

FSRC

**Florida Society for
Respiratory Care**

**2008 Advocacy
Agenda**



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Florida Society for Respiratory Care

Profession Description

Vision and Mission Statement

The Florida Society for Respiratory Care (FSRC) will continue to be the leading professional association for Respiratory Care in the state of Florida. The FSRC will encourage and promote professional excellence, advance the science and practice of Respiratory Care, and serve as an advocate for patients, their families, the public, the profession, and the Respiratory Therapist.

Definition of Respiratory Care

Respiratory Care is the health care discipline that specializes in the promotion of optimum cardiopulmonary function and health. Respiratory Therapists apply scientific principles to prevent, identify, and treat acute or chronic dysfunction of the cardiopulmonary system. Knowledge of the scientific principles underlying cardiopulmonary physiology and pathophysiology, as well as biomedical engineering and technology, enable respiratory therapists to effectively offer preventative care to, as well as assess, educate, and treat patients with cardiopulmonary deficiencies.

As a health care profession, Respiratory Care is practiced under medical direction across the health care continuum. Critical thinking, patient/environment assessment skills, and evidence-based clinical practice guidelines enable respiratory therapists to develop and implement effective care plans, patient-driven protocols, disease-based clinical pathways, and disease management programs. A variety of venues serve as the practice site for this health care profession including, but not limited to: acute care hospitals, sleep disorder centers and diagnostic laboratories, rehabilitation, research and skilled nursing facilities, patients' homes, patient transport systems, physician offices, convalescent and retirement centers, educational institutions, field representatives and wellness centers.

Respiratory Care Scope of Practice

The practice of Respiratory Care encompasses activities in: diagnostic evaluation, therapy, and education of the patient, family and public. These activities are supported by education, research and administration. Diagnostic activities include but are not limited to: (1) obtaining and analyzing physiological specimens; (2) interpreting physiological data; (3) performing tests and studies of the cardiopulmonary system; (4) performing neurophysiological studies; and (5) performing sleep disorder studies.

Therapy includes but is not limited to application and monitoring of: (1) medical gases (excluding anesthetic gases) and environmental control systems; (2) mechanical ventilator support; (3) artificial airway care; (4) bronchopulmonary hygiene; (5) pharmacological agents related to Respiratory Care procedures; (6) cardiopulmonary rehabilitation; (7) hemodynamic cardiovascular support; (8) polysomnography; and, (9) hyperbaric oxygen therapy.

The focus of patient and family education activities is to promote knowledge of disease process, medical therapy and self help. Public education activities focus on the promotion of cardiopulmonary wellness.

Statement of Ethics and Professional Conduct

If the conduct of any member shall appear to be in violation of the Bylaws, American Association for Respiratory Care (AARC) Statement of Ethics and Professional Conduct (see below), or prejudicial to the Society's interests' the Judicial Committee may recommend to the Board of Directors and the Board may, by a two-thirds (2/3) vote, expel or otherwise discipline such member.

The Judicial Committee will notify the member of the decision of the Board of Directors. Notification shall be in writing and sent to the address on file by certified mail requesting return receipt.

Within thirty (30) days after receipt of notice of expulsion or other form of discipline, the member shall have the right to appeal the decision to the Board of Directors. Any such action shall also be reported to the Judicial Committee of the AARC.

AARC Statement of Ethics and Professional Conduct

In the conduct of professional activities the Respiratory Therapist shall be bound by the following ethical and professional principles. Respiratory Therapists shall:

- Demonstrate behavior that reflects integrity, supports objectivity, and fosters trust in the profession and its professionals. Actively maintain and continually improve their professional competence and represent it accurately.
- Perform only those procedures or functions in which they are individually competent and which are within their scope of accepted and responsible practice.
- Respect and protect the legal and personal rights of patients they treat, including the right to privacy, informed consent and refusal of treatment.
- Divulge no protected information regarding any patient or family unless disclosure is required for responsible performance of duty, or required by law.
- Provide care without discrimination on any basis, with respect for the rights and dignity of all individuals.
- Promote disease prevention and wellness.
- Refuse to participate in illegal or unethical acts.
- Refuse to conceal, and will report, the illegal, unethical or incompetent acts of others.

- Follow sound scientific procedures and ethical principles in research.
- Comply with state or federal laws which govern and relate to their practice.
- Avoid any form of conduct that creates a conflict of interest and shall follow the principles of ethical business behavior.
- Promote health care delivery through improvement of the access, efficacy, and cost of patient care.
- Encourage and promote appropriate stewardship of resources.

Fiduciary Responsibility

Conflict of Interest

A conflict of interest is defined as any situation in which a Director or Officer has a direct or indirect outside personal interest which has the potential of being contrary to the best interest of the Society.

Fiduciary Duty

The fiduciary duty is the highest form of legal duty owned by one person to another. Directors and Officers of the FSRC shall retain fiduciary duty to manage the affairs of the Society so that its property will be used for the purpose for which it has been entrusted.

- Directors and Officers shall be considered “fiduciaries” and therefore have a status similar to that of trustees.
- Directors and Officers shall act solely for the benefit of members of the Society in scrupulous good faith and candor.
- The fiduciary standards applicable to the Directors and Officers shall be as summarized below to provide background for determining conduct to which a Director or Officer should adhere. (For explicit details, please refer to the FSRC Policy and Procedure Manual).
 - Duty of Loyalty
 - Doctrine of Corporate Opportunity
 - Use of Inside Information
 - Duty of Care

Each Board member shall complete a “Conflict of Interest” statement as directed by the FSRC President.

Respiratory Therapist Education

To adequately prepare graduate respiratory therapists to practice across a broad spectrum of sites, it is the position of the FSRC that:

- The minimum education leading to entry into practice of Respiratory Care should be successful completion of an associate degree Respiratory Care education program.

- Programs should prepare graduates as respiratory therapists.
- Programs that educate respiratory therapists should be accredited through a body, and a process, which will confirm that the programs meet minimum educational requirements.
- Graduate respiratory therapists, upon completion of the above-described minimum education, should be eligible to pursue and to obtain a credential that acknowledges the didactic preparation and related skills required for practice as a respiratory therapist.

The FSRC will continue to support the practice of Respiratory Care by providing continuing education opportunities, and collecting and sharing information on the changing healthcare environment as it impacts Respiratory Care education and practice.

Entry Level Degree

One of the principle recommendations made as a result of the consensus conference process was setting the associate degree as a requirement for entry into practice. The expanded scope of practice and the demands of employers for workers with a broader array of skills demand that, minimally, a Respiratory Care Practitioner (RCP) should have enhanced communication skills, be computer literate, and possess critical-thinking skills. Respiratory Care educators are fully aware of the need to adequately prepare students for the entry-level examination. To avoid extending the length of a program, many educators merely established evermore expanded course prerequisites. The student leaves a program having spent two or more years preparing to enter the profession without a diploma. This is not fair to the consumer-student, and it is not fair to the consumer-employer.

Accreditation

Accreditation of Respiratory Care programs is currently outcomes oriented. A program is evaluated on its ability to enroll students, educate them to an announced level, determine their success on nationally standardized examinations, and survey employers to determine the efficacy of the education rendered. This orientation divorces the institution from following a prescribed pattern and permits innovative approaches to meeting the needs of the communities of interest. The need to provide certain baseline information remains, since the matrix of the entry-level examination addresses essential skills and knowledge. An educator responsive to the needs of the community of interest can add skills like advanced cardiac life support (ACLS), electrocardiogram administration, noninvasive cardiac testing, or whatever skills are in demand by employers.

