The Respiratory Exchange

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President's Report

Don Steinert, MS, RRT

The old saying "time flies" certainly does apply! Summer is almost gone and school is about to get under way. That can only mean one thing; Conference By The Sea is around the corner! I will be looking forward to seeing many of you September 10-12 at CBS!

This has been a very busy (and successful) legislative year. At the federal level, the passage of the Medicare Improvements for Patients and Providers Act with a specific Medicare benefit for pulmonary rehabilitation finally became law. President Bush had actually vetoed this bill but both the House and the Senate overturned the veto! This bill will allow pulmonary rehabilitation programs across the country to have better and more consistent coverage. Another important part of this bill is the repeal of the home oxygen equipment rent-to-own provision. This will allow patients who require home oxygen to continue to rent without having to purchase the equipment outright after 36 months. Medicare will now continue to pay for their oxygen rental needs.

The Maryland/District of Columbia Society for Respiratory Care has also requested to be listed as a supporter for the FDA Tobacco Legislation, "The Family Smoking Prevention and Tobacco Control Act (S625/HR1108)" which is now working it's way through congress.

In 2007 House Bill 3968 was introduced to congress. It was followed by Senate Bill 2704. The basics of these bills is to allow respiratory therapists with a baccalaureate degree (BSRT) to provide services such as smoking cessation, MDI device selection and patient education, asthma management and the like, without the physician having to be present at the facility. In Medicare lingo this is known as "general" supervision, as opposed to "direct" supervision. The bills require baccalaureate trained therapists because the baccalaureate is considered the minimal standard of training for non-physician health care providers that Medicare recognizes. These bills are now working their way "through the system" as well and we are hopeful for a favorable response "down the rode".

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In This Issue:

President's Report Continued.. So far nothing legislative has been going on in the District of Columbia but three items have come up in Maryland. The first issue came up in January of this year, with the polysomnography community requesting a three year extension on the deadline date for requiring licensed professionals only to be providing sleep studies. The request was for the deadline date of October 2009 to be pushed back to October 2012. This bill died for lack of Senate support in Maryland and the original date of October 2009 remains law as of this writing. Your Board of Directors were very active in opposing this legislation.

In April your Society sent a letter to the Senate Education, Health, and Environmental Affairs committee in support of HB 1517.

In April your Society sent a letter to the Senate Education, Health, and Environmental Affairs committee in support of HB 1517. This bill covers radiation therapists, radiographers and nuclear medicine technologists as well as respiratory therapists. The bill basically eliminated sections which were outdated and no longer required as well as streamlining the administrative process for regulating the practice of the above mentioned professions.

The most resent activity the Board has been involved with is regarding some regulatory changes by the State Department of Health and Mental Hygiene. These changes had to do with activities that Certified Nursing Assistants/Geriatric Nursing Assistants would be allowed to perform. The proposal wanted to allow CNA/GNA to do a number of skills that infringed on respiratory licensure. We have responded to the State with our concerns. As of this writing, the bill is still in committee and our concerns are being considered.

I would be remiss if I did not mention that The University of the District of Columbia Respiratory Therapy Program will soon be taking applications for their new baccalaureate degree (BSRT) program. Both full and part-time students will be accepted. Look for the UDC's booth at Conference by the Sea. This has been a great year for the MD/DC Society for Respiratory Care. There will be new openings on the Board of Directors for next year, and I hope that you will consider running for one of the offices. Looking forward to seeing many of you at CBS.

Sincerely,

Don

Important Upcoming Dates & Information:

Next MDDC Board of Director's Meeting
Friday, November 7, 11-2 pm at Baltimore Washington Medical Center, Tate Center

Respiratory Care Week
October 19-15, 2008

Dont' Forget to VOTE!
MDDC Board of Director's Ballot will be mailed in November

Installation of Officers Dinner
January, 2009

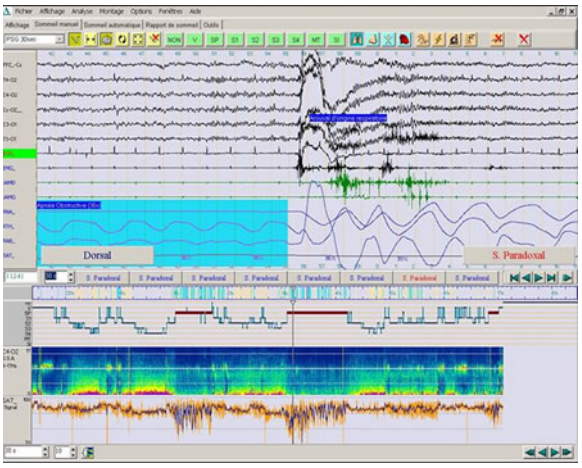
AARC National Convention
Decmember 13-16 2008, Anaheim, CA

Conference by the Sea

2008- Highlights!!

