higher in healthcare, with over 80 percent of health-related professions requiring strict occupational licensing (Johnson, 2026; Dillender et al., 2026).

The purpose of occupational licensing is to provide information to consumers, in this case patients, about the quality and safety of a good or service. Yet, there has been substantial debate on the tradeoff between information and access to cost-effective goods and services (Kleiner, 2006). Proponents of broader and stricter occupational licensing hold that this is a

[1] On June 24th, 2026, Alaska became the 50th state to license respiratory therapists. At the time of writing, the SOP for RTs is still being designed and has not yet been implemented by the relevant boards.

critical policy for improving safety and quality of professions (Noghanibehambari and Fletcher, 2024). Yet, the literature finds that there are limited quality increases within licensed professions (Plemmons et al., 2026), and that instead these stricter rules create wage premiums while leading to higher prices for consumers (Kleiner, 2006).

While across most professions an occupational license gives permission to enter a field, within healthcare there is an additional set of requirements related to the provider's SOP. These SOP laws determine which tasks and duties the provider is able to perform, and these tasks differ widely across states (Plemmons, 2024). For professions with large SOP differences, these regulatory structures have affected where providers move (Shakya and Plemmons, 2020), job switching to other fields and industries (Kleiner and Xu, 2025), entry into healthcare professions (Yelowitz and Ingram, 2021), as well as educational attainment decisions (Noghanibehambari and Fletcher, 2024).

While much is known related to large, primary care-related non-physician provider SOP due to large-scale regulatory collection by teams in the profession, such as for nurse practitioners and physician assistants (McMichael and Markowitz, 2023; McMichael, 2025), no empirical studies exist in economics, health policy, or respiratory therapy care for RT SOP. While there has been no known investigation of how regulatory structure affects patient outcomes in respiratory care, there have been some attempts at documenting the regulatory environment through large-scale reviews of initiatives and services provided by RTs or discussion of pathways to creating an advanced practice provider within respiratory therapy (Zaccagnini et al., 2025; Varekojis et al., 2021; Rickards and Kitts, 2018). Our study aims to address this gap in the literature by providing researchers with the policy variation and legal framework determining RT SOP across states.

3 Data Construction

The dataset was constructed by systematically collecting and verifying RT SOP laws for all 50 U.S. states and the District of Columbia. Each scope area was gathered using the statutes, rules, and regulatory code listed by each state legislature. We also include the differences in how states define respiratory therapy, or the practice thereof, and the specific procedures that RTs are or are not allowed to perform. Data was collected by a legislative analyst at the Knee Regulatory Research Center at West Virginia University with assistance from undergraduate research fellows. The data was reviewed and confirmed by a lawyer specialized in occupational licensing legal interpretation at the Knee Regulatory Research

Center. This multi-step validation procedure ensures the accuracy of state-level regulatory requirements.[2]

Following the framework of key tasks and duties of RTs from the American Association for Respiratory Care, the dataset classifies state laws into several major SOP areas. These areas include performance and collection of diagnostic information, patient assessment, the application of therapeutics to respiratory care, assessment of therapeutic interventions, disease management of acute and chronic diseases with and without clinical decision support systems, discharge planning and case management, provision of emergency, acute, critical and post-acute care, and advanced care or end-of-life planning discussion facilitators. Table 1 presents the definitions of each SOP category included in the dataset. Table 2 provides the definitions of the organizing categories used to classify RT SOP, as well as the definitions of authorization and supervision requirements.

4 Results

The nine maps, shown in figures 1 – 9, summarize the state-level variation in the SOP for RTs across nine functional areas, including diagnostic information collection, patient assessment, therapeutic applications, assessment of interventions, disease management, discharge planning, emergency and critical care, advanced care planning, and telehealth. Each map categorizes whether RTs may perform specific activities under different authorization and supervision conditions, including performing tasks with authorization but without supervision, with both authorization and supervision, with authorization or supervision, under supervision without authorization, emergency independence, not requiring a license at the time of the study period, or when the state does not explicitly specify the authority requirement in the regulatory code and leaves the interpretation to boards and facilities. Although the maps examine different components of respiratory care practice, several common patterns emerge across functional areas.