Licensure

States are categorized according to the definition of licensure, certification, and registration used by the Council on Licensure, Enforcement and Regulation (CLEAR). States with licensure laws are considered to have practice acts, while states with certification laws have title protection acts.

Although a credentialing body, the National Board for Respiratory Care (NBRC), exists, its examination system is purely voluntary. Without licensure, the credentialing body only serves to

attest to the fact that an RCP has successfully passed an examination. Licensure helps to provide a mandatory testing system resulting in the highest quality and most efficient medical care being rendered to the public. Through licensure, the quality of health care in the field of Respiratory Care increases to a level based on nationally accepted standards.

The incidence of harm or abuse by Respiratory Therapists is most effectively tracked through the state licensure mechanism. In this regard, the AARC, FSRC, and NBRC are helping to strengthen the public protection goals of licensure through the development of the National Respiratory Care Disciplinary Database. State boards and advisory committees for Respiratory Care will be able to access this compilation of public, documented evidence of disciplinary actions against Respiratory Therapists nationwide. In view of the mobility of our society today, the establishment of this protective tool is absolutely essential.

Defining Licensure, Certification, and Registration

FSRC classifies these laws according to the definitions of licensure, certification, and registration developed by the Council on Licensure, Enforcement and Registration (CLEAR). CLEAR's web site is www.clearhq.org. Licensure is the most restrictive form of professional and occupational regulation. Licensure is often referred to as the right-to-practice. Under licensure laws, it is illegal for a person to practice a profession without first meeting state or provincial standards.

Linkage Between Practice and Education

RCPs, since the beginning of their existence, have adapted the scope of their role to the environment's needs. The RCP of the future will have skills necessary to work in acute, sub-acute, and long-term care settings. This means that practitioners will continue to have a firm foundation in the basic sciences and technology, but will also have the critical-thinking skills necessary to use patient-driven protocols. They will serve as adjuncts to physicians in the management of health care delivery. They will assume the role of patient educators and care coordinators. They will play an active role in disease management. RCPs will effectively follow a patient across the entire spectrum from acute care to sub-acute care and into home care.

Continuing Education

The need for all health care practitioners to participate in continuing education is well established. Participation in continuing education, whether mandatory or voluntary, offers the potential to be one of the most powerful tools to ensure quality patient care. In recognition of the value of and need for participation in continuing education, the FSRC recommends that practitioners participate in continuing education activities each year. The FSRC also supports Respiratory Therapists striving to pursue baccalaureate and graduate degrees after the required entry level education.

FSRC members may utilize the Continuing Respiratory Care Education (CRCE) system as the mechanism for recognition and documentation of such activities.

Respiratory Therapists are encouraged to select their continuing education activities carefully in order to meet their own personal and professional needs. Providers of continuing education activities (which can include clinical institutions, educational institutions, public and private associations or organizations, and proprietary corporations) are encouraged to assist respiratory therapists in their efforts with activities which will enable practitioners to meet their professional goals.

Florida Society for Respiratory Care

Strategic Goals, Objectives and Strategy

In addition to specific goals which are recommended to the Board by the President, the following shall remain perpetual goals of the FSRC:

- Develop and execute strategies that will increase membership and participation in the FSRC.
- Develop and execute strategies that will increase recruitment of high school graduates as well as adults in transition into the Respiratory Care profession.
- Participate in activities that will increase the public awareness of our profession.
- Participate in activities that will increase the public awareness of COPD, asthma and other lung diseases and promote early detection efforts.
- Participate in efforts to increase patient access to Respiratory Therapists in all care settings.
- Develop and participate in activities which promote and encourage members to seek and obtain the registered respiratory therapist (RRT) credential.

The FSRC also accepts and adopts the AARC Strategic Objectives and Strategies. They are:

Objectives:

1. *Refine and expand the scope of practice for respiratory therapists in all care settings.*
 - a. **Strategies for Implementation:**
 - i. Collect and disseminate information that documents the costs in dollars, length of stay, and lives of Respiratory Care being provided by persons other than respiratory therapists.
 - ii. Assist respiratory therapists to eliminate the provision of inappropriate Respiratory Care.
 - iii. Focus the attention of respiratory therapists on providing Respiratory Care at the lowest cost.
 - iv. Increase the access of underserved populations to the services of respiratory therapists.
 - v. Promote positive models of excellence in Respiratory Care.
 - vi. Develop model position descriptions for respiratory therapists in various

roles which emphasize quality, access, and cost control.

- vii. Encourage protocol-based care and the use of Respiratory Care plans.
- viii. Develop model, evidence-based protocols and Respiratory Care plans for clinical practice.
- ix. Promote the development of specialty tracks and/or specialty programs for respiratory therapists (e.g. polysomnography).

2. *Advance the knowledge base and educational preparation of respiratory therapists to ensure competent patient care and to foster patient safety initiatives.*

a. **Strategies for Implementation:**

- i. Support existing educational programs in colleges and universities.
- ii. Promote the continuing development of baccalaureate and graduate degree education in Respiratory Care.
- iii. Encourage respiratory therapists to pursue advanced and continuing education.
- iv. Encourage all respiratory therapists to seek and obtain the RRT credential.
- v. Support the development of new specialty credentials, as appropriate, and encourage current practitioners to seek and obtain credentials for advanced and specialty practice.
- vi. Assist educational programs in recruitment of quality students by developing materials which will present the profession positively and promote the profession.

3. *Support research and scientific inquiry to strengthen the scientific foundation and promote best practice for patient care.*

a. **Strategies for Implementation:**

- i. Financially support research which seeks to advance the science and practice of Respiratory Care provided across all care sites.
- ii. Publish scientific information which advances the science and practice of Respiratory Care.
- iii. Work collaboratively with other health professions to conduct research to demonstrate the value of allied health professionals.

- iv. Demonstrate the effectiveness of the respiratory therapist in health promotion and disease prevention.
4. *Establish professional standards and outcomes that are supported by scientific evidence.*
- a. **Strategies for Implementation:**
 - i. Continue to develop and revise evidence-based Clinical Practice Guidelines to reflect the science of Respiratory Care and the role of the respiratory therapist.
 - ii. Conduct scientific conferences to advance the science and practice of Respiratory Care.
 - iii. Develop and publish white papers and position statements related to Respiratory Care practice, education and management.
5. *Advocate for federal and state health care policies that enhance patient care, patients' access to care and professional practice.*
- a. **Strategies for Implementation:**
 - i. Legislators: Provide information to assist them to advocate for their constituents with a focus on safety and cost advantages of Respiratory Care provided by respiratory therapists.
 - ii. Regulators: Emphasize support of legislatures, focus on cost savings, quality of care and improved patient safety from utilizing respiratory therapists.
 - iii. Payers: Emphasize cost effectiveness due to improved outcomes and lower cost than other providers.
 - iv. Decision Makers: Emphasize provision of high quality care by respiratory therapists while controlling costs of that care. Focus on the value of Respiratory Care and the respiratory therapist as the best practitioner to provide that care, control inappropriate utilization of Respiratory Care and ensure patient safety.
6. *Partner with governmental agencies, community organizations, third party payers, professional societies and the public to promote healthy behaviors and prevent cardiopulmonary disease.*
- a. **Strategies for Implementation:**

- i. Participate in consumer, professional and governmental coalitions to promote lung health.
- ii. Support efforts to encourage smoking cessation and tobacco control.
- iii. Partner in public education efforts to advise the public on lung health and cardiorespiratory disease.
- iv. Participate in efforts to educate patients, their families and the public on the importance of disease management for chronic respiratory disease (e.g. Asthma and COPD).

