The Coalition Chronicle

Coalition for Baccalaureate and Graduate Respiratory Therapy Education

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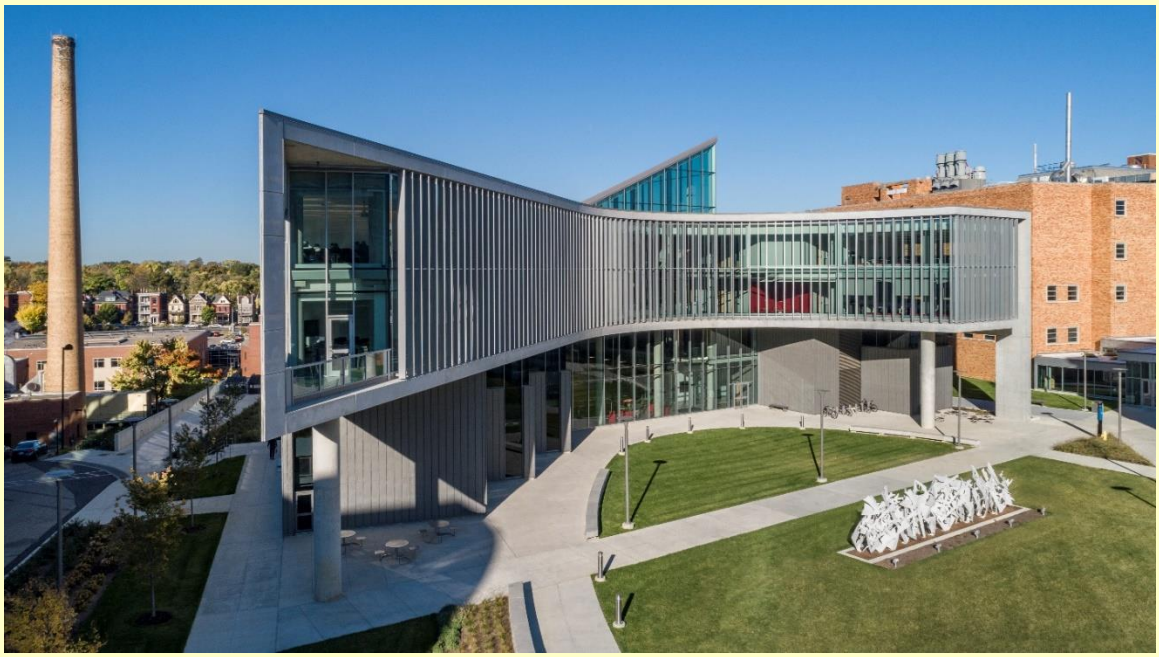
Spotlight Article

University of Cincinnati, College of Allied Health Sciences



Respiratory Therapy Degree Advancement Programs
Bachelor of Science
Master of Science

By Nancy E. Colletti, PhD, RRT, CPFT, FNAP
Professor, MSRT Program Director

The University of Cincinnati (UC), founded in 1819 is a global founder of cooperative education providing students with a balance of educational excellence and authentic real-world experience. UC is a public research university with an enrollment of nearly 48,000 students and is listed in the Top Tier of American's Best Colleges by the U.S. News & World Report in the latest 2023 rankings. More than a quarter-million living alumni count themselves as Bearcats

— united not just by their loyalty to our nationally known sports teams, but by their common love of the place, the people and the ideas that make up the UC.

The College of Allied Health Sciences (CAHS) began in 1995 and was granted college status in March 1998. The CAHS is part of UC's academic health center joining the College of Medicine, James L. Winkle College of Pharmacy, and College of Nursing. The four colleges work together to promote interprofessional education and collaborative practice, which is crucial to providing safe, efficient, and effective health care with superior patient outcomes. The CAHS is involved in enhancing and improving the quality of life for people everywhere by discovering, teaching, and applying knowledge related to health sciences. The undergraduate and graduate online respiratory therapy degree advancement programs are an integral part of CAHS, promoting the lifelong dedication to continuing education as a key element in maintaining professional competence.

The CAHS proudly opened their new $61 million-dollar Health Sciences Building in 2019 on the east campus, also known as the medical campus. While most of our respiratory therapy students do not visit campus until graduation our new building has allowed our program to grow and develop opportunities for interprofessional education and collaborative research.

The Bachelor of Science (BS) in Respiratory Therapy degree advancement program, started in 2013 with our first cohort of students graduating in 2015. The BSRT program is designed to challenge and engage active respiratory therapists to improve real-world clinical competence. The goal is to prepare them for a lasting future in the healthcare industry. The curriculum enhances their ability to perform critical thinking in a variety of clinical settings and facilitates their ability to conduct creative writing and pilot research.

The Master of Science (MS) degree in Respiratory Therapy program enrolled its first cohort in fall 2019, graduating the first class in spring 2021. The MSRT program is designed to educate respiratory therapists with a bachelor's degree with the knowledge and skills to prepare them for leadership roles as educators, managers, and/or researchers. Graduate prepared respiratory care professionals are essential to meet the multifactorial demands of our evolving and challenging healthcare environment.

Both the BSRT and MSRT Programs are designed for working respiratory therapists. Professors teaching in our program take special care to build in some flexibility for these working professionals. Surveyed students and graduates of both the BSRT and MSRT programs find the program challenging, relevant, and career building.

Many graduates following graduation have reported a promotion with a pay raise for changes in role and responsibility.

BSRT Program

The first year BSRT program focuses on an integrated core of courses designed to enhance skills in critical thinking, reflective writing, problem solving, research methods and team building. In the second year, students take advanced courses in designated fields and specialty areas in respiratory care. Students will complete the program with a capstone course and clinical observation experience at a healthcare setting close to home, and in many cases, with their current employer giving them experiences. The program is completely online and can be completed in as little as 20 months with only part-time enrollment.

