Millner, Lawson

From: NCSRC - Publications <ncsrc@ncsrc.ccsend.com> on behalf of NCSRC - Publications <ncsrc@ncsrc.org>
Sent: Wednesday, April 01, 2015 12:05 PM
To: Millner, Lawson
Subject: NCSRC Newsletter

NCSRC Times

Welcome to the return of the NCSRC times. We hope that you find the information helpful and enjoyable. The primary purpose of this newsletter is to provide an information outlet on state and national topics. We hope you enjoy this edition and we hope that you will be encouraged to submit an article to future publications. To submit an article, simply send it along with a photo to linabnit@uncc.edu. We encourage suggestions for what you want to see in your newsletter.

Remember that the NCSRC Symposium is scheduled for September 29th through October 2nd, 2015 in Wilmington.

Sincerely, your editors

Jhaymie Cappiello
Lanny Inabnit
Lawson Millner

Highlights Of The North Carolina Respiratory Care Board

By
Bill Croft, Ph.D., RRT, RCP, FAAIM
NCRCB Executive Director

The 2014-2015 fiscal year has already seen many changes to the Board. Among the changes included the retirement of Floyd Boyer, BS, RRT, RCP, FAARC. Mr. Boyer retired as the NC Respiratory Care Board (NCRCB) Executive Director on July 31, 2014 after 13 years' of service to the board and with over 40 years of distinguished service to the respiratory care profession in NC.

Floyd has been involved at every level of the profession. Under his leadership with NCRCB, he has been able to facilitate advancements in the practice of respiratory care to help fulfill the charge of the NCRCB, which is to protect the public from the unqualified practice of respiratory care and from unprofessional conduct by persons licensed by NC. These

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advancements have strengthened the standards to ensure the board can complete its mission on a daily basis. In fact, the board is one of the most efficient licensing boards in the state. He has also distinguished himself by representing NC on the national level with other state respiratory care boards looking to NC for guidance. We wish him well in his retirement.

Since July 2014, the Board was very active by addressing a number of items including position statements, rulings, and policies at the October and January meetings.

Following Mr, Boyer's retirement, the Board Office Location and Hours changed in September. The administrative offices of the North Carolina Respiratory Care Board (NCRCB) are now located at: 125 Edinburgh South Drive, Suite 100, Cary, NC 27511. Office hours are 8:00 a.m. until 4:00 p.m., Monday through Friday, except North Carolina state holidays. The phone and fax numbers remain the same. The staff and Board are very happy in this new location. It is much more accessible to the major interstates and offers a number of amenities for those visiting the office.

The following summary of Board activities occurred during the last three meetings of the Board.

October 2014 Actions
The Board approved a position statement on Social Media
Social Media has implications for your professional licenses, so we encourage everyone to read this position statement. Essentially, you are responsible for your behavior on and off the job even when using social media.

Please check out the FAQ's section of the website. The Board approved several updates by adding clarifying language for unlicensed individuals, sexual harassment, and the continuing education requirements.

The Board approveda consent order to address the growing issue of lapsed CRT and RRT credentials. According to Board rule21 NCAC 61 .0302 (d), the licensee shall maintain current respiratory care credentials as issued by the National Board for Respiratory Care and shall provide proof of the credentials to the Board upon renewal and upon request. RCP's who allow their credentials to expire will receive an automatic $100 civil penalty with suspension. If the individuals, once they receive the consent order, comply with the directions in the consent order within 30 days then the Board will waive the suspension and the $100 civil penalty.

The Board approved a new policy on records retention. The Board adopted the state guidelines presented to the Board based on N.C. Administrative Code, Title 7, Chapter 4, Subchapter M, Section 500 for schedule of retention and disposition of records. This policy allows destruction of records after five years of inactivity. When reapplying after five years, RCP's will be required to reapply and resend all relative documents. The best way to maintain a file is to go inactive. RCP's may be inactive for five years provided they pay their annual fees.