7. *Broaden consumer and health care providers' knowledge and understanding of the value of respiratory therapists in providing safe, competent and cost effective care.*

a. **Strategies for Implementation:**

- i. Consumers: Provide information on higher mortality and increased costs when Respiratory Care is not provided and when it is provided by someone other than a respiratory therapist. Focus on quality, safety, and cost issues.
- ii. Other Health Professionals: Provide information and assistance to assure that Respiratory Care is provided by appropriate personnel when such care falls outside of the domain covered by the training and demonstrated competence of those individuals.
- iii. Current Respiratory Therapists: Provide information to assist them in developing and maintaining their skill as asthma educators, disease management specialists and experts in smoking cessation and chronic disease management.

8. *Assure the Society has the resources to meet the needs of its members.*

a. **Strategies for Implementation:**

- i. Increase the membership of the Association.
- ii. Increase the diversity of the members of the Society by providing information to encourage persons who are members of underrepresented groups to enter the Respiratory Care profession and actively participate in the AARC.

- iii. Develop and increase the revenue sources needed to support the activities of the Association.
- iv. Participate collaboratively with strategic partners for mutual benefit.
- v. Provide mechanisms to assure a continuous supply of interested, qualified leaders.
- vi. Increase the involvement of members in the activities of the Association.
- vii. Reduce costs of delivering services to members by using the technology which is available.
- viii. Improve the responsiveness of the leadership to the rapidly changing environment today and in the future.
- ix. Provide information to non-member respiratory therapists which will reveal why being an AARC member will benefit them in terms of developing and maintaining their skills and convinces them that not supporting the AARC will be a detriment to their career.
- x. Provide information to instructors and managers to encourage active participation of students in the AARC and its chartered affiliates and assure they are fully informed of the science of Respiratory Care.
- xi. Align incentives with state affiliates.

Florida Society for Respiratory Care

Position Statements Summary

The FSRC is supportive of:

- Administration of sedative and analgesic medications by Respiratory Therapists.
- Age appropriate care of the respiratory patient.
- Competency requirements for the provision of respiratory therapy services.
- The advancement of cultural diversity among its members, as well as in its leadership.
- Legislation that would require all hospitals to have a safe patient lifting policy.
- Affordable housing for healthcare workers.
- An all-hazards disaster preparedness, response, and recovery strategy by the State of Florida.
- Service provision in hospitals and alternate sites scope of practice.
- Efforts toward the prevention of hazardous material exposure; appropriate hazardous material exposure guidelines; and, a community-wide plan for the management of exposure to hazardous materials.
- Health promotion and disease prevention endeavors.
- Education, training, and competency testing for the provision of prescribed home Respiratory Care.
- Outpatient Pulmonary Rehabilitation programs.
- Using Respiratory Therapists as Extracorporeal Membrane Oxygenation (ECMO) Specialists.
- Telehealth and Electronic Health Records.
- The revision of Florida law to eliminate special informed consent requirements for HIV testing of source patients involved in significant provider blood exposure accidents.
- The rights of non-tobacco users, the use of tobacco litigation settlement funds toward tobacco reduction and medical treatment for smoking-related diseases, legislative and regulatory efforts to control tobacco use, and the development and sponsorship of smoking-cessation programs.
- Respiratory Therapy in all care sites under Medicaid.
- Patient access to medically necessary home oxygen.
- Hyperbaric Oxygen therapy delivery in the state of Florida.
- RRTs and CRTs transcription of verbal physician orders for drugs and treatments directly related to the provision of Respiratory Care.

The FSRC is opposed to:

- Fraudulent practices in Respiratory Care.
- Prescribed caregiver-to-patient ratios and public reporting of staffing data legislation.

Florida Society for Respiratory Care

Position Statements

1. Administration of Sedative and Analgesic Medications by Respiratory Therapists

Position: The FSRC is supportive of the administration of sedative and analgesic medications by Respiratory Therapists.

The FSRC recognizes the fact that Respiratory Therapists are called upon to assist physicians with the administration of sedative and analgesic medications during diagnostic and therapeutic procedures and patient transportation.

“Sedation” and “analgesia” describe a physical state in which the patient is able to tolerate unpleasant procedures, while maintaining adequate cardiorespiratory function, and the ability to respond purposefully to verbal commands and tactile stimulation. This is commonly referred to as moderate sedation. The FSRC believes that Respiratory Therapists working under qualified medical supervision can assist physicians during diagnostic and therapeutic procedures and patient transportation, and help to minimize risks by administering prescribed medications and closely monitoring the patient.

The FSRC recognizes and acknowledges the following:

- The American Society of Anesthesiologists (ASA) has published the document “Practice Guidelines for Sedation and Analgesia by Non-anesthesiologists.” Reference: *Anesthesiology*, 2002; 96: 1004-1017.
- The purpose of the ASA document is to allow clinicians to provide their patients with the benefits of sedation and analgesia while minimizing associated risks.
- The ASA Guidelines should be followed by all Respiratory Therapists called upon to provide this service.
- The clinicians and their facilities have the ultimate responsibility for selecting patients, procedures, medications, and equipment.
- Respiratory Care education programs approved by the Commission on the Accreditation of Allied Health Education Programs/Committee on Accreditation for Respiratory Care (or their successor organizations) provide appropriate pharmacologic and technologic training to enable Respiratory Therapists to safely administer sedatives and analgesics by following the ASA Guidelines.

Following successful completion of a specialized education and competency assessment program the Respiratory Therapists must:

- Be knowledgeable about the techniques, medications, side effects, monitoring devices, response or untoward effects of medications, and documentation for any specific procedure.
- Meet qualifications to be certified as competent, in accordance with her/his facility's and Respiratory Care Department's policies, to administer sedatives and analgesics under qualified medical direction.

The FSRC supports Respiratory Therapists who have successfully completed a specialized education and competency assessment program on sedation and analgesia based on the ASA's Guidelines, and who have been certified as competent by the appropriate medical director and department head or governing body. Such therapists should be permitted to provide the service in accordance with ASA's Guidelines, facility policies, procedures, protocols, and service operations, as well as with the Joint Commission and state requirements and policies.

2. Age Appropriate Care of the Respiratory Patient

Position: The FSRC is supportive of age appropriate care of the respiratory patient.

Patients with respiratory disease should receive the highest quality of care in a timely and professional manner. Respiratory Therapists (RTs) have the training and expertise to deliver Respiratory Care to all age groups, from neonate to elderly. RTs are trained, tested, uniquely qualified, and specifically credentialed to provide Respiratory Care as attested in official supporting statements by the American Society of Anesthesiologists (ASA), the American College of Chest Physicians (ACCP), and the National Society for Medical Direction of Respiratory Care (NAMDRRC).