BSRT Student Qualifications

We are actively seeking students with the following minimum qualifications. (Students seeking admission must also meet University of Cincinnati requirements).

☐ Hold an associate degree from a CoARC-accredited respiratory care/respiratory therapy program at a regionally accredited institution.

☐ Be credentialed by the National Board for Respiratory Care (NBRC) as a registered respiratory therapist (RRT) or a certified respiratory therapist (CRT) who is eligible for the clinical simulation examination by earning the high cut score on the therapist multiple choice (TMC) exam. "CRT's must be credentialed as a registered respiratory therapist (RRT) before matriculating into the capstone course

☐ Have earned a minimum GPA of 2.5.

*Our program includes the Kettering RRT Home Study for CRTs. No additional cost is incurred by the student.

Sample or Possible BSRT Curriculum Map

Semester	Term	Core Courses	Credits
Spring	Full Semester	RSTH 3002: Health Care Documentation & Communication	3
	1st Half Semester	RSTH 3001: Ethics in Respiratory Therapy	3
	2nd Half Semester	RSTH 3004: Community Health Problems & Practices	3
Summer	1st Half Semester	RSTH 3010: Integration of Delivery of Respiratory Therapy	3
	2nd Half Semester	RSTH 3040: Management in Respiratory Therapy	3
	1st Half Semester	RSTH 3065: Caregiving in the Respiratory Therapy Professions	3
Fall	1st Half Semester	RSTH 3050: Aging and Respiratory Therapy	3
	1st Half Semester	RSTH 3080: Disease Management/Patient Education	3
	2nd Half Semester	RSTH 4060: Introduction to Respiratory Therapy Research	4
	Flex	HLTH 3100: Mid-Collegiate Interprofessional Touch Point Conference	0
Advanced Courses 1st Semester			
Offered Each Semester	1st Half Semester	RSTH 4070: Advanced Respiratory Therapy/Specialty Observation	3
	Full Semester	RSTH 4001: Research Methods and Analysis	5
	2nd Half Semester	RSTH 4030: Alternative Practices and Current Trends in Respiratory Care	4
Advanced Courses 2nd Semester			
Offered Each Semester	1st Half Semester	RSTH 4075: RT Specialty II	3
	1st Half Semester	RSTH 4050: Adv Respiratory Therapy/Leadership & Project Mgmt	4
	2nd Half Semester	RSTH 5001: Capstone	6
		Total	50

MSRT Program

The MSRT curriculum is designed for full-time working professionals attending classes part-time. The program of study is entirely online and includes 30-credit hours completed over 5-semesters (20-months):

- 18-credits of core courses,
- 9-credits of concentration courses
- 3-credit capstone course

Students enroll in two courses each semester. The first 3 semesters are core courses which provide the theoretical foundation in leadership, management, education, and research.

Areas of Concentration

Students choose one of three available concentration options selecting 9-credits from within the concentration to focus on and excel in the career that is right for them. Concentration options are:

- Health Informatics
    - Healthcare and Public Landscape
    - Health Informatics, Information Systems, and Technology
    - Vocabularies, Terminology, Knowledge Discovery and Related Health Information Technology Standards
    - Workflow Process Analysis, System Development, Human Factors and Usability
    - Leadership and Strategic Management in Health Setting
    - Guided Study
- Health Administration
    - Health Systems Management 1: Organization & Delivery
    - Health Systems Management 2: Principles of Leadership
    - Health Policy 1: Health Policy & Regulation
    - Health Policy 2: Legal & Ethical Issues

- Education
    - Assessing Learning in Online and Blended Environments
    - Universal Design for Learning
    - Tools for Online Learning Creation and Assessment
    - Multimedia Studio
    - Overview of the American Community College
    - Educational Equity and Diversity in Higher Education
    - Health and Wellness Coaching
    - Stress Reduction
    - Wellness and Chronic Disease
    - Culture, Equity, and Vulnerable Population Health
    - Social and Behavioral Foundations of Public Health
    - Grant Writing and Resource Development
    - Curriculum Development & Evaluation in Medical Education
    - Attitude Formation and Change in Medical Education
    - Human and Adult Learning in Medical Education
    - Application of Instructional Design and Technology in Medical Education

Capstone

In the final semester of the MSRT program students complete a 3-credit hour capstone course in which they plan and carry out a project related to their chosen area of concentration and the delivery of respiratory care. Projects address a research question, need, problem or opportunity related to respiratory care, healthcare organization, educational institution, or community. Student work on the capstone project is guided by the principles and knowledge they have gained throughout their course of study.

MSRT Student Qualifications

We are actively seeking students with the following minimum qualifications.

☐ Hold bachelor's degree in a health-related field with a minimum GPA of 3.0

☐ Active National Board for Respiratory Care (NBRC) registered respiratory therapist (RRT) credential

☐ Active state respiratory care professional license

☐ Two-years of professional respiratory care experience

Faculty

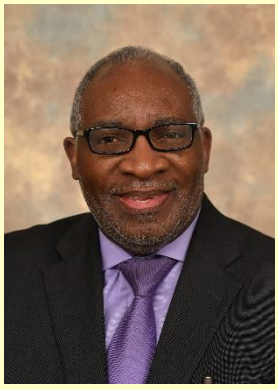
Maya Clark, PhD, RRT, RRT-NPS, assistant professor joined the CAHS faculty in August 2019 and became program director of the BSRT program in January 2023. Dr. Clark earned a BS degree in biology with a concentration in respiratory therapy from Millersville University; a MEd degree specializing in elementary education from Arcadia University; and a PhD degree specializing in higher education and leadership and administration from Capella University. She has served as a laboratory specialist and clinical instructor for 15-years at the Community College of Philadelphia. Dr. Clark also taught online at Nova Southeastern University.