Maryland Board of Physicians: Proposed Polysomnography Licensure Regulations

By Tom Striplin, MEd, RRT



The Maryland Board of Physicians recently published the proposed licensure regulations for Polysomnography in the State of Maryland. The purpose of this action is to establish requirements for the licensure and discipline of a new allied health profession, polysomnographic technology. The regulations include requirements for the advisory committee, requirements for licensure and scope of practice for a polysomnographic technologist, grounds for discipline and hospital reporting requirements for polysomnographic technologists, and other matters pertaining to polysomnographic technologists. The initial licensure fee is $200.

The regulations as written, and if adopted by the Maryland Department of Health and Mental Hygiene will go into effect as of October 1, 2009. Individuals who choose to continue to practice as a polysomnographic technician will need to be licensed before the October 1, 2009 deadline. The proposed regulations provide for the establishment of a Polysomnography Professional Standards Committee. The professional standards committee will be composed of three licensed polysomnographic technologists and three physicians and one consumer member.

Polysomnographic technologist's who plan to continue to practice in the state of Maryland will need to meet certain requirements prior to the October 1, 2009 deadline. The primary requirements to obtain a license and to continue to practice as a Polysomnographic technologist in the state of Maryland require at least one of the following three options: (1) Passing the national certifying examination of the Board of Registered Polysomnographic Technologists on or before September 30, 2009; (2) obtaining certification by the Board of Registered Polysomnographic Technologists as a registered polysomnographic technologist at the time of application; (3) be a graduate from a polysomnographic educational program that is accredited by the Commission on Accreditation of Allied Health Education Programs.

In addition, an alternative pathway to meeting the deadline regulations and one that directly relates to the profession of respiratory care requires both of the following: (1) Graduation from a respiratory care educational program that is accredited by the Commission on Accreditation of Allied Health Education Programs; and (2) Completion of the Committee on Accreditation for Respiratory Care's curriculum for a polysomnography certificate that is accredited by the Commission on Accreditation of Allied Health Education Programs. There is also an alternate provision for electroneurodiagnostic technology educational programs.

Interestingly enough, the regulations contain the standard provision clause: This licensure requirement does not prohibit an individual from practicing a health occupation that the individual is authorized to practice under Health Occupations Article, Annotated Code of Maryland. That raises an interesting question related to scope of practice of respiratory care and the scope of practice of polysomnography and those areas where the scope crosses.

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Proposed Polysomnography Licensure Regulations...

The Maryland/District of Columbia Society for Respiratory Care Board of Directors and its legislative committee has opposed any move by the polysomnographic community to reduce the current legislative requirements to obtain licensure as a polysomnographic technologist in the State of Maryland. The MD/DC Society board has firmly stated that licensed professions should have to meet similar standards as it relates health occupation articles. Professionals who want to be considered a "licensed" profession should meet at least the two minimum health occupation standards:

(1) Pass a national certifying examination

(2) Graduate from an accredited program in the specific discipline.

A considerable amount of disagreement has risen between the respiratory care community and certain elements of the polysomnography community since the inception and introduction of the original Legislative Bill by the polysomnography community. The respiratory care community has been steadfast about maintaining minimum standards to obtain a license and be recognized as a licensed profession in the State of Maryland. The respiratory care community should continue to oppose any reduction in licensure requirements that would permit or allow individuals to practice without meeting the above two standards (see 1& 2).

The polysomnography community has had sufficient time to promote and encourage those practicing in the field to obtain the BRPT credential. The polysomnography community that has supported the licensure act has known for sometime that the deadline would be October 1, 2009. Those un-credentialed sleep technologists who have been working in the field have had sufficient time prepare, study and pass the national exam and obtain a credential in order to qualify for a license by the October 2009 deadline. Failure by the majority of sleep technologists to pursue their credential is not sufficient cause to reduce the current proposed regulatory requirements.

