AARC’s 2015 & Beyond Taskforce Recommendations: The Coming Storm

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Assistant Manager
Respiratory Care Department
Harborview Medical Center
A Brief Refresher on Some RT History

1947: ITA forms

1960: American Association Inhalation Therapists forms precursor to NBRC, the American Registry of Inhalation Therapists

May 1961 35 RT's were RIT credentialed

First RIT credential awarded later that year. Exam included written and oral components

1969: only 10% of RT workforce held the RIT credential.

Late 1969: AAIT launches “Technician Certification Program” (CITT)

1974 AART hands CITT credential over to ARIT and the NBRT is formed

2009 CoARC announces it will no longer accredit one year programs

2010 CoARC announces it will use CRT pass rates to accredit 2 year programs
Tripartate of Respiratory Therapy
Some Inconvenient Truths

• Our current education and credentialing system is insufficient to facilitate future practice or supply RTs to fill key roles in the field.
  – i.e. Management / education/ research
  – Particularly in the west

• Despite advances in technology and changes in health care, the RT educational system has remained largely unchanged for 40 years.

• Our two-tiered credentialing system creates significant confusion for outside stakeholders.
  – RN versus LPN is **NOT** the same as RRT versus CRT.
Objectives

- Review / Summarize the three 2015 taskforce conferences
- List / discuss recommendations from the 2015 Taskforce
- Discuss retiring the CRT examination
- Discuss the movement towards the BSRT entry
My Disclosures

- I hold an ASRT from Highline Community College: 1996
- I hold a BSRT from the University of Kansas: 2008
- I am enrolled in a MSRC program at Northeastern University, expected graduation: 2012
- I have no financial ties to any industry or colleges (except student loans)
The AARC 2015 & Beyond Taskforce

• In 2008 the AARC began an initiative to determine what the profession will look like in the future and to develop a plan to meet future needs.

• Objectives of the taskforce:
  – To identify the emerging values of the United States’ evolving health-care delivery system.
  – To define potential new roles and responsibilities of RT’s in 2015 & Beyond.
  – To identify the skills, knowledge, attributes, education, and competency-documentation that RT’s will need for the new roles and responsibilities.
The AARC 2015 & Beyond Taskforce

- Sam Giodrano, MBA RRT FAARC
- Robert Kacmarek, PhD RRT FAARC
- John Walton MBA RRT FAARC
- Thomas Barnes EdD RRT FAARC
- Woody Kageler MD MBA
- Lynda Goodfellow EdD RRT FAARC
- David Vines MSHS RRT FAARC
- Lynn LeBoeuf, BSRC RRT
- William Dubbs, Med MHA RRT FAARC
- Neil MacIntyre, MD FAARC
- Dave D Gale, PhD
- Shelly Mishoe, PhD
- Sherry Barnhart, RRT-NPS FAARC
- Christopher Logsdon MBA RRT
- Robert Williams PhD
- Charles Durbin Jr MD FAARC
- Edward O’Neil PhD MPA
- Gordon Rubenfeld MD MSc
- Patrick Dunne MEd RRT FAARC
- John Walsh
- Col Micheal J Morris
- Judy Blumenthal PhD
The AARC 2015 & Beyond Taskforce

Conference One

• Predicted changes in health care
  – Costs will increase & everyone will pay more
  – Treatment will be aimed to maximize outpatient management
  – Goal of the healthcare system will become “health promotion”
  – Electronic medical records will become the norm
  – New delivery models will emerge- “accountable care organization”
How will these changes impact RT?

• RT’s will need to focus more energy in learning new skills and knowledge
• RT will need to function more in role of interdisciplinary team member…and at times the leader
• Care will be driven by clinical practice guidelines and patient driven protocols
• RT field will need to gain new skills
  – Case management
  – Research manager
  – Administrative
  – Health care informatics
The AARC 2015 & Beyond Taskforce

• Conference II’s goal: determine the skill-set required by respiratory therapists to meet the vision set forth by conference I.

