The Coalition Chronicle

Coalition for Baccalaureate and Graduate Respiratory Therapy Education

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Spotlight Article

Radford University

Waldron College of Health & Human Services

Radford University Carilion Respiratory Therapy Program

By Chase Poulsen, PhD, RRT, RRT-NPS, RRT-ACCS

Associate Professor and Program Director

Institutional History and Overview

Radford University, a public university with over 11,000 students, has received national recognition for many of its undergraduate and graduate academic programs. The University offers a wide range of academic, cultural, human service and research programs and is well known for its strong faculty/student bonds, innovative use of technology in the learning environment and vibrant student life on a 204-acre campus. Radford offers students many opportunities to get involved and succeed in and out of the classroom through 76 bachelor's degree programs in 47 disciplines, three associate degrees, and six certificates at the undergraduate level; 27 master's programs in 22 disciplines and six doctoral programs at the graduate level; and 14 post-baccalaureate certificates and one post-master's certificate.

In addition to the robust academic offerings and engaging student experiences on the main campus, Radford University also offers a clinical-based educational experience for more than 1,000 students in Roanoke, Virginia as part of Radford University Carilion (RUC), a public-private partnership focused on the cutting-edge delivery of health sciences programming, outreach and service. RUC was created as a result of the merger of Jefferson College of Health Sciences into Radford University in July 2020, making it the only state institution within the Commonwealth to offer a Bachelor of Science in Respiratory Therapy.

RUC prides itself on being affiliated with Carilion Clinic, a healthcare organization employing nearly 14,000 healthcare professionals with facilities across Southwest and Central Virginia. RUC students have access to state-of-the-art equipment and facilities that are national leaders in all areas of healthcare practice and administration. RUC is also dedicated to interprofessional education. Each semester, RUC hosts interprofessional experiences, which provide students with crucial, one-of-a-kind, hands-on learning opportunities.

The Bachelor of Science in Respiratory Therapy at RUC is a four-year program that combines hands-on laboratory, classroom and clinical learning. The program provides graduates with the knowledge, skills and experience needed to begin their careers. The program was acknowledged by the NBRC in the Summer 2019 with the distinguished RRT credentialing success award, and its outcomes continue to be above the national average. The program and clinical affiliates provide hands-on experience in sub-acute care, pediatric, neonatal and adult ICU rotations, flight transport, long-term vent units, physician office rotations, sleep labs, pulmonary function testing and more.

Entrance Requirements

In addition to the traditional four-year academic path in Respiratory Therapy, RUC offers the opportunity for junior-level transfer with a minimum cumulative GPA of 2.5 and eight credits of anatomy and physiology if applicants have done one of the following:

1. Completed the first two years of our plan of study;
2. Graduated from a VCCS school with an associate degree; or
3. Graduated from a regionally accredited institution with a bachelor's degree

Plan of Study

RUC 2020 Respiratory Therapy Curriculum

Coursework Needed to Complete Prior to Year Three		
BIOL 310/311 or 322	Anatomy and Physiology I and II / A&P for Pre-Majors	6-8*
University and College Core and General electives		39-41*
TOTAL CREDITS Needed to Progress (GPA >2.5) OR JUNIOR LEVEL TRANSFER CRITERIA		**47**
Year Three – Fall Semester		
HLTH 215	Medical Terminology	2-3 *
RETH 302	Foundations of Respiratory Care I	4
RETH 304	Cardiopulmonary Anatomy and Physiology	3
RETH 305	Integrated Sciences for Respiratory Therapy	3
RETH 308C	Clinical Practice I	1
RETH 309	Patient Assessment	3
ELECTIVE	General Elective	0-1
	TOTAL	17
Year Three – Spring Semester		
BIOL 334	Microbiology	4
RETH 310	Cardiopulmonary Pharmacology	3
RETH 311	Foundations of Respiratory Care II	4
RETH 318C	Clinical Practice II	3
RETH 332	Pulmonary Function Studies	2
	TOTAL	16
Year Three Summer Semester		
BIOL or NURS 321	Pathophysiology	3
HCMA 300	U.S. Healthcare System	3
RETH 320	Mechanical Ventilation	4
	TOTAL	10
Year Four – Fall Semester		
STAT 130 or 200	Statistics Course	3
RETH 330	Cardiopulmonary Pathophysiology	3
RETH 420	Neonatal/Pediatric Respiratory Therapy	3
RETH 430	Patient Case Management I	3
RETH 448C	Clinical Practice III	3
	TOTAL	15
Year Four – Spring Semester		
HSCI 300	Foundations in Healthcare Research or Research Course	3
RETH 411	Patient Education and Rehabilitation	2
RETH 450	Patient Case Management II	3
RETH 478C	Clinical Practice IV	3
RETH 488C	Clinical Specialty Rotation	1
RETH 490	Professional Seminar	3
	TOTAL	15
TOTAL CREDITS NEEDED TO GRADUATE		**120**

