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

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A Brief Refresher on Some RT History

1947:

ITA forms

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

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

May 1961 35 RT's were RIT credentialed

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
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- 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”

The AARC 2015 & Beyond Taskforce

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 inter-disciplinary 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
  - Assessment of therapy
  - Evaluation of therapy

Competencies in Disease Management

Table 3. Competency Area II: Disease Management*

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

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

Barnes et al. Competencies needed by Graduate RT's. Respir Care. 2010;55(5):601-616.

Other Competencies

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

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

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

Table 6. Competency Area V: Leadership*

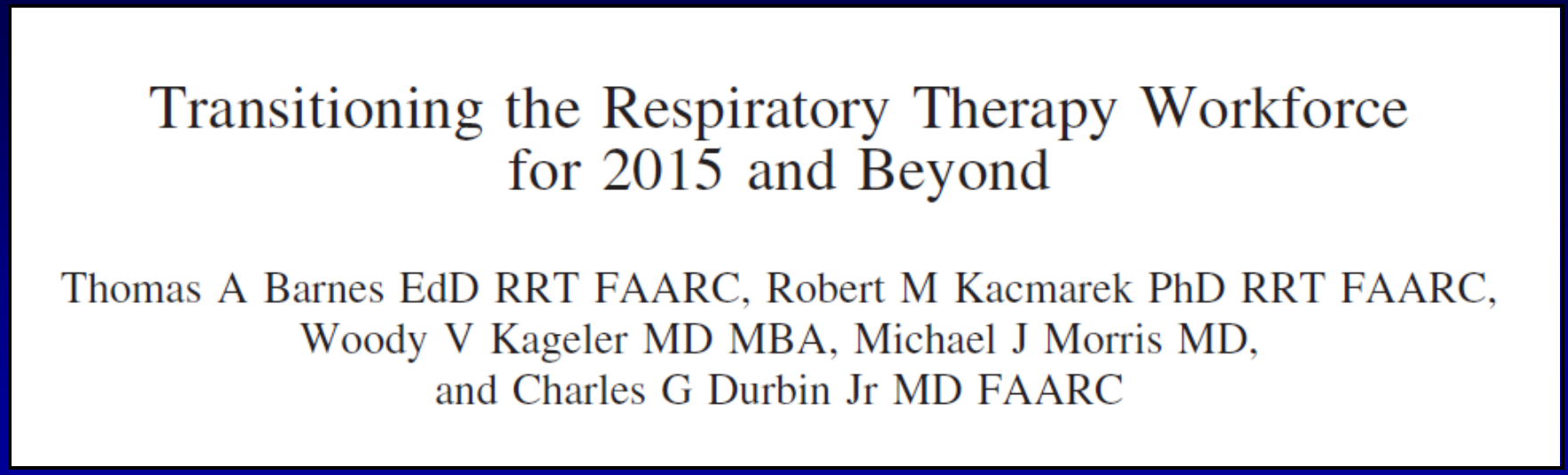
Descriptor	Definition
A. Team Member	Understand the role of being a contributing member of organizational teams as it relates to planning, collaborative decision making, and other team functions.
B. Healthcare Regulatory Systems	Understand fundamental/basic organizational implications of regulatory requirements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

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

Barnes et al. Competencies needed by Graduate RT's. Respir Care. 2010;55(5):601-616.

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:

