Government of the District of Columbia
Department of Health
Board of Respiratory Care

899 NORTH CAPITOL ST. NE – 2ND FLR.
WASHINGTON, DC 20002

March 9, 2015

9:00 am - 12:00 pm

MEETING AGENDA

OPEN SESSION: Call to Order

OS-0309-01	**SENIOR DEPUTY DIRECTOR'S REPORT**	
OS-0309-02	**EXECUTIVE DIRECTOR'S REPORT**	
OS-0309-03	**BOARD ATTORNEY'S REPORT**	
OS-0309-04	**CHAIRPERSON'S REPORT**	
OS-0309-05	**OPEN SESSION MINUTES** **Board Action: To consider the Open Session Minutes of the February 9, 2015 meeting.**	
OS-0309-06	**THERAPIST DRIVEN PROTOCOLS** **Board Action: To continue the discussion of therapist driven protocols.**	
OS-0309-07	**AUDIT** **Board Action: To discuss the upcoming audit.**	

TO BE READ BY THE CHAIRPERSON PRIOR TO THE END OF THE PUBLIC SESSION

This concludes the public open session meeting and pursuant to the DC Official Code 2-575B and for the purposes set forth therein, the Board will now move into the closed executive session portion of the meeting.

Government of the District of Columbia
Department of Health
Board of Respiratory Care

899 NORTH CAPITOL ST. NE – 2ND FLR.
WASHINGTON, DC 20002

February 9, 2015

9:00 am - 12:00 pm

OPEN SESSION
MEETING MINUTES

ATTENDANCE:

BOARD MEMBERS:		
	CAROLYN WILLIAMS, CHAIRPERSON	Present
	JEAN WILLIAMS, BOARD MEMBER	Present
	TIMOTHY MAHONEY, BOARD MEMBER	Present
		Absent
STAFF:	ROBIN Y. JENKINS, EXECUTIVE DIRECTOR	Absent
	ERIC YEAGER, HEALTH LICENSING SPECIALIST	Present
	REBECCA ODRICK, INVESTIGATOR	Present
LEGAL STAFF:	PANRAVEE VONGJAROENRAT, ASSISTANT ATTORNEY GENERAL	Present
GUESTS:	Edward Palmer, Maryland D.C. Society for Respiratory Care	Present

OPEN SESSION: Call to Order

OS-0209-01	**SENIOR DEPUTY DIRECTOR'S REPORT** **Board Action: There was no report.**	
OS-0209-02	**EXECUTIVE DIRECTOR'S REPORT** **Board Action: There was no report.**	
OS-0209-03	**BOARD ATTORNEY'S REPORT** **Board Action: There was no report.**	
OS-0209-04	**CHAIRPERSON'S REPORT** **Board Action: The Board Chair took a moment to wish everyone a Happy Valentine's Day and welcomed visitor Edward Palmer of the Maryland/DC Society for Respiratory Care.** **The Board Chair then announced that Hill Day will be held on March 18, 2015, and that the briefing will be held on March 17th. To date, she said, the Maryland/DC Society for Respiratory Care has registered 9 respiratory care practitioners, 3 patient advocates and 4 students for Hill Day, and that the group has confirmed appointments with 7 of the 11 Congressional Members for Maryland and D.C.** **The Board Chair then handed out a draft of the Medical Telehealth bill, which is currently being developed and does not yet have a legislative number.**	
OS-0209-05	**OPEN SESSION MINUTES** **Board Action: The Open Session Minutes of the January 12, 2015 meeting were approved with the clarification that the Maryland/DC Society for Respiratory Care held the Annual Installation of Officers and Awards Banquet on January 9, 2015.**	
OS-0209-06	**MINIMUM LICENSING CRITERIA (VISIT BY EDWARD PALMER)** **Board Action: Edward Palmer began by thanking the DOH team for the hard work and success with the licensing renewal. He said that every member of his team who filed an application was renewed successfully.** **Mr. Palmer then explained that the Maryland/DC Society for Respiratory Care has a proposal in the State of Maryland that would create a single credentialing requirement that is more**	

