Introduction

The subject of Clinical Respiratory Services (CRS) has been confusing to many of our customers. The Joint Commission has reviewed its policy regarding Clinical Respiratory Services and is providing guidance to assist accredited organizations.

The purpose of this guide is to:

1. Explain the eligibility of the organization to be surveyed for CRS
2. Explain the Joint Commission's definition of CRS
3. Provide resources and tools to help you determine if your organization is providing CRS as defined by the Joint Commission.
4. Identify the standards that apply to CRS
5. Provide additional information regarding the requirement for care planning (PC.01.03.01)
6. Help you develop a Clinical Respiratory Services Plan.

DEFINITION and ELIBILITY:

THE JOINT COMMISSION (TJC) identifies Clinical Respiratory Services (CRS) eligibility and services in the Accreditation Process Chapter (ACC) in the Home Care Accreditation Manual.

Organizations are eligible to be surveyed under the Joint Commission's standards for DME (DMEPOS) and CRS (Clinical Respiratory Services) if they comply with all the following conditions:

- The organization meets the DME eligibility criteria
- Services are provided by respiratory care practitioners or other licensed health care professionals
- Services are associated with the provision of DME services by the same organization
- The organization provides CRS* to patients

*Clinical Respiratory Services (TJC CRS definition) may include the following: Patient assessment, such as history and physical, pulmonary function testing and oximetry (when used by the respiratory care practitioner or other licensed health care profession for clinical monitoring of the patient); clinical patient education related to disease management; medication and treatment administration; and monitoring of outcomes of care.

To further identify Respiratory Services, various **AARC** (American Association of Respiratory Care) Position Statements have been cited/paraphrased to define Respiratory Care Services relative to home care, including but not limited to:[1]

- Patient assessment and monitoring
- Diagnostic and therapeutic modalities and services
- Disease Management
- **Patient/family/caregiver education**
- Telehealth (new position statement)[2]
- Application of therapeutics to respiratory care: Medical gas therapy, Humidity therapy; Aerosol Therapy; Artificial airway insertion, management and care; Airway clearance; Invasive and non-invasive mechanical Ventilation.[3]

[1] AARC https://www.aarc.org Resources, Professional Documents, Position Statements, Home Respiratory Care Services

[2] AARC https://www.aarc.org Resources, Professional Documents, Position Statements, Telehealth and Respiratory Therapy

[3] AARC https://www.aarc.org Resources, Professional Documents, Position Statements, Respiratory Care Scope of Practice

These services can be performed in a patient's residence, assisted living facilities, medical equipment companies, physician offices and clinics, sleep disorder centers, and a variety of other settings.[4] [5]

Please note that TJC defined **Clinical Respiratory Services (CRS) are **surveyable in any location** they are provided by the home care team and are **eligible** for survey **even if only performed one time** in a calendar year.

So, now that you have read the eligibility requirement and you have read the definition, **what services are you providing that would equate to (CRS)** clinical respiratory services? (the following examples are not all inclusive).

- **Educating patients**, families or caregivers related to disease management, to include telehealth . Example: explaining from a medical and physiological standpoint why the patient needs the therapy they are receiving, discussing the patient's sleep study or other medical report, discussing co-morbidities, discussing physiology, teaching patients to perform clinical procedures such as suctioning, trach care etc
- **Performing Oximetry to determine levels of oxygen:** For example, walking oximetry to determine the patient's level of oxygen on a conserving device system; titration of oxygen (with physician orders) to determine appropriate settings or liter flow based on saturation.
- **Assessment:** evaluating lung and breathing disorders and recommending treatments. Ex. performing vital signs and chest physical exams to be reported to the physician for the purpose of informing the health care team on the patient's condition in response to the care plan and / or recommending a change in therapy.
- **Reviewing Clinical Documents:** for the purpose of informing the health care team about the patient's condition and response to the care plan and / or recommending a change in therapy. Ex. CPAP downloads, apnea monitor downloads, ventilator downloads, oximetry studies.
- **Ventilator Management and Airway Management:** Educating the patient and patient's family regarding the physiological need for the ventilator and/or how to perform clinical tasks such as suctioning; titration of ventilator parameters either by physician order or through protocols; evaluation of the airway, trach care, trach replacement.
- **Disease Management:** COPD management programs, Asthma Management programs (may include medication management).
- **Application of Therapy:** Administration of therapy i.e., aerosol treatments, chest physiotherapy, and depending on state law, this may include the choosing of PAP masks, ETCO2 monitoring, pulmonary function testing, etc.

