

THE CREDENTIALING WARS: THE NBRC COMMISSIONS A FEASIBILITY STUDY *by Steven Grenard RRT, RPSGT*



In early December an unknown number of postcards went out to National Board of Respiratory Care (NBRC) respiratory therapists and techs asking them if they would be willing to participate in an online survey administered by Applied Measurement Professionals, the purpose of which was to determine the feasibility of the NBRC setting up and administering a subspecialty credentialing examination for sleep technologists. Presumably such an exam would first require any applicants to be registered as respiratory therapists since this is the format of the NBRC's other subspecialty exams. As such it immediately might be perceived as a backdoor way of disenfranchising BRPT registered polysomnography techs from performing several routine procedures done as part of the standard PSG testing: **Therapeutic trials:** PAP titration and if indicated/ordered oxygen titration (during sleep) and **Diagnostic parameters:** the recording of cardiopulmonary data including ECG, airflow, chest wall and abdominal movement associated with breathing, capnography and pulse oximetry.

As many readers will recall from last year, it was the American Association of Respiratory Care and many, but not all, of its local or state chapters, that waged a campaign against polysomnography techs, hinging their argument on the premise that the above procedures done during sleep testing fall under the "scope of practice" of RTs in many (but again not all) state laws that licensed RTs but which did not license polysomnography techs. These procedures also happen to fall under the scope of practice of polysomnograph-

ic technologists and always have. Since then the professional organizations representing both the sleep physicians and the polysomnography techs, both those who are RTs and those who are not RTs, have responded by successfully promoting legislation for PSGT licensing in States where a conflict between licensed RTs and unlicensed PSGTs existed or obtaining, in a few cases, exemptions allowing other professions, including PSGTs, to perform the above PAP/O₂ trialling and diagnostic data recording during sleep testing. The American Academy of Sleep Medicine has moved to establish an accrediting mechanism for an 80-contact hour PSG training program. The Association of Polysomnographic Technologists issued curricula, core competencies and backed grass roots initiatives to either get the procedures claimed by RTs exempt from licensing requirements or a separate law in place to license qualified, board registered or state tested PSGTs as well. The Board of Registered Polysomnographic Technologists moved forward with a plan to assure continuing education of its registrants by limiting certification to five years unless a technologist acquires 50 CEUs (10 per annum) or starts from scratch, and retakes the exam every five years. This emulates most state RT laws which require CEUs for re-licensure so in states without PSGT licensing, the certified polysomnography technologists must meet the same sort of continuing educational requirements as if they were licensed.

So while the effort to license PSGTs is moving along and a number of precedent setting states have already done so, the battle it would seem now moves into a different arena: who is going to control and administer the voluntary credentialing testing of sleep techs and what would be the pre-reqs for taking that exam. And while nothing has been announced let alone set in stone on the matter, from the nature of the questions in the NBRC survey, the option being looked at is to limit the sleep subspecialty applicant to an individual who is already an RT credentialed by the NBRC. Then along comes the need for the states to decide if the NBRC's RT based sleep subspecialty exam is required to become licensed OR if the BRPT's exam becomes the gold standard for this purpose. Hence the characterization of an NBRC administered sleep tech exam which allows only NBRC credentialed and state licensed RTs into the testing room as a back door to overcoming the bigger arguments addressed previously in this debate. If the NBRC exam prevails in a particular state then only RTs, by default, would be allowed to be licensed as sleep techs. If the BRPT exam prevails or if both are recognized, then both RTs and non-RTs would be allowed to be licensed.

Among the questions which the NBRC survey is looking at is how many RTs and non-RTs work in the lab of the responder. If the number is low or a small % of all the PSGTs working then the NBRC may have too small a market to make their effort worthwhile. One hopes that the NBRC decides to share both the raw data and statistical results of their survey with the interested public, e.g. physicians, sleep techs and RTs working in sleep testing or who are interested in working in sleep and can entry into the field by passing the BRPT exam now. Any decision they reach should be based on the obvious feasibility of such an effort BUT must not work against

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effecting access to sleep testing by patients by limiting the practice of sleep technology to the credentialed members of their own group while thousands of practitioners have been competently performing this job for decades. This would be unacceptable and may have ramifications it would be premature to discuss now.