	stringent than the dual system which currently gives one the option of practicing after obtaining either the entry level CRT credential or the advanced level RRT credential. Under this proposal, all newly licensed practitioners in Maryland would be required to obtain the advanced level RRT credential. **Mr. Palmer then clarified that this proposal has a grandfathering element and would not apply to any therapists currently licensed or currently in school. Further, he stressed that the rationale behind this proposal is not to force people out of jobs, but instead to increase the proficiency of practitioners and to render a higher level of patient care. However, he recognized that this proposal has created some controversy and has some detractors.** **The Board Members asked Palmer about some concerns raised by the National Board for Respiratory Care (NBRC) in a letter dated November 12, 2014, which was distributed to all present at the meeting. On the NBRC's point that this proposal would have "unintended consequences" such as a possible 38 percent reduction of the number of therapists in the D.C./Maryland area, Palmer noted that D.C. has the highest per capita number of respiratory therapists and that Maryland follows closely behind. Further, he noted that this proposal does not have to be adopted by hospitals, which may or may not choose to make their hiring requirements more stringent.** **Palmer said that the Maryland/District of Columbia Society for Respiratory Care would like this change to occur in Maryland in 2016, but that the Maryland Board of Physicians prefers to wait until 2017. Palmer added that his group plans to send a letter to the Maryland Board of Physicians in the near future, and that he will send a copy of that letter to the D.C. Board. The Board Members said that they looked forward to seeing that letter and closed the Open Session.**	

	OPEN SESSION CLOSED AT 10:20 a.m.	

To: The District of Columbia Board of Respiratory Care
From: Chris Boone, Law Clerk
Date: January 2014

MEMO: Best Practices for Patient-Driven Protocols for Respiratory Care Therapy, and the Analysis of the District of Columbia Board of Respiratory Care's Draft on the Proposed Respiratory Care Regulations for use of 'Protocol' Ordering of Treatment.

Background

Board Member Tim Mahoney submitted a draft on the Proposed Respiratory Care Regulations for use of 'Protocol' Ordering of treatment (the "Draft"). The Draft consisted of the following paragraph and three provisions:

"Respiratory Therapists may provide therapy to patients using a protocol driven order regime under these conditions:

1. The respiratory therapy needs to be ordered by physician or other approved healthcare professionals (eg: Nurse Practitioner)
2. The therapist will administer therapy to a patient using approved parameters for treatment. These parameters will allow the therapists to make on-going adjustments to a patient's therapy based upon the patient's evaluated parameters of health.
3. Should there develop a disagreement between the therapy regiment in place under the protocol ordering and the ordering physician's judgment, the physician may suspend the protocol order and instead institute a new therapy regimen for the patient in question."

Analysis

I. Best Practices

I sampled the respiratory care statutes and regulations of eight states: Maryland, Virginia, Pennsylvania, Texas, West Virginia, California, Nevada, and Washington. The results are as follows:

- Pennsylvania and California respiratory care statutes explicitly permit the practice of respiratory care therapy under patient-driven protocols ("PDP's").

- Virginia and West Virginia statutes permit respiratory care therapists to implement respiratory care protocols via virtually the same language present in California's statute, but do not address PDP's explicitly, as California does.
- Maryland respiratory care therapy statutes indicate that respiratory care may be practiced "under the supervision of and in collaboration with a physician." The Maryland Board referred interpretation of their statutes to a representative for the Maryland DC Society for Respiratory Care, who concluded that Respiratory Care Therapists can apply protocols, so long as they do so under the direction of a supervising physician.
- Representatives for the boards in Washington, Texas, and Nevada informed me that PDP's are permitted in their respective states. Neither the statutes nor the regulations of these states pertained to the permissibility or prohibition of protocols.

Notably, I did not come across Board-related statutes or regulations governing how PDP's must be developed, nor any which established any requirements that PDP's must maintain in any of the states I sampled. The representatives from the various state Boards generally advised that PDP's simply must fall within the recognized standards of care. The District of Columbia Board of Respiratory Care may be a trailblazer, should it choose to explicitly identify the parameters within which PDP's must operate.

In speaking with representatives of the various state respiratory boards and advisory boards, it came to my attention that health care facilities already create and implement their own PDP's in the absence of specific regulations from regulatory boards to govern the creation of those protocols. In fact, most states do not mention PDP's in their respiratory care statutes, at all. Instead, in most jurisdictions, statutes authorizing the practice of respiratory care provide that respiratory care may be performed pursuant to the orders of a physician or other authorized health care professional, or under qualified medical direction. The construction of the language of most of the respiratory care statutes sampled, including those of the District of Columbia[1] permits health care facilities to create and implement PDP's, which the attending physician will sign off on or modify before the respiratory care therapist begins carrying out the protocol.