Faculty

Chase Poulsen, Ph.D., RRT, RRT-NPS, RRT-ACCS. Poulsen is the Program Director and Chair of the Department of Clinical Health Sciences. He graduated from Mansfield University with an A.S. in Respiratory Therapy in 1993. After graduation and working for a year at Arnot Ogden Medical Center in Elmira, N.Y., Poulsen continued his education and career at the State University of New York Health Science Center in Syracuse, N.Y., with a certificate in Cardiopulmonary Services. Moving to Grand Junction, Colorado, in 1996, he obtained a Master of Education in Curriculum and Instruction from Colorado Christian University while being employed by St. Mary's Hospital. Pursuing his interests in the educational field, Chase moved to Bangor, Maine, in 1998, and secured a faculty position at Kennebec Valley Community College, where he stayed until 2004, at which point he moved to Jefferson College, now RUC. He finished his Ph.D. in Education through Old Dominion University in May 2013. His research has focused on interprofessional education and collaborative efforts among programmatic students. He holds the rank of associate professor at both RUC and the Virginia Tech School of Medicine, where he instructs first- and second-year medical students.

Linda Cochran, M.S., RRT, RRT-NPS, AE-C, CPFT, RRT-ACCS is the current Director of Clinical Education, has been a respiratory therapist since 1974, starting out as an O.J.T. (On-the-Job Training). Her A.S. degree in Respiratory Therapy is from Butler University, and her B.S. and M.S. degrees are from Indiana University in Indianapolis. She completed 27 quarter hours of masters-level respiratory therapy coursework through Northeastern University. She also has the credentials of a neonatal pediatric specialist, certified asthma educator, certified pulmonary function technician, and adult critical care specialist. Cochran is retiring in 2020 and has made exemplary strides in clinical education. She has been a dedicated faculty member and will be sorely missed by the faculty and students within RUC. She holds the rank of assistant professor.

Douglas Wright, Ph.D., RRT, RRT-ACCS. Wright first received an A.A.S. from the Community College of the Air Force in Mechanical and Electrical Technology while serving as an airman in the United States Air Force. After military service, he went on to receive his B.S. in Cardiopulmonary Science from Louisiana State University Health Sciences Center-Shreveport (LSUHSC-S), School of Allied Health Professions. After working briefly as a registered respiratory therapist, he was accepted into the doctoral program in the Department of Molecular and Cellular Physiology at LSUHSC-S. During his tenure as a graduate assistant, he taught Pulmonary Physiology to allied health students. His research focused on two DNA repair proteins from *M. tuberculosis*.

Kathy Pellant, M.S., RPSGT, RRT obtained her A.S. degree in Respiratory Therapy from the Jefferson College of Health Sciences (Roanoke, Virginia) and her B.S. in Health Sciences from Old Dominion University in Norfolk, Virginia. She completed her Master of Science in Respiratory Care through Northeastern University in Boston, Massachusetts, in 2020. In addition to being credentialed in respiratory therapy, Pellant is credentialed in polysomnography and is the manager of Carilion Clinic Sleep Lab.