• Competencies were formulated by field experts and by consensus

• Defines Graduate Therapist
  – Anyone coming out of an approved program
The AARC 2015 & Beyond Taskforce

- Diagnostics
- Disease Management
  - Chronic and Acute
- Evidence-based Medicine and Respiratory Care Protocols
- Patient Assessment
- Leadership

- Emergency and Critical Care
- Therapeutics
  - Assessment for need
  - Assessment prior to therapy
  - Evaluation of therapy
### Competencies in Disease Management

<table>
<thead>
<tr>
<th>A. Chronic Disease Management</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> Understand the etiology, anatomy, pathophysiology, diagnosis, and treatment of cardiopulmonary diseases (e.g., asthma, chronic obstructive pulmonary disease) and comorbidities.</td>
<td></td>
</tr>
<tr>
<td><strong>2.</strong> Communicate and educate to empower and engage patients.</td>
<td></td>
</tr>
<tr>
<td><strong>3.</strong> Develop, administer, and re-evaluate the care plan:</td>
<td></td>
</tr>
<tr>
<td>a. Establish specific desired goals and objectives.</td>
<td></td>
</tr>
<tr>
<td>b. Evaluate the patient.</td>
<td></td>
</tr>
<tr>
<td>c. Apply a working knowledge of the pharmacology of all organ systems.</td>
<td></td>
</tr>
<tr>
<td>d. Provide psychosocial, emotional, physical, and spiritual care.</td>
<td></td>
</tr>
<tr>
<td>e. Education on nutrition, exercise, wellness.</td>
<td></td>
</tr>
<tr>
<td>f. Environmental assessment and modification.</td>
<td></td>
</tr>
<tr>
<td>g. Monitoring and follow-up evaluation.</td>
<td></td>
</tr>
<tr>
<td>h. Development of action plans.</td>
<td></td>
</tr>
<tr>
<td>i. Apply evidence-based medicine, protocols, and clinical practice guidelines.</td>
<td></td>
</tr>
<tr>
<td>j. Monitor adherence through patient collaboration and empowerment, including proper and effective device and medication utilization.</td>
<td></td>
</tr>
<tr>
<td>k. Implement and integrate appropriate patient-education materials and tools.</td>
<td></td>
</tr>
<tr>
<td>l. Utilize appropriate diagnostic and monitoring tools.</td>
<td></td>
</tr>
<tr>
<td>m. Document and monitor outcomes (economic, quality, safety, patient satisfaction).</td>
<td></td>
</tr>
<tr>
<td>n. Communicate, collaborate, and coordinate with physicians, nurses, and other clinicians.</td>
<td></td>
</tr>
<tr>
<td>o. Assess, implement, and enable patient resources support system (family, services, equipment, personnel).</td>
<td></td>
</tr>
<tr>
<td>p. Ensure financial/economic support of plan/program and related documentation.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Acute Disease Management</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> Develop, administer, evaluate, and modify respiratory care plans in the acute-care setting, using evidence-based medicine, protocols, and clinical practice guidelines.</td>
<td></td>
</tr>
<tr>
<td><strong>2.</strong> Incorporate the patient/therapist participation principles listed in chronic disease management (see IIA.).</td>
<td></td>
</tr>
</tbody>
</table>

*Upon entry into the workforce, a graduate respiratory therapist must possess all of these competencies.*
Other Competencies

Table 4. Competency Area III: Evidence-Based Medicine and Respiratory Care Protocols*

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Evidence-Based Medicine</td>
<td>1. Review and critique published research.</td>
</tr>
<tr>
<td></td>
<td>2. Explain the meaning of general statistical tests.</td>
</tr>
<tr>
<td></td>
<td>3. Apply evidence-based medicine to clinical practice.</td>
</tr>
<tr>
<td>B. Respiratory Care Protocols</td>
<td>1. Explain the use of evidence-based medicine in the development and</td>
</tr>
<tr>
<td></td>
<td>application of hospital-based respiratory care protocols.</td>
</tr>
<tr>
<td></td>
<td>2. Evaluate and treat patients in a variety of settings, using the</td>
</tr>
<tr>
<td></td>
<td>appropriate respiratory care protocols.</td>
</tr>
</tbody>
</table>

* Upon entry into the workforce, a graduate respiratory therapist must possess all of these competencies.