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[4] AARC https://www.aarc.org Resources, Professional Documents, Position Statements, Definition of Respiratory Care

[5] AARC https://www.aarc.org Resources, Professional Documents, Position Statements, Respiratory Care Scope of Practice

ARE YOU PROVIDING CLINICAL RESPIRATORY SERVICES?		
IF		THEN
Is a Respiratory Therapist or other licensed health care professional providing services to patients of the HCO?	NO	**STOP:** NO Clinical Respiratory Services Being Provided
	YES	Continue to next question
Does the Respiratory Therapist or other licensed professional teach only about the equipment use, function and cleaning of the equipment?	YES	**STOP:** If the health care professional is ONLY speaking to the patient regarding the use, function and maintenance of the equipment there are NO Clinical Respiratory Services being provided.
	NO	If you answered NO to this question, proceed to the next question.
Does the licensed professional, provide 'respiratory care' as defined by the State Scope of Practice? Examples of respiratory care services include: • Disease process education • Provide oximetry to determine levels of oxygen or if the patient can use a conserving device • Perform patient assessment • Review clinical documents • Titrate oxygen or ventilator settings • Collaborate with the physician about the patient's care	**YES**	You are providing Clinical Respiratory Services. Refer to your State Practice Act to identify exactly what constitutes "respiratory" care in your state and which services should be provided under the direction of a physician or licensed independent practitioner. If you have provided these services even one time in the past calendar year, you are eligible for CRS accreditation.

* To further determine which of your services are CRS, please proceed to your state Respiratory Care Act. Per Joint Commission definition, a non-clinician may be allowed by state law to perform equipment management, however a non-clinician may NOT perform clinical respiratory services.

ADDITIONAL PERFORMANCE IMPROVEMENT TOOLS

Step 1: Place the name of the therapy in Box 1

Step 2: Designate who is providing services (ex. Technician or Clinician)

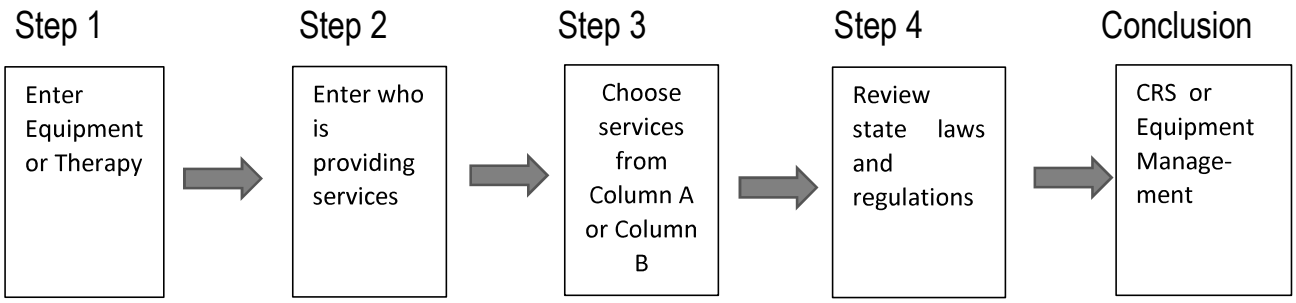
Step 3: Choose services from column A or B (next page)

Remember that anything from Column B is CRS unless state law says otherwise.

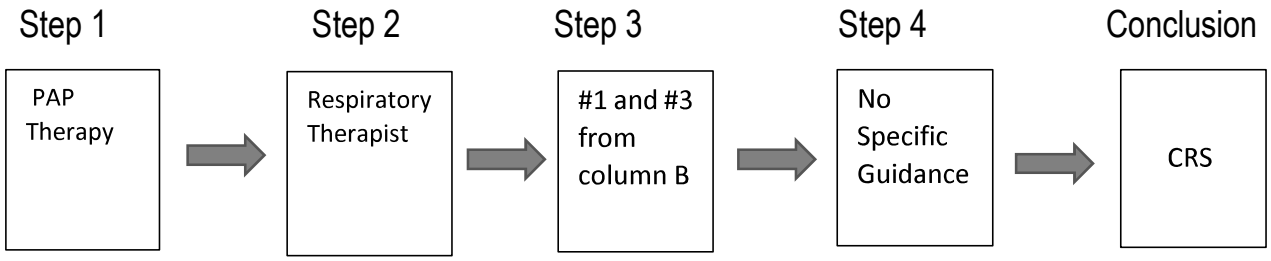
Step 4: Review State Law and Regulation, contracts and Respiratory Therapy licensure laws.