Dr. Clark came to the University of Cincinnati with 27 years of experience as a respiratory therapy clinician treating both adults and children. She has worked in several hospitals in and around Philadelphia, PA including, the Children's Hospital of Philadelphia for over 25 years. Dr. Clark worked as a laboratory specialist, clinical instructor, and a visiting lecturer for over seventeen years at the Community College of Philadelphia, prior to working at the University of Cincinnati.

Nancy Colletti, PhD, RRT, CPFT, FNAP, professor joined the CAHS faculty in January 2018 as the BSRT program director obtaining professional accreditation from the Commission on Accreditation for Respiratory Care (CoARC) for the program in 2020. In addition, she developed and gained approval for the Master of Science Respiratory Therapy program from the Ohio Department of Higher Education. Dr. Colletti serves as chair of the CAHS Interprofessional Education (IPE) Council and represents CAHS on the UC Academic Health Center IPE Steering committee organizing interprofessional learning experiences for students enrolled in CAHS as well as the colleges of Medicine, Nursing, and Pharmacy. She has been teaching online for over 15 years and is an active Quality Matters peer reviewer and master reviewer.

Dr. Colletti earned her BS degree in cardiorespiratory sciences, MS degree in health sciences, and Advanced Certificate in health care management from Stony Brook University. She completed her PhD in Education with a specialization in instructional design for online learning from Capella University. She has been teaching in respiratory care programs for over 35 years, starting as a hospital based clinical instructor before transitioning to classroom/laboratory teaching at Stony Brook University and then later at Kettering College.

Dr. Colletti has been an active member of the Ohio Society for Respiratory Care (OSRC) serving on multiple committees including Program Planning and Legislative, as well as district director and vice-president to the OSRC board of directors. She is currently serving as president of the OSRC.



William Phillips, DHsc, RRT, assistant professor began at CAHS as a part-time adjunct professor in the BSRT program in 2015 transitioning to a full-time faculty position in August 2019. Dr. Phillips is formerly director of Cardiopulmonary Services and Pulmonary Diagnostic Labs, Sleep Disorders Center, and Remote Monitoring at Methodist University Hospital specializing in acute critical care. Dr. Phillips is also formerly assistant professor at the University of Mississippi Medical Center, School of Health-Related Professions. Dr. Phillips taught personal and ethical leadership, healthcare reimbursement and finance, contemporary issues in healthcare finance as well as organizational behavior.

William is formerly Le Bonheur's vice president of community outreach responsible for grants and fiscal management, First Years, LEAD, School Health, Therapy Outreach, Center for Children and Parents, Child Maltreatment, Community HIV, Safe Kids/Injury Prevention and Volunteer Services.

He holds a doctorate in health science from Nova Southeastern University in Fort Lauderdale, Fla., a master's degree in human resource development from the University of Tennessee, Knoxville, and bachelor's degree in adult education from the University of Tennessee, Knoxville, and diploma in respiratory therapy from the University of Mississippi. He has also been active in the public health arena through his church work at Brown Baptist in Southaven, Miss. He received the 2005 Silver Star Award for Outstanding Community Service from the Silver Star News. He is a multiyear recipient of the Distinguished Service Award from the Tennessee Society for Respiratory Care. He also serves a multi-year appointment on the Tennessee State Department of Education Advisory Board for the Health Science Division. Dr. Phillips is currently serving his fifth four-year term as OSRC delegate to the American Association for Respiratory Care.

Contact Information

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https://online.uc.edu/undergraduate-degrees/bachelors-in-respiratory-therapy/

https://online.uc.edu/masters-programs/masters-in-respiratory-therapy/

So, what is a Bearcat anyway? (I mean besides being the best educated students in the world!) The bearcat (the animal!) is neither a bear or a cat! It's more closely related to The Mongoose Family. Depending on which reference you use it

is considered either a carnivore or an omnivore. Experts agree however that it eats mostly fruit, has a distinctive smell (like hot popcorn) and has a prehensile tail. Checkout this guy on-line and you will see an animal that looks a lot like a cat and a bear (in the face anyway).

So now you know!

INTERVIEW

Sam P. Giordano, MBA, RRT, FAARC
Executive Director Emeritus
American Association for Respiratory Care
Publisher Emeritus, *Respiratory Care*

By Tom Barnes, EdD, RRT, FAARC
Professor Emeritus of Cardiopulmonary Sciences
Northeastern University, Boston

1. **Tell us about your career as a respiratory therapist.**
   -What brought you into this profession?
   -What is involved with your present position?

When I was a teenager, I worked as an orderly in the x-ray department on weekends transporting patients/developing x-rays, at St Mary's Hospital. Then I went to college and worked evenings in a full-service (check air, oil, clean windshield) gas station. That was in February 1963, and it was a cold winter in Kansas City, Missouri. I decided that an inside job was needed. I knew the nuns at St. Mary's Hospital from my previous employment as an orderly and because my sister was a radiologic tech there. I needed a job on the 3-11 shift so I could continue my education.

The nun that remembered me, asked "what about inhalation therapy?" Since it was 3-11, I decided to take it. I didn't know what it was, but it was going to get me out of the cold. Once I started, I liked it, and saw potential. St Mary's was a medium sized community hospital of about 250 beds; after about a year, I became an assistant chief therapist. I had to change to the day shift and leave college to get the promotion. But my plan was to complete my education and set a personal goal of a graduate degree. About a year later, they promoted me to replace the chief therapist who went to a hospital in Iowa. I was in the chief therapist position for only about a year and a half before being recruited to go Barnes Hospital (now Barnes Jewish Christian Hospital) (BJC) in St Louis, Missouri. The department director, who was also the guy that hired me initially, at St. Mary's in Kansas City. After about a year, I became department director at BJC Hospital when he left the field.