RTs provide services to all age groups across the continuum of care, including physician's offices, acute care hospitals, sub-acute care facilities, rehabilitation facilities, skilled nursing facilities, hospice facilities, and patients' homes. RTs should participate in the initial assessment of the patient to maximize the effective and efficient use of Respiratory Care service resources. The RT should work under a medical director and provide Respiratory Care services under medical direction, as ordered by a physician and/or in accordance with a prescribed Respiratory Care protocol or clinical pathway, and should offer recommendations for an appropriate regimen of care. RTs should be a part of the team providing education of the patient, family members, and other health caregivers regarding Respiratory Care to ensure appropriate disease management.

In accordance with the recommendations of two Education Consensus Conferences, the FSRC encourages Respiratory Care educators/managers to include: a gerontology module in Respiratory Care training program curricula, and clinical training at long term care and rehabilitation facilities to provide students with the opportunity to learn how to appropriately plan for and provide Respiratory Care services for geriatric patients. Topics focused on the geriatric patient and his/her special health care needs in departmental continuing education programs to assure the desired quality of care for this patient population, and to meet the requirements of health care organization accreditation for age-specific professional training.

3. Competency Requirements for the Provision of Respiratory Therapy Services

Position: The FSRC is supportive of competency requirements for the provision of respiratory therapy services.

Anyone providing Respiratory Therapy to patients, regardless of the care setting and patient demographics, shall successfully complete formal training and demonstrate initial competency prior to assuming those duties. This formal training and demonstration of competence shall be required of any health care provider regardless of credential, degree, or license.

Formal Training and Competency Documentation

Formal training is defined as a supervised, deliberate, and systematic continuing educational activity in the affective, psychomotor, and cognitive domains. It is intended to develop new proficiencies with an application in mind, and is presented with attention to needs, objectives, activities, and a defined method of evaluation.

The training shall be approved by a local, regional, or national accrediting entity. In the allied health field, this training includes supervised preclinical (didactic and laboratory) and clinical activities, as well as documentation of competence through tests determined to be valid and reliable. The qualifications of the faculty providing this training shall be documented and also meet accreditation standards.

Prior to providing Respiratory Therapy services, competency shall be demonstrated in the following areas:

- Review all information contained in the patient's medical record regarding history, established diagnoses, current care regimen, and current signs and symptoms.
- Assess the patient's overall cardiopulmonary status by interview, inspection, palpation, and auscultation.
- Perform and assess diagnostic procedures. Diagnostic procedures include, but are not limited to: pulmonary function studies (spirometry before and after bronchodilator administration, Peak Expiratory Flow Rates, inspiratory/expiratory pressures, lung capacities/volumes by gas and/or plethysmography methods, lung compliance, airway resistance, bronchoprovocation studies, cardiopulmonary exercise testing, indirect calorimetry), pulse oximetry, blood gas analysis, 12-lead ECG, and hemoximetry.
- Initiate, monitor, and recommend appropriate continuous mechanical ventilation modalities and relevant care (e.g., tracheal tube cuff pressure, assessment of the patient's ability to be weaned from continuous mechanical ventilation).
- Determine the appropriateness of the prescribed Respiratory Care plan, recommend modifications where indicated, and participate in the implementation and further development of the Respiratory Care plan. Work interdisciplinarily to include the Respiratory Care plan with the overall care plan for the patient.

- Select, assemble, and use equipment appropriate for the necessary Respiratory Therapy services, assuring its cleanliness and proper function. Identify and correct malfunctions. Respiratory Therapy equipment includes but is not limited to: oxygen administration devices; humidifiers; aerosol generators; ventilators; artificial airways; suctioning devices; gas delivery, metering, and clinical analyzing devices; manometers and gauges; resuscitation devices; high frequency chest wall oscillation devices; Positive Expiratory Pressure (PEP) devices; Electrocardiogram (ECG) machines; incentive breathing devices; patient breathing circuits; percussors and vibrators; environmental devices; and metered dose inhalers, dry powder inhalers, and spacers.
- Educate the patient and family members/other caregivers as to the planned therapy and goals.
- Observe universal precautions and other appropriate measures to protect the patient from nosocomial infection.
- Provide care to achieve maintenance of a patent airway, to include placement and care of an artificial airway and suctioning. This may include the insertion of oro- and nasopharyngeal airways, maintenance of proper tracheal tube cuff inflation, trach care, performing chest physiotherapy, and the administration of aerosol therapy.
- Administer medicated aerosols, including but not limited to bronchodilators, mucolytics, and anti-inflammatories with spontaneous ventilation including Intermittent Positive Pressure Breath (IPPB)/Intermittent Positive Ventilation (IPV) therapy.
- Provide therapeutic services to achieve and maintain adequate arterial and tissue oxygenation, which may include positioning to minimize hypoxemia; administering oxygen; initiate and adjust Positive End Expiratory Pressure (PEEP)/Continuous Positive Airway Pressure (CPAP)/bi-level pressure devices and PEP therapy.
- Evaluate the patient's response to therapy and recommend and implement modifications to the care plan.
- Provide emergency Respiratory Therapy services such as Cardiopulmonary Resuscitation, newborn resuscitation, and placement of artificial airways.
- Provide Respiratory Care services utilizing techniques and practices that create a safe patient environment and follow accepted practices that enhance patient safety.

4. Cultural Diversity

Position: The FSRC is supportive of the advancement of cultural diversity among its members, as well as in its leadership.

The FSRC is committed to the advancement of cultural diversity among its members, as well as in its leadership. This commitment entails:

- Being sensitive to the professional needs of all members of racial and ethnic groups,
- Promoting appreciation for, communication between, and understanding among people with different beliefs and backgrounds,
- Promoting diversity education in its professional schools and continuing education programs, and

- Recruiting strong leadership candidates from under-represented groups for leadership and mentoring programs.

5. Fraudulent Practices in Respiratory Care

Position: The FSRC is opposed to fraudulent practices in Respiratory Care.

The FSRC opposes and condemns fraudulent practices in Respiratory Care and encourages respiratory therapists to take all possible measures to prevent such practices. The vast majority of respiratory therapists are honorable and dedicated professionals who are themselves harmed and diminished by fraudulent practices.

Fraudulent practices may include, but are not limited to, submitting claims for payment for services not provided; falsification of documentation to indicate that services were provided which were not, in fact, provided; falsification of patient assessment data, such as lab tests or other diagnostic measurements, to justify services or reimbursement or for other reasons; providing services which are not medically necessary, or which have not been ordered; or using/reporting improper billing codes and/or inflating service charges for selected patient groups to enhance reimbursement.

Fraudulent practices violate the trust which should exist between patients, their caregivers, and payors and present an image of non-professionalism, lack of compassion, and overpowering greed. Fraudulent practices undermine legitimate practices and add to the burden on the nation's already financially stressed health care system. Those who commit fraudulent practices undermine the efforts of the FSRC's promotion of the profession of Respiratory Care as a credible force in the delivery of health care.

6. Hospital Staffing

Position: The FSRC is supportive of legislation that would require all hospitals to have a safe patient lifting policy.

Position: The FSRC opposes prescribed caregiver-to-patient ratios and public reporting of staffing data legislation.

