



NORTH CAROLINA RESPIRATORY CARE BOARD
125 Edinburgh South Drive, Suite 100
Cary, NC 27511

October 8, 2015

Chad A. Harvey BSRT, RRT, RCP
Director of Respiratory Care, Respiratory Care-NorthEast
Carolinas HealthCare System
920 Church St. N
Concord, NC 28025

Dear Mr. Harvey,

This letter is sent on behalf of the North Carolina Respiratory Care Board in response to your initial phone call and email of August 21, 2015 requesting the Board's interpretation of state statutes and rules that relate to the performance of screening pulmonary function tests by Medical Assistants. The Board has discussed similar requests in the past. On October 14, 2010, the Board met and approved the following interpretation of state statutes and Board rules:

Based on the information provided to the Board on October 14, 2010, the Board understood that screening pulmonary function tests would be performed in a medical practice or other health care facility, and under the direct supervision of a licensed physician. These tests would be performed solely to make an initial, screening determination about whether further follow-up diagnosis is needed. For this reason, the Board determined the provision of **screening** pulmonary function tests which are performed under the direct supervision of a licensed physician are exempted from licensure under the Respiratory Care Practice Act:

§ 90-664. Persons and practices not affected.

The requirements of this Article shall not apply to:

(1) Any person registered, certified, credentialed, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, credentialed, or licensed to engage in another profession or occupation in this State who is performing work incidental to or within the practice of that profession or occupation and does not represent himself or herself as a respiratory care practitioner.

To ensure that these screening pulmonary function tests fit within this exemption in the Act, and to assure the quality and efficacy of the testing, the practice or facility where these tests are performed must:

- 1) maintain written policies and guidelines that define the persons who may perform this procedure;
- 2) establish clear guidelines for the interpretation and use of the data collected; and



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- 3) require each Medical Assistant to have documented training and annual competency reviews in the procedure that are conducted by a Respiratory Care Practitioner, a credentialed Pulmonary Function Technologist, or by another appropriate medical professional.

Finally, of course, the practice or facility should refer the patient for a complete pulmonary function study if the screening pulmonary function test results are abnormal.

Based on the information which you provided to the Board prior to its October 8, 2015 meeting, the Board understands that the screening pulmonary function tests in facilities owned by Carolinas HealthCare System may extend beyond the traditional parameters recognized by the American Thoracic Society (ATS). This letter serves to provide further clarification and guidance insofar as your facility policies and procedures for pulmonary function testing are affected by the Respiratory Care Practice Act, including the above-quoted exemption provision.

The Pulmonary function test concept (PFT) is a generic term used to indicate a battery of studies or maneuvers that may be performed using standardized equipment to measure lung function. A PFT can include simple screening spirometry, formal lung volume measurement, diffusing capacity for carbon monoxide, and arterial blood gases. These studies may collectively be referred to as a complete pulmonary function. These interchangeable names often lead to a misunderstanding about the personnel who may perform these studies.

According to the ATS, spirometry (aka. screening spirometry or basic spirometry) is defined as a physiological test that measures how an individual inhales or exhales volumes of air as a function of time. The primary signal measured in spirometry may be volume or flow. The Board recognizes spirometry as an invaluable screening test of general respiratory health in the same way that blood pressure provides important information about general cardiovascular health. However, on its own, spirometry does not lead clinicians directly to an etiological diagnosis. Based on the definition provided by ATS, the most important aspects of spirometry are the forced vital capacity (FVC). Other spirometry variables derived from the FVC maneuver include the force expiratory flow in one second (FEV1), FEV1/FVC ratio or percent, peak expiratory flow (PEF), spirogram, and the flow-volume loops. Thus, the spirometry is generally regarded as a screening tool used to collect basic lung function data regarding airflows and volumes, and to determine if more extensive testing is needed.

Based on the National Board for Respiratory Care (NBRC) testing matrix and the ATS, advanced pulmonary function testing may include: 1) a 6 minute walk test; 2) exhaled nitric oxide test; 3) lung diffusion capacity; 4) methacholine inhalation challenge; 5) cold air and mannitol challenge tests; 5) oximetry with ambulation; 6) arterial blood gas; 7) respiratory muscle strength test; 8) altitude simulation tests; 9) diffusion capacity; 10) bronchoprovocation; 11) body plethysmography; 12) He dilution; 13) Nitrogen washout; and 14) progressive exercise testing.

These more advanced procedures require some level of training in pulmonary function such as a person with an active license as a CRT or RRT. However, persons who are not licensed by



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this Board, but hold the CPFT or RPFT credential do meet the criteria under § 90-664 to be exempt from licensure under the Respiratory Care Practice Act, and may perform these advanced procedures without holding a license from this Board.

While it is desirable for a licensed RCP to have either the CPFT or RPFT certification offered by the National Board for Respiratory Care as well, it is not required for actively licensed RCPs because the initial training for the CRT and RRT meet the ATS education and training recommendations.

Please advise if you have any other questions about this issue.

Regards,

A handwritten signature in black ink, which appears to read "William Croft", followed by the text "Ph.D., RRT, RCP" in a smaller, less distinct script.

William Croft, Ph.D., RRT, RCP
Executive Director