After a couple great years at BJC, things were going fine, and I was happy. Early one morning at 6:00 AM, I received a call from Dr. Vincent Collins who was one of our best-known advocates of inhalation/respiratory therapy. I thought it

was a joke, and I said, “the hell you are,” and hung up. He called right back and said, “damn it don’t hang up on me.” I was unaware that Bill Morrison, RRT and Dr. Duncan Holiday, both at the University of Chicago, had recommended me for the director position at Cook County Hospital in Chicago.

I went to Chicago and successfully interviewed for the position. Although BJC had been a big jump for me with its 1,200 beds and being a large university medical center; Cook County had 2,300 beds. A reporter from the Chicago Tribune said, “Cook County Hospital was an island of excellence in a sea of mediocracy.” The surgical ICUs, trauma unit, burn unit and NICU (one of the country’s first) were all outstanding. After 5 years things were going very well, and Cook County was the highlight of my clinical career. We had 450 combined house staff, and a large anesthesiology service since we were affiliated with 6 medical schools. Our 500 bed children’s hospital was doing a lot of first-time innovative surgeries. There were always anesthesiology residents assigned to our department and I was actively involved educating residents about respiratory therapy and mechanical ventilation. We also had the opportunity to train all surgical and medical residents and interns; many from outside the United States. This insight into working with physicians helped me throughout the rest of my career.

I was then recruited by St. Luke’s Hospital back in Kansas City, Missouri by the president of the medical staff to strengthen the respiratory care department. I had some exposure to biomedical engineering at Cook County because the space industry had laid off people and I was able to work closely with two PhD biomedical engineers. St. Luke’s had received a large several million-dollar grant to open a coronary care unit on the condition it had to be computerized. They needed someone to start a biomedical engineering department, as well as direct respiratory services. When hired to direct the RT department my title was expanded to director of biomedical and technical services. It was kind of a catch-all for hyperbaric (monoplace), ECG, cardiac diagnostics, pulmonary lab, respiratory care, and biomedical engineering. I was at St. Luke’s Medical Center for 7 years (1973-1981).

I was then asked by AARC’s Board of Directors to consider becoming executive director of AARC. I accepted this position in January of 1981, following a year as AARC’s president in 1980. Please know that the primary reason I ran as AARC president was to obtain licensure for RTs.

We knew it would be an uphill fight. The doctors did not want us to have it, the nurses were against it, and the hospital associations were against it. Yet it became very clear that state licensure of RTs (or legal credentialing) was a missing element. But it was critically important to become a legitimate profession

on a par with and compare favorably with virtually all other health professions. We had to have legal credentials as well as voluntary credentials.

Back in the 1970s the Federal Government called a moratorium on licensure. The medical and the hospital communities thought that they had been burned by other licensed health professionals and were opposed to licensure for RTs.

We were once again sailing against the wind. I was discouraged, but then AARC Past President, Houston Anderson RRT, told me before I became President: "that if you really want licensure for RTs, you need to become AARC president, step up and push for it." I kept his advice in mind throughout my term, and career. But it was only a start. The heavy lifting came from AARC, its state societies, our members, and our allies.

2. Who were your mentors?

In my early days of being an RT as well as AARC's Executive Director; Barry Shapiro MD, Walter O'Donohue MD, and Tom Petty MD were invaluable to me. These doctors were associated with physician organizations, and they suggested I reach out to Sandy Iannotta, Executive Director of the American Thoracic Society (ATS), and Alfred Soffer MD Master FCCP, Editor of *CHEST* for 25 years (1968 to 1993) and Executive Director of American College of Chest Physicians (ACCP) for 23 years (1969 to 1992).

Mr. Iannotta and Dr. Soffer taught me how to be an executive director of a professional organization. If it wasn't for Barry, Walter, and Tom, I wouldn't have thought to seek help from Sandy and Alfred. This was definitely an inflection point in my career.

I met Houston Anderson RRT (AARC president in 1976) when I was in AARC's House of Delegates in the late 1960s. He took the time to enlighten me not just on what we were doing but also to appreciate the multifaceted inner workings of trying to move a profession and its organization forward to better serve our patients. He encouraged me to keep stepping up for what that required. Once I got to the AARC board, I sought his advice on many issues. He then served as Protocolarian when I was AARC president in 1980.

In November 1973, I ran for the AARC Board and was also nominated to become speaker of the House of Delegates. Then AARC Immediate Past President, Jimmy Young MA, RRT, visited the House of Delegates and told me I had won a board of directors' seat and was no longer eligible to be speaker of the house. The news was special to me coming from Jimmy.

I considered Jimmy Young a mentor before I was elected to the AARC Board. Indeed, when I ran, and lost the election for the board, in 1972. Jimmy had just given his speech as incoming AARC president, and he was surrounded by people

congratulating him and wishing him well. In the midst of this, he called me over and said, “I know you lost but we need you, and you should run for the board again.” I had no intention of running for anything again; I was finished until he told me that. He was subsequently assigned as my “big brother” after I was elected to the Board in the fall of 1973 while he served as Past President. It was another career inflection point. Without his encouragement I wouldn’t have run for the Board a second time and most certainly not president subsequently. If not for that; I would not have become AARC Executive Director in 1981.

In recalling my mentors, I reflect back to my younger years; there were three physicians (Shapiro, O’Donohue, and Petty) and three therapists (Young, Anderson, and Masferrer). There were so many more over the years too numerous to mention, but all well remembered and appreciated.

