



AMERICAN SOCIETY OF EXTRACORPOREAL TECHNOLOGY

AmSECT Today March-April 2012

Licensing And Ancillary Perfusion Services
Mike Troike, LP, CCP, Chairman
Government Relations Committee
Lee Bechtel, Director of Government Relations

Recent Perlist posts provided commentary on the topic of “Proving Our Value”. The gist of the posts centered on perfusion services being a hospital cost-center of scrutiny being lead by reductions in hospital revenues and profit margins due to reductions in insurance reimbursement payment rates and income. And, seeking ideas on what perfusionists can do to take on ancillary duties to better substantiate their value to justify their salaries. In other words, what are some of the duties a perfusionist can do outside of the operating room to extend their role in hospital clinical services for hospital administration?

This is not a new professional concern and is one that will continue as hospitals face continued cost savings/reduction pressures to remain in the black, regardless of their profit or non-profit corporate structure, their institutional affiliations/networks, or geographical locations. One example of things to come was released in January, when the Medicare Payment Advisory Commission (MedPAC) voted to recommend that Medicare DGR payments be increased by one percent for hospital inpatient care in fiscal 2013. However, the recommendations also included reductions in hospital reimbursements that, according to MedPAC projections, would reduce the profit margins hospitals have shown on Medicare patients dropping from a current negative 4.5 percent in 2010 to a negative seven percent in 2012. The profit margin figures take into account both inpatient and outpatient Medicare payments for services. So, profit margins are already being constrained and future reductions on the Medicare revenue for hospitals, on average, could be reduced by 2.5 percent in the next two years. Hospital impacts will not be evenly distributed nationwide, but the point is made on the future trend on salaried hospital employees.

The heart of the issue relates to ancillary perfusion services and involvement in functions outside of the operating room. This matter has a linkage with whether perfusionists have state sanctioned and authorized recognition to perform ancillary services they have been educated and trained to perform. In other words, whether the ancillary functions can be directly or indirectly linked to their state licensed medical functions for which they are legally authorized to perform. Perfusionists often forget to calculate this licensing factor into the decisions that hospital administration makes. Hospitals are licensed by the state and are required to meet other state requirements applying to their staff employees and what they can and cannot do clinically without potential repercussions. They have an obligation to make sure that their

employees are credentialed and perform the medical functions for which they are legally authorized to perform. Many perfusionists have the opinion that if their hospital has a requirement that the hospital only hire ABCP certified perfusionists, or that if their hospital requires continued certification to continue their employment, that this is sufficient to justify their qualifications to be the primary go-to clinicians to fulfill staffing service needs. It is not the end of the story when it applies to the hospital complying with the legally recognized state licensed medical scope of practices for the persons they utilize in the delivery of medical services.

As it applies specifically to the performance of ancillary perfusion services, perfusionists in the currently licensed 18 states have a distinct advantage over those practicing in non-licensed perfusionist states. The state recognized perfusion scope of medical functions provides leverage with hospital administration when it comes to internal staffing protocols. One cannot dismiss the role of the cardiovascular or cardiothoracic surgeons in the decisional process. All things being equal, which is practically never the case in internal hospital administrative politics, the ability to use this argument does give perfusionists leverage that they would not otherwise have as an unlicensed allied health staff professional. ABCP certification as a voluntarily adopted hospital employment standard carries no recognized compliance weight with a hospital when it comes to its legal responsibilities under state law for the delivery of patient care. In unlicensed perfusion states there is no negative downside for a hospital to use a licensed respiratory therapist, registered nurse, or physician assistant to be the lead team member involving the use of extracorporeal devices. These usually come into play in cases involving Ventricular Assist Devices (VAD), Extracorporeal Membrane Oxygenation (ECMO), Cardiopulmonary Support (CPS) device systems, or related Mechanical Circulatory Support devices and their adaptations to staffing protocols. There are other clinical areas that involve a perfusionist and ancillary services for which they are the best trained to perform, like blood management, removing IABP's, chest tubes, pacing leads etc.

To use just two of the aforementioned perfusion service functions, ECMO and CPS, for adult and neonatal cases, the clinical function relationships between licensed respiratory therapists and unlicensed perfusionists in the government relations program effort to nationally license perfusionists on the state level has a history in and of itself. Hospital protocols differ from institution as to the respective clinical functions of both professions. It is fairly well established practice that the perfusionist is the person who prepares the device for the surgical field. Postoperatively, they are the "point person" for this device. If the ICU nurses have questions or problems, the Perfusionist is called to field the questions or requested to go to the ICU to troubleshoot the device. When ECMO is used, once ECMO is placed the patient is transferred to the ICU and a Perfusionist sits with the patient adjusting flows, giving medications and maintaining the integrity of the ECMO device system. We shall leave mobile ECMO out of this equation.

A critical consideration in unlicensed states with the sharing of functions with a licensed respiratory therapist or ICU nurse is whether a perfusionist is performing, without a license granting them the authority to do, a licensed medical task or function. The perfusionist is in a unique position to educate and mentor the ICU RN in ECLS. There is, perhaps, no one in a better position to explain the equipment and its uses in an interdisciplinary-oriented pediatric and adult ECLS or ECMO programs. However, going from an educator role to the clinical practitioner changes the legal and liability game. If aware of this, hospitals and even State Medical Boards have frowned on this because it is illegal and carries civil monetary penalties for hospitals, not to mention the potential for lawsuits if things go wrong.

Respiratory therapists are licensed in 48 of the 50 states (Alaska and Hawaii do not have licensure). Based on limited state research, their licensing law scope of practice language is fairly standardized. Perfusionists are licensed in 18 of these 48 states, leaving the potential for complications to perfusionists performing these ancillary services in 25 states. There are five states that are contemplating or have pending perfusionist licensing legislation. The expectation is that licensing laws will be passed and eliminate an overlapping conflict, if one presently exists.

The Government Relations Committee has not done an extensive research project in these 25 unlicensed perfusionist states to determine whether overlapping clinical responsibility practices do or do not pose practice issues for perfusionists. We are asking any AmSECT member in an unlicensed state who is willing to do a bit of Internet searching of their respective statutory laws or regulations applying to respiratory therapists to help in this endeavor. Any interested member can contact their GRC representative by visiting the committee's webpage for contact information, or contact Lee Bechtel, Director of Government Relations at balobby@verizon.net for assistance with how this can be done.