Most jurisdictions' respiratory care statutes do not indicate any restriction against the creation or implementation of PDP's by health care facilities. Out of the eight jurisdictions sampled, only Nevada's respiratory care statutes indicated that a respiratory care therapist's practice may be restricted to carrying out the written orders of a physician, physician assistant, certified registered nurse anesthetist or an advanced practice registered nurse, *only*.[2] However, the counsel to the Nevada Board of Physicians (which oversees the Advisory Board for Respiratory Care) ultimately disagreed. The attorney looked to Nevada respiratory care statutes and

[1] D.C. Official Code § 3-1201.02(17A) "Practice of Respiratory Care" means the performance in collaboration with a licensed physician[...]."

[2] Under Nevada statute, Practice of Respiratory Care is defined as "Carrying out the written orders of a physician, physician assistant, certified registered nurse anesthetist or an advanced practice registered nurse relating to respiratory care." NRS 630.021 .6

concluded that respiratory care therapists can operate on a patient-driven protocol, citing the statute at NRS 630.021.6 as the rationale for his decision. Even the construction of the Nevada statute's relatively limiting language does not explicitly prohibit a health care facility from creating a PDP, which the attending physician will sign off on or modify before forwarding the protocol instructions to the respiratory care therapist to carry out.

The staff members authorized to order the initiation of a PDP varies greatly, depending on jurisdiction. Some jurisdictions permit orders from a physician, only, whereas others permit orders from registered nurse practitioners and physician assistants, as well. The jurisdictions' requirements are as follows:

- Maryland, Virginia, and Texas statutes authorize PDP's to be ordered only under the prescription of a physician. The District of Columbia's statutes similarly limit the practice of respiratory care to being in collaboration with a physician, only.
- Pennsylvania statutes authorize PDP's to be ordered by a physician or while under medical direction consistent with standing orders or protocols.
- California statutes authorize PDP's to be ordered under the prescription of a physician or surgeon, under the supervision of a medical director, or under emergency.
- West Virginia statutes authorize PDP's to be ordered by physician or, when under the direction of a qualified medical director, a nurse practitioner or a physician assistant.
- Nevada statutes authorize PDP's to be ordered by a physician, physician assistant, certified registered nurse anesthetist, or an advanced practice registered nurse.
- Washington statutes authorize PDPS's to be ordered by "a health care practitioner," which may be a physician, osteopathic physician, or a surgeon, or, acting within the scope of their license 1) a podiatric physician and surgeon, 2) an advanced registered nurse practitioner, 3) a physician assistant, or 4) an osteopathic physician assistant.

(See Appendix)

II. Compatibility of Protocol with current District of Columbia Law

District of Columbia law does not prohibit the initiation of PDP's, so long as those protocols are initiated in collaboration with a physician.

As stated in the D.C. Official Code, the practice of respiratory care means the performance *in collaboration with a licensed physician*, of actions responsible for the treatment, management, diagnostic testing, control, and care of patients with deficiencies and abnormalities associated with the cardiopulmonary system.[3] Further, the District of Columbia Municipal Regulations require that a licensed respiratory care therapist practice only within the scope of his or her

[3] D.C. Official Code §3-1201.02 (17A) (emphasis added).

competence, qualifications, and any authority vested in the licensed respiratory care practitioner by a physician.[4]

The District of Columbia's requirement that respiratory care be practiced in collaboration with a physician does not statutorily preclude the use of PDP. Instead, current D.C. law simply requires that a physician be in collaborative effort with a respiratory care therapist in the treatment of a patient. PDP's, generally, are created in collaboration with physicians and can be ordered by a physician, only, in Maryland, Virginia, and Texas. Under current District of Columbia law, PDP's would be permitted to be initiated upon the prescription of a physician, only, as it is done in Maryland, Virginia, and Texas.

III. Analysis of the D.C. Board's proposed draft on Respiratory Care Regulations for use of 'Protocol' Ordering of treatment

In its publication, "Guidelines for Respiratory Care Department Protocol Program Structure," (the "Guidelines") the American Association for Respiratory Care ("AARC")[5] published recommendations for each respiratory care board to consider when establishing PDP's across the nation. The Guidelines proffer that the AARC recognizes and supports the use of PDP's [6] defined as: Initiation or modification of a patient care plan following a predetermined structured set of physician orders, instructions, or interventions in which the therapist is allowed to initiate, discontinue, refine, transition, or restart therapy as the patient's medical condition dictates.