Edmundo R. Rubio, M.D is Co-Medical Director/Faculty, Carilion Clinic
Dr. Rubio is Section Chief, Pulmonary and Critical Care Medicine, Carilion Clinic and has specialties in critical care medicine, pulmonary medicine and sleep medicine. He is certified in internal medicine, critical care, pulmonary medicine, sleep medicine.
Colleges: University of Chile Medical School
Internships: New Hanover Regional Medical Center
Residencies: New Hanover Regional Medical Center
Fellowships: Pulmonary, Critical Care and Sleep Medicine, Tulane University School of Medicine

Joseph Tamez, M.D. is Co-Medical Director/Faculty, Carilion Clinic
Specialties: Pediatric Hospitalist, Pediatric Pulmonology
Certifications: Pediatric Pulmonology, Pediatrics
Colleges: University of Texas
Internships: Arkansas Children's Hospital
Residencies: Arkansas Children's Hospital
Fellowships: Pediatric Pulmonology – Children's Medical Center, Cincinnati, Ohio

Northeastern has Lost a Colleague and a Friend

By Thomas A. Barnes, EdD, RRT, FAARC
Professor Emeritus of Cardiopulmonary Sciences
Northeastern University, Boston, Massachusetts

Craig D. Smallwood, PhD, RRT, 36 years of age, died suddenly at home in the very early morning hours of April 10, 2020. The cause of his death is unknown at this time; he had been in good health prior to his passing. Dr. Smallwood has been a member of the faculty for the Master of Science in Respiratory Care Leadership program since 2018 when he came on board to teach the Neonatal and Pediatric Respiratory Care course. He earned two degrees from Northeastern, a Bachelor of Science in cardiopulmonary science graduating in 2007 and in 2018 he completed a Doctor of Philosophy degree in the School of Engineering, Department of Bioengineering. While an undergraduate he was awarded an ambassador scholarship and an athletic scholarship for Division 1 men's rowing and was on the Dean's List. His doctoral dissertation was *oxygenation and pulmonary mechanics in critically ill children receiving mechanical ventilation: a computational phenotype and machine learning approach to clinical outcome prediction.* His clinical experience included work throughout Boston Children's Hospital (BCH) with a focus on pediatric respiratory care in the intensive care unit.

Dr. Smallwood served as a research associate for BCH and Harvard Medical School since 2010 and in 2019 was given a faculty academic appointment at Harvard Medical School as Assistant Professor of Anesthesia. He developed predictive models using advanced data mining algorithms to classify likelihood of a clinical intervention having a positive effect, namely predicting physiologic effects during mechanical ventilation. Craig was working on the design and deployment of respiratory assist devices for treatment of COVID-19 patients in the developing world where ventilators are scarce. The first five prototype units are currently undergoing testing at Korle Bu Hospital in Ghana, Africa.

He served on the editorial board of *Respiratory Care*, has lectured throughout the United States and around the world, published over 50 papers, contributed chapters to multiple textbooks and worked to develop the ventilator simulator (a free, online, immersive computer simulation of mechanical ventilation). Dr. Smallwood’s passing is a huge loss to Northeastern University, Boston Children’s Hospital and the entire respiratory care profession. He was a leader, mentor, role model, researcher, author, inventor and an outstanding clinical practitioner – Craig will be missed.

Coalition for Baccalaureate and Graduate Respiratory Therapy Education

Press Release

Respiratory therapists are specialized healthcare practitioners with training and expertise in the diagnosis, treatment, and management of cardiopulmonary diseases, including mechanical ventilation in emergency, critical care, and long-term care settings. Respiratory therapists are licensed, and specialty board credentialed to implement and manage mechanical ventilation; in this process, they work together with critical care physicians and nurses to develop treatment strategies.

Respiratory therapists understand how to manage airways, administer specialty gases, manage mechanical ventilation, and deliver pharmacologic agents. Their education and clinical experience include assessment of patients' oxygenation, ventilatory and hemodynamic status as well as recommending care based on the results of laboratory tests and medical imaging. Respiratory therapists are skilled at assessment, treatment and care of patients with acute respiratory failure to include support of oxygenation and ventilation, and care of patients with pneumonia, sepsis and adult respiratory distress syndrome. The respiratory therapist is also skilled at anticipating other needs of critically ill patients to include nutritional support, prevention of ventilator associated pneumonia, hemodynamic support and end-of-life care.