Union-promoted staffing legislation has been successfully opposed by many Florida healthcare associations and advocacy groups for years. The focus of proposed legislation has included prescribed caregiver-to-patient ratios, public reporting of staff and patient census data, and mandated "no lift" programs for patient movement.

The FSRC opposed prescribed caregiver-to-patient ratios and public reporting of staffing data legislation. FSRC instead proposes legislation that would require all hospitals to have a safe patient lifting policy. Support for such legislation will further demonstrate the commitment from hospitals towards patients and employee safety. Legislation should include the following:

- A safe patient lifting policy developed by a committee with equal membership from management and employees, inclusive of Respiratory Care. The committee may be existing or it may be created for this purpose.
- The committee should use data to evaluate the risk of injury to patients and employees associated with patient lifting and handling.
- The committee should consider the appropriateness of alternative patient lifting and handling strategies, based on the hospital-specific patient population and identified risk factors, which include, at a minimum, the following:
 - Use of mechanical lifting devices or other engineering controls which maximize the need for manual lifting and movement of patients;
 - Use of lift teams;
 - Safe patient lifting and handling training for all patient care employees; and,
 - Consideration of the feasibility of incorporating physical space and construction design for safe patient lifting engineering controls in any architectural plans for hospital renovation and new construction.
- The committee should develop an ongoing evaluation process to determine the effectiveness of the policy.

7. Affordable Housing

Position: The FSRC supports affordable housing for healthcare workers.

Access to affordable housing has become a significant factor, which is negatively affecting Florida's hospitals' efforts to recruit and retain their workforce. While no specific data are available to measure the magnitude of this problem, anecdotal accounts indicate that health care workers, including Respiratory Therapists, are leaving or choosing not to locate in areas where home ownership is not feasible. There are other occupations, such as nurses and teachers, equally affected by this issue. The legislature has defined "essential services personnel" as persons in need of affordable housing who are employed in occupations or professions in which they are considered essential services personnel, as defined by each county and eligible municipality within its respective local housing assistance plan.

The Sadowski Workforce Housing coalition is a group focused solely on repeal of the cap on the Sadowski Housing funds in order to provide a dedicated revenue source for affordable housing in Florida. The Sadowski Act provides state and local housing funds and helps working families become homeowners through a variety of public-private partnerships. The cap was not repealed during the 2007 Legislature and now the Sadowski Act Trust is subject to repeal in 2008

The FSRC supports the Sadowski Workforce Housing Coalition for the continuation and repeal of the cap on the Sadowski Housing funds.

8. All-Hazards Disaster Preparedness, Response, and Recovery

Position: The FSRC supports an all-hazards disaster preparedness, response, and recovery strategy by the State of Florida.

Whether it is hurricanes or terrorism, the FSRC has been working diligently to enhance the Respiratory Care profession's capability and capacity to prepare, respond, and recover from disasters in an all-hazards approach. Chapter 252, F.S., establishes the intent, policy, purpose, and limitations for Emergency Management as defined for the State of Florida. Section 252.34 (4) (c), F.S., describes emergency response “. . . using all systems, plans, and resources necessary to preserve adequately the health, safety, and welfare of persons or property affected by the emergency.” A hospital's Comprehensive Emergency Management Plan is defined in Chapter 395, F.S., as a required component of hospital licensing and regulation and includes a job action sheet for a “Cardiopulmonary Leader”.

FSRC has participated in select grant appropriations (est. \$3 million in FY2006-2007) through the National Bioterrorism Hospital Preparedness Project sponsored by the U.S. Department of Health and Human Services. This funding has augmented hospital response capability to risk associated with the devastating, and sometimes lasting, impact of a natural or man-made disaster as it relates to mechanical ventilation. FSRC has been active and involved in hospital preparedness and emergency management efforts making recommendations as a representative voice in Florida's emergency planning, management, response, and recovery efforts.

FSRC supports legislative efforts to assist hospitals, providers, and healthcare systems in continued efforts towards disaster preparedness, including seeking increased federal and state funding to aid community coordination, protecting workforce and facilities, and furthering a cooperative model with federal, state, and local authorities.

9. Service Provision in Hospitals and Alternate Sites Scope of Practice

Position: The FSRC supports Service provision in hospitals and alternate sites scope of practice.

The practice of Respiratory Care encompasses activities in: diagnostic evaluation, therapy, disease management and education of the patient, family and public. These activities are supported by education, research and administration.

Diagnostic activities include but are not limited to: (1) obtaining and analyzing physiological specimens; (2) interpreting physiological data; (3) performing tests and studies of the cardiopulmonary system; (4) performing neurophysiological studies, and (5) performing sleep disorder studies. Therapy includes but is not limited to application and monitoring of: (1) medical gases and environmental control systems; (2) mechanical ventilatory support; (3) artificial airway care; (4) bronchopulmonary hygiene; (5) pharmacological agents; (6) cardiopulmonary rehabilitation; and (7) hemodynamic cardiovascular support.

The focus of patient and family education activities is to promote knowledge and management of disease process, medical therapy and self-help. Public education activities focus on the promotion of cardiopulmonary wellness.

- **Practice Settings**
 - Elements of the scope of practice of Respiratory Care are performed in acute care hospitals and alternative sites where patient care is provided. Alternative sites include, but are not limited to; military and Veteran's Administration treatment facilities, physician offices, patients' homes, convalescent centers, clinics, skilled nursing facilities, and retirement centers.
 - The complexities of Respiratory Care are such that the public is at risk of injury and health care institutions are at risk of liability when Respiratory Care is provided by inadequately educated and unqualified health care providers rather than by practitioners with appropriate training and education.
- **Practitioner Qualifications**
 - Practitioners who provide Respiratory Care services shall demonstrate their ability to meet the educational and experience requirements for the safe delivery of Respiratory Care services through competency validation mechanisms established by either legislative or regulatory acts of their respective states or commonwealth, or through a validated voluntary credentialing mechanism endorsed by the National Commission for Health Certifying Agencies.

It is the position of the FSRC that the RCP as a vital member of the health care team is essential to the provision of safe, appropriate, and cost-effective patient care in acute-care hospitals and alternative patient care sites.

10. Hazardous Materials Exposure

Position: The FSRC supports efforts toward the prevention of hazardous material exposure; appropriate hazardous material exposure guidelines; and, a community-wide plan for the management of exposure to hazardous materials.

The Centers for Disease Control and Prevention (CDC) have classified emergency response and hospital personnel as high risk groups for exposure to infectious and toxic substances.

The Environmental Protection Agency defines a hazardous material as any substance or material in a quantity or form that poses an unreasonable risk to health, safety, and property when transported. This material is extremely hazardous to the community during an emergency spill, or release, as a result of its physical or chemical properties.

The FSRC holds:

- Respiratory therapists must be knowledgeable in treating, reversing, and avoiding the effects of these hazardous materials.

- Respiratory therapists must be alert to the potential effects of hazardous materials and be able to support their patients until the effects wear off, or the materials are neutralized.
- Respiratory therapists, while providing care, must avoid any of the deleterious effects of the agents to which the patients have been exposed.
- The FSRC supports efforts toward an epidemiological approach to the prevention of hazardous material exposure.
- The FSRC supports the institutional development of appropriate hazardous material exposure guidelines that adhere to standards from both the Occupational Safety and Health Administration and the Joint Commission.
- The FSRC encourages and endorses the inclusion and participation of respiratory therapists in the development of a community-wide plan for the management of exposure to hazardous materials.