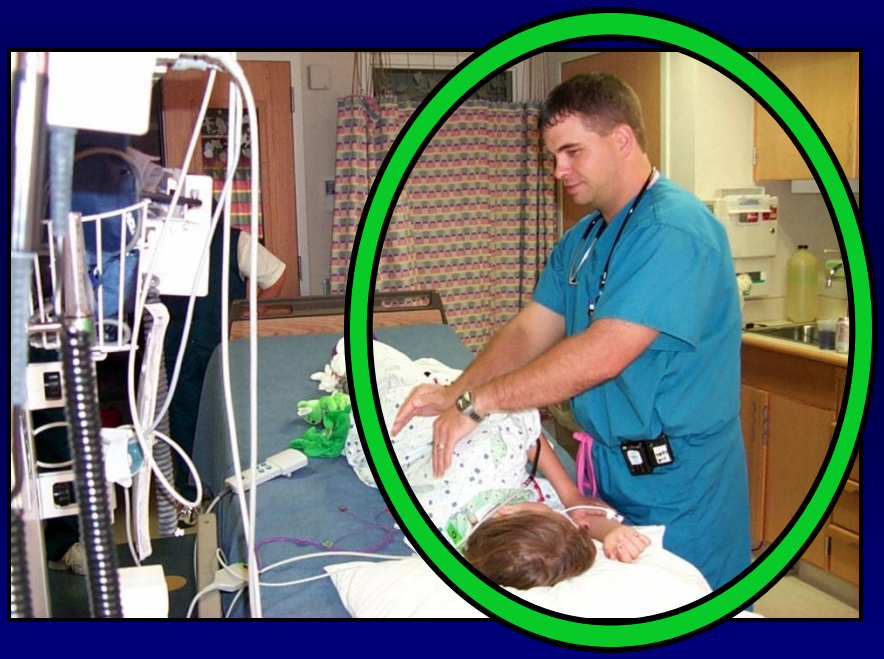
- The AARC requests CoARC to change by July 1, 2012 the accreditation standard:
  - Sponsoring institution must provide a baccalaureate or graduate degree
  - Programs accredited prior to 2013 that do not offer a baccalaureate or graduate degree must transition to awarding those degrees to students matriculating 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

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Retiring the CRT Examination

Let's revisit some facts about the CRT credential

- "Technician Certification Program" developed to address un-credentialed 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

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

*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.

Source: 2009 AARC Human Resource Study

Retiring the CRT Examination

Table 54. Respiratory therapy training/education

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

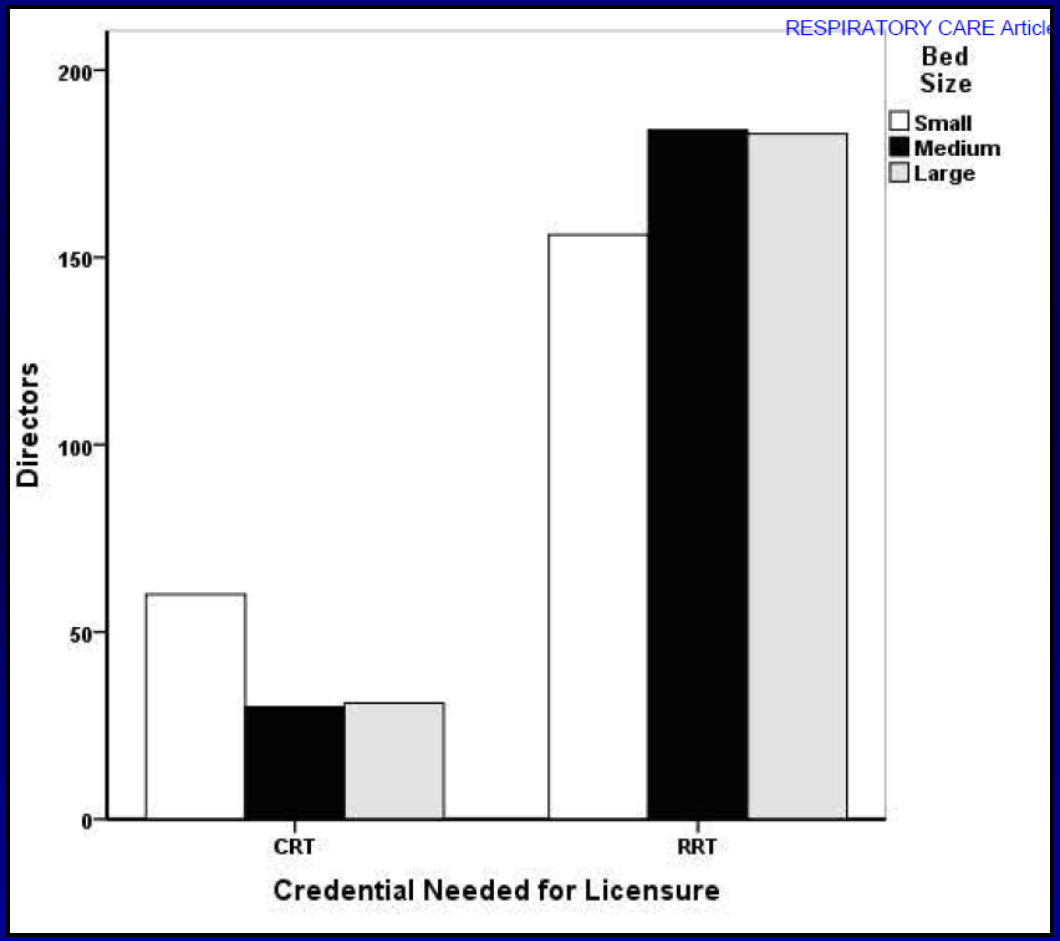
* Projected total does not equal the sum across training due to 326 cases with missing data for training. Projected training = (Frequency/3139) x 145117, where 145117 = number of active therapists in total population.