The BRPT has responded to the stated intent of the NBRC to study the feasibility of establishing a sub-specialty credentialing exam by pointing out that while their organization has been engaged in this endeavor since 1978 and has considerable experience in this field, the NBRC does not. The BRPT has credentialed over 9000 sleep technologists since 1979. It is recognized by the National Commission for Certifying Agencies so has legitimate and equal status with the NBRC. The BRPT maintains close ties with both the physician/professional sleep medicine society (AASM) and technical association (APT). The BRPT consults with and utilizes input from the fields of respiratory therapy, adult and pediatric pulmonology, adult and pediatric neurology, electroneurodiagnostic technology (EMG & EEG), cardiology, (ECG), psychology, otorhinolaryngology and other medical specialties and subspecialties which are directly or peripherally involved with sleep disorders of one type or another. The NBRC's thrust is solely on the respiratory/cardiopulmonary side. The BRPT feels the field is too diverse to be placed under the aegis of an organization whose current thrust is just cardiopulmonary even if that thrust is to a far greater depth than any sleep tech would be required to perform. The BRPT has always and continues to accord dispensation to credentialed RTs to take the polysomnographic exam by allowing them to do so without benefit of any other pre-requisite other than 6 months experience working in a sleep lab; but, they value RTs as essentially equal members of the polysomnographic team. Their philosophy is not to exclude or restrain any properly trained individual from sitting the exam and, if they can pass it, be accorded the BRPT credential.

On the subject of dual credentialing that an NBRC sub-specialty exam would engender, the BRPT feels a second credential would directly compete with the BRPT credential. This could lead to candidates "shopping" both exams to see which is better for them. It would cause confusion among patients, physicians, hospitals, and the sleep medicine community at large. It would also complicate pathways to education. The respiratory curriculum is much longer and encompasses skill sets and training not required of a sleep technologist. This would make it much more expensive, would lower numbers of individuals available to work in either field, RT or sleep, and negatively impact patient diagnosis and care.

Sleep techs need a smattering of knowledge from several otherwise unrelated fields while RT has developed into a complex field all its own requiring in-depth knowledge and far more critical patient care responsibilities than that required of sleep technologists who are recording data and applying a few "respiratory procedures" on a trial basis. For example life threatening emergencies in sleep labs are extremely rare to almost non-existent whereas they are an everyday occurrence for the RT professional. Unstable patients are not, nor should they be, sent into a sleep lab for testing. They are hospitalized, RT administered PAP if required, and then sent as outpatients to the lab after they are stable and it is safe to do so. Third party payers categorize sleep testing as an outpatient procedure. But recognizing that cardiac arrests can occur anyplace, anytime, the BRPT requires sleep techs to have current BCLS training and certification in order to take the BRPT exam and maintain their credential. It remains to be seen what the NBRC survey will show and what action that organization takes on it. We will have to wait and see.

genation, improves symptoms of heart failure, improves the left ventricular ejection fraction and decreases sympathetic nervous activity. Nearly half of those with stable and optimally treated congestive heart failure have an apnea-hypopnea index of more than 26 episodes per hour with central apnea or obstructive apnea during sleep associated with oxygen desaturation. NPPV and CPAP are both safe and effective clinical applications for patients with congestive heart failure and sleep disturbances. Indeed, in patients with CHF, NPPV or CPAP may improve oxygenation by enhancing the opportunity for improved V/Q matching, enhancement of lung volumes and reducing the effects of hypoxic events by increasing oxygen stores.

Two to six hours a day of NPPV therapy can significantly reduce the effects of dyspnea. The mechanism of action is the topic of several theories attempting to explain why intermittent NPPV is effective. One theory holds that intermittent rest of chronically fatigued muscles improves respiratory-muscle function. Another theory says that intermittent NPPV improves lung compliance in patients with neuromuscular or chest-wall disease by recruiting atelectatic regions of the lung. A third theory holds that by preventing nocturnal hypoventilation NPPV prevents the blunting effect of the central ventilatory drive that occurs with hypercapnic states.

A significant population of the most severely ill patients may be able to avoid both the trauma and potential risks of endotracheal intubation and mechanical ventilation through greater utilization of NPPV. NPPV is an evidence based option that is an effective treatment for specific patients with acute respiratory failure and clinical signs of respiratory distress. NPPV can have a positive impact on the quality of life in selected patients with chronic respiratory and sleep conditions and appears to have some benefit for patients with acute cardiogenic pulmonary edema and congestive heart failure. Indeed, the widest clinical application seems to be in the population of patients with sleep-related breathing disorders. The complete and informed practitioner should expand their awareness of noninvasive ventilation devices and techniques. It is the responsibility of every caregiver to offer evidenced based therapeutic options for all of their patients. NPPV holds great promise for delivering more care with fewer traumas to our patients with severe respiratory insufficiency and CHF.

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