Over the past years, the respiratory community has heard numerous arguments as to why polysomnographic technologist's should be a licensed and independent profession from that of respiratory care. Arguments have also been raised that the plight of the polysomnographic community was and is similar to that of the respiratory community when it was trying to evolve as a profession and obtain licensure. This is where we disagree with the polysomnographic community! When the respiratory profession was seeking certification/licensure by the state of Maryland our profession met the two standards of national licensure, and graduate from a accredited degree program.

The polysomnographic community has every right to pursue licensure and declare them selves an independent and unique profession. However, their timing seems to be very bad and in retrospect, they should have waited until they had established programs in polysomnographic technology prior to seeing licensure status. The respiratory community should continue to oppose any changes to the regulations that allow the polysomnographic community to obtain a license without meeting established standards of practice; regardless of the impact on the inability to staff labs should the proposed regulations remain unchanged.

The respiratory community should continue to oppose any changes to the regulations that allow the polysomnographic community to obtain a license without meeting established standards of practice

It should be pointed out that the polysomnographic community pushed for and asked for this licensure requirement/ proposed regulations. It seems contradictory for them to even consider coming back to the legislative table and asking for a change to the current law by reducing the requirements to obtain and practice polysomnography in the State of Maryland

Is it Time for a Masters Prepared Mid-Level Respiratory Care Practitioner?

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This editorial suggests that healthcare now requires the establishment of a respiratory care mid-level practitioner. We posit that increased patient numbers and heightened patient care complexities support the need for a physician-extender respiratory care practitioner. Defined as a master's degree prepared clinician, much like a nurse practitioner or physician assistant, we propose that the development and acceptance of this mid-level Respiratory Care Practitioner is a proper professional growth landmark that would greatly improve patient care. Citing the development of other allied health professions, which in many cases has evolved through masters level preparation into clinical doctoral preparation, we assert a present need for certain advanced respiratory care practices, and those within our scope of practice not yet actualized, to be consistent with higher education achievement. Finally, we suggest that current Medicare reimbursement advancements, which are tied to the baccalaureate level, offer excellent motivation for incorporating a master's level professional growth perspective.

For those of us who have worked in Respiratory Care for a while, there seems to be evolving a willingness to discuss a facet of our much beloved profession that seems to have, well, not developed. Other medical professions have expanded their academic requirements with clinical masters and doctoral degrees, and with that have expanded their practice domains. The progress in the practice of respiratory care seems to be less consistent than other medical professions and more responsive to local needs than to organized national leadership.

We believe it is professionally responsible to ask, " Is the Respiratory Care profession going to continue development and do what is necessary to match those who were once our professional peers?" In short, these "peer" professions host mid-level practitioners, and it is our assertion that it is time for the Respiratory Care profession to do what is required to host its own mid-level practitioner. (Definitions for mid-level practitioner vary. For the purpose of this conversation, we define a mid-level provider as; (a), a physician extender, following a nurse practitioner or physician assistant model, and (b), at least a clinical masters degree prepared practitioner).

Clearly, the nursing and physician assistant mid-level practitioners have set a professional standard that we in respiratory care should respect. And, even as we suggest a clinical masters degree for respiratory care, we must be mindful that other higher, non-medical doctoral practice degrees are now being assimilated into their respective professions. These include: "doctor of audiology (AudD), doctor of clinical nutrition (DCN), occupational therapy doctorate (OTD), and doctor of nursing practice (DNP)" .[1] Additionally, pharmacists have the PharmD, and physical therapists have the doctor of physical therapy (DPT). From our perspective, respiratory care's communities of interest would benefit greatly by our aggressive closure of this dramatic, and widening, professional academic dissonance.

continued on page 7... see “Master’s Prepared”

"Masters Prepared continued.."

The changing environments over the past four decades have presented themselves equally to all medical professions, and we must be forthright to acknowledge that some professions have better prepared and applied themselves toward professional advancement than have we. What other successfully developed professions have done is to aggressively prepare competent practitioners for a timely insertion into expanded medical practice. This expanded practice was carefully developed to satisfy the changing model of medicine delivery. These professions enacted an effective professional maturation plan, and the elevated roles of nurse practitioners, physician assistants, and physical therapists stand as irrefutable proof to the premise.