If you are interested in setting up an interview with a respiratory therapist to discuss mechanical ventilation of the COVID-19 patient, please contact: Dr. Christy Kane at ckane@bellarmine.edu or Dr. Doug Gardenhire at dgardenhire@gsu.edu.

To find a baccalaureate or graduate respiratory therapy program, please use the links below.

ASRT to BSRT & MSRC Degree Advancement Programs

BSRT and MSRT Entry Programs

Graduate Respiratory Therapist Programs

www.cobgrte.org

Joint Statement on Multiple Patients Per Ventilator

(March 26, 2020) – The Society of Critical Care Medicine (SCCM), American Association for Respiratory Care (AARC), American Society of Anesthesiologists (ASA), Anesthesia Patient Safety Foundation (APSF), American Association of Critical-Care Nurses (AACN), and American College of Chest Physicians (CHEST) issue this consensus statement on the concept of placing multiple patients on a single mechanical ventilator.

(Reprinted with permission from the AARC)

The above-named organizations advise clinicians that sharing mechanical ventilators should not be attempted because it cannot be done safely with current equipment. The physiology of patients with COVID-19-onset acute respiratory distress syndrome (ARDS) is complex. Even in ideal circumstances, ventilating a single patient with ARDS and nonhomogenous lung disease is difficult and is associated with a 40%-60% mortality rate. Attempting to ventilate multiple patients with COVID-19, given the issues described here, could lead to poor outcomes and high mortality rates for all patients cohorted. In accordance with the exceedingly difficult, but not uncommon, triage decisions often made in medical crises, it is better to purpose the ventilator to the patient most likely to benefit than fail to prevent, or even cause, the demise of multiple patients.

Background: The interest in ventilating multiple patients on one ventilator has been piqued by those who would like to expand access to mechanical ventilators during the COVID-19 pandemic. The first modern descriptions of multiple patients per ventilator were advanced by Neyman et al in 2006[1] and Paladino et al in 2013.[2] However, in each instance, Branson, Rubinson, and others have cautioned against the use of this technique.[3-5] With current equipment designed for a single patient, we recommend that clinicians do not attempt to ventilate more than one patient with a single ventilator while any clinically proven, safe, and reliable therapy remains available (i.e., in a dire, temporary emergency). Attempting to ventilate multiple patients would likely require arranging the patients in a spoke like fashion around the ventilator as a central hub. This positioning moves the patients away from the supplies of oxygen, air, and vacuum at the head of the bed. It also places the patients in proximity to each other, allowing for transfer of organisms. Spacing the patients farther apart would likely result in hypercarbia.

Spontaneous breathing by a single patient sensed by the ventilator would set the respiratory frequency for all the other patients. The added circuit volume could preclude triggering. Patients may also share gas between circuits in the absence of one-way valves. Pendelluft between patients is possible, resulting in both cross-infection and over-distension. Setting alarms can monitor only the total response of the patients' respiratory systems as a whole. This would hide changes occurring in only one patient. The reasons for avoiding ventilating multiple patients with a single ventilator are numerous.

These reasons include:

- Volumes would go to the most compliant lung segments.
- Positive end-expiratory pressure, which is of critical importance in these patients, would be impossible to manage.
- Monitoring patients and measuring pulmonary mechanics would be challenging, if not impossible.
- Alarm monitoring and management would not be feasible.
- Individualized management for clinical improvement or deterioration would be impossible.
- In the case of a cardiac arrest, ventilation to all patients would need to be stopped to allow the change to bag ventilation without aerosolizing the virus and exposing healthcare workers. This circumstance also would alter breath delivery dynamics to the other patients.
- The added circuit volume defeats the operational self-test (the test fails). The clinician would be required to operate the ventilator without a successful test, adding to errors in the measurement.
- Additional external monitoring would be required. The ventilator monitors the average pressures and volumes.
- Even if all patients connected to a single ventilator have the same clinical features at initiation, they could deteriorate and recover at different rates, and distribution of gas to each patient would be unequal and unmonitored. The sickest patient would get the smallest tidal volume and the improving patient would get the largest tidal volume.
- The greatest risks occur with sudden deterioration of a single patient (e.g., pneumothorax, kinked endotracheal tube), with the balance of ventilation distributed to the other patients.
- Finally, there are ethical issues. If the ventilator can be lifesaving for a single individual, using it on more than one patient at a time risks life-threatening treatment failure for all of them.