The first group consists of three closely related clinical activities: Application of Therapeutics (Figure 1), Performance and Collection of Diagnostic Information (Figure 2), and Patient Assessment (Figure 3). These three maps demonstrate highly similar SOP structures, with most states allowing RTs to perform these activities with authorization and with supervision. Several states allow RTs to perform tasks with authorization but without

[2] The provided data only categorizes the regulatory code as defined by the relevant state legislature. Boards of independent facilities may have stricter interpretations or rule structures for the providers. We do not account for these board and facility-level differences.

supervision. A few states demonstrate unique regulatory patterns across these three areas. Alaska is the only state classified as “Not Licensed” for these activities. Pennsylvania is the only state that allows RTs to perform these activities with authorization or with supervision. In contrast, Georgia is the only state where the scope of practice is classified as “No information,” indicating that publicly available regulatory documents do not provide sufficient information to determine whether respiratory therapists are authorized to perform these activities.

Assessment of Therapeutic Interventions (Figure 4) represents a related but distinct category. Although it shares many of the same authorization and supervision classifications observed in the three ares above, more states are classified as “Does not state,” indicating that the scope of practice for assessing therapeutic interventions is less explicitly defined in some states.

Several functional areas demonstrate more unique patterns compared with the core clinical activities. Disease Management of Acute and Chronic Diseases (Figure 5) includes a broader range of scope categories than most other areas. While the majority of states follow the common authorization and supervision framework, Arkansas and Pennsylvania are the only two states that allow RTs to perform disease management activities with authorization or with supervision. In addition, Indiana is the only state that allows RTs to perform these activities without authorization but with supervision, representing a unique expansion of RT authority for disease management activities. Emergency, Acute, Critical, and PostAcute Care (Figure 6) represents another distinct regulatory pattern. Nebraska is the only state classified under the “Emergency Independence” category, indicating that RTs in this state have explicitly recognized independent authority in emergency situations.

In contrast, a large number of states Do not state their policy on Discharge Planning and Case Management (Figure 7) and Advanced Care/End-of-Life Planning Discussion Facilitation (Figure 8). These responsibilities are not consistently addressed in state-level RT SOP regulations. Finally, Telehealth (Figure 9) demonstrates considerable regulatory variation, with more than half of states do not state their policy and nearly another half of states allow RTs to provide telehealth services with authorization and with supervision.

5 Potential Applications for Future Research

This dataset provides several opportunities for future research examining how respiratory therapist SOP regulations influence healthcare, workforce, and patient outcomes. First, the

dataset can be used to study how variation in RT SOP laws affects access to respiratory care services. Differences in authorization requirements, supervision requirements, and professional independence may influence the availability and efficiency of respiratory care, particularly in areas facing healthcare workforce shortages or limited access to specialized providers.

Additionally, the dataset can support research examining the relationship between RT SOP regulations and healthcare outcomes. Researchers may investigate whether broader RT authority is associated with differences in hospital quality indicators, emergency care, length of stay, or patient self survey report. By providing detailed state-level regulatory information, the dataset allows researchers to incorporate RT SOP variation into empirical analyses of healthcare quality.

6 Conclusion

This paper introduces a new dataset documenting respiratory therapist SOP laws across all 50 U.S. states and the District of Columbia. By collecting the state-level regulations, the dataset provides detailed information on the authorization requirements, supervision requirements, and professional authority granted to RTs across nine major functional areas of respiratory care.

The descriptive analysis demonstrates substantial variation in RT SOP regulations across states. While main clinical activities such as application of therapeutics, diagnostic information collection, and patient assessment generally follow similar authorization and supervision frameworks, other areas show meaningful differences. Disease management and emergency care include expanded categories that recognize additional forms of RT autonomy, while planning-oriented responsibilities and telehealth remain less consistently defined across states.

This dataset provides an important gap in healthcare workforce regulation for future empirical research examining how respiratory therapist SOP laws influence healthcare access, workforce, and patient outcomes. It offers researchers and policymakers a valuable resource for evaluating current regulations and informing future healthcare policies.

