Introduction to Respiratory Care

CRC 330
Cardiorespiratory Care
University of South Alabama
Discussion Points

- Respiratory care and the healthcare system
- History
  - RC education
  - Credentialing
  - Professional organization
- Hospital-based services
- Ethical practice
Respiratory Care and the Health Care System

• Sites of health care
  – Hospitals
  – Nursing homes/SNFs
  – Clinics/physician offices
  – Homes
  – Hospices
  – Urgent care
Who bears the cost of health care?

- Paying for care
  - Out-of-pocket (self-pay; “the uninsured”)
  - Medicare-care for the elderly/disabled
  - Medicaid-grants to the states for indigent care
    - Primary focus of ACA
  - Veterans Administration
  - Blue Cross and other private insurance
    - Prior authorization
  - Pharmaceutical and medical supply industries
    - Research
Breakdown of Funding Sources

- Federal Tax Subsidies: $267 billion
- Patient/Consumer Out of Pocket: $340 billion

52% Private Health Insurance: $1.05 trillion
48% Medicare, Medicaid & CHIP: $929 billion

- Out of Pocket
- Private Health Insurance
- Other Private Expenditure
- Private Research/Infrastructure
- Medicare, Medicaid, CHIP
- Public Health
- FEHBP and TRICARE
- VA and IHS
- Other Public Programs
- Tax Subsidies for Private Coverage
- Public Research/Infrastructure
Regulation/Payment

- Voluntary groups
  - TJC, HFAP, DNV, CLIA accredit hospitals & laboratories
  - CoARC, APTA, other health education accreditation groups
  - ANSI and others (industrial)

- Federal and state government
  - Centers for Medicare and Medicaid Services (CMS)
    - Medicare
    - Medicaid
    - Health Insurance Portability and Privacy Act (HIPAA)
    - ACA
  - State Children’s Health Insurance Program (SCHIP)
<table>
<thead>
<tr>
<th>Comparison Element</th>
<th>The Joint Commission</th>
<th>Healthcare Facilities Accreditation Program (HFAP)</th>
<th>Det Norske Veritas Healthcare, Inc. (DNV)</th>
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<td>Organization Focus</td>
<td>The Joint Commission has collaborated with healthcare organizations for more than half a century to focus on safe, quality care for the American public through a voluntary independent evaluation process. Healthcare is the sole industry served.</td>
<td>The HFAP is a nationally recognized accreditation organization with deeming authority from CMS. Its mission is to advance high quality patient care and safety through objective application of recognized standards.</td>
<td>DNV’s corporate purpose is safeguarding life, property, and the environment. DNV received deeming authority for hospitals from CMS on September 26, 2008.</td>
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<td>Number of Accredited Hospitals</td>
<td>Nearly 5,000 hospitals and approximately 10,000 other healthcare organizations are accredited or certified by The Joint Commission.</td>
<td>Nearly 200 hospitals and more than 200 other healthcare facilities as well as laboratories are listed on the HPAP Web site.</td>
<td>Since receiving deeming authority from CMS in September 2008, DNV has accredited more than 27 hospitals and will be listed soon on the DNV Web site.</td>
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Health Insurance Portability and Accountability Act of 1996 (HIPAA)

• Standards of privacy
• Goal is to balance protecting individual health information and impeding exchange of health information needed to provide quality care
• Protect "protected health information"
• Maintain confidentiality
Issues in Health Care

• Cost: out of control, how to control, who’s in control?
• Entitlements: who gets what and how much of it, Cadillacs for all?
• Technology: everything for everybody, or maybe not?
• Decision-making: who’s in control?
• ACA
Health Care Grows as a Share of GDP

For decades, health care has been taking up an increasing piece of the U.S. economy, and totaled a record 17.5 percent of GDP in 2014, up from 17.3 percent the year before.

Source: Office of the Actuary, Centers for Medicare and Medicaid Services
History of Respiratory Therapy Education

- First program in Chicago, 1950s
- Increasing numbers in the 60s
- 1963 Board of Schools
- 1970 JRCITE; 1977 JRCRTE
- 1998 CoARC accredited by CAAHEP
- 2009 CoARC freestanding, responsible to Council for Higher Education Accreditation
Educational Program Sponsors

- Junior/Community colleges
  - Wallace Dothan
- Universities
  - USA, Nova Southeastern, Tx Southern
- Medical Centers
  - Georgia Regents, UTHSCSA, Rush
- Proprietary (private)
Types of Educational Programs

- Two-year advanced practitioner
  - AS, grads take CRT and RRT exams
- Two-year +
- Baccalaureate
  - BS, grads take RRT exams, other specialty credentials
- Master’s
  - Entry-level, Advanced Practice RT
- DRTP?
History of Credentialing

- 1960: ARIT
- 1969 Technician Certification Board
- 1974 ARIT and TCB merged to form NBRT; MC test for techs and for therapists, OJTs could work in the field and work their way up
- NBRT eventually required two years of college along with OJT to take registry exam
- 1983: single entry level exam for all graduates, clinical simulation examination along with a MC test for therapists,
- All therapist program graduates take 2 exams
History of Credentialing