Table 6. Competency Area V: Leadership*

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Team Member</td>
<td>Understand the role of being a contributing member of organizational</td>
</tr>
<tr>
<td></td>
<td>teams as it relates to planning, collaborative decision making, and</td>
</tr>
<tr>
<td></td>
<td>other team functions.</td>
</tr>
<tr>
<td>B. Healthcare Regulatory Systems</td>
<td>Understand fundamental/basic organizational implications of regulatory</td>
</tr>
<tr>
<td></td>
<td>requirements on the healthcare system.</td>
</tr>
<tr>
<td>C. Written and Verbal Communication</td>
<td>Demonstrate effective written and verbal communication with various</td>
</tr>
<tr>
<td></td>
<td>members of the healthcare team, patients, families, and others</td>
</tr>
<tr>
<td></td>
<td>(cultural competence and literacy).</td>
</tr>
<tr>
<td>D. Healthcare Finance</td>
<td>Demonstrate basic knowledge of health-care and financial reimbursement</td>
</tr>
<tr>
<td></td>
<td>systems and the need to reduce the cost of delivering respiratory care.</td>
</tr>
<tr>
<td>E. Team Leader</td>
<td>Understand the role of team leader: specifically, how to lead groups in</td>
</tr>
<tr>
<td></td>
<td>care planning, bedside decision making, and collaboration with other</td>
</tr>
<tr>
<td></td>
<td>healthcare professionals.</td>
</tr>
</tbody>
</table>

* Upon entry into the workforce, a graduate respiratory therapist must possess all of these competencies.

Conference III: Transitioning the Respiratory Therapy Workforce For 2015 & Beyond

• Goal: “determine what changes in the profession are necessary to position RT’s to fulfill the roles and responsibilities identified in conference one and to ensure that future and practicing RT’s acquire the competencies identified in conference II.”

Transitioning the Respiratory Therapy Workforce for 2015 and Beyond

Thomas A Barnes EdD RRT FAARC, Robert M Kacmarek PhD RRT FAARC, Woody V Kageler MD MBA, Michael J Morris MD, and Charles G Durbin Jr MD FAARC
Objectives

• Review / Summarize the three 2015 taskforce conferences

• List / discuss recommendations from the 2015 Taskforce

• Discuss retiring the CRT credential

• Discuss the movement towards the BSRT and controversies
2015 & Beyond Taskforce Recommendations

Education:

- The AARC requests CoARC to change by July 1, 2012 the accreditation standard:
  - Sponsoring institution must provide a baccalaureate or graduate degree
  - Programs accredited prior to 2013 that do not offer a baccalaureate or graduate degree must transition to awarding those degrees to students matriculating after 2020.
  - AARC to recommend to CoARC to consider development of consortia and cooperative models for ASRT programs to align with BSRT programs
2015 & Beyond Taskforce
Recommendations

Credentials

• AARC to recommend to the National Board for Respiratory Care (NBRC) on July 1, 2011, that the CRT exam be retired after 2014

• On July 1, 2011 the CRT exam material be combined with the written RRT exam
2015 & Beyond Taskforce Recommendations

Retire the exam, **NOT** the practitioner
2015 & Beyond Taskforce Recommendations

• Licensure
  – On July 1, 2011 a commission to assist state regulatory boards in transition to the RRT requirement for licensure as an RT
  – This would require a rule change in Washington State
2015 & Beyond Taskforce Recommendations

- Specialty sections to develop standards to assess competency of RT’s in workforce relative to those areas

- Encourage the use of clinical simulation

- Develop career ladder options for members of existing workforce

- AARC to provide $$$ to assist ASRT programs to transition to BSRT

- AARC request the ARCF to donate $$$ to help ASRT programs transition to BSRT programs
2015 & Beyond Taskforce Recommendations

Not Approved:

• Two levels of practice (RRT vs. CRT)

• AARC to recommend to the states that a RRT be required to practice
Objectives

- Review / Summarize the three 2015 taskforce conferences
- List / discuss recommendations from the 2015 Taskforce
- Discuss retiring the CRT credential
- Discuss the movement towards the BSRT and controversies
Retiring the CRT Examination

Let’s revisit some facts about the CRT credential

- “Technician Certification Program” developed to address un-credentialled workforce in 1969 after the RIT (now RRT) was developed
- Represents 12-18 months training
- 2009: CoARC will no longer accredit any one year programs
## Retiring the CRT Examination