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Appendix

Table 1. Definitions of Respiratory Therapist Scope of Practice

Scope Area	Definition
Performance and collection of diagnostic information	Duties and procedures performed by respiratory therapists involving the measurement and analysis of cardiopulmonary function, including pulmonary function tests, diagnostic procedures (invasive and noninvasive), sleep studies, and blood gas or lab analyses.
Patient assessment	Evaluation of a patient's respiratory status through physical examination and interpretation of diagnostic data to determine the nature and severity of cardiopulmonary conditions.
Application of therapeutics to respiratory care	Administration and management of respiratory treatments such as medical gas, humidity, aerosol, and airway clearance therapies, including advanced procedures like mechanical ventilation, airway or vascular catheter care, extracorporeal life support, hyperbaric oxygen therapy, and related cardiopulmonary interventions.
Assessment of therapeutic interventions	Examining how procedures and treatments have impacted the patient.
Disease management of acute and chronic diseases with and without clinical decision support systems	Addressing patient symptoms of ailments of varying severity with and without the use of tools and technologies available in a clinical setting.
Discharge planning and case management	Organizing and making the necessary preparations for patients to be discharged from care and managing their care while being treated.

Provision of emergency, acute, critical and postacute care, including, but not limited to:	Delivery of respiratory care across all acuity levels, including patient assessment, diagnostic and therapeutic interventions, medication administration, and management of patient transport within and between healthcare facilities.
Scope Area	**Definition**
Advanced care / end-oflife planning discussion facilitators	Planning and overseeing care of patients in need of advanced or end-of-life care.

Table 2. Definitions of Organizing Categories, Authorization, and Supervision

Category	Definition
Panel A: Organizing Category Definitions	
Can perform fully independently	Respiratory therapists can practice the treatments and procedures listed under this scope category without prior authorization from a licensed physician, or other qualified medical authority referenced in the state practice act, and without supervision from a qualified medical director or other overseeing personal referened in the state practice act.
Can perform w/ authorization & w/ supervision	Respiratory therapists can practice the treatments and procedures listed under this scope category with prior authorization from a licensed physician, or other qualified medical authority referenced in the state practice act, and with supervision from a qualified medical director or other overseeing personal referened in the state practice act.
Can perform w/ authorization but w/o supervision	Respiratory therapists can practice the treatments and procedures listed under this scope category with prior authorization from a licensed physician, or other qualified medical authority referenced in the state practice act, but without supervision from a qualified medical director or other overseeing personal referened in the state practice act.

Can perform w/o authorization but w/ supervision	Respiratory therapists can practice the treatments and procedures listed under this scope category without prior authorization from a licensed physician, or other qualified medical authority referenced in the state practice act, and with supervision from a qualified medical director or other overseeing personal referened in the state practice act.
Can perform w/ authorization or w/ supervision	Respiratory therapists can practice the treatments and procedures listed under this scope category with prior authorization from a licensed physician, or other qualified medical authority referenced in the state practice act, or with supervision from a qualified medical director or other overseeing personal referened in the state practice act.
Can't order, refer, or perform	Respiratory therapists can not practice the treatments and procedures listed under this scope category.
Does not state	The scope of practice for respiratory therapists makes now mention of the specific scope area.
Emergency Independence	Respiratory therapists are allowed temporary independence to take emergency measures to stabilize a patient until other medical personnel and/or staff arrive.
Panel B: Authorization and Supervision Definitions	
Authorization	Requires a referral, prescription, or other written documentation that allows a respiratory therapist the extent of their scope of practice within a state but does not require a physician, qualified medical director, or other personnel qualified to practice medicine to oversee the treatment of the patient, either directly or indirectly.

Supervision	Requires that a physician, qualified medical director, or other personnel qualified to practice medicine oversee the attending respiratory therapists and direct patient care either in person or indirectly away from the patient, but can still be on site of the treatment facility or remotely. Note: The definitions for both direct supervision and indirect supervision vary across states. For indirect supervision, state definitions can range from including the use of facility procedures and protocols, to physicians not needing to be physically present but can issue orders to respiratory therapists or not needing to be present onsite but still reachable remotely or by phone or email.

Figure 1. State-level scope of practice variation for the application of therapeutics to respiratory care among respiratory therapists.