- 1984 NBRC: has a board, members are physicians and RTs, writes and sets the qualifications for taking the credentialing exams
- Current exams are TMC, CSE, C/RPFT, peds/neo, critical care, polysomnography
- Publishes a newsletter
- Strict methodology of examination construction and validation
- 2015: TMC with two cut scores and 20 question CSE
History of the Professional Organization

- Inhalation Therapy Assn. formed in 1947
- 1954: ITA became the AAIT; 1951 sponsored by the ACCP
- 1955–1972 the AAIT supported educational activities and published a Journal
- 1973: became the AART, sponsored by the ASA, ACCP, ATS, AAP, ACA
- 1982: became the AARC
AARC

- 40,000+ members
- numerous committees and membership sections
- state and national legislative representatives
- based in Dallas
- elected officials and board
- BOMA, HOD
- annual International Congress, seminars, Summer Forum
- chartered affiliates (state societies)
- political action committee (AARCPAC)
- online continuing education offerings
- publishes Respiratory Care Journal & AARCTimes
- RC week
- scholarship and award organization (ARCF)
- International Council for Respiratory Care
- 2015 and beyond conferences set the stage for the future
• **Mission**
To protect the citizenry against the unauthorized, unqualified, and improper administration of respiratory therapy and from unprofessional or unethical conduct by persons licensed to practice respiratory therapy (Section 34-27-B-1).

**Vision**
Licensed Respiratory Therapists provide quality respiratory healthcare to Alabama citizens, promoting their health and self-sufficiency.

• **Values**
1. We value the rights of respiratory therapy patients.
2. We value continuous improvement of Board staff in order to provide efficient, effective, and ethical service to consumers and licensees.
3. We value public awareness of respiratory therapy.

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Hospital-Based Respiratory Care Services

- Medical director
- Respiratory therapists
  - RRT
  - CRT
  - OJT
  - CPFT, RPFT, AE-C
Hospital-Based Respiratory Care Services

• Protocol-based
  – Guidelines for delivering appropriate respiratory care
  – Often use algorithms
  – Successful use of protocols and algorithms depends on use of appropriate standards and the presence of appropriate personnel who possess prerequisite skills and knowledge
Hospital-Based Respiratory Care Services

- Technical Direction
  - Provided by the department manager, usually an RRT with BS or higher
  - Under the direction of a hospital administrator
  - Responsible for preparing protocols, equipment safety and maintenance
  - Charged with quality assurance program
Protocols

• Guidelines for delivering appropriate RC treatments that are indicated, delivered by the correct method, and discontinued when no longer needed

• Key elements of a protocol
  – strong and committed medical direction
  – capable therapists
  – active quality monitoring
  – collaboration among care-givers
  – responsiveness to address and correct problems
Protocols

- Clearly stated objectives
- Outline, including an algorithm
- Description of alternative choices at decision and action points
- Description of potential complications and corrections
- Description of end-points and decision points at which the physician must be contacted
- Protocol use program
FIGURE 2-1 Respiratory care protocol. Aerosolized bronchodilator therapy algorithm for current or history of bronchospasm.
Ethical Practice

• Ethics guide us in carrying out our duties in a morally defensible way
  – Violation results in censure or expulsion from the profession
• Laws establish the minimum legal standards to which practitioners must adhere
  – Violation results in fines, punishment, incarceration
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 the scope of accepted and responsible practice.

• Respect and protect the legal and personal rights of patients they care for, including the right to informed consent and refusal of treatment.

• Divulge no confidential 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.

• 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.

• Refrain from indiscriminate and unnecessary use of resources.
Ethical theories and principles

- **Autonomy** - personal liberty, right to decide, informed consent
- **Veracity** - tell the truth
- **Nonmaleficence** - avoid harm and actively prevent harm
- **Beneficence** - actively contribute to the health and well-being of the patient
Ethical theories and principles

- Confidentiality—say nothing about the patient in an insecure arena
- Justice—fair distribution of care; current issues surrounding HMOs
- Role fidelity—do your job, within the description of your profession
  - AARC has defined the profession (AARC.org)
Ethical viewpoints and decision-making: Formalism

- Reliance on rules and principles
- Ethical standards of right or wrong are described in terms or rules or principles, functioning apart from consequences
- However, most rules have exceptions, which may in turn conflict with other rules or principles
Ethical viewpoints and decision-making: consequentialism

- Reliance on the assessment of consequences
- Acts are based upon whether they will bring good or evil “Primum non sincere”
- Rule utilitarianism - compromise between formalism and consequentialism: which rule would promote the greatest good if it were generally followed?
Ethical viewpoints and decision-making: Virtue Ethics

- Reliance on what the virtuous person would do
- How would the good therapist act?
- Based on historical traditions
- Places too much reliance on past experience and stifles creative problem-solving
Legal Issues

• Negligence
  – Duty
  – Breach of duty
  – Proximate cause
  – Injury
Legal Issues

- Avoiding negligence
  - do what it says in the procedure manual
  - Don’t perform a procedure you don’t know how to do—ask!
  - maintain confidentiality
  - stay within your scope of practice
  - conform to all legal requirements of licensure
  - maintain standard of care
  - active risk management and appropriate guest relations