Contrast our profession's position with that of other professional organizations. For instance, the National Accrediting Agency for Clinical Laboratory Sciences (NAACLS) and the American Society for Clinical Laboratory Sciences (ASCLS) are presently studying a model curriculum for the doctorate in clinical laboratory science (DCLS) .[2] Also consider the American Association of Colleges of Nursing (AACN), which represents nursing's baccalaureate, and higher, degrees. Since 2004, the AACN has been actively advocating the "practice doctorate" for nursing .[3] Further, the AACN is suggesting that all advanced practitioner registered nursing program be at the doctoral level by 2015 .[4] We should also remember that 79% of the nations PA programs are at the masters level, with professional considerations for expanding to a clinical doctorate .[5] Comparing the respiratory care professions lagging growth and development to these other professions invites consideration of our relative position in fie or even ten years. This consideration is troubling.

It is our belief that the medical community would embrace, as it has with mid-level physical therapist, nurse, and physician assistant providers, properly educated respiratory therapist who contributes to more efficient and more competent advanced patient care. Encouragingly, there are several circumstances that suggest development of a mid-level Respiratory Care practitioner would be presently successful. First, some respiratory care practitioners now in de facto role of mid-level practitioner. Clearly, many respiratory care practitioners practice in a manner similar to nurse practitioners and physician assistants. Physician office practice, especially pulmonary physician office practice, has been improved by the work of well-qualified respiratory care practitioners, who extend the physician's influence to the patient.[7]

A second reason for success is that hospital respiratory care practice expense has been drastically reduced by profession-wide protocol applications (a practice developmental task toward mid-level practitioner status.)

Respiratory Care should be proud of both physician and therapist directed protocol effectiveness.[8] Enjoying nationwide acceptance, these protocols have significantly reduced medical costs, and more importantly, have vastly improved the application of appropriate cardio-respiratory interventions.[9-11] In many ways, these applications are indistinguishable from nursing and physician assistant mid-level practitioner behaviors.

A third reason for success is that virtually all states have licensure, and these licensure laws' scopes of practice, generally, do not preclude mid-level practitioner development. Our profession's agreement on the necessity of state licensure facilitates the establishment of mid-level practitioners. To be certain, however, existing licensure provisions will need to be expanded, and in many states, we suggest that the physician licensing entity may be best suited to administer licensure for the mid-level practitioner, if this is not already in effect.

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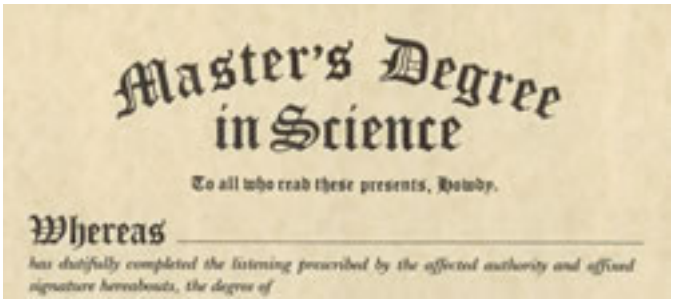
“Masters Prepared continued..”



Finally, the now well-established capitation culture has benefited greatly by nurse practitioner and physician assistant integration.[12] Timely, accessible, and competent medical services are available to more people as the physician's influence is extended through appropriately educated mid-level practitioners. We suggest that the addition of a mid-level respiratory care practitioner within the physician's office, the intensive care unit, or emergency department, would bring similar benefit to the medical community, and more importantly, the community at large. Beyond that, we concur with the Leapfrog Group's call for expanded "intensivist" placements[13] and suggest that the mid-level Registered Respiratory Therapist will be an integral part of this actuality. Given these considerations, we suggest that the pursuance of a respiratory care, masters-educated mid-level practitioner, is a realistic, reasonable, and present professional outcome. To that end, the Salisbury University Respiratory Therapy Program faculty is considering creating a clinical master's degree program in Respiratory Care. We are pleased to hear your thoughts on this issue.

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Prince George's Community College Student- Sputum Bowl Champions

The student respiratory team from Prince George's community college won the sputum bowl competition held at Conference by the Sea. The team will represent the MD/DC Society at the national student competition in Anaheim, California in December. Best of luck to the team members and the program from Prince George's!!