The Board approved a Military Guidance Document
for the website that provides licensing instructions for the military and their spouses in North Carolina. This document helps military RCP's make the transition to civilian practice easier. They are still required to meet the same educational and credentialing requirements.

The Board reviewed the documentation procedure developed for Advanced Practice Registration and Endorsement based on the request from Robert Williams, RRT, RCP from Cape Fear Valley Medical Center. RCP's holding the appropriate credentials will receive a Board endorsement that will appear on the website verification section. The addition is exciting as the advanced practitioners will be recognized for their skill level. RCP's are not allowed to practice the skills unless they are operating under established policies, procedures, and protocols. Of course, the endorsements are not transferable. For this reason, endorsement applications are required
for each practice site.

Lastly, the Board approved a request from Terry Smith, RCP concerning RCP's using chlorhexidine gluconate oral rinses for VAP patients. An interpretive letter was issued to indicate that chlorhexidine gluconate oral rinses for VAP patients are within the RCP scope of practice to use and can be ordered by RCP's within established hospital policies, procedures, and protocol for VAP/VAE.

The Board held a special meeting on October 31, 2014 to discuss the Board Rule change for 21 NCAC 61.0401, Continuing Education Requirements For License Holders. This final rule was approved by the Board then by the NC Rules Review Commission on December 17, 2014. Licensee's completing all of their CE requirements prior to January 31, 2015 will be evaluated using the current rule regardless of the renewal month. Any CE's taken after January 31st will need to be evaluated for compliance with the amended rule. Please check the Board Rules and FAQ's section for the specifics.

January 8, 2015 Actions
In January, the Board welcomed two new Board members. Dr. Albert Curseen, MD, was appointed by the Old North Medical Society and Bernard Nobles was appointed by the Governor.

In 2013, House Bill 285 was approved by the House. It died a slow death in the Senate Health Committee due to the budgetary debate taking legislative priority. There were no healthcare bills discussed during the short session of the NC General Assembly. Therefore, the Board approved a new draft bill for the 2015-16 Legislative Session. Representative Ken Goodman agreed to sponsor the bill in February 2015. The bill is currently in the drafting phase and will be posted on the website when introduced.

The Board approved two amendments to the ECMO Declaratory Ruling based on requests from Jhaymie Cappiello MS RRT-ACCS RCP, Education Director at DUMC and Cheryl Adams, MS, RRT, AE-C at Carolinas Healthcare. The changes include: a) requirements for ACLS, PALS, and NRP credentialing based on the RCP's patient population; and b) a scope of practice outlined for ECMO specialist providing continuous renal replacement therapy (CRRT) within approved hospital policies and protocols. Essentially, ECMO endorsed RCP's will be allowed to perform CRRT under the circumstances provided for in the declaratory ruling. The ruling does not mean any RCP can provide CRRT.

The Board approved an interpretive letter regarding the scope of practice for RCP's authorizing medication refills when utilizing a physician ordered protocol while working in physician offices based on a request from Joy

Key, RN, BSN, CPHRM, Patient Safety Manager at Cornerstone Health. Therapists cannot fill prescriptions, but they can complete the necessary paperwork when working to authorize refills of existing prescriptions in physician's office.

The Board established an Adhoc Committee on Patient Education to develop advanced practice endorsement guidelines for a Pulmonary Disease Patient Educator based on a request from Terrie Ray, RRT, BSRT. The committee will investigate and recommend guidelines to the Board for patient educator credentialing. The guidelines could take the form of an endorsement similar to the other advanced practice endorsements.
The new Board rules for continuing education allow for clinical precepting to be counted towards 3 of the 12 CE' each year. The Board approved the requirements for preceptor documentation for CE credit. The requirements are in the FAQ's section of the website; however, the Education Committee will be updating the requirements in the near future.

Lastly, the Board approved a new policy to allow licensees to print their renewal cards. This change will allow RCP's to print renewal cards rather than waiting for the mail. We initially thought it would take until May 2015, but the webmaster was able to complete this change almost immediately. As of February 1st, 2015, RCP's will be prompted to print their cards after renewing online. New licensees will still be mailed their original certificates and cards. After the first initial license is mailed, all renewals are to be printed by the RCP or saved as a PDF file. This change makes it much more efficient for everyone.