Ray Masferrer deserves special mention. He was elected to the AARC Board a year after me. I first met him when he was at Parkland Medical Center in Dallas and Chairman of AARC’s Publications Committee. We hit it off and shared many concerns and goals for our profession. About a year after I became Executive Director, Ray joined the AARC staff. He served as *de facto* chief operations officer (COO) for many years. His no hold barred feedback made me a better leader and professional. I could always count on him to tell me things that are hard to hear but essential to know. That is indispensable to success in any endeavor.

Beginning as AARC President and continuing as Executive Director I was able to help the AARC convince nurses, physicians, and hospital associations to soften their opposition to RT licensure. We made sure they knew that we wanted to work with them and were not interested in exclusionary licensure, were okay with working under medical direction, and not restricting the nursing scope of practice.

Once the AARC Board of Medical Advisors (BOMA) understood our intent, their organizations supported our efforts or agreed not to oppose them. State licensure then became much easier to accomplish.

3. **How did furthering your education contribute to your career path?**
   -What contributed to your path as a leader in the AARC?

Furthering my education helped validate and legitimize me as a member of an educated professional community. There is no substitute for education in the healthcare sector. Higher education was especially important in the early days of our profession. Our scope of practice was expanding beyond the ability to master it with just on the job training (OJT).

We could have no influence without the credibility of education. I was always concerned about how the medical and nursing staff felt about our staff. At St. Luke's Hospital we eventually required the staff to have a baccalaureate degree in a health-related science. At that time, you had to have 60 semester hours of health-related science to qualify for the NBRC registry exam.

I distributed an education profile of my department to the CEO, director of nursing, heads of medical staff sections, and all department heads. When they found out that 90% of my staff had baccalaureate degrees, they saw, and treated them with more respect.

We are in an industry that is primarily based on education. We didn't have a choice, we began as OJTs, but it didn't mean we would have to stay that way. Just because we start out and evolve from certificate to diploma to associate degree, doesn't mean we have to stop at that level. Rather, we must expand our scope of practice to meet unmet patient needs as scientific evidence emerges. We must not stop our education at an associate degree, because the future of the profession includes continued expansion of our scope of practice to address unmet patient needs. RTs will do more for patients, not less. They'll work in other all care settings, not just hospitals.

I earned my master's degree after I was employed as AARC Executive Director. This milestone marked the end of my quest to earn baccalaureate and a masters' degree after 71/2 years of night school starting back in the 1970s. Back in the 1960s when I dropped out of school, I made a vow to not only have a baccalaureate degree but also obtain a master's degree by the time I was 40 years old. I made it. I did it by not giving up and being afraid to fail. I was also too scared to take even a semester off because I might quit and not return to pursue my education goal.

RTs have evolved based on enhancing current clinical interventions or identifying and meeting unmet patient needs. Those are the RTs who will always be in demand. Meeting unmet needs of pulmonary patients in all care settings provides more potential for growth and value of our profession today, than ever before. We always looked for supporting data. We sought answers to questions regarding the economic impact of not taking care of patients with chronic diseases and limiting patient access to RTs.

Much of that information is now available. That was not the case 20-30 years ago. We had nothing. Now we have good science to back up RTs value. We need to exploit that science and look for patient needs not currently met, then find ways for RTs to meet them as they relate to our profession. Pulmonary patients have an enormous number of unmet needs. Let's leverage the data to guide

expansion and refinement of our scope of practice. Then we must measure our impact clinically and economically.

I was selected as chair of the U.S. COPD Coalition (USCC) and served in its leadership for several years. Patients continue to ask for access to RTs in all care settings outside the hospital. Our next goal should be to provide access to RTs by patients, regardless of care setting. We must expand our reach beyond acute care settings. This will mean new employers such as physician practices, managed care organizations; in addition to care given in hospitals and critical care.

In the future more care will be rendered outside of hospitals because of technology, and cost. I know some advocate for advanced degrees. We'll need more education to work across the health care delivery spectrum. I know that is appropriate.

The majority of patients are outside of the hospital, and we could help manage them as employees of physician practices, accountable care organizations, and Medicare managed care. We need to be involved in prescribing, administering, and managing a broader range of medications appropriate for our patients. Of course, this should be done under medical direction. What we don't need is direct physician direction, indirect has served us, and our patients well for decades.

We may have an opportunity with the Veterans Health Administration. The VA system doesn't have as many payment barriers like the Medicare system. That will give RTs more freedom to prove the value of RTs working in expanded roles in care settings outside of the hospital.

Let's call it proof of concept. Having physician champions, like Russ Acevedo MD, is a must. Especially if you can document unmet patient needs and their devastating impact on our patients and the cost to our system.

I have been following the Rural Coalition in terms of the medically under-served. Pulmonary patients are getting the short end of the stick. There are many unmet needs for rural patients. They are managed by primary care physicians, and they will appreciate help from RTs, especially those with advanced education. Opportunity knocks!

One of our biggest opportunities is to help rebuild our pulmonary rehab infrastructure. RTs can and should help rebuild the pulmonary rehabilitation programs, which were devastated by Covid pandemic.

The data shows that 95% of pulmonary patients never receive pulmonary rehabilitation. As physicians attempt to correct this situation, Medicare reimbursement must improve, and along with reimbursement for telemedicine rehabilitation, there will be huge growth for RTs who know how to manage their patients. RTs have tremendous potential to help the medically underserved.

An added benefit of increasing access to RTs may emerge when you consider RTs who have worked in hospitals for several years. They worked nights, weekends, and holidays. But we might like to work in a physician's office with regular hours, as we get older. We need to give our colleagues another option, as their lives change to keep them from leaving the profession.

4. **What are some key lessons you have learned as a clinician, educator, and leader in the profession?**

The patient will always be the horse with the profession as the wagon. We need to make sure the wagon has RTs with expanding skills to meet the needs of our patients. Our patients need to lead the profession. They are the reason our profession exists.

