



Diagnos^tics

January / February 2003

Bulletin

Notes from the Chair

by Catherine M. Foss, BS, RRT, RPFT

2003 has arrived. Did you make any New Year's resolutions? I have a suggestion for you. Let's all band together to expand our ranks. There is strength in numbers. With more members of the Diagnostic Section, we will have more of a voice in establishing agendas pertinent to our issues. Talk to your peers at work and others in your community who are involved in diagnostic respiratory care at surrounding institutions and offices. Discuss professionalism. Invite those not involved to take up the banner of involvement and join the AARC and the section. I challenge each one of you to recruit just one new member to the section this year. Explain the value of the section listserve, Resource Panel, Bulletin, and our program at the AARC Congress. Ask your colleagues to join us in making their voices heard.

As you read Carl Mottram's article in this Bulletin, I also want you all to consider where you are on the professional, educational and credentialing ladder. If you have achieved the credentials you desire, consider mentoring others as they learn in your institution. If you are looking to advance your credentials, review the previous Bulletin for ideas and resources on NBRC exam preparation. Also think about your credentials and their relationship to your license. How do your state licensure regulations affect practice on a daily basis? Is there good quality practice at labs across your state? We have formed a committee to look at the appropriateness of the verbiage in, and interpretation of, state licenses in respect to

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Editorial: Competent or Not, That Is The Question

by Carl Mottram, BA, RRT, RPFT, FAARC, coordinator, Mayo Clinic pulmonary function laboratories and rehabilitation; assistant professor of medicine, Mayo Medical School, Rochester, MN

The issue of who is "qualified" to perform pulmonary function testing (PFT) has been a point of discussion at both the state and national levels. Debate has taken place on the various online chat forums, with a consensus for strong statements maintaining only respiratory therapists (RTs) are qualified to perform PFTs. Several states have even moved forward and proposed or included this exclusionary language in their state licensure or registration acts.

As I listen to the discussion, it seems to me that most people appear to be concerned about the quality of the test data and the safety of the patients, both of which are honorable objectives. As the manager of a large tertiary medical center pulmonary function laboratory, however, I routinely see poor quality tests that have been performed at referring medical facilities. Many of these tests lead to improper diagnosis, further extensive and expensive testing, and inappropriate initiation of treatment. And many of them have been performed by RTs. So the question becomes not which allied health professionals should perform the test but how is their training and competency assessed?

The educational requirements for performing various pulmonary diagnostic tests and working in a pulmonary function laboratory have been reported in the literature by various organizations. The American Thoracic Society (ATS) published a position paper entitled Pulmonary Function Laboratory Personnel Qualifications¹ that defines the minimal educational background to initiate training as a high school education with a strong mathematical and science background. Although these recommendations were written in the early-'80s, more recent statements by this organization are consistent with these suggestions². The AARC also qualifies the personnel requirements in the numerous clinical practice guidelines (CPGs) related to pulmonary diagnostic testing³⁻⁷. The CPGs define two levels of practitioner/technologist. The first level, Level I, requires a minimum of a high school education that is consistent with the ATS's position paper. A Level II technologist is a person who has graduated from an accredited program in respiratory therapy or has completed two years of college work in biological sciences and mathematics. These CPGs also recommended that the technologist should attain the credential of Certified Pulmonary Function Technologist (CPFT) or Registered Pulmonary Function Technologist (RPFT).

The critical language in both organizations' guidelines is that the requirements are "a minimum." Specific training in pulmonary diagnostics once the individual enters the laboratory is essential regardless of educational background. An effective training program should include a systematic process that develops and fine-tunes both the technical and cognitive skills of the technologist throughout the continuum of testing. This process begins with basic spirometry testing, proceeding through the more sophisticated pulmonary diagnostic procedures, which require months of experience to acquire proficiency.

The training procedure should be well defined and include a step-by-step checklist to assist the laboratory supervisors and/or trainers in documenting the training process. Training and competency assessment checklists can also assist the trainers by eliminating any areas that may have been overlooked during the teaching process. Checklists can be developed by the management team in conjunction with the laboratory's policy and procedure manual, or are available through other sources⁸.