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CoBGRTE Chronicle Interview

James M. Maguire, Ph.D., RRT FCCP Emeritus
President, Maguire Healthcare Consulting, LLC
Senior Consultant, VA Regional Medical Center
Visiting Professor of Medicine, Xi'an Medical University

By Jeffrey Ward, MEd, RRT, FAARC
Mayo Clinic
Multidisciplinary Medical Simulation Center
Rochester, Minnesota

Tell us about your early days as a respiratory therapist and how your professional career evolved over time?

I was discharged from the US Army in 1967 and then began considering a job as I returned to the workforce. Prior to going into the military, I had taken, and passed my Stationary Operating Engineer License Exam. It was a good paying job, and I enjoyed it, but, I like working with people. In the interim, I had gone back to school, thanks to the GI Bill, and earned my BA degree in Biology/Psychology. I thought about going to medical school or nursing school but counselors suggested that I take a job in a hospital to see firsthand what it really was like to be in the medical profession. I found a job as a respiratory therapy equipment technician, at a large teaching hospital in Providence, RI. I had never heard of respiratory therapy. First impressions were that the staff was a professional looking group and it seemed much more appealing to me than being a nurse or a physician. The RT department at this hospital was a big one, and a good one, but with some onerous dress code rules. All members of the department wore a white uniform. The Director of the department was an RN, not unusual back then. If a skirt was worn, it had to be within a certain distance from the knee. And, measurements were taken, anytime there were any questions about proper dress length. For the men, if white shoes were worn, white socks must also be worn, black shoes required black socks. Equipment Techs changed equipment, and processed it for reuse. They moved oxygen tanks around the hospital, and, when necessary, the therapist did as well. All ventilators were cleaned, serviced, and set up at the bedside.

Northeastern University had a special program for people who had bachelor degrees. I only had to take one science lab course in order to meet the admission requirements. I took that course, and along with two other RT equipment techs, began the program at Northeastern University. I loved the program, and was challenged with its fast pace. In my class there were two future presidents of the AARC.

After graduation, I looked for a job and applied to several hospitals. My second interview was at St. Anne's hospital in Fall River, MA and was hired immediately. I learned a lot there, loved my job, but it was a long ride from my home in Providence. I did have some challenges when establishing relationships with nursing. One day however, I was suctioning a patient, when a nurse charged into the room and grabbed the suction catheter out of my hand, she said to me: ‘You’re not allowed to suction, your only an RT and we don’t let RTs suction here. I got her supervisor and we had a talk. She pointed out that I didn’t have a degree, and I was likely an OJT, and it was unsafe for someone who wasn’t a nurse to suction a patient. Her manager, who I had gotten to know, explained that I had two undergraduate degrees and graduated from the RT program at Northeastern University. Having that degree made the difference and I never had an issue with her, or any other nurse. A similar event occurred after I received an order from a physician, a thoracic surgeon, to set up a ventilator. He had default orders for every ventilated patient. I mentioned to him that his patient needed a different ventilator settings and orders. He asked me to meet him at a conference room, where he read me the riot act. I explained the rationale for my recommendations; he was red in the face, but he listened and agreed to those changes. He and I became lifelong friends and colleagues. It was a great lesson, and confirmed the values of credentials, a science background and a professional demeanor. My third position was at another hospital in Providence, RI affiliated with a medical university, and I loved working there. We still had to move around a lot of oxygen tanks, and got along great with nursing. I was asked to run the RT Department when the former manager retired. I agreed to serve temporarily, as I had applied for graduate school as a full time student. As a disabled vet, I qualified for a very generous monthly stipend, books and tuition payments. I didn’t have to work and go to school, or so I thought.