According to the Guidelines, those responsible for drafting protocols and related policy should incorporate the following recommendations:

1. Department policy must specify which respiratory therapists can deliver care outlined in the protocol, inclusive of the competencies required of individuals and demonstration of skills and knowledge.

2. Medical Director oversight and accountability for services provided using protocols must also be specified in department policy.

3. The protocols should be written to reflect the indications, precautions, and therapy specifics as outlined in the AARC Clinical Practice Guidelines, or other evidence based references.

---

[4] 17 DCMR 7609.1(c).

[5] AARC is the leading national and international professional association for respiratory care, according to their publication, "Guidelines for Respiratory Care Department Protocol Program Structure," and is the association that creates the guidelines by which the District of Columbia Board of Respiratory Care requires its licensees to abide.

[6] The Guidelines uses the term "therapist implemented protocols" instead of "patient-driven protocols." An article by James K. Stoller, MD, entitled "Respiratory Therapist-Driven Protocols" clears up this confusion, indicating that "therapist-driven protocols" are also known as respiratory care- or patient-driven protocols.

4. All policies related to protocols, as well as the protocols themselves, must be approved by the appropriate institutional governing bodies.

5. Policies for protocols must be compliant with other institutional policies related to the provision of care, with specific attention to pharmacy and nursing services. Because many therapist implemented protocols involve the administration of medication, there must be a single standard throughout the facility regarding the procurement, control and administration of medications.

6. A physician order is required to implement respiratory therapy managed by protocols. The order may include a request for "Respiratory Protocol", a specific request such as "MDI Protocol" or other order details as specified and approved by the Medical Staff.

7. Protocols must include criteria, thresholds, and decision points that require the physician be notified for continuation of the protocol, options to consider including exemption from protocol with requirements for new non-protocol orders.

8. Policy should also define emergent situations in which respiratory therapists can immediately initiate protocols without a physician order. Protocols initiated in this manner shall be reviewed and authorized by physician signature within 24 hours.

9. A quality assurance mechanism should be in place to assess if the respiratory therapist is providing care in compliance with protocol as well as capturing adverse responses.

The proposed Draft currently contains three provisions. Provision 1 states, "The respiratory therapy needs to be ordered by physician or other approved healthcare professionals (eg: Nurse Practitioner)." Similarly, the Guidelines' Recommendation 6 states, "A physician order is required to implement respiratory therapy managed by protocols. The order may include a request for "Respiratory Protocol", a specific request such as "MDI Protocol" or other order details as specified and approved by the Medical Staff." Provision 1 is commensurate with the Guidelines' Recommendation 6, and does not conflict with any Recommendation.

Provision 2 states, "The therapist will administer therapy to a patient using approved parameters for treatment. These parameters will allow the therapists to make on-going adjustments to a patient's therapy based upon the patient's evaluated parameters of health." Similarly, the Guidelines' Recommendation 4 states, "All policies related to protocols, as well as the protocols themselves, must be approved by the appropriate institutional governing bodies." Provision 2 is commensurate with the Guidelines' Recommendation 4, and does not conflict with any Recommendation. The Board may want to consider specifying which body(ies) of authority shall be responsible for approving the parameters for treatment in Provision 2.

Additionally, Recommendations 3 suggest that the protocols should be written to reflect pertinent portions of the AARC Clinical Practice Guidelines or other evidence-based reference,

and Recommendation 5 advises that policies for protocols must be compliant with other institutional policies related to the provision of care, with specific attention to pharmacy and nursing services. As part of the Draft's Provision 2, the Board may want to require the body(ies) of authority that will approve protocols and parameters to consider the advice of Recommendations 3 & 5 before finalizing its approval.

Provision 3 states, "Should there develop a disagreement between the therapy regiment in place under the protocol ordering and the ordering physician's judgment, the physician may suspend the protocol order and instead institute a new therapy regimen for the patient in question." There is no Guideline Recommendation patently equivalent with Provision 3; however, Provision 3 is still in the same spirit as the Guidelines' Recommendation 2, which requires that the policy establishing the PDP's must specify that the Medical Director has oversight and accountability for services provided using protocols. The spirit of Provision 3 and Recommendation 2 are the same in that both require that a chain of command be established in order to maintain oversight and control of the respiratory therapists' services who are practicing under the protocols. Provision 3 does not conflict with any Recommendation.