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]

Retiring the CRT Examination

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 years 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

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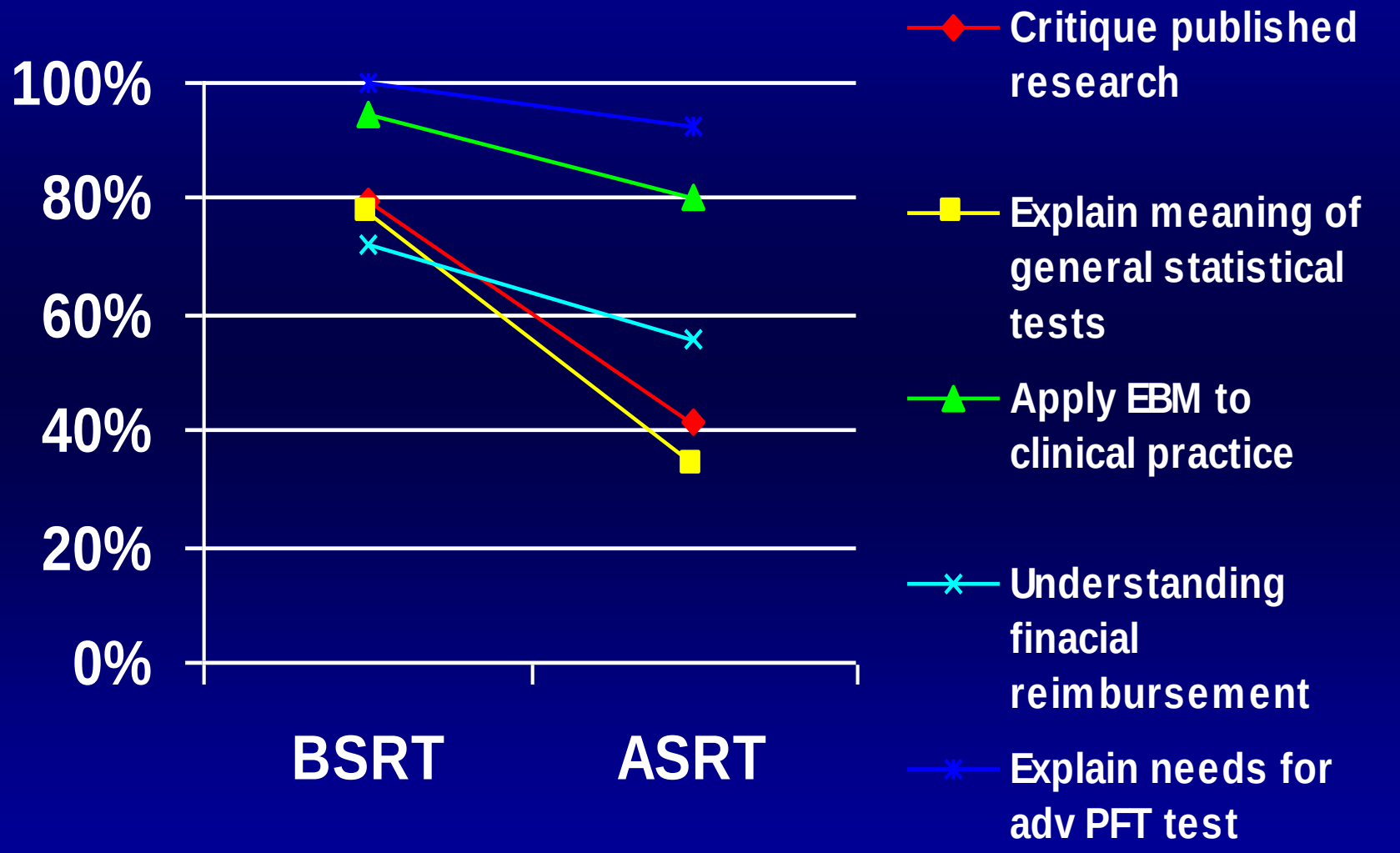
Under-educated troglodyte!!
You elitist snob!!
The four year graduate
The two-year graduate