The true measure of competency is taking the National Board for Respiratory Care's (NBRC) certification or registry exams, which all technologists should do once training is complete and the eligibility criteria have been met. The CPFT exam and credential was first

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introduced in 1984 as a replacement for the examination previously offered by the National Society for Cardiovascular and Pulmonary Technology (NSCPT) or the National Board for Cardiovascular and Pulmonary Credentialing (NBCPC). The NBRC still accepts the CCPT credential as meeting the eligibility criteria for taking the RPFT test. The current CPFT and RPFT examinations are based on a thorough job analysis that is reassessed every five years. Successful completion of these examinations assures that the practitioner has a thorough understanding of the tests they are conducting.

Our outpatient PF lab here at Mayo consists of 28 staff members, 22 of whom are either CPFT or RPFT credentialed but do not have a respiratory therapy background. These technologists provide excellent quality, safe pulmonary diagnostic testing by objective criteria. I would hate to see well intended but not well informed RTs exclude these highly talented and qualified technologists from providing necessary and often underutilized testing.

RTs have developed into an excellent source for filling the human resource pool needed in many PFT labs. Their ability to function across a variety of clinical areas, their clinical assessment skills, and their knowledge of cardiopulmonary physiology make them a natural fit in the PF laboratory. But the knowledge-base needed to effectively deliver high quality, safe testing is not inherent to the RT credentials. A comprehensive training and competency assessment program, along with passing marks on the NBRC specialty examinations, are better keys to answering the question of who is a qualified technologist. ♦

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Are You Hip on HIPAA?

by Catherine M. Foss, BS, RRT, RPFT

HIPAA is almost here — is your diagnostic equipment compliant? If not, take action now!

The final HIPAA regulations were originally slated to go into effect two years after the date of publication in the Federal Register. The security ruling has yet to be published, but the privacy rule was published on December 28, 2000. However, there was an extension, so the target date is now April 14, 2003 - a mere month and a half away. The issues of concern for those of us in diagnostics involve the security and privacy regulations. Your information technology (IT) department should be working with you to ensure compliance with these regulations.

I suggest all of you look over your equipment software carefully. What is the Windows platform, if applicable? We need to call the vendors supplying our diagnostic equipment and request that they upgrade software packages to meet the HIPAA regulations. I feel it is unreasonable to be forced to purchase expensive new hardware just because the software is not compliant on the old hardware. In many cases, equipment that is one to two years old does not meet guidelines, due to the software version.

In talking to an IT representative at my institution, I was advised that systems need to run on Windows 2000 or XT to be compatible with regulations. Windows 95 and 98 are not compliant. So, check it out and see what you have in your department or office. I urge you to put pressure on the equipment vendors to support existing hardware by upgrading software. ♦

AARC Membership: Join as a Group and Save!

So you know some coworkers who are considering joining the AARC - and hopefully, this section - but the membership fee seems to be an issue for them. What can you do? Suggest the AARC's group membership plan. You can get a discount on your AARC membership if you join or renew as a group. "This program is great for hospital staffs or local RTs who want to pull together and purchase at least ten memberships in the AARC," says Sherry Milligan, AARC associate executive director for membership. New members get an especially good deal - they save the \$12.50 new member processing fee, plus they get a discount on their membership fee.

Single membership in the AARC is \$90 per year. Through the discounted group program, you can save on bulk membership purchases:

- 10-19 memberships: \$85 per membership
- 20-39 memberships: \$80 per membership
- 40-99 memberships: \$75 per membership
- 100 or more memberships: Call the AARC for an even bigger savings

Every member can benefit from this group rate. As your renewal time approaches, get a group together and join at the same time and save money. For instance, by joining as a group of 12, and maintaining section membership, your total per member cost is only about \$1.92 a week. Give up a couple of break-time snacks, and you're there!

By recruiting new members and retaining current members, the AARC and this section can grow. With numbers comes strength; we need practicing respiratory therapists to be active members in their professional organization. For more information about the group plans, contact Pat Lee at the AARC office, (972) 243-2272. ♦

Smoking Weakens Pharynx Reflex

A new study in the December issue of *Gut* finds cigarette smoking weakens a vital reflex in the pharynx, called the pharyngoglottal closure reflex, which momentarily closes off the vocal cords when fluid enters the pharynx. The result may put smokers at increased risk for aspiration.