Step 5: Using the If/Then tool and the information from Column A and Column B come to a conclusion if the process meets the rules for CRS or Equipment Management.

Process Map



EXAMPLE: How to use the Process Map tool:



FOR USE WITH PROCESS MAP

Column A Equipment Management	Column B Clinical Respiratory
1. Education: • Teaching patients to use the equipment, cleaning, maintenance and safety	1. Education: • Teaching the physiological reason for using the equipment. • The clinical consequences of not using the therapy
2. Oximetry: • Overnight study, only delivery and pick up. • Obtain reading and report to physician	2. Oximetry: • Determine appropriate liter flows based on doctor's orders to maintain saturation • Conserving device evaluations
3. Downloads: • For Billing Purposes • Not for interpretation, to deliver to 3rd party	3. Downloads: • For purposes of informing health care team or for titration, etc. Apnea downloads, vent downloads, Oximetry studies, etc. • To educate the patient about the results, interpretation, ex. Sleep study results etc.
4. Ventilator Management: • A clinician doing only ventilator checks and maintenance • A non-clinician would never be involved in ventilator *management*	4. Ventilator Management: • Teaching physiological need for equipment and expected outcomes • Titration of settings per physician • Clinical assessment of patient
5. Disease Management: • A non-clinician would never be involved in Disease Management	5. Disease Management: • COPD management programs, Asthma management programs (may include medication management)

Who decides if I am going to provide Clinical Respiratory Services (CRS)?

1. CRS can be dictated by state law. In certain states, a Respiratory Therapist is required to do a follow up patient assessment after an oxygen set up. In some states, choosing and fitting a CPAP mask is considered clinical. Leadership of the organization should be aware of these regulations. If you are not sure about these regulations, check with your state DME Association.

2. CRS can be dictated by a contract. In some instances, a contract can require the follow up or assessment of a patient by a clinician. For example, Medicaid rules sometimes require a clinician to assess the patient periodically.

3. If none of the about situations are true in your organization, then it is up to leadership to determine what services they choose to provide. There is no requirement by The Joint Commission to provide CRS. Many organizations provide equipment management services only. However, if you meet the eligibility of CRS and your staff is providing services identified as CRS, you must be surveyed for CRS.

Remember, it is not the equipment that you provide, and it is not the service being performed by the clinician, it is the ACTIONS of the clinician that determine if you are providing CRS.

If the state or your contracts do not require you to provide CRS, it is a leadership decision. How does the leadership decide if they are going to provide CRS or if they are already proving CRS? And, what are some of the CRS services that DME companies are providing?

These are just some example (not all inclusive) of the services that can be provided:

- Organizations can decide that their patients have many questions about their PAP therapy and don't really understand why they need the machine, or the consequences of not using the therapy. In that instance leadership may decide to provide those services to the patient, by the clinician, at set up in the form of education.
- Other organizations feel that it is prudent to perform oximetry testing on patients who desire a conserving device. The therapist may get an order to exercise the patient to see if they tolerate the device, or the order might be to "titrate" (adjust) the settings on the conserving device per the physician's order.
- Sometimes, physicians request special services. For example, they may ask for a patient assessment or they may ask for repeated oxygen saturation studies. If this is the case, leadership must determine if they want to provide those services. If they do, the surveyor will evaluate the situation to make sure the therapist has provided the ordered services at the frequency the doctor has identified.

- Clinicians can be involved with oxygen patients. For example, teaching about the oxygen, teaching breathing exercises or, with a physician's order the clinician may "titrate" or adjust the patient's liter flow based on oximetry readings.
- When ventilator care is provided, the organization can provide equipment management and just check the machine periodically, but often the therapist is also involved in doing a patient assessment or working with the physician to determine the patient's settings.
- A clinician may observe a patient in the home that needs clinical intervention and may call the physician for advice, for changes in settings, or to get permission to provide oximetry or clinical assessment.
- On occasion, based on the need in the community or request by an insurance company, disease management programs may be administered. These can be asthma programs or COPD programs that help patients manage their diseases and stay out of the hospital.

Except for education, most clinical services must be ordered by a physician. Again, this will be dependent upon state and federal laws and the practice act in your state. There will be a link to a list of state resources at the end of this document.