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

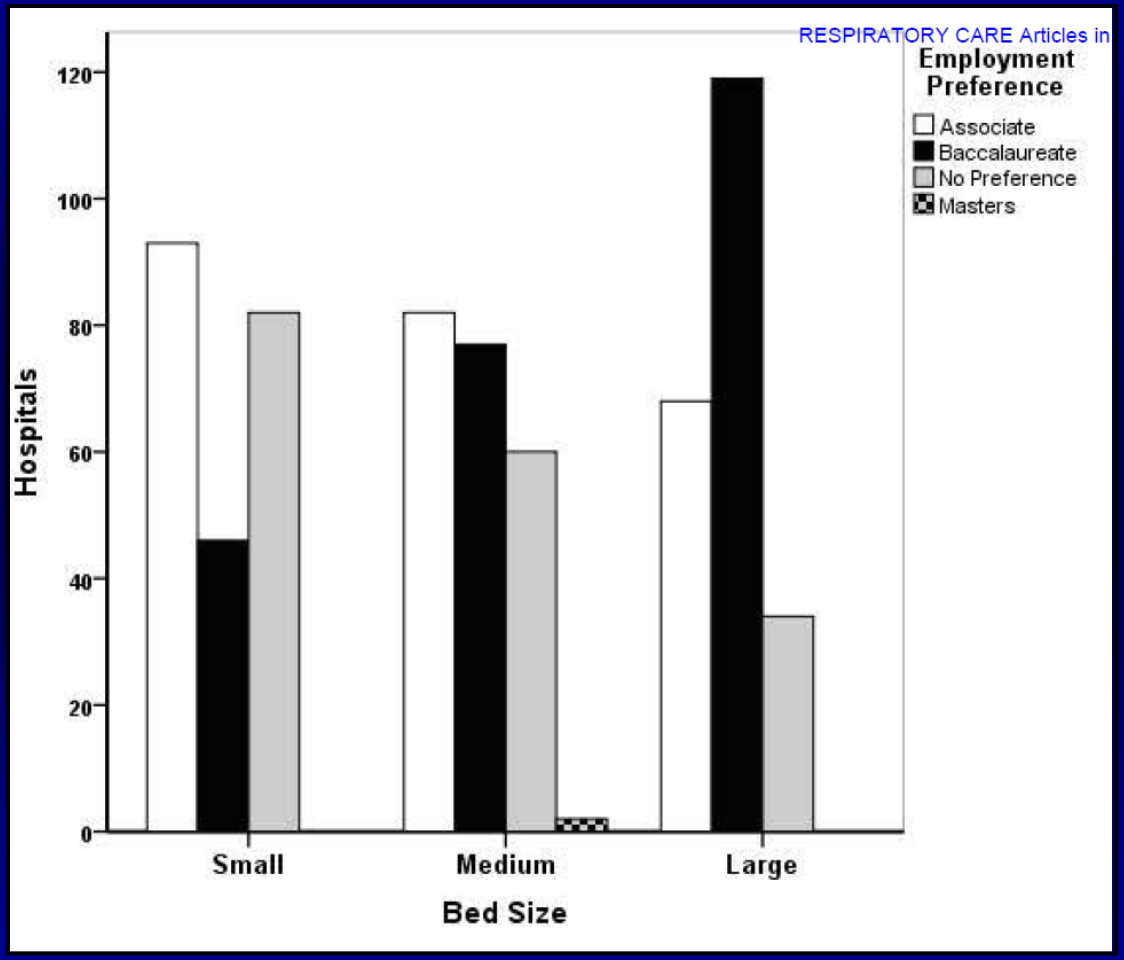


Barnes et al. Survey of RT program directors. Respir Care [e-pub ahead of print]

Moving towards BSRT