The AARC Recommendations contain several provisions which are not specifically addressed in the Board's proposed draft. The Board may wish to consider including these provisions. They are as follows:

The AARC has written in Recommendation 1 that department policy must specify which respiratory therapists can deliver care outlined in the protocol, inclusive of the competencies required of individuals and demonstration of skills and knowledge.

The AARC has written in Recommendation 2 that the Medical Director oversight and accountability for services provided using protocols must also be specified in department policy. The Draft does not currently contain a provision placing ultimate oversight and accountability upon the Medical Director of the facility issuing the PDP.

The AARC has written in Recommendation 4 that all policies related to protocols, as well as the protocols themselves, must be approved by the appropriate institutional governing bodies. The Draft currently requires that the respiratory care therapist administering therapy must use approved parameters for treatment. The Draft does not, however, state that every policy related to the PDP, including the PDP, itself, must be approved by the Board.

The AARC has written in Recommendation 5 that policies for protocols must be compliant with other institutional policies related to the provision of care, with specific attention to pharmacy and nursing services. Because many therapist implemented protocols involve the administration of medication, there must be a single standard throughout the facility regarding the procurement, control and administration of medications. The Draft does not currently contain a similar provision.

The AARC has written in Recommendation 6 that a physician order is required to implement respiratory therapy managed by protocols. The order may include a request for "Respiratory Protocol", a specific request such as "MDI Protocol" or other order details as specified and approved by the Medical Staff. The Draft currently requires that the respiratory therapy needs to be ordered by a physician or other approved healthcare professional (eg. Nurse Practitioner). However, the Draft does not include a provision that a physician may order specific protocols.

The AARC has written in Recommendation 7 that protocols must include criteria, thresholds, and decision points that require the physician be notified for continuation of the protocol, options to consider including exemption from protocol with requirements for new non-protocol orders. The Draft does not currently contain a similar provision.

Conclusion

Many states permitting the use of PDP's in the practice of respiratory care have not codified statutes or regulations governing the establishment of those PDP's, nor have they explicitly identified the requirements that those PDP's must satisfy in order to be compliant with the law, beyond maintaining compliance with that jurisdiction's standards of care. In explicitly identifying PDP parameters, the District of Columbia Board of Respiratory Care may be the first. The proposed Draft by the Board contains three provisions that are compliant with the recommendations made by the AARC. However, there are many more recommendations that the AARC strongly suggests be included when establishing regulations that govern PDPs. The Board may wish to consider including those recommendations.

APPENDIX

Do other states allow RC's to provide therapy services under patient-driven protocols ("PDP's")?

State	Allow for PDP's?	Citation to state law or reg?	Notes
MD	YES	MD Code 10.32.11.02(B); § 14-5A-01	Practice of Respiratory Care can be under the supervision of and in collaboration with a physician. RC therapists must have access to physicians when providing care according to the protocol.
VA	YES	VA § 54.1-2900	Definition of Practice of Respiratory Care includes that "RC may be performed … under qualified medical direction" & "implementation of …respiratory care protocols" (same as Cali)
PA	YES	Title 49 PA Code §18.305 – Functions of RC Practitioners	"a respiratory care practitioner may perform the activities listed in subsection (a) only upon physician prescription or referral or while under medical direction consistent with standing orders or protocols in an institution or health care facility"
TX	YES	Title 25 TX Admin Code 140.202(23)(I) "RCT Procedures"	Per Ann Hammer – Program Director for Licensing: PDP's are normal in hospitals, just not regulated by the TX Board.
CA	YES	Yes – (RC Practice Act) Cali Business & Professions Code, Division 2, Chapter 8.3, Section 3702 "Practice of Respiratory Care"	Definition for Practice of Respiratory Care includes "implementation of …respiratory care protocols" & "Respiratory care protocols means policies and protocols developed by a licensed health facility through collaboration with admins, physicians, and surgeons."
WA	YES		Per, Sue Gragg, Program Manager – RC Practitioner Program
NV	YES	NRS 630.021 .6	"Practice of RC" defined as Carrying out the written orders of a physician, physician assistant, certified registered nurse anesthetist or an advanced practice registered nurse relating to respiratory care
WV	YES	WV §30-34-2 (d), (d)(4)	Definition of Practice of Respiratory Care includes that "RC may be performed … under the direction of a qualified medical director" & "implementation of …respiratory care protocols" (Same as Cali)