After my first year at graduate school, I took a position at another hospital in Providence; and realized I wasn’t making enough to live on. Another great job, working evenings and days, and I continued school, but taking fewer classes. I met my future wife at the hospital, she was charge nurse in the CCU, got married, and, looked for a part time job. I got a certificate in Gerontology and also took and passed a test to be a Licensed Nursing Home Administrator, while I was working on my master’s degree. I approached a large nursing home that was accredited to care for very sick patients, a step down facility if you will. I introduced them to the idea of caring for mechanically ventilated patients, they liked it; we started to admit ventilator patients with the intent to wean them and to get them home. From a patient care perspective we were very successful at weaning these patients, unfortunately, the nursing home couldn’t make money because of reimbursement issues, and after a year, we had to stop the program. Keep in mind this was about 1976, the era of growing intensive care units in the United States and demand for both ventilators and therapists.

I was approached by a friend who worked for a home care company, and he asked me if I would like to give lectures to nurses, on how to care for patients with pulmonary problems. I could schedule the lectures around my classes. After one of these lectures, a nurse asked me if the company that sponsored my lecture, would have therapists visit patients in the home, I didn’t know, but thought if they weren’t doing that, they should. I talked to upper management of the company, and they thought it was a good idea, as I had convinced them that it would increase the possibility that patients would use their oxygen properly, increasing oxygen use, and ambulation.

In those days, homecare companies were paid by the amount of oxygen a patient used, it was a win for the patient, the oxygen company, the homecare nursing agency, and, I could make some money doing what I loved doing, working with patients and teaching.

After attaining my master's degree, the company offered me a full time position as the patient care manager. I hired and trained therapist to visit patients in their homes, the company stood out from their competition, and grew into a national home care equipment company. The therapist would visit the patient in the home, teach them how to use their meds, equipment, etc., and write a report for the physician, hospital and nursing agency. I wrote patient education manuals for every product, including exercises and diets, in conjunction with experts in those areas. I was promoted into a national position, to re-create our New England program, to all the companies' locations.

The promotion meant a move to Florida. I loved the relocation as I love to fish and sail. The company continued to expand, and, I hired and trained all the therapist and nurses, and lectured all over the country, on homecare and pulmonary rehabilitation. Eventually this led me to being appointed as chairman, to AARC's newly developed Pulmonary Rehabilitation and Homecare Section. The section prospered, even though there reimbursement had not evolved to pay for pulmonary rehab, or homecare. Therapists, working in home care, were not allowed to be "active" AARC members at that time, as they had no designated medical director. They could join only as "affiliated or allied member status." As section chair, this motivated me to urge the AARC to reconsider their position which was consistent with the AARC's mission. Homecare therapists were eventually allowed to become active member. The section became the third largest AARC section. I was Chairman for four consecutive years, finally had to get back to my work, school and family. I continued to work on my doctorate degree, as my company offered to pay my expenses, including tuition and books, along with incidentals. Two years later I was awarded my Ph.D. in Health Sciences.

Turns out my family didn't like Florida; after seven years, I looked for another position. Once again, my professional networking came to the rescue as I was connected with a manufacturer that was looking for a therapist to review medical literature, and to teach critical care nurses, anesthesia nurses, infection control personal, respiratory professionals, pulmonary/critical care physicians, and anesthesiologists. They agreed to move me back to New England, and, I worked for the next 25 years in that role. The rigors of travel, work, family and school, had prepared me for this job, and next to my family and friends, became one of the pleasures of my life. I've traveled the world, lectured at universities, hospitals and every AARC State Affiliate except for Alaska. I became friends with many, many, brilliant therapists, nurses and physicians. The people I worked with were to become my best friends, in many ways, a dream job.

Who were your mentors?
-What/how did they contribute to your career?