### Table 49. NBRC Credentials Earned

<table>
<thead>
<tr>
<th>Credentials</th>
<th>Responses</th>
<th>Percent of Responses</th>
<th>Percent of Cases in the Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certified Respiratory Therapist (CRT)</td>
<td>1,998</td>
<td>36.1%</td>
<td>69.3%</td>
</tr>
<tr>
<td>Certified Pulmonary Function Technologist CPFT</td>
<td>408</td>
<td>7.4%</td>
<td>14.2%</td>
</tr>
<tr>
<td>Neonatal/Peds Specialist (CRT-NPS or RRT-NPS)</td>
<td>483</td>
<td>8.7%</td>
<td>16.8%</td>
</tr>
<tr>
<td>Sleep Disorders Specialist (CRT-SDS or RRT-SDS)</td>
<td>8</td>
<td>.1%</td>
<td>.3%</td>
</tr>
<tr>
<td>Registered Pulmonary Function Tech (RPFT)</td>
<td>177</td>
<td>3.2%</td>
<td>6.1%</td>
</tr>
<tr>
<td>Registered Respiratory Therapist (RRT)</td>
<td>2,458</td>
<td>44.4%</td>
<td>85.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5,532</td>
<td><strong>100.0%</strong></td>
<td><strong>85.3%</strong></td>
</tr>
</tbody>
</table>

*The percentage was based on the number of people who responded to this question.

**Respondents were allowed to select each option that applied. Respondents who earned the CRT and RRT credentials selected both options. Therefore, the sum of row frequencies exceeds 3139.*
### Table 54. Respiratory therapy training/education

<table>
<thead>
<tr>
<th>Training Level</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
<th>Projected Population*</th>
</tr>
</thead>
<tbody>
<tr>
<td>On-the-job training</td>
<td>117</td>
<td>3.7</td>
<td>4.2</td>
<td>4.2</td>
<td>5,409</td>
</tr>
<tr>
<td>Entry level</td>
<td>219</td>
<td>7.0</td>
<td>7.8</td>
<td>11.9</td>
<td>10,124</td>
</tr>
<tr>
<td>Advanced level, eligible for the RRT</td>
<td>2477</td>
<td>78.9</td>
<td>88.1</td>
<td>100.0</td>
<td>114,513</td>
</tr>
<tr>
<td>Total</td>
<td>2813</td>
<td>89.6</td>
<td>100.0</td>
<td></td>
<td>130,046</td>
</tr>
<tr>
<td>Missing</td>
<td>326</td>
<td>10.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>3139</td>
<td>100.0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Projected total does not equal the sum across training due to 326 cases with missing data for training. Projected training = (Frequency/3139) x 145117, where 145117 = number of active therapists in total population.

Source: 2009 AARC Human Resource Study
Retiring the CRT Examination

RT managers preference on which credential should be required to enter practice

Overall

RRT  81.2%

CRT  18.9%

Kacmarek et al. Respir Care [e-pub ahead of print]
RRT would become new “base credential”
  - Specialty exams to reflect areas of expertise
  - Adult Critical Care Specialty (ACCS) will be available 2012

Will the NBRC accept the recommendation?
• No
• NBRC has announced their revisions to credentialing process
  – Combines written CRT & RRT exams
  – Does not retire CRT examination
  – Full details to be announced at this year’s Summer Forum
Retiring the CRT Examination

• What are other states doing?
  – Ohio’s Board of Respiratory Care
    • Response to new schools “diploma mills” producing unqualified candidates.
    • Will make RRT credential a requirement for new licensure applications
  – Virginia Board of Respiratory Care
    • Will make a recommendation to governing Medical Board to establish the RRT credential as a requirement for new licensure applications
Objectives

• Review / Summarize the three 2015 taskforce conferences

• List / discuss recommendations from the 2015 Taskforce

• Discuss retiring the CRT credential

• Discuss the movement towards the BSRT and controversies
Under-educated troglodyte!!

You elitist snob!!

The four year graduate

The two-year graduate
Moving towards BSRT

Some more questions to ponder….

• Are students from ASRT programs fully prepared to work after graduation?

• Nationally, RRT pass rates are falling - why?

• Many students spend 1-2 years doing pre-requisites prior to entering the program & only get an ASRT, is this fair?

