AMERICAN SOCIETY OF EXTRACORPOREAL TECHNOLOGY

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Influence Of Emerging Technology On Professional Licensing

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Meeting of Arizona Perfusionists

The Government Relations Committee extends an invitation to attend a meeting September 8, 2012 in the Phoenix area. The committee is meeting with perfusionists to answer questions about the legislative process and the pros and cons of licensing of the profession. There is no cost to attend and NO CEUs are attached with attending the meeting. To register and for location information Arizona perfusionists can contact James Ferguson at fergy2ccp@q.com or Donald Wilson at wilson.donald@mayo.edu.

States Seeking Credentialing

Licensing bills are now in legislative consideration in Kansas, New York, and the District of Columbia. Efforts are also underway to organize perfusion state societies and pursue credentialing in Arizona, Colorado, and Virginia. The following persons can be contacted for information in these states.

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Influence Of Emergent Tools and Methods

There is a common thread between these six states with the goal of having the professional recognition of being a licensed profession. It is no secret that our profession will continue to be challenged with identifying new opportunities, driven by changes in technology and devices and the means of patient medical care delivery. Licensure is the best method of guaranteeing that a perfusionist's clinical responsibilities are not gradually or stealthily taken away, especially when it comes to services outside of the operating room. Fifty-three percent (53%) of certified perfusionists nationally are already licensed.

For example, portable extracorporeal cardiopulmonary life support (ECLS) devices are gaining the attention of mainstream medicine. On the surface such attention could only be expected to benefit patients with occurrences of acute respiratory failure or acute myocardial infarction. While some heart failure and respiratory failure patients are treated with immediate transplants, the limited availability of donor organs often requires MCS devices as a bridge to transplant, bridge to decision or as destination therapy. The use of extracorporeal membrane oxygenation (ECMO) has developed into a specialized, multidisciplinary effort. Perfusionists know the advantages and disadvantages of these devices. Device manufacturers realize the untapped markets for these advanced products and pursue bringing mechanical circulatory support (MCS) devices to the mainstream despite the risk that the future operators of these devices may not include perfusionists in the current unlicensed states. The recent introduction of percutaneous mechanical circulatory support devices to cardiac cath labs has shown the direction that newer generations of portable ECLS devices will most likely take. This is why the AmSECT Mechanical Circulatory Support Committee issued a Society Position Statement for manufacturers and members to use in their respective hospitals. This has direct membership usefulness in the current 18 licensed states, and perhaps helps in the unlicensed states.

Licensed perfusionists in such situations have an advantage over those in non-licensed states. Unless the selected manufacturer-trained OJT medical personnel is a licensed perfusionist, a licensed respiratory therapist, or a licensed nurse with ELSO certification, the person would be engaged in practicing medicine without a license granting them the state-sanctioned authority to operate a device. In non-licensed perfusionist states this professional leverage is not available. Licensing establishes minimum entry to practice requirements and grants to the practioners of the profession the right to challenge hospital-staffing decisions that may ignore the established state recognized scope of clinical practice. Decisions like this are now occurring across the country.

There are other examples of how being an unlicensed perfusionist can cause staffing value and recognition problems when it comes to being able to fully utilize our specialized training and skills. For example, the functions of the profession will continue to expand into the areas of

perioperative blood management, wound healing, and ventricular assistance. From time to time on PerList, with the heading of “How do we increase our value”, there are exchanges of ideas on how to do this beyond just running the pump. Bypassed, pardon the pun, in discussions is the fundamental question of whether a blogger is licensed or not? A licensed perfusionist credentialed by the state, with a recognized scope of practice, has avenues of opportunity that may otherwise be overlooked or be assigned by hospital administration to other licensed allied health professionals, even though the unlicensed perfusionist is better educated and trained for use of a device.

Three perfusion specialty services/functions involve blood management responsibilities and decisions impacting day-to-day clinical use. The blood management field has exponentially grown Blood management is a multidisciplinary hospital team approach to blood conservation, blood component fractionation, and transfusion. The perfusionist, for the most part but not necessarily, is the most logical from a patient safety and knowledge base perspective to assume a lead role. Now and in the future, blood management is expected to continue to be a multidisciplinary and multimodality patient treatment service, with various devices used.

