



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

April 29, 2016

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 is a revised letter originally sent October 8, 2015 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. As stated in the previous letter, the Board 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
- 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.



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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.

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.

Delegating the above mentioned advanced procedures to unlicensed individuals does not fall within the exemption unless they have the appropriate credentials even when supervised by another licensed individual. In consultation with the NC Medical Board Attorney, their guidelines state:



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The following principles should be taken into account when determining whether delegation of a particular task is "established by custom."

- 1. What do other physicians within the specialty do?*
- 2. Is it generally considered acceptable to other physicians within that specialty to delegate the task?*
- 3. Is the task invasive or does it involve a level of risk to the patient?*
- 4. Does the task require licensure if done by someone not working under a physician's supervision?*
- 5. Is the activity in question regulated by another Board or agency?*

If the answer to Questions 1 or 2 is "no," meaning that physicians within the specialty do not typically delegate such tasks to others or believe it is unacceptable to do so, then the Board would likely determine that delegation is not "established by custom." In addition, the more invasive a procedure is (Question 3), the more unlikely it is to be customarily delegated to an unlicensed healthcare worker to perform".

While the NCRCB is not interpreting the NCMB statute, based on their guidance, pulmonary function studies fall within the scope of practice regulated by the NCRCB and meets threshold for number five as these advanced procedure do require licensing or credentialing to perform those procedures. For this reason, the Board wanted to reinforce the requirement that the more advanced procedures as previously discussed require some level of training in pulmonary function studies such as a person with an active license as a CRT or RRT since there is risk associated with those procedures. However, persons, who are not licensed by this Board, must hold the CPFT or RPFT credential to meet the criteria under § 90-664 for the licensure exemption under the Respiratory Care Practice Act, in order to perform these advanced procedures without holding a license from this Board.

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

Regards,

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