Winning Team Members: (left to right)
Deborah Akinmoloyan, Sarah Jones, Selam Woldearegay

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Next Edition will be published Jan 30 2009. Submission deadline is Jan 15, 2009.

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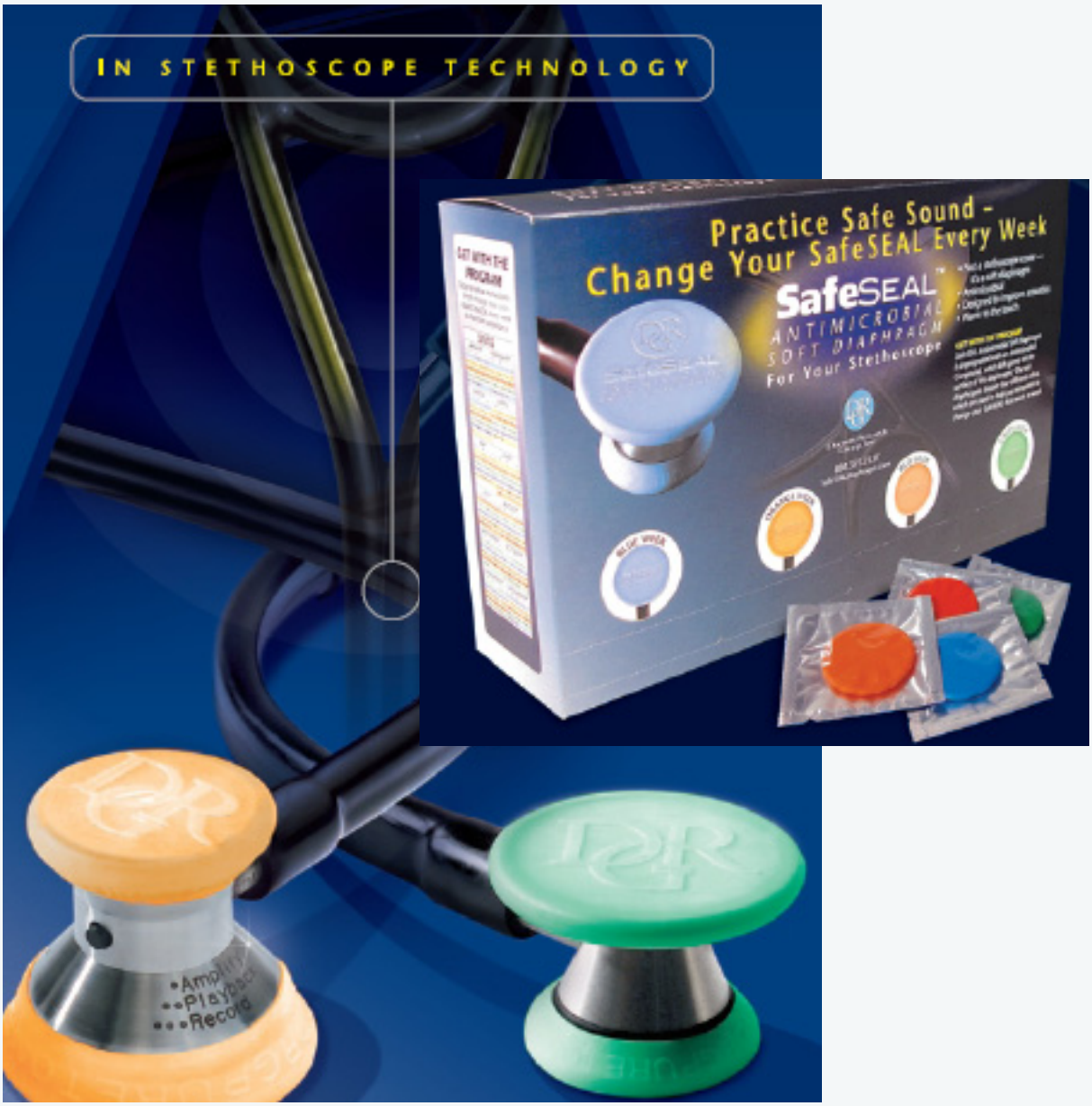

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