Department directors preference for new hires

	Overall
BSRT	36.7%
ASRT	36.8%
No preference	26.5%



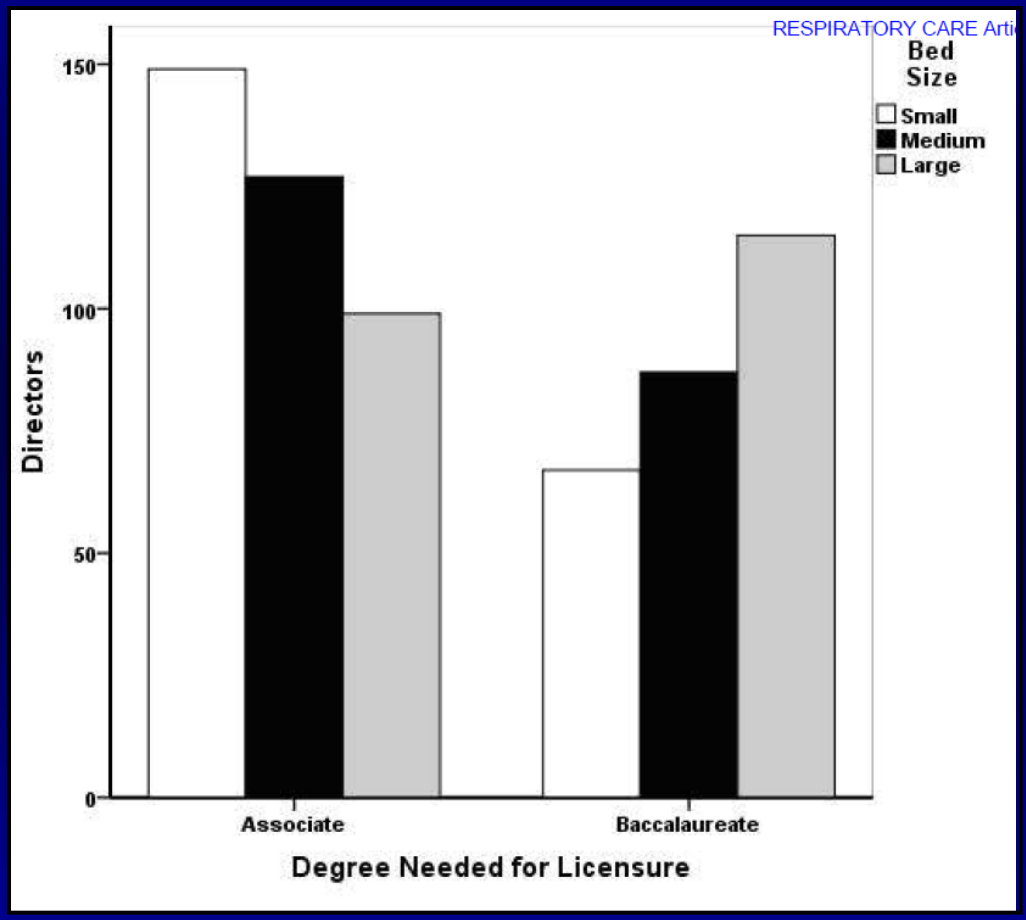
Kacmarek et al. Respir Care [e-pub ahead of print]