• Has the educational material grown beyond the ability for educators to cover in two years?
Moving towards BSRT

- Critique published research
- Explain meaning of general statistical tests
- Apply EBM to clinical practice
- Understanding financial reimbursement
- Explain needs for adv PFT test

Barnes et al. Survey of RT program directors. Respir Care [e-pub ahead of print]
Moving towards BSRT

Department directors preference for new hires

Overall

BSRT: 36.7%

ASRT: 36.8%

No preference: 26.5%

Kacmarek et al. Respir Care [e-pub ahead of print]
Moving towards BSRT

RT managers preference on which degree should be required to enter practice in the future

Overall

BSRT/MSRT 41.8%
MSRT
ASRT 58.2%

Kacmarek et al. Respir Care [e-pub ahead of print]
Moving towards BSRT

Programs adequately prepare students to work in pediatric/neonatal environment

Walsh BK, et al. Respir Care 2011;56(8)1122-1129.

Kacmarek et al. Respir Care [e-pub ahead of print]
Moving towards BSRT

Source: 2009 AARC Human Resource Study
Moving towards BSRT

- Where are the next educators coming from?

Table 76. Distribution by recruitment difficulty.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Responses</th>
<th>Percent</th>
<th>Percent of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicants didn’t meet academic preparation requirements</td>
<td>64</td>
<td>31.4%</td>
<td>69.6%</td>
</tr>
<tr>
<td>Salary we could offer was not sufficient</td>
<td>63</td>
<td>30.9%</td>
<td>68.5%</td>
</tr>
<tr>
<td>Applicants lacked teaching experience</td>
<td>58</td>
<td>28.4%</td>
<td>63.0%</td>
</tr>
<tr>
<td>Other reasons for recruitment difficulty*</td>
<td>19</td>
<td>9.3%</td>
<td>20.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>204</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>221.7%</strong></td>
</tr>
</tbody>
</table>

* Respondents’ free responses to this question can be found in Appendix C
**Respondents were instructed to ‘Select all that apply’.

Source: 2009 AARC educator survey
The Wisconsin Campaign to Promote the Applied Associate Degree as the Continued Career Entry Point for Respiratory Therapists

Background

There is a strong movement within the American Association for Respiratory Care (AARC) to phase out the current associate degree career entry point for respiratory therapists. In fact, members of the AARC group named the Coalition for Baccalaureate and Graduate Respiratory Therapy Education (CoBGRT) have published two papers to date documenting this viewpoint. The following excerpt was taken from a white paper published on the AARC website:
Table 2

% of WI Graduates Obtaining RRT per 3-year Block

<table>
<thead>
<tr>
<th>Year Block</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004-2006</td>
<td>57%</td>
</tr>
<tr>
<td>2005-2007</td>
<td>65%</td>
</tr>
<tr>
<td>2006-2008</td>
<td>71%</td>
</tr>
<tr>
<td>2007-2009</td>
<td>72%</td>
</tr>
</tbody>
</table>

Wisconsin Technical College System: Position paper
Washington State RT Schools

Moving towards BSRT

• US RT educational structure
  – 406 ASRT programs
  – 5 ASRT/BSRT (2+2)
  – 51 BSRT
  – 5 Masters programs
    • 2 have pre-licensure options
    • More on the way

• Coalition on Bachelor Graduate Respiratory Therapy Education (CoBGRTE)
  – Currently looking to expand 150 BSRT programs, have identified Washington State as a desirable location
Moving towards BSRT

Source: CoBGRTE 2011 Roster
Moving towards BSRT

- Concern over supply for new RT’s entering field
  - Need approximately 7,000 grads per year
- Opponents blame “degree creep”
- NN2 group has threatened to establish their own accreditation agency

www.nn2rc.org
Moving Towards BSRT

• “Degree Creep”
  – Process by which ever increasing academic requirements are placed on people entering a particular field.
    • Examples include Pharmacy, Speech Language Pathology, Physical Therapy.
    • Done to enhance professional prestige?
  – Problems with degree creep
    • Cuts community colleges / technical college out of offering training programs
    • Claims increased degrees increase health care costs
    • Increases barrier to field entry by non-traditional students
RCSW Response

• Formed an Ad-hoc group to address these issues:

  Jon Jahns (chair)  Carl Hinkson  Fred Goglia
  Jim Kumpula       Bob Bonner

  – Adopted position Statement on a BSRT option in WA State
Summary

- Where are these recommendations?
  - AARC president Karen Stewart has created an Ad hoc committee to evaluate recommendations
  - Process will take two years
- Health Care delivery system is constantly changing & RT’s must adapt
- RT field faces many tough decisions in the future
- RT field needs to revisit our current credentialing structure & education system
Questions?

Contact: Carl Hinkson
E-mail: gooddog@uw.edu