My story provides a series examples of how fortunate I was in having a succession of professional contacts. They began with being directed to test out a hospital job and falling into a respiratory therapy department. There were several important mentors who were part of my Northeastern University respiratory care experience. Pursuing my education to obtain my master's and doctorate degrees continued to open up both jobs and professional volunteer opportunities.

The bottom line is that, you must love your job and continue to make yourself better at it. My advice is to get advanced degrees, cultivate friendships, look for opportunities, think outside the box, volunteer for national professional association and state affiliates. When possible, conduct research, and publish its findings. Help other professionals learn so they can become better at what they do. I've learned the value of treating everyone as you want to be treated, and never, never, ever, lose sight of what a privilege it is, to make the world better place for our patients.

CoBGRTE™

Entrusting the Advance Practice Respiratory Therapist

David Lopez, EdD, RRT[1], Abdullah Alismail, M.S, RRT, RRT-NPS, SDS, FCCP[1,2]
[1]Department of Cardiopulmonary Sciences, School of Allied Health Professions, Loma Linda University.
[2]Department of Medicine, School of Medicine, Loma Linda University.

Competency based medical education is the primary method of assessment and evaluation in respiratory therapy education. In respiratory care, the Commission on Accreditation for Respiratory Care (CoARC) requires certain competencies to be achieved by all graduates of an accredited respiratory care program. This includes the new established designation of an Advanced Practice Respiratory Therapist (APRT). According to CoARC standards, graduates must achieve competency in the following core competency domains upon graduation: respiratory care knowledge, interpersonal & communication skills, patient care, professionalism, system-based practice, and inter-professional practice. [1]

Since advanced practice is a new and emerging concept within the field of respiratory care, the authors provided the CoARC an alternative to the continued use of Competency Based Medical Education (CBME) as an assessment and evaluation tool for APRTs. A proposed framework was introduced by the authors, employing the concept of the Entrustable Professional Activities (EPA) process. The EPA method has been used by ACGME (Accreditation Council for Graduate Education) and other advanced practice providers such as nurse practitioners (NP) and physician assistants (PA).[2-4] EPAs were first introduced in 2005 by Cate to encourage educators to incorporate "trust" as a factor for an advanced level of assessment of the learner [5,6] To trust someone to perform a specific procedure or process independently involves assessment of intangible areas such as professional behaviors and critical thinking. According to Cate, these intangible areas are necessary for a holistic assessment. The assessment and evaluation of EPAs encompass the continuum of care, i.e. of more than discrete competencies or skills. Therefore, it could be argued that it is time to consider using a higher-level assessment tool, such as EPAs. A sample framework with 8 EPA attributes linked to CoARC core competencies was proposed by Alismail and Lopez (i.e. to promote and improve the quality and safety of healthcare, and provide consultation to the medical team and healthcare providers (physicians, nursing, etc.).[7] Moreover, to develop valid EPA components for the APRT, the respiratory care education community as a whole must contribute to the process. Proposed questions for the RT education community to consider include: is it time to consider an advanced standardized assessment tool for the APRT? If EPAs are approved as a model, how many EPAs will be required and what are their descriptions? Finally, what are the sub-competencies included within each EPA?

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Editorial Board Recommended COVID-19 Articles

1. Marini JJ, Gattinoni L. Management of COVID-19 Respiratory Distress. JAMA 2020.
2. Wadman M, Couzin-Frankel J, Kaiser J, Matasic C. How does corona virus kill? Clinicians trace a ferocious rampage through the body, from brain to toes. April 17, 2020.
3. NIH COVID-19 Treatment Guidelines
4. Richardson S, Hirsch J, Narasimham M. Presenting Characteristics, Comorbidities, and Outcomes Among 5700 Patients Hospitalized With COVID-19 in the NewYork City Area JAMA April 22, 2020. doi:10.1001/jama.2020.6775.
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6. Wang Y, et al. Remdesivir in adults with severe COVID-19: a randomised, double-blind, placebo-controlled, multicentre trial