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Note: Much material is courtesy of the Emergency Nurses Association.

11. Health Promotion and Disease Prevention

Position: The FSRC supports health promotion and disease prevention endeavors.

The FSRC acknowledges that respiratory therapists in both the civilian and uniformed/military services are integral members of the health care team, in hospitals, home health care settings, pulmonary laboratories, rehabilitation programs and all other environments (including ICU's and critical care transport) where Respiratory Care is practiced.

The FSRC recognizes that education and training of the respiratory therapist is the best method by which to instill the ability to improve the patient's quality and longevity of life, and that such information should be included in their formal education and training in CoARC accredited programs.

The FSRC recognizes the respiratory therapist's responsibility to participate in pulmonary disease teaching, smoking cessation programs, pulmonary function studies for the public, air pollution alerts, allergy warnings, and sulfite warnings in restaurants, as well as research in those and other areas where efforts could promote improved health and disease prevention. Furthermore, the respiratory therapist is in a unique position to provide leadership in determining health promotion and disease prevention activities for students, faculty, practitioners, patients, and the general public in both civilian and uniformed service environments.

The FSRC recognizes the need to 1) provide and promote consumer education related to the prevention and control of pulmonary disease, 2) establish a strong working relationship with other health agencies, educational institutions, Federal and state government, businesses, military and other community organizations, and 3) monitor such activities. Furthermore, the FSRC supports efforts to develop personal and professional wellness models and action plans that will inspire and encourage all respiratory therapists to cooperate on health promotion and cardiorespiratory disease prevention.

12. Home Respiratory Care Services

Position: The FSRC supports education, training, and competency testing for the provision of prescribed home Respiratory Care.

Home Respiratory Care is defined as those prescribed Respiratory Care services provided in a patient's personal residence. Prescribed Respiratory Care services include, but are not limited to, patient assessment and monitoring, diagnostic and therapeutic modalities and services, disease management, and patient and caregiver education. These services are provided on a physician's written or verbal order and practiced under appropriate law, regulation, and medical direction. A patient's place of residence may include, but is not limited to, single-family homes, multi-family dwellings, assisted living facilities, retirement communities, and skilled nursing facilities. The goal of home Respiratory Care is to achieve the optimum level of patient function through goal setting, education, the administration of diagnostic and therapeutic modalities and services, disease management, and health promotion.

It is the position of the FSRC that the respiratory therapist- by virtue of education, training, and competency testing- is the most competent health care professional to provide prescribed home Respiratory Care. The complexities of the provision of home Respiratory Care are such that the public is placed at a significant risk of injury when Respiratory Care services are provided by unqualified persons, either licensed or unlicensed, rather than by persons with appropriate education, training, credentials, and competency. Therefore, the FSRC recommends that practitioners who are employed to provide home Respiratory Care possess the certified respiratory

therapist (CRT) or RRT credential awarded by the NBRC, as well as state licensure or certification where applicable. In addition, the FSRC supports efforts to improve access to home Respiratory Care through improvements in public and private insurance coverage, state and federal reimbursement programs, and enhancement of services in provider models.

13. Pulmonary Rehabilitation

Position: The FSRC supports outpatient Pulmonary Rehabilitation programs.

A program of pulmonary rehabilitation is a multi-faceted continuum of services designed for persons with pulmonary disease and their families. As a component of respiratory disease management, the goals of pulmonary rehabilitation are to restore patients to their highest possible level of independent function and to improve their quality of life. Pulmonary rehabilitation, generally conducted by a multi-disciplinary team of specialists, should be included in the overall management of patients with respiratory disease to assist in alleviating symptoms and optimizing health. The respiratory therapist, by virtue of specialized education and interest in the individual's Respiratory Care, is a key partner in a successful rehabilitation program.

14. Extracorporeal Membrane Oxygenation (ECMO)

Position: The FSRC supports using Respiratory Therapists as Extracorporeal Membrane Oxygenation (ECMO) Specialists.

The FSRC endorses the use of qualified and appropriately educated Respiratory Therapists as Extracorporeal Membrane Oxygenation (ECMO) Specialists.

ECMO is a modified cardiopulmonary bypass technique used for the treatment of life threatening cardiac or respiratory failure. An ECMO Specialist is the technical specialist educated to manage the ECMO system including blood pump, tubing, artificial oxygenator, and related equipment. The ECMO Specialist, under qualified medical direction and supervision, is also educated to be responsible for the clinical needs of the patient on ECMO which can include: (1) maintenance of normal acid-base balance, oxygenation, and ventilation, (2) administration of blood and blood by-products, (3) medication delivery, and (4) maintenance of appropriate anticoagulation.

The Respiratory Therapist's education provides extensive training in maintenance of normal acid-base balance; oxygenation and oxygen delivery; ventilation; and cardiorespiratory anatomy, physiology, and pathophysiology. These fundamentals of Respiratory Care education make the Respiratory Therapist uniquely qualified to undertake further education as an ECMO Specialist. Additionally the Respiratory Therapist's ability to function in multiple clinical settings among all age groups enhances his/her value as an ECMO Specialist, allowing for care of all patient populations in a variety of critical care environments.

The requisite qualifications for educating a Respiratory Therapist to be an ECMO Specialist should include: (1) the successful completion of an accredited Respiratory Care educational

program, (2) an earned RRT credential from the NBRC, (3) a state license (where required), and (4) clinical experience in critical care. Education as an ECMO Specialist should be in accordance with the Extracorporeal Life Support Organization's (ELSO) document entitled "Guidelines for Training and Continuing Education of ECMO Specialists."

15. Telehealth, Electronic Health Records and Respiratory Therapy

Position: The FSRC supports Telehealth and Electronic Health Records.

Telehealth, also known as telemedicine or telepractice, refers to the use of electronic communication technologies and the internet to allow health care providers in one location to offer services and provide consultations to patients and health care providers at another location. Services can include patient assessment and education, diagnostic evaluation, sleep testing, monitoring, disease management, disease prevention, health promotion, and rehabilitation as well as specific patient consultations.

The FSRC supports efforts to provide patients access to Respiratory Therapy services via telehealth. Furthermore, the FSRC supports the recognition of respiratory therapists as providers of telehealth services under Medicare, Medicaid, commercial and other health insurance programs.

The widespread adoption of electronic health records (EHRs) holds the promise of improving patient safety and reducing the cost of healthcare by preventing duplicative procedures. However, adoption of information technology within the healthcare sector is trailing behind other sectors of the U.S. economy according to a recent report from the National Center for Health Statistics (NCHS).

The Agency for Health Care Administration's (AHCA) strategy has focused predominately on the development of Regional Health Information Organizations (RHIOs). Florida now has approximately 10 RHIOs operational, each with varying degrees of capacity for electronically exchanging health information. The Florida Hospital Association (FHA) has identified several issues with existing Florida medical records statutes that slow the exchange of paper records and have the potential to significantly complicate the electronic exchange of healthcare information.