In closing, the 2014-2015 fiscal year has seen many changes thus far. We have been extremely active, but the Board has always been proactive. As the new Executive Director replacing Mr. Boyer, it is my pleasure to be a part of the process and look forward to serving the profession in another capacity. Thanks for all that you do for improving patient care and the profession of Respiratory Care!

Retirement of NCRCB Executive Director

by Lara Lockwood

If you look at your license from the NCRCB, whose signature is on that license? Floyd Boyer, BS, RRT, RCP. On October 10, 2013, at the North Carolina Respiratory Care Board meeting, Floyd announced his retirement in 2014. Floyd was a Board member and Chairman of the North Carolina Respiratory Care Board from July 2000 to July 2002 and has been the Executive Director of the Board since July 2002.

Floyd started his medical profession as an orderly in ICU at NC Baptist Hospital in 1968. Bill Brown was our Technical Director at that time. While working closely with Inhalation Therapist in ICU in 1969, Larry Snead, who was the Assistant Director in our department, approached Floyd and asked him "Why don't you work with us?" Floyd trained in the On-the-Job Training program in our department. He wanted to learn more so, in 1971, he started his education in the Inhalation Therapy program, which at that time was hospital based. The Bowman Gray/Baptist Hospital

program was transferred to Forsyth Technical Institute in 1972 along with all other allied health professions. All classes were held at the Allied Health Building on Beach Street where the Comprehensive Cancer Center now stands. He received his AAS in Inhalation Therapy from FTI in 1973. After graduation, he taught Respiratory Care and became Program Director for Respiratory Care at FTI for eight years along with being adjunct instructor at Jacksonville Junior College, Jacksonville, FL; and Medical College of Georgia, Augusta, GA.

His experience includes Adult, Pediatric and Neonatal while at NC Baptist Hospital, Winston-Salem, NC; Moses Cone Hospital, Greensboro, NC; Baptist Medical Center, Jacksonville, FL; and Bladen County Hospital, Elizabethtown, NC. He has over twelve years experience as Director of hospital Respiratory Care Departments at both Moses Cone Hospital and Bladen County Hospital. In 1983, he started a home care company and sold it in 1985 to a major company. Currently, he is a Surveyor and Clinical Consultant for the Accreditation Commission for Health Care. In his duties as a Clinical Consultant, he writes standards, data collection material and articles as well as answering questions from companies preparing for surveys. Floyd is an ACHC Board member and is a member of ACHC's Standards Review Committee.

The North Carolina General Assembly passed the Respiratory Care Practice Act in 2000. Licensure for Respiratory Care Practitioners in NC became effective on October 1, 2002. Floyd's licensure number is 1. Floyd drives 65 miles from Autryville to Raleigh one way every weekday. He has a car that he bought in 2002 and has 427, 000 on his odometer. He expects that our profession will continue to grow with further education requirements and requests we support House Bill 285 that is currently in the NC General Assembly that will improve and strengthen the profession of Respiratory Care.

Floyd is a private, instrument-rated pilot and has logged over 1200 hours. Although he stays very busy with regulatory matters and consulting, he finds time to fly and ride his Harley-Davidson motorcycle for relaxation. He has ten grandchildren to spend time with. Upon retirement from the NCRCB in 2014, he will continue to keep his license active by attending seminars and symposia.

My grateful thanks to Floyd Boyer, BS, RRT, RCP for being an inspiration for our profession!

A Look at the Medicare Telehealth Parity Act 2015

Lawson Millner

On Wednesday, March 18, 2015, Tim King and I as the NCSRC PACT representatives and along with Sharon Kennedy, headed to Capitol Hill to lobby our lawmakers to support what was HR 5380 in the 113th Congress. Every year PACT representatives from each state society as well as the District of Columbia head to Washington, D.C. to meet with their states lawmakers to try to gain their support on bills that impact patient care and respiratory therapy. This year, Tim and I were able to meet with 12 of our 15 representatives. This is the first time that we were unable to secure meetings with all of the NC representatives.