Aquapheresis/Ultrafiltration are two terms of art that have become interchangeable in clinical practice and is yet another example. Supporting the medical use of ultrafiltration, documenting its benefits to safely and effective remove excess fluid from patients suffering from heart failure, liver cirrhosis, hypertension and certain kidney diseases will expand with the increasing number of “baby boomers” getting older. Congestive heart failure is the most common reason for fluid overload. Aquapheresis is an extracorporeal therapy in which a small amount of blood is withdrawn using specialized venous access catheters. The blood passes continuously through a special filter resulting in the production of isotonic fluid. The remaining blood is pumped back to the patient. The clinician, based on the state of the patient, determines the rate of isotonic fluid removal. The goal is to restore the normal fluid balance (euvolemia).

Platelet Gel production/Bone marrow aspiration are two more perfusion functions that could also become complementary in future perfusion clinical practices, based on recent Bone Marrow Aspiration (BMA) research. Platelet Gel production preceded BMA in the linage of blood product uses to accomplish a host of specific treatment outcomes. Platelet-rich plasma (PRP) has been in use since it was first was introduced in 1987. The use of PRP in treating patients in has grown exponentially. Although providers practicing musculoskeletal (MSK) medicine began using PRP in the early 1990s (intraoperative fusions and fracture repair), an informed patient population has accelerated interest in this therapeutic alternative to enhanced healing of bone and soft tissue on a cellular level. PRP is in use in multiple medical specialties - cosmetic surgery, podiatry, neurosurgery, dentistry, maxillofacial surgery, urology, surgical wound healing and even ophthalmology. The use of bone marrow-derived stem cells (BMA) with PRP is a more recent clinical application in musculoskeletal medicine.

The profession's scope of practice has evolved beyond just pumping an adult or pediatric CPB case. The cardiovascular surgical field will continue to evolve to keep abreast of new medical practice procedures and device technological changes. Research and the medical device marketplace drive these forces. It is true that hospitals or surgical groups will not uniformly adopt future clinical use applications nationally. However the examples herein cover our core professional responsibilities and change and adaptation are always around the corner. Perfusionists have no control over these influences, but do have control over whether they will be in the clinical position to effectively respond. There are and will be lost opportunities to expand the utility of our specialized training and knowledge unless and until, as a collective professional position, in an unlicensed state, perfusionists become licensed medical professionals. The proactive pursuit to get professionally organized and pursue state legal credentialing in these six states is hopefully the implicit understanding and acceptance of the need to have more control over our profession as the tools and the methods change. This is good not just for patient safety purposes, but also for proving our value to our respective employers.

What the Medicare "Doc Fix" Means

Some may have heard their surgeons refer to the "Doc Fix". The recently enacted extension of the Social Security payroll tax cut included a doc fix for the rest of this year. Physicians want to repeal the Medicare Sustainable Growth Rate (SGR) method used to control the payment rates of all Medicare physician services. The SGR gives Congress the authority to suspend yearly decreases in payment rates, which has been regularly done. In 2010 the combined delayed reductions, if enacted, would have been a minus 21% in physician payment rates. For 2011 the delayed cuts increased to a -27% percent. The 2013 reduction is estimated at a -30% rate. In Congressional budgetary terms, the "pay-for" for the doc fix are future reductions in Medicare hospital DRG payments. Over the next 7 years Medicare hospital payments will be reduced by $1 billion per year. This is in addition to previous hospital payment reductions. The doc fix means continued reductions in Medicare hospital surgical procedure DRG payments for the foreseeable future. This does not bode well for hospital-employed perfusionists and perfusion service contract companies. For the surgical group employed, they may breath a bit easier for now. Steeper continued decreases in hospital Medicare revenues will cause downward pressure on professional salaries and perfusion related equipment and supply resources.