If you are performing services that are identified as clinical services, but an exception is made in your state that exempts that service, you will be required to have a copy of the state regulation, respiratory therapy act etc. that spells out the exemption. The surveyor will expect to see this document on site.

It is recommended that leadership accompany the clinicians on their visits to observe what is actually done and said at those visits. Often surveyors are told by leadership that they are not providing CRS, only to observe CRS during visits.

When an organization decides to provide CRS, it is usually spelled out in a CRS policy or CRS plan. In this document, the leaders identify who will provide the services, what service(s) that will be provided and how often those services will be provided.

It may be the only CRS the organization provides is clinical education at the time of PAP set up. It could be that the organization only performs oximetry studies when a patient gets a conserving device. Or, an organization may perform multiple services that are considered clinical. When a surveyor is on site and asks what you are doing that is considered clinical respiratory services, leadership should be able to identify those services.

If, as an organization, you choose to perform CRS, what will the surveyor be looking for on-site? What standards must you be in compliance with? Continue, to see a list of standards specifically related to CRS.

STANDARDS THAT APPLY TO CLINICAL RESPIRATORY SERVICES (CRS)

To see a complete list of standards that apply please refer to the Home Care Manual.

Directions for finding the Applicability Grid: In Joint Commission Connect, on your Joint Commission web site, hover over the resources tab. Go to E-dition. In the blue box on the left, towards the bottom of the column, click on Accreditation Process Information. Choose Standards Applicability Grid. In the Applicability Grid look in the column identified as CRS. If the standard and EP applies to CRS there will be an X in the column.

All standards that apply to DME also apply to CRS. You will need to comply with Equipment Standards, Emergency Management standards, Infection Control standards, Patient Care Standards etc.

However, there are a few standards over and above the DME standards that apply to Clinical Respiratory Services (CRS in the applicability grid).

Note: the following information is abbreviated and is not the full content of the standard, please see the complete standard in the Home Care Accreditation Manual.

NPSG.01.01.01 (Patient Identifiers)

EP 1 Use at least two patient identifiers when providing care, treatment or services.

Rationale: Wrong patient errors occur in virtually all stages of diagnosis and treatment. The intent for this goal is two-fold: first, to reliably identify the individual as the person for whom the service or treatment is intended; second, to match the service or treatment to that individual. Acceptable identifiers may be the individual's name, an assigned identification number, telephone number or any other person-specific identifier

Note: In the home care setting, patient identification is less prone to error than in other settings. At the first encounter, the requirement for two identifiers is appropriate; thereafter, and in any situation of continuing one-on-one care in which the clinician "knows" the patient, one of the identifiers can be facial recognition. In the home, the correct address is also confirmed. The patient's confirmed address is an acceptable identifier when used in conjunction with another individual specific identifier.

EP 2 Label containers used for blood and other specimens in the presence of the patient

(This applies for those who may still be doing blood gas draws in the home, or sputum specimens)

PC.01.02.01 Assessment / Reassessment

The goal of assessment is to determine the care, treatment or services that will meet the patient's initial and continuing needs. Patient needs must be reassessed throughout the course of care, treatment or services.

Depth and frequency of *assessment* depends on a number of factors, including the patient's needs, program goals and the care, treatment or services provided.

EP1 The organization defines, *in writing*, the scope and content of screening, assessment and reassessment of information it collects. Patient information is collected according to these requirements.

EP2 The organization defines, *in writing*, criteria that identify when additional, specialized or more in-depth assessments are performed.

EP5 This EP applies to CRS but should be familiar to you, as it is also a requirement for DME.

PC.01.02.03 The organization assesses and reassesses the patient and his or her condition according to defined time frames.

This should not be a new standard to you, it also applies to DME. However, it is prudent to mention in this guide that if you or the physician have identified a frequency to perform a service or a patient assessment, the surveyor will be looking to see that the service or assessment was done when required.

EP 1 The organization defines in writing, the time frames within which it conducts the patient's initial assessment in accordance with law and regulation.

(This would apply in those states requiring an RT assessment be done within a specified time frame after set up.)

EP3 Each patient is reassessed as necessary based on his or her plan of care or changes in his or her condition.

PC.01.03.01 The organization plans the patients care (*Written* care plan)

Planning for care, treatment or services is individualized to meet the patient's unique needs. The first step in the process includes creating an initial plan for care, treatment or services that is appropriate for the patient's specific needs. To continue to meet the patient's specific needs the plan is maintained and revised based on the patient's response. The plan may be modified or terminated based on reassessment, the patients need for further care treatment or services, or the patient's achievement of the goals.