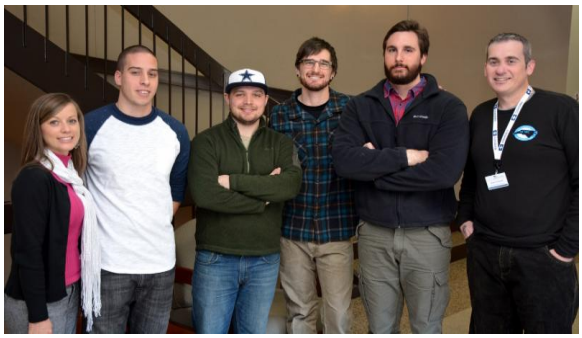
In years past, the AARC has pushed for their own bill, most recently HR 2619. HR 2619 was exclusive to respiratory therapy in that it would allow patients with chronic conditions to be able to schedule appointments and meet with a respiratory therapist at physicians offices. While in theory, this sounded like a good approach, the Congressional Budget Office thought that the cost to implement this bill was too expensive. So for 2015, the AARC decided to push to support HR 5380, the Medicare Telehealth Parity Act (MTPA).

The MTPA is a multi-disciplinary bill where licensed respiratory therapists are covered as qualified practitioners in addition to audiologists, physical therapists, occupational therapists, speech - language pathologists and certified diabetes educators. From a respiratory perspective, COPD is one of the three chronic conditions covered under remote patient management services that include patient monitoring, training, clinical observation, assessment and treatment. Other chronic conditions include congestive heart failure and diabetes.

As of today, COPD is 4th among the most costly hospital readmissions and has been added to the list of conditions subject to hospital readmission penalties since October 2014. In 2010, Medicare beneficiaries with two or more chronic conditions including COPD and asthma accounted for almost 98% (1.9 million) of all hospital readmissions.

Upon passage of this bill, new opportunities will open for respiratory therapists to share their knowledge and expertise with patients diagnosed with COPD via telehealth. This bill will give patients access to respiratory therapists that they currently do not have. Medicare beneficiaries trained by respiratory therapists via telehealth to recognize and reduce the symptoms and triggers of their chronic lung disease can lead to reduced exacerbations and lower the incidence of costly acute care interventions. Other opportunities include providing education on proper inhaler techniques and saturation goals, all of which will help reduce costly acute care interventions. Respiratory therapists are already making a difference in their hospitals by establishing best practices to reduce COPD readmissions that can also be applied via a telehealth delivery system.

We expect the MTPA will be reintroduced to the 114th Congress soon. It has bipartisan support, a definite advantage looking at the 2015 Congressional landscape. Since the MTPA is multidisciplinary, it will be lobbied and supported by many other disciplines as well as the American Telehealth Association. More emails and calls to Congress are needed to keep the momentum going and the Parity bill on the front burner. This year, NC ranked 20th with 303 emails sent using the AARC's Capital Connection. If you have not written your representative yet, please take a few minutes to send your emails asking your representatives to support the Medicare Telehealth Parity Act using the AARC's Capital Connection http://capwiz.com/aarc/issues/?style=d. If you have questions or need more information, please contact me at rlmillner@novanthealth.org.



SCC students post North Carolina's best-ever finish at national quiz competition

Las Vegas trips are supposed to be all about fun, and what could be more fun than placing high at a national competition?

That's exactly what second-year students in Southwestern Community College's respiratory therapy program accomplished Dec. 9-12 by finishing fourth in the American Association for Respiratory Care's annual "Sputum Bowl." It was the highest finish ever for a team representing North Carolina at the quiz-style contest, which this year included 40 teams from across the country.

Team members are Noah Jones of Candler, Benjamin Lackey of Franklin, Zac Short of Asheville and Justin Wilson of Asheville.Team advisors are program coordinator Samantha Campbell of Clyde and clinical coordinator Brent Holland of Asheville.