FSRC supports changing hospital licensing statute to conform to the practitioner practice acts and permit hospital records to be sent without patient consent to both hospital attending physicians and personnel, as well as other practitioners outside the facility involved with treatment of the patient. Conflicts between the Florida health information exchange, medical records statutes, and the Health Insurance Portability and Accountability Act (HIPAA) should be identified. FSRC supports working with the Florida House of Representatives and Senate staff, along with other organizations, to develop proposed legislation to conform medical information exchange statutes within Florida and conform to HIPAA as appropriate.

16. Informed Consent for HIV Following Healthcare Worker Exposure

Position: The FSRC supports The revision of Florida law to eliminate special informed consent requirements for HIV testing of source patients involved in significant provider blood exposure accidents.

Florida Law mandates special requirements for HIV testing, specifically for informed consent and confidentiality. At the same time, in accordance with the Centers for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration (OSHA) recommendations, hospital occupational health programs must implement comprehensive protocols when a significant occupational blood exposure accident occurs. With respect to HIV prevention, according to the CDC, occupational blood exposures “should be considered urgent medical concerns” and HIV testing should be facilitated immediately. Technological advances in rapid HIV testing are also recommended by the CDC, preventing the unnecessary administration of partial episode payment to healthcare providers, such as Respiratory Therapists – and thus, the imposition of serious side effects and emotional trauma, which are frequently associated with occupational blood exposures.

In many years since section 381.004, F.S., was enacted, there has been tremendous progress in the diagnosis and management of HIV infection in the United States. The CDC has revised HIV testing recommendations for healthcare settings, which reflects the need to “normalize” the screening for HIV. No changes to this statute were promulgated in 2007.

The FSRC supports the revision of Florida law to eliminate special informed consent requirements for HIV testing of source patients involved in significant provider blood exposure accidents.

17. Tobacco and Health

Position: The FSRC supports the rights of non-tobacco users, the use of tobacco litigation settlement funds toward tobacco reduction and medical treatment for smoking-related diseases, legislative and regulatory efforts to control tobacco use, and the development and sponsorship of smoking-cessation programs.

The FSRC is a professional organization dedicated to the protection of health through public education and the provision of the highest standards of Respiratory Care. By virtue of their education and health care experience, respiratory therapists are professionals who have a clear understanding of the nature of cardiopulmonary disease and are in a position to act as advocates for healthy hearts and lungs. The FSRC recognizes its responsibility to the public by taking a strong position against cigarette smoking and the use of tobacco in any of its various forms. In view of the evidence, which confirms the health-threatening consequences of tobacco, the FSRC strengthens its commitment toward and reaffirms its belief in the need for the elimination of smoking and the use of any tobacco products and the inhalation of any toxic substance.

The FSRC acknowledges and supports the rights of non-smokers and non-tobacco users pledging

continuing sponsorship and support of initiatives, programs, and legislation to reduce and eliminate smoking. The FSRC extends its concern beyond the smoking of tobacco to the use of smokeless tobacco by oral and nasal application. These products are linked to diseases of the gastrointestinal tract, mouth, and nose. There is also evidence that these products, when applied to the mucous membranes, diffuse into the circulation and cause ill effects in remote organs of the body.

In November 1998, the attorneys general from 46 states, the District of Columbia, Puerto Rico, and three territories reached a settlement on their lawsuit against the nation's five largest cigarette manufacturers for the cost of treating smoking-related illnesses of Medicaid patients. The settlement is worth \$206 billion over the next 25 years, of which \$195 billion will be paid directly to the states. Prior to this agreement, Florida, Minnesota, Mississippi and Texas had individually settled their lawsuits with the tobacco industry for more than \$40 billion.

State officials originally promised to use the funds for projects to reduce tobacco use, such as smoking cessation and prevention. Since that time, however, many states have decided to use all or a major portion of their settlement funds for other state projects. Most states decide how to allocate these funds through the legislative process.

As tobacco settlement monies begin to flow into state coffers, there is heightened interest on just where these monies will be spent. The FSRC advocates the use of these funds toward tobacco reduction and medical treatment for smoking-related diseases. The FSRC encourages its members to become involved in legislative or regulatory activities that determine how to spend tobacco settlement funds.

State Medicaid plans may include coverage and reimbursement for smoking cessation treatment services. The FSRC supports the recognition of Respiratory Therapists as providers of these services. The FSRC is involved in tobacco control and smoking-cessation issues. The FSRC supports legislative and regulatory efforts to control tobacco use, especially among children, and promotes the development and sponsorship of smoking-cessation programs.

18. Medicaid

Position: The FSRC supports Respiratory Therapy in all care sites under Medicaid.

Breathing makes a difference to patients with deficiencies and abnormalities of the cardiopulmonary system. Respiratory Therapists are involved in many high-tech specialties with these patients. The Respiratory Therapist who is a Medicaid provider sees a diverse group of clients ranging from newborns to pediatrics. The therapist must focus to assemble, operate and monitor complex devices (i.e.- mechanical ventilators, therapeutic therapy, gas administration apparatus, environmental control systems, and aerosol generators). Respiratory Therapy Medicaid providers assist patients with breathing exercises and monitor some of the diseases or conditions often requiring respiratory care such as asthma, chronic or restrictive pulmonary diseases, pneumonia, cystic fibrosis, as well as conditions brought on by shock, trauma or postoperative

surgical complications. Using a multi-disciplinary approach, the Respiratory Therapy Medicaid provider is the forerunner of therapy groups of prescribed care to safely rehabilitate a patient.

FSRC advocates for the inclusion of Respiratory Therapy in all care sites under Medicaid. The following areas provide opportunities for increased access to Respiratory Therapy by Medicaid recipients. FSRC members are encouraged to work directly with their state Medicaid officials to educate them on the value of Respiratory Therapy.

The Medicaid program is a state and federal partnership covering numerous benefits and programs ranging from welfare reform to nursing home quality. The Florida Medicaid program is authorized by Chapter 409, Florida Statutes (F.S.) and Chapter 59G, Florida Administrative Code (F.A.C.).

General information regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy and important resources for providers are included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all Medicaid providers and is updated as needed. The handbook is available on the Medicaid fiscal website at: <http://floridamedicaid.acs-inc.com>.

An excellent place to find information is to visit the federal government's Centers for Medicare and Medicaid Services area devoted to the Medicaid program.

Children's Health Insurance Program (SCHIP)

Under the State Children's Health Insurance Program (SCHIP), created by the Balanced Budget Act of 1997, block grants are available to states to expand health care access to children. States have the option of taking three different avenues to achieve the goal of reaching more children in need of health services:

- Expand current Medicaid eligibility for children,
- Establish a new program that subsidizes private insurance, or
- Devise a combination of the two.

Congress authorized \$40 billion over 10 years to help pay for SCHIP. All US state and territories now have approved SCHIP programs in place covering, 3.3 million children.

These Web sites provide more information on the SCHIP:

- <http://cms.hhs.gov/schip>
(This federal site provides contact information for each state's SCHIP plan.)
- <http://www.kff.org/medicaid/index.cfm>
(The Kaiser Family Foundation provides an excellent resource for comparing individual state Medicaid and SCHIP information.)

19. Medicare

Position: The FSRC supports patient access to medically necessary home oxygen.