Moving towards BSRT

RT managers preference on which degree should be required to enter practice <u>in the future</u>

Overall

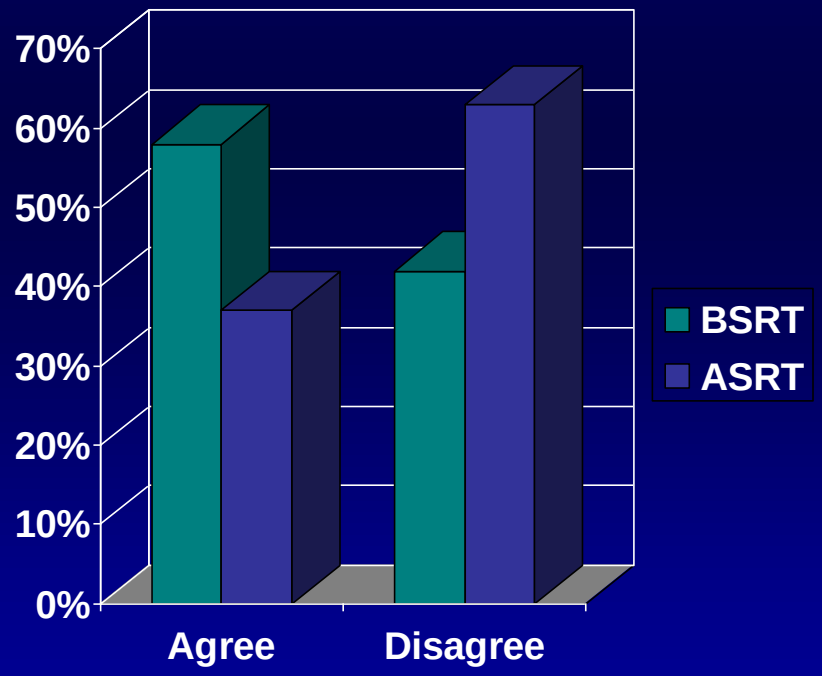
BSRT/ MSRT	41.8%
ASRT	58.2%



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

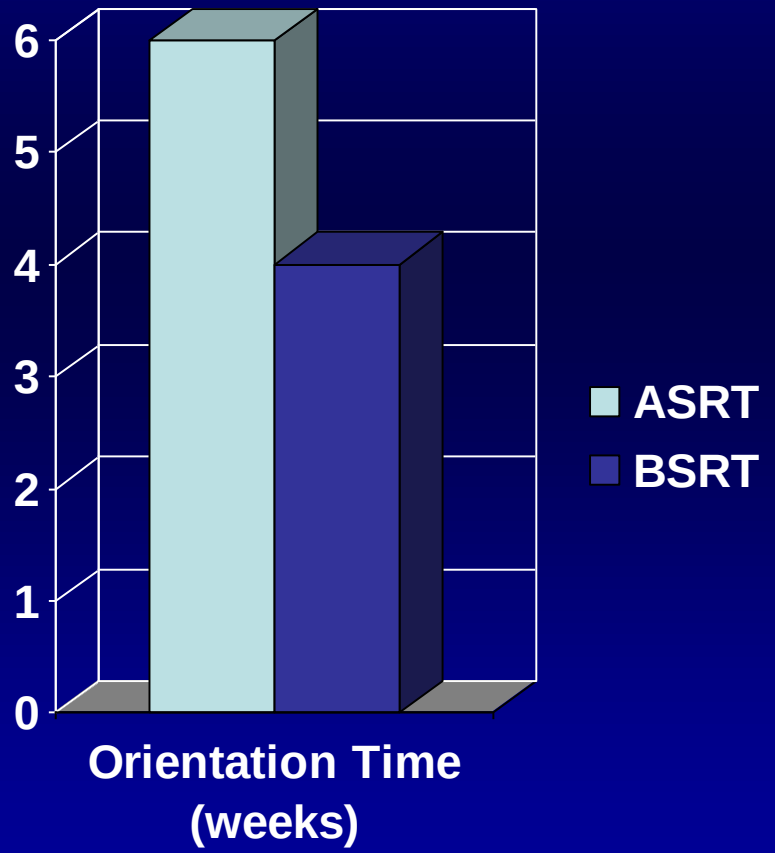