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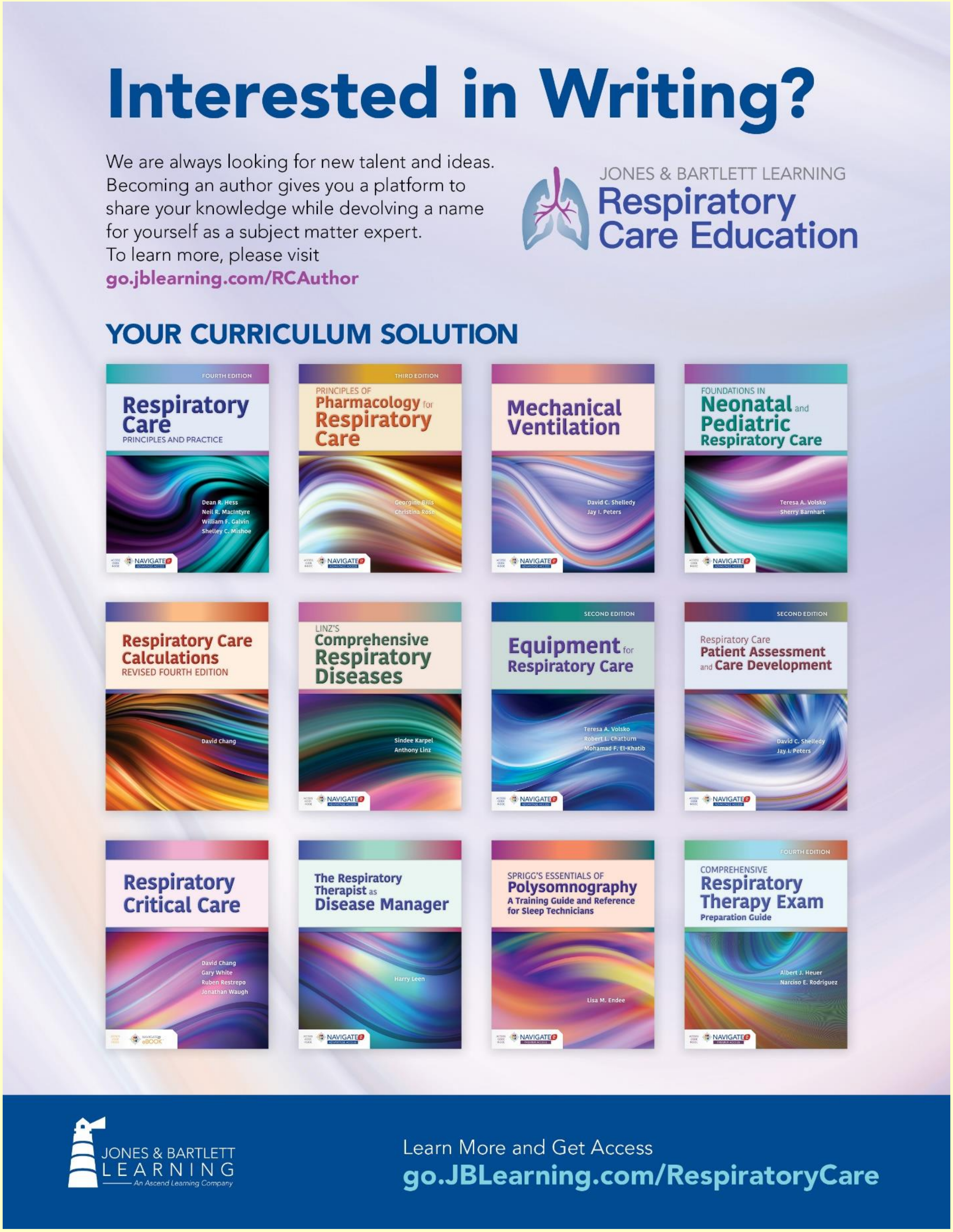
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David Chang Gary White Ruben Restrepo Jonathan Waugh
The Respiratory Therapist as Disease Manager
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If you haven't already decided to become a CoBGRTE member after visiting www.cobgrte.org, the following are 14 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.

Become a CoBGRTE member by completing the application on the Membership Page: [http://www. cobgrte.org/membership. html](http://www.cobgrte.org/membership.html)