"Samantha and I are so proud of this group," Holland said. "They spent a lot of time studying, and they just worked so hard. We are really going to miss them; they're due to graduate in May. I joked with Samantha that we need to find a way to fail them so they'll stay around another year. In all seriousness, they represented North Carolina very well."

PIMA Medical Institute of Colorado won the student competition, which was set up in a tournament format where two teams squared off head-to-head with the winner advancing to the next round.

SCC's team won its first few rounds but was eliminated shy of the championship round when judges voted 3-2 against accepting their response to a highly technical question about mechanical ventilation. "We answered correctly, but we didn't use a specific word they were looking for - we used a synonym," Jones said. "It was disappointing to know we could have gone on, but the team that won was very good. They'd been working on this from the start of their first semester. We just started preparing for this contest in August."

By winning the North Carolina contest in September, the SCC squad had its travel and hotel expenses covered by the North Carolina Society for Respiratory Care. The SCC Foundation paid the team's registration fees. Besides participating in the contest, Southwestern's students attended an international conference that included lectures on the latest advances in their field.

"It was very educational," Jones said. "We met students from other colleges and learned a lot. It was a great experience."
For more information about respiratory therapy and SCC's other programs, visit southwesterncc.edu, call 828.339.4000 or swing by Southwestern's Jackson Campus in Sylva.

A Respiratory Therapist Experience of Living and Working in the Middle East

Valerie David of Whitsett, North Carolina has been a healthcare professional for the last 25 years. As a Respiratory Care Practitioner and Leader, she has treated a wide variety of patients in the Alamance and Guilford county areas.

Valerie has added international travel to her curriculum vitae after spending 3 tours and a total of six years of service as a Respiratory Therapist working for major healthcare organizations in the Middle East. David, sought out the unique opportunity to travel abroad as a healthcare worker after spending a rewarding career of excellence in patient care and satisfaction. Working overseas has impacted my life in a big way as I had the opportunity to work with healthcare workers from sixty-seven different nationalities. All of the hospitals were modern with state of the art equipment and the healthcare model was based on the North American standard of care. As well, each facility was Joint Commission International Accredited. The work was challenging and the medical cases very complex cases, a lot of which I had never worked with in my previous experiences.

Working in the Middle East was a transition personally, culturally, and professionally. I learned about other nationalities and cultures, their language and their mores. The climate was hot and dry most of the time. I lived on a compound with other healthcare professionals and we all shared a common bond of having left our families behind for "adventure". I was able to earn a great living and travel to some exotic places around the world.

Living and working as a Respiratory Therapist in a foreign country was amazing on both and personal and professional level as it taught me how to survive and how to adapt in an ever-changing healthcare environment and world. The experience was priceless.

Ethics in Respiratory

Neil Ryan, MHA, RRT

As Respiratory Therapists we often find ourselves facing moral and ethical dilemmas as we care for our patients, especially those on ventilators. From the largest teaching hospitals to small community hospitals RT's are increasingly involved in physician rounds where their input is both welcome and expected in regards to patient care plans. When patients are on ventilators and decisions concerning life support are made, how often are you as an RT, asked to participate in discussions regarding any ethical concerns raised by the prospect of mechanical ventilation? How often is your input welcome, expected, and taken into consideration when the care team is faced with difficult ethical decisions?

The decision to place someone on a ventilator, or to decide that intubation is not an option, can lead to a multitude of ethical decisions, dilemmas, conflicts, and debates. Yet in most healthcare settings, the ethical aspect of life support or withdrawal is often a topic not discussed unless a

caregiver or family member raises concerns and questions. Concerns and questions, rising from various perspectives, can often divide caregivers and family members. This can lead to mistrust and create communication barriers between physicians and family members. These issues are often addressed without input from one key member of the healthcare team, the RT.

In ICU settings ethical considerations can reach far beyond the medical team, staff, and patient, to include the family and friends who care about the patient. Each may have separate moral, legal and ethical issues that need to be addressed. Find out how your workplace offers assistance in these cases and whether an ethics consultation service is available. As our baby-boomer population ages, such a service will become more valuable with each passing year.