Re-testing of Home Oxygen Patients for the Purpose of Re-Certification

The FSRC supports patient access to medically necessary home oxygen. Home oxygen is used to treat patients with hypoxemia (i.e., a below normal level of oxygen). Using home oxygen to treat hypoxemia reduces stress on other organs, reduces morbidity and mortality, and encourages patients to live full and productive lives within the scope of their disease.

The Health Care Financing Administration (HCFA) issued policies regarding the re-testing of patients for the purpose of re-certification for home oxygen. The first policy (transmittal 1685) issued on November 17, 2000, required Group I* or Group II** patients to be tested between the 61st – 90th day after the date of initial certification. On February 8, 2001, HCFA revised this policy (transmittal 1696) by continuing to require that Group II patients be tested between the 61st – 90th day, but allowing Medicare contractors to determine the re-testing requirements for Group I patients.

The FSRC understands the need for determining medical necessity. In this regard, we believe any re-certification requirements should employ a re-testing methodology equally available to all patients that does not interrupt their access to needed home oxygen.

The FSRC urges HCFA's consideration of the following recommendations:

- **Medicare should provide options for re-testing in order to ensure uninterrupted patient access to medically necessary home oxygen.**
 - According to the revised policy (transmittal 1696), it is unclear how each Medicare contractor will determine what re-testing requirements are necessary to re-certified Group I patients. It is inappropriate, however, to use a single, static test as the sole determinant. Patients who meet the laboratory values embodied in the definition of Group I are usually severely hypoxemic. While some of these patients may improve, there is limited and conflicting science in this area, and none that provides a standardized method to identify these exceptions.
 - The FSRC recommends that Medicare provide options for re-testing that include single pulse oximetry (while at rest), multiple pulse oximetry (while ambulating or other exertion), and overnight pulse oximetry (while sleeping). Medical literature indicates that patients suffering from hypoxemia may experience different levels of oxygen desaturation (i.e., lower oxygen levels) while resting versus exertion, and at night. Test selection should be based upon the attending physician's evaluation of the patient. Unless several options are available, simply using a single laboratory test as the sole determinant may not correctly pinpoint a patient's need for oxygen.
- **Medicare should establish coverage of and reimbursement for pulse oximetry in all care settings.**

- Pulse oximetry testing is needed to evaluate oxygen dependent patients during their activities of daily living (ADLs). Although patients can be re-tested using arterial blood gas (ABG) analysis, it is a painful, invasive, and relatively expensive procedure that offers only a single, static representation of the patient’s clinical condition. ABG analysis, for example, is inadequate to determine a patient’s level of hypoxemia while ambulating or sleeping.
- Recent changes to Medicare policy (under the outpatient prospective payment system) eliminated coverage of and reimbursement for single, multiple and overnight pulse oximetry. This change in policy leaves physician offices, and independent diagnostic testing facilities (IDTFs) as the primary sites for patients to be re-tested. However, in many areas of the country, patient access to IDTFs is limited or nonexistent. Furthermore, many physician offices are not adequately equipped to provide comprehensive pulse oximetry testing, especially overnight. If these options are not available, then the only alternative is for the patient to be admitted to an acute care hospital in order to conduct the test.
- To enable patients to comply with re-certification requirements, HCFA must properly establish a re-testing mechanism that includes coverage of and reimbursement for pulse oximetry in all settings, including the patient’s home. This coverage would be especially helpful to home oxygen patients in rural, urban, and other underserved areas. Patients depend upon these options.
- **Medicare should provide fair compensation for pulse oximetry.**
 - It is our understanding that Medicare payment for pulse oximetry, where reimbursable, has been slashed by 35 percent for overnight pulse oximetry, and by 24 percent for multiple pulse oximetry. Below is the current Medicare fee schedule for pulse oximetry in physician offices and IDTFs:

CPT Code	Description	Allowed Amount
94760	Spot Check Pulse Oximetry (i.e., single)	\$ 5.82
94761	Exertion Pulse Oximetry (i.e., multiple)	\$12.74
94762	Overnight Pulse Oximetry	\$16.79
[Amounts may vary by state. Medicare pays 80 percent of the allowed amount.]		

- While we are sensitive to HCFA’s concerns regarding Medicare costs, there should be fair and realistic compensation for providers to offer pulse oximetry in order to ensure safe and appropriate patient care as well as to meet re-certification requirements. To do this, Medicare reimbursement should take into account the cost of technology, the clinician, and the travel to and from a patient’s home.

- Medicare should ensure appropriate oversight of home oxygen patients in the re-certification process.
 - Appropriate oversight is not only good patient care, but addresses potential problems of patient non-compliance with re-certification requirements. Such oversight should include the use of safe and appropriate patient testing methodologies previously mentioned that allow each patient to be assessed fairly and equally. By doing so, patients who are dependent on home oxygen can continue to receive treatment on an uninterrupted basis.
 - Oversight should not be the sole responsibility of the patient or the suppliers of home oxygen. Suppliers should not be placed in a position where they are at risk for any type of fraud, or become liable if they must remove oxygen from a patient who was not adequately tested. Finally, patients should not be held financially responsible for the cost of home oxygen due to inadequate re-testing options that disable them from re-certifying.
 - The AARC looks forward to working with HCFA on this issue in order to ensure that patients have uninterrupted access to home oxygen, when medically necessary.

* Group I patients are those with an arterial PO₂ at or below 55 mm Hg, or arterial oxygen saturation at or below 88 percent.

** Group II patients are those with an arterial PO₂ from 56 to 59 mm Hg or whose arterial blood oxygen saturation is 89 percent.

20. Hyperbaric Oxygen Therapy

Position: The FSRC supports Hyperbaric Oxygen therapy delivery in the state of Florida.

Several years ago the AARC submitted comments to the Health Care Financing Administration regarding the Agency's transmittal on hyperbaric oxygen therapy (HBO).

Because the jobs of many respiratory therapists were threatened by this policy, the AARC made a strong statement to HCFA's director of Coverage and Analysis. Transmittal AB-99-21 would require that 1) physicians be in constant attendance at the bedside during HBO therapy, and that 2) they would have to undergo extensive credentialing requirements. These demands placed on HBO therapy were threatening the closure of many HBO units around the country, and with it the jobs of respiratory therapists.

In comments directed to HCFA, the AARC called for:

- Evidence that point to a need to have a physician at the bedside constantly. "What is not critical, is medically unjustifiable, and is extremely costly to the Medicare program is the enforcement of the requirement that demands the physician's attendance during the entire hyperbaric oxygen therapy procedure regardless of the medical stability of the patient," said AARC President Dianne Kimball in her letter.

- Clarification of the need for physicians to be certified in Advanced Cardiac Life Support.
- Clarification on how physicians can meet the requirement for 60 hours of training in hyperbaric medicine, when the organizations that provide this training have core courses of only 40 hours.

HCFA has stated that the implementation of this policy has been delayed from May 1 to July 1, but no official confirmation has yet been forthcoming on this point. The Medicare Program continues to refine the coverage criteria for HBO therapy.

The FSRC supports the comments and recommendations of the AARC as they related to HBO in the state of Florida.

21. Verbal Orders

Position: The FSRC supports RRTs and CRTs, subject to local health care institution policy, may transcribe verbal physician orders for drugs and treatments directly related to the provision of Respiratory Care.