We can improve effectiveness in hospital RT departments by shortening hospital stays. This has a direct financial impact and will further underline the value of RTs. RTs can improve by being utilization gatekeepers and being actively involved in deployment of therapist driven protocols.

RTs working in physician practices will be a big part of our future but also work to enhance hospital efficiencies. It follows that if you have a program available for a pulmonary patient upon discharge from the hospital; then they can be discharged quicker.

We have evidence that RTs can contribute to a faster discharge. This can be a strength that should be capitalized on by department directors and staff. We must help the hospitals while at the same time working with physicians to keep patients out of hospitals.

5. **What would you recommend to new graduate therapists just beginning their careers.**

The younger generation of RTs need to be as comfortable with economics of health care as they are with clinical practice. There is no room for spectators, the profession does not have enough bandwidth for them. Everyone must be on the playing field. How many RTs know how our healthcare system works and how to influence change? Both are now our business. If it's not us – who?

Never stop critical thinking. Be a change agent. Look at a patient as a whole person, including what happens to them after hospital discharge.

Be more analytical about cost and quality drivers. RTs should dig a little deeper to determine what triggered an admission. There are many inpatient stays that could have been avoided, if the patient had access to an RT before admission was required.

In 2017, there was a Statistical Brief (SB 259) that stated there was 7 billion dollars in preventable hospital admissions just for COPD patients, that came to 800,000 admissions with an average aggregate cost of $8,750 each [Healthcare Cost and Utilization Project (HCUP), U.S. Department of Health & Human Services]. We must stop treating patients for exacerbations and then discharging them with no follow-up. Statistical Briefs provide basic descriptive statistics on a variety of topics using HCUP administrative healthcare data. Check it out.

We desperately need more researchers. Younger RTs should try to find a way to be involved with research studies. They don't have to plan a full blown randomized controlled trial. You can start by just asking a question, and trying to get it answered as objectively, and scientifically as possible. Just get your beaks wet first.

Research round tables may be a way to generate more interest. It is a great place to start, but we need RTs to come to that table. A great place to start is to analyze current government reports and identify respiratory related unmet patient's needs.

We must never forget the sick are why we exist. Everything we do and consider doing should be played back against the question, "does this help our patients?"

Professional Positions Posted

***Georgia State University, *University of North Carolina-Charlotte, *University of Nebraska Medical Center, *Massachusetts College of Pharmacy and Health Sciences, *Thomas Jefferson University, *Stony Brook University, *University of Missouri, *Liberty University, *St. Catherine University, *University of North Carolina-Wilmington, *Augusta University, *Upstate Medical University-Syracuse, *Norton Healthcare, *University of Virginia Health System**

Introduction to Respiratory Care in Japan

Yoshihiro Uzawa, PhD, RPT, RRT
Kameda General Hospital, Kamogawa, Japan

The respiratory care of patients is one of the important areas of health care and is provided by a multidisciplinary approach. In the United States, respiratory therapists have a relatively comprehensive scope of practice. They are nationally certified and licensed by medical boards in individual states. As you are all aware, respiratory care is an important part of health care in every country, but its clinical operational format, or how different medical disciplines are utilized varies from country to country. In some countries, such as the United States, the practice is largely carried out by a specialized healthcare professional, while in other countries, other professionals cover that specialty area. The purpose of this article is to review the situation in Japan.

Before I tell you about RT in Japan, I would like to briefly review my own experience. After I obtained my physical therapist degree in Japan, I worked at Kameda General Hospital which provides acute care. After about 6 years of experience, I decided to study respiratory care in the United States. I applied for and enrolled in the Respiratory Therapy program at the University of Toledo in Ohio, USA. After graduation, I completed my NBRC RRT and returned to Japan.

Readers may be curious as to my motivation to take on the work, expense, and time for training to become a respiratory therapist in the US. When I had been providing physical therapy to patients on ventilators in acute care settings, the ventilator settings and the patient's spontaneous breathing would not match up, so alarms would go off. When this happened, I could not figure out what was causing the problem. I wanted to understand more about ventilators based on these experiences, so I attempted to learn on my own; that was not very successful. Then, through an acquaintance, I learned about the American respiratory therapist education and certification systems. Going to the United States seemed like a better approach to reach my goals.

There are several differences in the respiratory care delivery system between Japan and the U.S. In the U.S., there are both national educational and certification systems for respiratory care practitioners. Graduates of accredited programs can achieve credentials through the NBRC such as RRT and CRT. In addition, there are subspecialty areas for critical care, pulmonary function testing and neonatal pediatrics. In Japan the work performed by respiratory care practitioners in the U.S. is carried out by physicians, nurses, clinical engineers

(like medical biotechs in the US), and physical therapists. Each works within their respective professions' scope of practice. For example, physicians perform arterial blood gas punctures, initiate mechanical ventilation and make setting changes, and perform tracheal intubation and extubation. Nurses take blood samples from arterial lines, perform tracheal suctioning, do basic inhalation therapy such as oxygen therapy aerosol drug delivery, and periodic ventilator checks. Clinical engineers are responsible for equipment maintenance, preparing and checking ventilators and monitoring equipment, and managing ventilators when ventilated patients require transport. Physical therapists are mainly responsible for mobilization and rehabilitation but can also perform tracheal suctioning. Thus, in Japan, the work of an American RT is carried out by multiple professions.