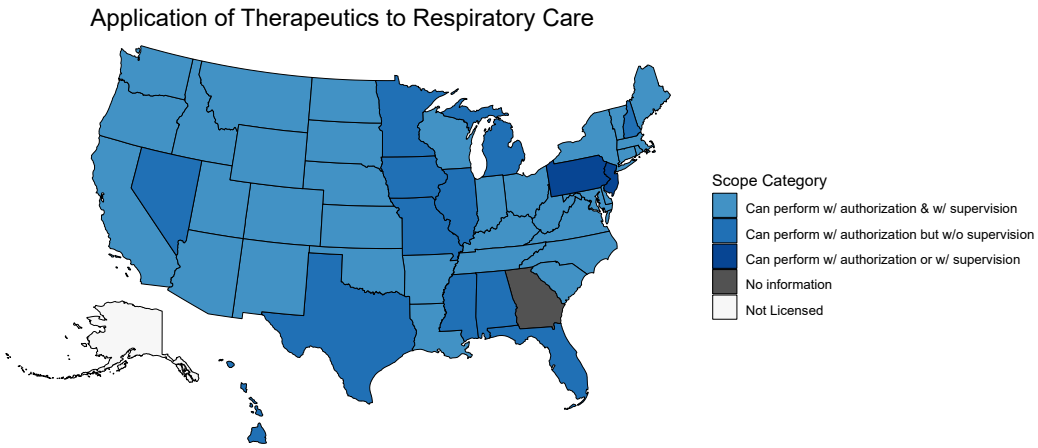

Figure 2. State-level scope of practice variation for the performance and collection of diagnostic information by respiratory therapists.

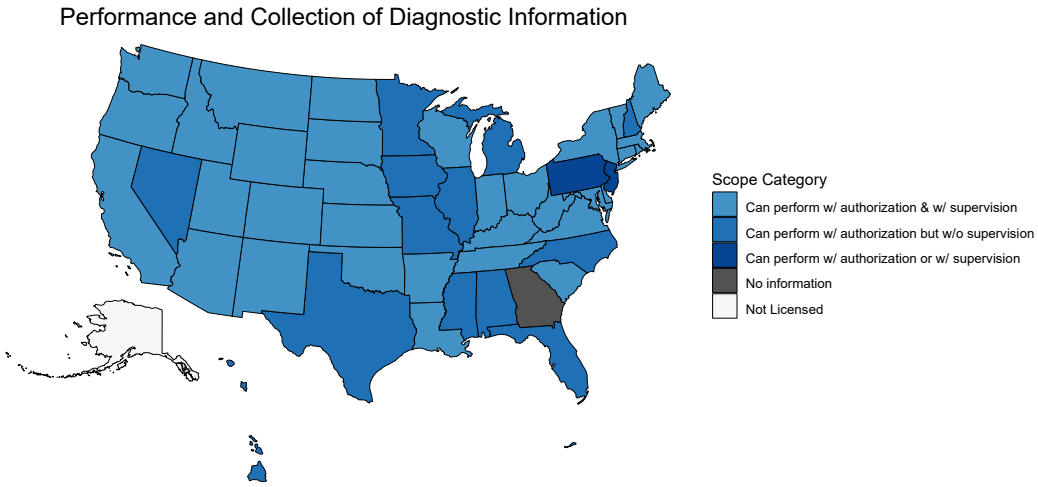

Figure 3. State-level scope of practice variation for patient assessment activities performed by respiratory therapists.

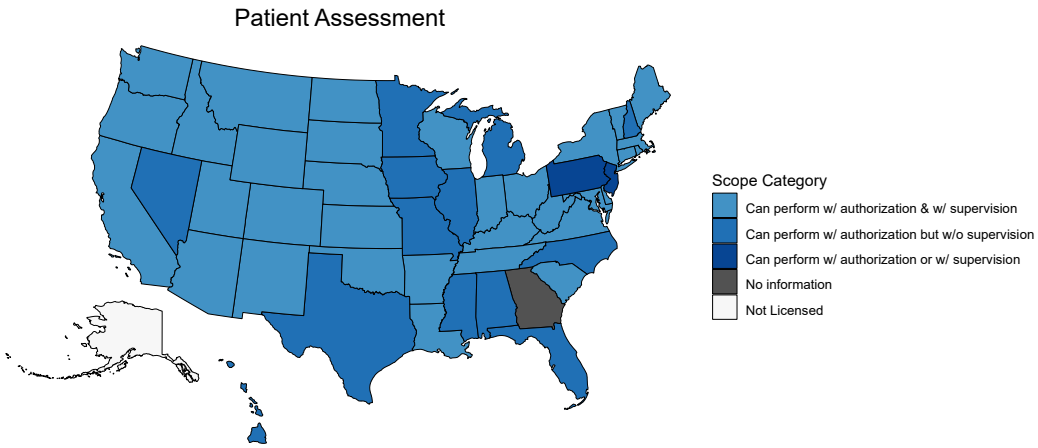

Figure 4. State-level scope of practice variation for the assessment of therapeutic interventions performed by respiratory therapists.