EP1 The organization plans the patient's care, treatment or services based on needs identified by the patient assessment.

EP5 The *written* plan of care is based on patient's goals and the time frames, settings, and services required to meet those goals.

EP22 Based on the goals established in the patient's plan of care, staff evaluated the patient's progress.

EP23 The organization revises plans and goals for care, treatment or services based on the patient's needs. The revised plan of care reflects current information from the patient's updated comprehensive assessment and the patient's progress toward goals and measurable outcomes.

*The care plan may be on a traditional plan of care form or may be incorporated into clinical respiratory care documents designed by the organization. However, those documents must clearly identify the problem, goal, action and outcome, i.e., the patient's achievement of the goal.

RC 02.01.01 The organization maintains complete and accurate patient records

*A medication list is required when performing CRS, even if only one time**.**

EP2 The patient record contains the following clinical information (other items in this EP list may be applicable to CRS. Cited here is the portion of the standard related to the medication list)

The patient record contains the following clinical information: a list of medications, including dose, strength, frequency, route, date and time of administration for prescription and non-prescription medications, herbal products and home remedies that relate to the patient's care, treatment or services.

The organization should identify what classifications of medications the clinician will collect (ex. The organization could include cardiac meds, diuretics, respiratory medications, pain medications, sleep aids etc. This decision is up to the organization.) **At a minimum**, the organization **must** include a list of ***Respiratory Medications***.

The clinician uses the list to determine if medications are being taken or not and relates to the physician if there are any discrepancies. The clinician can also report if he/she feels the medications or lack of use of the medications may be affecting the tests or procedures they are performing. A medication list is completed each time clinical respiratory services are provided.

RI.01.04.01 The organization respects the patient's right to receive information about the individual(s) providing his or her care, treatment or services.

EP2 The organization respects the patient with information about the identity and role of the staff member(s) who will provide care, treatment or services. Staff should identify themselves as a nurse, an RT etc. and should have corresponding identification. Entries into the patient record should be done with the staff member's signature and credential.

How Do I Develop a Plan of Care?

Example of a Traditional Care Plan

Problem/Need	Goal	Action/Intervention
The patient doesn't understand the reason for the machine and does not understand the physical repercussions of not using the therapy	The patient will be able to verbalize the reason for needing the machine and will acknowledge understanding about the effects of not using the therapy.	The clinician will educate the patient regarding the physiology of sleep apnea and will review the sleep study with the patient. The clinician will also explain the physical and mental effects of not using the therapy and why the patient should use the machine. Outcome: The goal has been met.

The idea of providing clinical respiratory services is that there is a **PROBLEM or a NEED** for the services. For example, the patient doesn't understand the reason for the CPAP machine and does not understand the repercussions of not using the therapy. This is the Problem / Need. (see above)

There should be an ACTION or Intervention that the clinician will do to correct this problem. For example, the clinician will educate the patient regarding the physiology of sleep apnea and will review the sleep study with the patient. The clinician will also explain the physical and mental effects of not getting enough rest and why the patient should use the machine. (See above)

The **GOAL** will be what you hope to achieve by your actions and interventions. A goal should be *measurable and achievable*. For example, the patient will be able to verbalize the reason for needing the machine and will acknowledge understanding about the effects of not using the therapy.

This is an example of **"one time CRS".** There is no ongoing goal. The problem was identified, action was taken and the goal was met.

In other instances, the patient might be a long term or **On-going** Clinical Respiratory Services patient.

For example, the organization may have a ventilator program that requires the patient to be followed up at certain time frames until the clinician is comfortable with the patient's settings and how the patient is responding to therapy. The doctor may order assessment (breath sounds, respiratory rate, pulse rate etc.) to be done at these intervals and may ask that the therapist also do oximetry to keep the patient's saturation at a certain level. A care plan for this scenario may look like this:

Example of a Traditional Care Plan

Problem/Need	Goal	Action/Intervention
1/1/19 Monitor patient per physician's orders to ensure patient is responding to therapy as expected.	Maintain patient's oxygen saturation levels at 90%	Per physician's orders: Perform a clinical assessment to include (should be identified on the Dr. order) Twice a week for two weeks. Report any abnormalities in assessment to physician to determine if parameters need to be adjusted. Titrate oxygen levels as needed to maintain 90%. Notify physician if need for oxygen is greater than 4lpm
1/5/19 patient oxygen saturation on the current setting was below 90%		Oxygen was increased from 1 lpm to 2lpm to achieve 90% saturation. GOAL was met. Physician notified. New prescription requested.