In the US, RT programs at colleges or universities provide comprehensive respiratory care education. In Japan, on the other hand, the respiratory care-related education for nurses, clinical engineers, and physical therapists occurs based on their respective profession's certification. Although it is not a national qualification, there is a voluntary program for certification called the Society's Certified Respiratory Therapy Certificate. It is an accredited program established jointly by three related-medical societies: the Japanese Society of Anesthesiology, the Japanese Respiratory Society, and the Japanese Society of Thoracic Surgery. Nurses, clinical engineers, physical therapists, and occupational therapists with at least two years of clinical experience are eligible to take its examination. After study, based on a series of video lectures, candidates take an examination to obtain their certification. This is a good incentive for beginning students to learn. However, the training is only knowledge-based and there is no hands-on instruction on clinical skills. In addition, even if one obtains the certification, they are not allowed to perform procedures other than those that are allowed through national certification by their specific profession. For example, even if a nurse or clinical engineer obtains a respiratory therapy certification, they cannot perform extubation or perform arterial puncture.

Besides the national training program through the Society Certified Respiratory Therapy Certificate, there are also programs within each profession. Nurses have a specific program called nursing *designated care*. This is a qualification for nurses with 3 to 5 years of experience after obtaining a nursing license to perform medical assistance acts called "specific acts" under the direction of a physician. It has more than 30 specialty areas, respiratory care and airway management being one of them. To obtain this qualification, the applicant must complete education in basic care areas, specific subjects, and have an evaluation performed of those clinical procedures. This certification is accredited by the Ministry of Health, Labor and Welfare and is more practical in nature

because it is connected to medical fee reimbursement. Like the Society's Certified Respiratory Therapist, they cannot perform medical procedures that a physician can perform, such as intubation or extubation, but they can change ventilator settings by following pre-determined protocols.

Clinical engineering technicians and physical therapists also have accredited and specialized respiratory care-related programs approved by their respective professional associations. Those who have been certified by their professional group for at least five years are eligible to take specialty exams. Programs are accredited by the respective professional associations and are classroom-based. These specialty certifications are not yet connected to the reimbursement of medical fees.

As described, without a national certification program for respiratory care in Japan, even if a practitioner is certified by a professional group, there are limitations on their scope of practice. Currently each professional association is working on this complex issue.

As readers know, respiratory therapists in the U.S. may be involved in home visits, outpatient clinical laboratories (pulmonary function testing, sleep studies), hyperbaric oxygen therapy, and care at other non-acute care facilities for breathing-related conditions not necessarily related to respiratory diseases. There are a very wide range of specialties involved in this spectrum of diagnostics and care. Of course, Japan also has outpatient care, clinical laboratories and home healthcare. But home healthcare is provided mainly by nurses. In this way, although there is no job title of respiratory therapist, it is implemented while being covered by multiple professions.

It remains to be determined if Japan will change to establish a new national certification system for respiratory therapists like the United States. Several other countries, including Canada, Singapore, Taiwan, and Saudi Arabia, have created respiratory therapist systems and educational programs for such therapists similar to that in the US. There was a time when there was talk that such a system should be established in Japan as well. As has been, the current direction is to provide respiratory care with a somewhat diverse system that operates in cooperation with previously existing professions.

Japan is still practicing Western medicine in the same way as the U.S., and there does not seem to be a significant difference in clinical outcomes between the U.S. and Japan. Although there is no *designated* respiratory therapist profession in Japan, other clinicians are performing what they are capable of performing in their respective professions.

There may be disadvantages of not having respiratory therapists in Japan. It is difficult to standardize the knowledge and practice of respiratory therapy. As mentioned above, respiratory therapy in Japan is practiced by a composite of other healthcare professionals at each facility. Although their activities have been organized by each profession and the implementation of protocols, standardization of respiratory therapy is still dependent on individuals. Not only are there differences among facilities, but even within the same facility, the practices may differ from ward to ward. It might be possible to maintain a more uniform standard of respiratory care if there were respiratory therapists, but this is not the case. In this respect, in environments where there are no respiratory therapists, it is necessary to set up operations and education to cover such differences.

CoBGRTE Scholarships Reminder

The Mission Continues

José D. Rojas, PhD, RRT, RPFT, FAARC
Chair CoBGRTE Scholarship Committee

The CoBGRTE Board of Directors, with steadfast tenacity, continue to make scholarship money available to help support school expenses for members pursuing baccalaureate, graduate, or doctoral degrees. Encourage your friends, colleagues, and students to apply! It is not an onerous process. This year to improve the process for application and distribution, the scholarship committee has made the recommendations outlined below. The process for application is relatively simple and the application has been posted on the CoBGRTE website since April 1, 2023. Don't let this opportunity pass you by! **The application cycle will remain open until October 1, 2023**, and we hope to make announcements of winners and present awards at the AARC Congress.

1. **The scholarship cycle:** for all awards (NBRC supported, Merit, Malinowski, Smallwood) opened April 1 and closes on 10/1/23. Send your applications in early!
2. **There are four award categories:**
    a. **Merit Scholarships ($8,000)**

-eligibility (BS and MS entry-level CoBGRTE member, BS and MS degree advancement members; *Propose to allocate four (4) $1,000*

scholarships for entry-level and four (4) $1000 scholarships for degree advancement depending on number of applications)

-required materials (letter of support from faculty/PD/DCE, professional resume, completed application, unofficial transcript, and essay)

b. Smallwood Research Scholarship ($2,000)

-eligibility: BSRC and MSRC entry-level CoBGRTE member, BSRC and MSRC degree advancement CoBGRTE members.