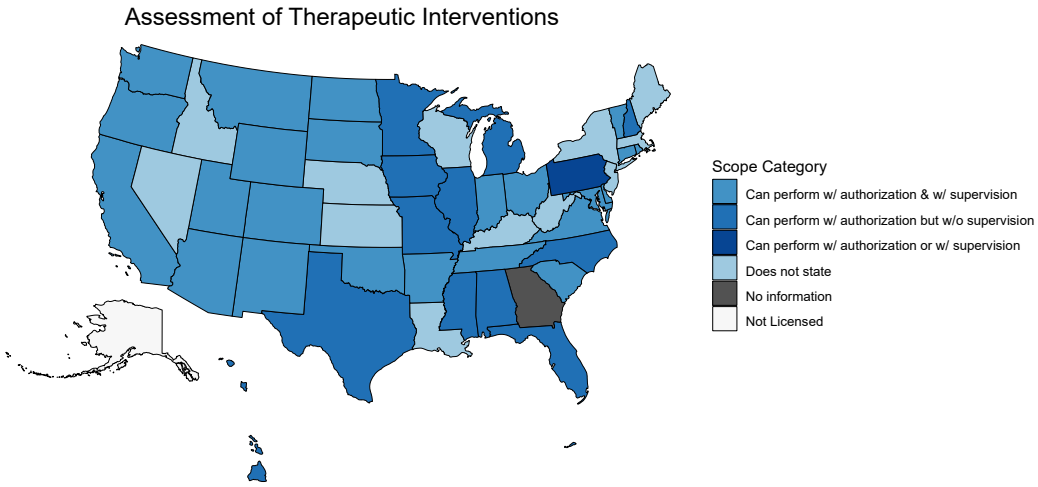

Figure 5. State-level scope of practice variation for respiratory therapists' involvement in acute and chronic disease management with and without clinical decision support systems.

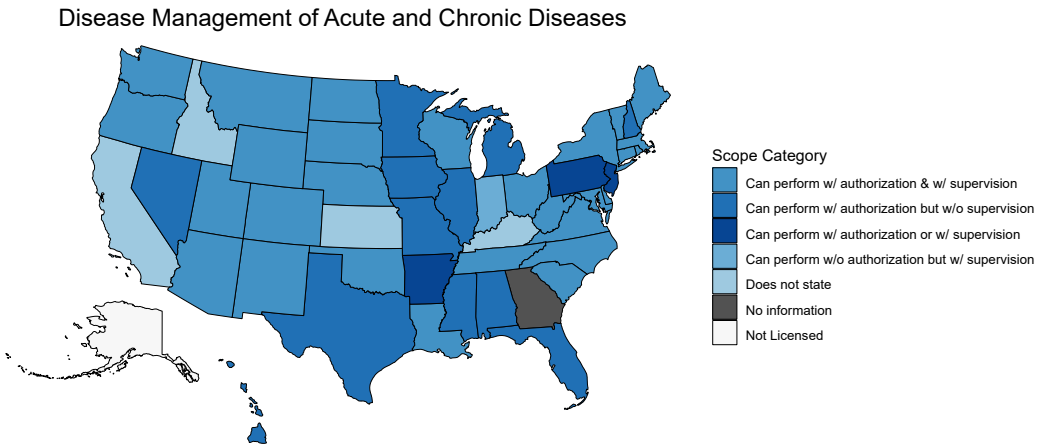

Figure 6. State-level scope of practice variation for the provision of emergency, acute, critical, and postacute care by respiratory therapists.