In this instance, the therapist will write progress notes at each visit and will evaluate the patient's progress toward goals. The care plan would be updated to identify any additional problems or changes to the plan of care. When the order is completed at two weeks, the clinician would document that patient has met the goals or, if the goal could not be met, what action was decided upon by the clinician and the physician.

How do I write a Clinical Respiratory Plan?

Start by identifying what service you are providing.

Identify who will be providing the services.

Define what the clinician will be doing.

Identify what assessments will be done and if applicable, how often they will be done.

Create a care plan – Care plans can take many forms. You may already have a care plan you use, you may research care plans online or you can use the traditional care plan in this document.

Identify when and how often the care plan should be updated.

Identify goals for your program and ensure they are measurable and achievable.

Determine how the clinician will document progress towards the goal. (This may be a form that the clinician fills out, or it could be progress notes, or a combination of the two).

Look at your state law and determine if you need an order for the services you are providing or plan to provide.

Ensure you have all the standards covered:

- Is the clinician using identifiers and what are the identifiers?
- Is the clinician wearing a badge that identifies their credential?
- Is the clinician identifying themselves to the patient?
- Have you created a Written Care Plan?
- Are there established goals?
- Have you identified when the care plan will be updated?
- Have you identified how the clinician will document progress to goals?
- Have you identified how you will record the patient's current medications and what medications that will include? (Respiratory Therapy drugs at a minimum)

Example of a Clinical Respiratory Care Plan

XYZ company will provide clinical respiratory services to patients requiring a conserving device as part of their portable system. (Identifies what the service will be).

Upon order by a physician, the clinician (identify if RT, RN, etc.) will perform a series of oximetry readings to determine if the patient can safely use a conserving device. (Identifies what allows the clinician to perform the service and what service they will be providing)

Upon arrival at the patient's or upon the patient's arrival at the organization, the clinician will identify themselves and will ask the patient for the two identifiers (describe here) to ensure the correct patient is being treated. (Identifies what should happen upon arrival at the home or the patient's arrival at the organization).

As described by the physician's order, the assessment may occur: (Describes the process that will occur) Ex: The clinician will follow the doctors order and test the patient:

- On the setting ordered by the physician at rest
- On the setting ordered by the physician during exercise without the conserving device
- On the setting ordered by the physician during exercise with the conserving device
- Will perform a 6 minute walking test* (defines how long the patient will be exercised)
- Will assess if the patient maintains the saturation the physician or clinical protocols require.

Additional assessment may occur if the physician allows or requests the clinician to "titrate" or adjust the setting on the conserving device to maintain a certain oxygen saturation.

- The clinician will adjust the settings on the conserving device to obtain the oxygen saturation requested by the physician or approved protocols.

The test will be recorded on the Clinical Respiratory Oximetry reporting form and will be sent to the physician within 24 hours. A plan of care will be completed.

If the patient maintains the oxygen levels set by the physician or dictated by the organization's clinical protocols, the conserving device will be left with the patient. If the patient fails the clinical trial and does not maintain the oxygen levels set by the physician, the device will not be left with the conserving device and the physician will be notified.

Example of reporting form: This is a sample only and should not be placed in use.

Clinical Respiratory Oximetry Form

Patient Name: Account number:

Date: Physician:

Care Plan		
Problem	Goal	Action
Determine if patient can safely use conserving device	Maintain saturation of 90% with exercise	Physician ordered a 6-minute walk test. Patient to maintain 90% at a setting of 2. Physician did not write an order for titration.

Oxygen at 2 liters per minute, at rest saturation 95%

Oxygen at 2 liters per minutes with exercise saturation 94%

Conserving device setting at 2 with exercise saturation 92%

Comments: Patient exercised at a setting of 2 for 6 minutes. Lowest saturation 92%. Patient met goal and maintained a saturation above 90%, conserving device was left with the patient.

Respiratory Medications:

- NA no respiratory medications
- Yes, patient takes Respiratory Medications:

Medication Name	Dose	Frequency	Route

Signature of Clinician, with credentials Date of Test

For questions or additional clarification, please contact the Joint Commission,

Standards Interpretation Group, DME Representative

1-800-965-5900

A list of Respiratory State Licensure Contacts are available on the AARC (American Association of Respiratory Care) web site.

https://www.aarc.org/advocacy/state-society-resources/state-licensure-contacts/