-required materials: research proposal that includes a budget; proposal should include literature review with hypothesis or research question; project timeline; letter of faculty support; and professional resume.

c. Malinowski Leadership Award ($2,000)

-eligibility (therapist in a supervisory or lead position; BSRC or MSRC degree advancement or clinical research program; CoBGRTE member)

-required materials (QI project or clinical research proposal; includes a budget; proposal should include literature review/hypothesis or research question/ specific aims/ project timeline; letter of faculty or hospital administration support; professional resume)

d. NBRC-supported faculty awards ($20,000)

-eligibility (RRT, CoBGRTE member, current faculty member or pursuing faculty position, enrolled in doctoral program)

-required materials (proposal for required funds that includes budget/justification; letter of support from Chair/Dean; CV)

-award $5,000 to $10,000 based on proposal/need

Members of the CoBGRTE Scholarship Committee

Bruce Adcock, M.Ed, RRT, RRT-NPS, CHSE	Assistant Professor University of Texas Medical Branch
Brian Cayko, MBA, RRT, FAARC	Clinical Assistant Professor Boise State University
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José D Rojas, PhD, RRT, RPFT, FAARC — Associate Professor
CoBGRTE Scholarship Committee Chair
University of Texas Medical Branch

ASRT to BSRT & MSRC Degree Advancement Programs

BSRT and MSRT Entry Programs

Graduate Respiratory Therapist Programs

www.CoBGRTE.org

International Spotlight

Martha Milena Diaz, TRC, MSc

Operation Director, Latin American Board for Professional Certification in Respiratory Therapy

International Fellow AARC

By Wendy Castro, MS, RRT, RRT-NPS

Chair, CoBGRTE International Outreach Committee

1. **Describe a typical day practicing as an RT in your country.**

Currently, I am working with the Latin American Council for Professional Certification in Respiratory Therapy. I am director of operations for Latin America and a legal representative of the company that is currently in Colombia. I have organized, administered, and supervised professional certification exams for respiratory therapy professionals or entire teams of respiratory therapists since 2014.

This process was carried out with the support of the National Board for Respiratory Care of the United States. Doing it hand in hand with Melanie Thomas, (Sr. Vice President, Credentialing Operations, National Board for Respiratory Care / NBRC) and Chuck Simpson, (Tier 2 Technical Support Specialist, Operations Helpdesk/PSI). This certification is based on an online exam managed from the United States by PSI/NBRC.

2. **What drew you to respiratory care?**

My first contact with respiratory care was at an early age, I had a brother with a cleft lip and palate. My mother had to spend a lot of time in the hospital, I understood very early that giving is much more grandiose than receiving and that I like to serve others because it fills my soul. These circumstances not only guided me but also my younger sister, who is pediatric dentist who works with children with special needs.

I have worked all my life in respiratory care and my professional life has evolved over time as I have had the chance to be in different working environments. I started working in pediatric and neonatal ICUs in different public hospitals in my country, then I was a clinical teacher for two years.

Nine years ago, I started working with the Latin American Council for Certification in Respiratory. Today I'm the Operation's Director in Latin America.

Specifically, I work with the Latin American Board for Professional Certification in Respiratory Care (CLACPTER) and the National Board for Respiratory Care (NBRC), performing the certification of respiratory therapy exams throughout Colombia and Latin America.

3. **What obstacles did you have to overcome to obtain your degree and practice in your country?**

In Colombia and Latin America, the culture of measuring skills and knowledge through a certification exam after graduation are not consolidated. The aim of determining weaknesses and strengths in respiratory care to work on difficulties and share strengths. The work has been hard visiting different cities and countries for more than 8 years sharing knowledge and empowering the measurement of skills and knowledge.

4. **What formal education did you have?**

- Rosario University, master's degree in epidemiology 2018
- International Fellowship in Respiratory Care Program 2017
- Area Andina University - Specialization in Pediatrics 1999
- Area Andina University - Respiratory Therapist 1997

5. **What profession associations are you a member of?**

- American Association for Respiratory Care (AARC)
- International Education Recognition System (IERS)
- Respiratory Care, International Council for Respiratory Care (ICRC)
- Latin American Board for Professional Certification in Respiratory Care (LABPCRT/CLACPTER)

CoBGRTE Membership Committee Drawing

Win an Apple Airpods Pro Second Generation when you pay for active membership using *Auto-renewal Option.*

Drawing will be held May 1, 2023

- **Personalized Spatial Audio with dynamic head tracking**
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Spokane Community College
York College of Pennsylvania
Northern Kentucky University
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University of Nebraska Medical Center
University of Michigan – Flint
Augusta University
West Chester University/Bryn Mar Hospital
Thomas Jefferson University

If you have not already decided to become a CoBGRTE member after visiting www.cobgrte.org, the following are 15 reasons why you should join the coalition.

Reasons Why You Should Become a CoBGRTE Member

1. Award scholarships to baccalaureate and graduate respiratory therapy students.
2. Assist in the development of ASRT to BSRT Bridge Programs.
3. Collectively work towards the day when all respiratory therapists enter the profession with a baccalaureate or graduate degree in respiratory care.
4. Support a national association, representing the 70 colleges/universities awarding baccalaureate and graduate degrees in respiratory care, to move forward the recommendations of the third 2015 conference.
5. Help start new baccalaureate and graduate RT programs thus leading to a higher quality of respiratory therapist entering the workforce.
6. Work to change the image of the RT profession from technical-vocational-associate degree education to professional education at the baccalaureate and graduate degree level.
7. Mentoring program for new graduates as well as new faculty members.
8. Join colleagues to collectively develop standards for baccalaureate and graduate respiratory therapist education.
9. Develop public relations programs to make potential students aware of baccalaureate and graduate respiratory therapist programs.
10. Help to publicize, among department directors/managers, the differences between respiratory therapists with associate, baccalaureate, and graduate degrees.
11. Access to over 75 Spotlight articles on BSRT and RT graduate programs, and major medical centers.
12. Round table discussion dinners and Meet & Greet member receptions held in conjunction with the AARC Summer Forum and the International Congress.
13. Help to support maintaining a roster and web site for all baccalaureate and graduate respiratory therapist programs.
14. Collaborate with CoARC and AARC to improve respiratory therapy education.
15. Faculty development through financial support and publishing/presenting opportunities.

Editorial Board

"Dedicated to Improving Respiratory Therapy Education"

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