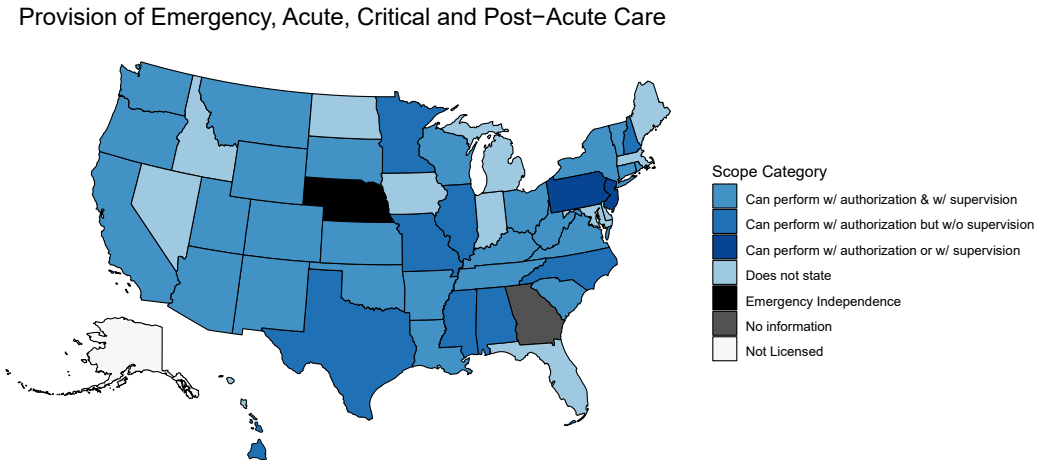

Figure 7. State-level scope of practice variation for discharge planning and case management activities performed by respiratory therapists.

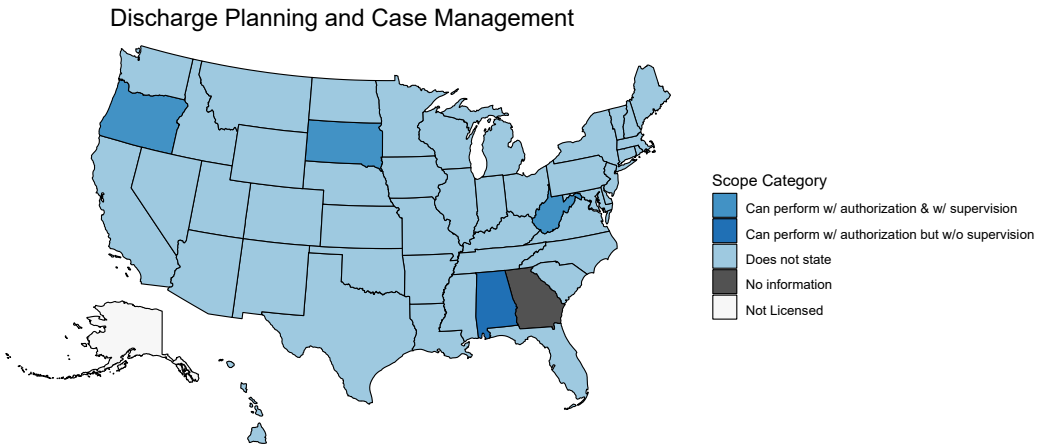

Figure 8. State-level scope of practice variation for advanced care and end-of-life planning discussion facilitation among respiratory therapists.

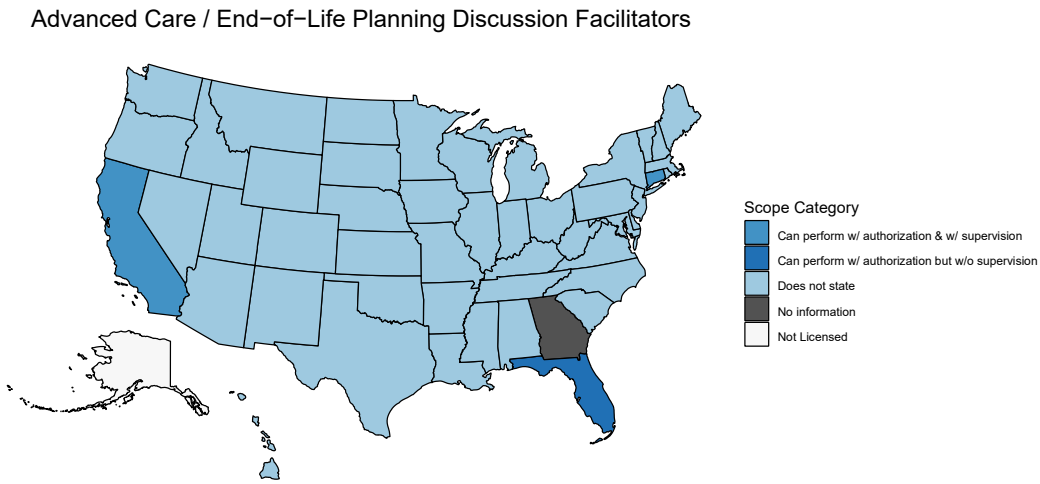

Figure 9. State-level scope of practice variation for telehealth services provided by respiratory therapists.