If you are fortunate to have an ethics committee at your place of employment, I would encourage you to actively advocate for appointment of a respiratory therapist on that committee. RT's have an abundance of knowledge and experience with life support and end-of-life care and will compliment any ethics committee. In addition, even in the absence of an official committee, advocating for your patients when you feel there are ethical issues that need to be addressed will benefit your patient, family members, the entire care team, and most of all, our profession.

Open Research Forum Named for Dan Grady

When you think of innovators in the field of Respiratory Therapy in our state, one name tends to be mentioned. Dan Grady has spent his career working to improve the ways that Respiratory Therapists approach their jobs. Dan has always been a huge advocate for research and started the research committee in hopes of fostering this in our state. The open research forum has continued to grow and this year saw the addition of a student open research forum. The Board of Directors and Executive Officers saw fit to acknowledge Dan and from now on the open research forum will be named the Dan Grady Open Research Forum. If you see Dan, please congratulate him on this honor and thank him for all he has done. Consider presenting your research at this year's Dan Grady Open Forum at the 2015 NCSRC Symposium in Wilmington, North Carolina.

Preventative Use of High Frequency Ventilation
Jacob Dyer

High frequency ventilation has long since been considered the standard form of ventilation for the treatment of acute pulmonary injury. It has proven itself time and again to treat injuries such as pneumothoraces and pulmonary interstitial emphysema in the neonatal population. It promotes healing while also preventing further injury with its gentle form of ventilation. With all the proven benefits of high frequency ventilation, why

is it only considered a rescue measure or a last ditch effort?

Early preterm neonates are at a very high risk for acute lung injury. Pulmonary interstitial emphysema and pneumothoraces are common conditions seen in neonatal intensive care units. These pulmonary injuries not only lead to a higher likelihood of mortality, but they also drastically increase the likelihood of long term pulmonary conditions such as bronchopulmonary dysplasia. They increase intubation times, increase FIO2 requirements, decrease survival rates, and increase likelihood of intra-cerebral hemorrhage. Neonates born less than twenty-five weeks of gestation are at an exceptionally high risk for these injuries. Most developed countries and even some hospitals in the United States do not even attempt to resuscitate this patient population due to the high likelihood of mortality and long term morbidities. I believe that neonates born less than twenty-five weeks gestation should never be placed on conventional ventilation. Unfortunately the technology to provide effective negative pressure ventilation to this patient population does not exist. However, we do have the technology to provide ventilation using very low volumes with high rates to achieve necessary mean airway pressure safely and effectively through high frequency ventilation.

High frequency ventilation should be used as the only form of mechanical ventilation in this patient group. The only reason it would not be used as the primary form of mechanical ventilation is because of the mentality that it is a last ditch effort. This is a common and unfounded misconception. The early preterm neonate would benefit from sole exposure to high frequency ventilation.

Meet your Vice President

Lanny Inabnit, MSc, RRT-ACCS/NPS, RCP

- What is your job/position

Clinical Assistant Professor in the Bachelors of Science Respiratory Therapy Program at UNC-Charlotte

- Education

AAS in RT from Southern Illinois University
BSRT in Health Service Management from East Carolina University
MSc in Respiratory Care Leadership from Northeastern University

- Where did you grow up?

Illinois

- How long have you been a Respiratory Therapist?

21 years

- How do you spend your days off?

I have a 13 and 10 year-old that keep me pretty busy with sports related activities. I enjoy volunteer coaching for my daughter's softball team and my son's football team. I love to read and really am interested in history especially the civil war.

- Can you tell us about your work with the NCSRC?

I got involved with the NCSRC about 8 years ago. I started by working on a couple committee at the beginning and was fortunate to be elected to a Board of Director position. One of my favorite committees was the education/program committee. I even got to co-chair this committee for a couple years. I am currently serving as the vice president for a one year term. I am also serving as a member of the publications committee and chair of the membership committee. I am honored to represent such a great group of individuals.

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