According to the investigators, "Smoking cigarettes affects this reflex adversely. Our findings identify yet another deleterious effect of cigarette smoking that can weaken the airway protective mechanisms against aspiration. These results may have implications in the cause of reflux-related respiratory complications in smokers."

The study is built on earlier research by the same team that looked at two other reflexes, pharyngo-upper esophageal sphincter contractile reflex (which closes the sphincter muscle that guards the upper end of the upper esophagus) and the reflexive pharyngeal swallow (automatic swallowing that a person cannot control). That study, published in the same journal in 1998, also showed definite impairment of these reflexes in smokers.

In the new study, researchers evaluated 10 healthy smokers (defined as those who had smoked a pack of cigarettes a day for at least two years) and 10 healthy non-smokers. All experiments were done before and 10 minutes after the participants smoked either a real cigarette (in the smokers) or an unlit cigarette (in the non-smokers).

The pharyngoglottal reflex was tested by injecting water into the subjects' throats, simulating stomach contents entering the pharynx. Compared to non-smokers, both this and the previous study showed that smoking adversely affects the triggering of these reflexes.

Researchers are not sure exactly why the effect occurs, but believe nicotine or other components contained in cigarette smoke may damage the nerve endings in the pharynx that trigger these reflexive mechanisms. However, they note that determining whether or not these effects in smokers lead to clinically significant consequences, such as predisposition to aspiration, will require further evaluation. ♦

Labs Offered New Package

The American Proficiency Institute (API), the American Society for Clinical Pathology (ASCP), and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are teaming up to offer a combined package of laboratory accreditation services, customized proficiency testing, and technological and scientific educational services to laboratories.

The package will allow labs to integrate menu-driven, web-based API proficiency testing which meets JCAHO accreditation requirements and participate in cutting-edge ASCP technological and scientific educational programs that are uniquely designed for customer needs. The collaborative effort is also expected to integrate the expertise of pathologists, skilled medical technologist surveyors, and an experienced proficiency testing provider into the JCAHO survey process. According to the three groups, the package will foster reduced costs, improved service, new educational opportunities, and enhanced surveyor expertise in a one-stop, coordinated fashion.

"With this new accreditation program, laboratory professionals are able to customize and pay for only the proficiency testing services they need," says API President Daniel Edson. "They could then report and access the proficiency testing results from a secure web site when it is convenient for them."

"Laboratories would also be enrolled in a portfolio of technological and scientific education programs that are tailored to the relevant needs of accredited laboratories," says E. Eugene Baillie, MD,FASCP, president of the ASCP.

Joanne Born, executive director of the laboratory program at the JCAHO adds, "It is our hope that in the future, JCAHO surveyors could review the API proficiency testing results prior to survey, instead of searching for them onsite. This enhancement would save time and enable more onsite discussion and education." ♦

Pulmonary Function Coding Issue

by Catherine M. Foss, BS, RRT, RPFT

The November issue of *Pulmonary Coding Alert* (Vol. 3, No. 11 pages 81-83) includes guidelines on PFT coding. Check with your institution's billing department and try to obtain a copy. In fact, you might want to request copies of each *Pulmonary Coding Alert* that is published. One item of note in the article is that if baseline spirometry results are "normal," further testing using code number 94060, spirometry pre and post bronchodilator, will not be reimbursed.

More information on this topic also appeared in an article called "Easy Tips to Take the Pressure Off Diagnosis Coding for Spirometry," in the August 2002 issue. ♦

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NOTES FROM THE CHAIR

diagnostic practice of respiratory care. If you would like to be involved with this committee, please contact me at the addresses/numbers on page 2.

Lastly, mark your calendars now for the 2003 International Congress in lively Las Vegas, NV, this December 8-11. Thanks to all of the wonderful suggestions for program topics you submitted this year, we'll have another great lineup of diagnostics presentations. It is always so helpful to have this direct input from the membership regarding your needs and desires for educational material. ♦