Moving towards BSRT

Programs adequately prepare students to work in pediatric/neonatal environment



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

Time for orientation



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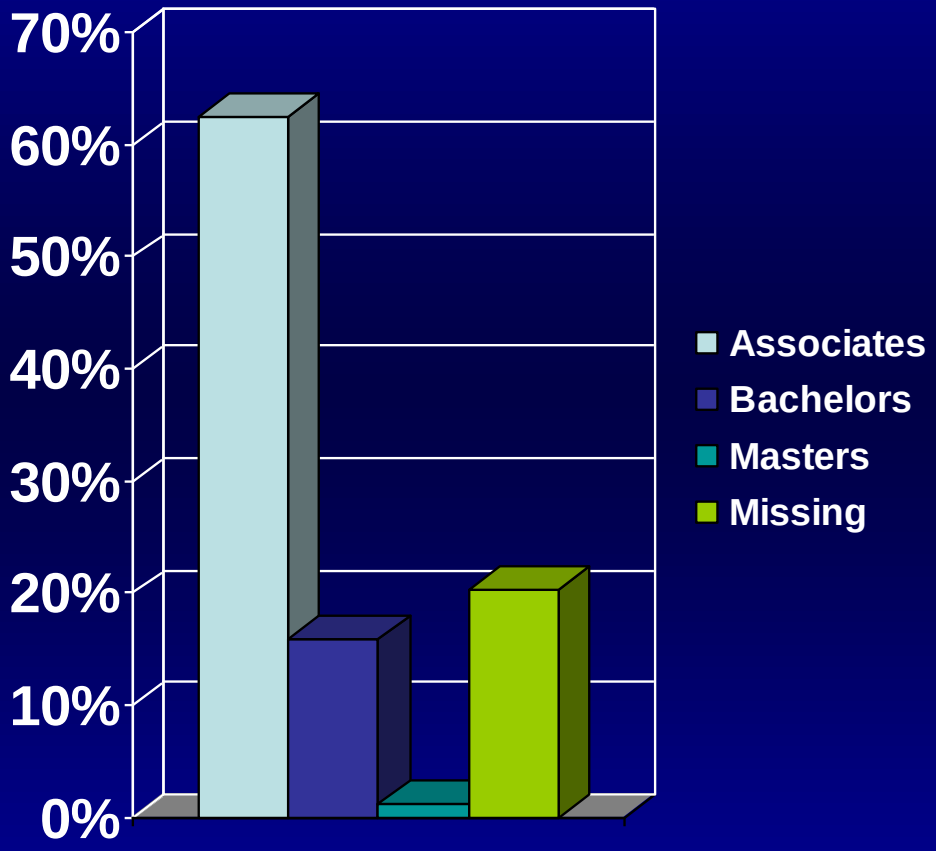
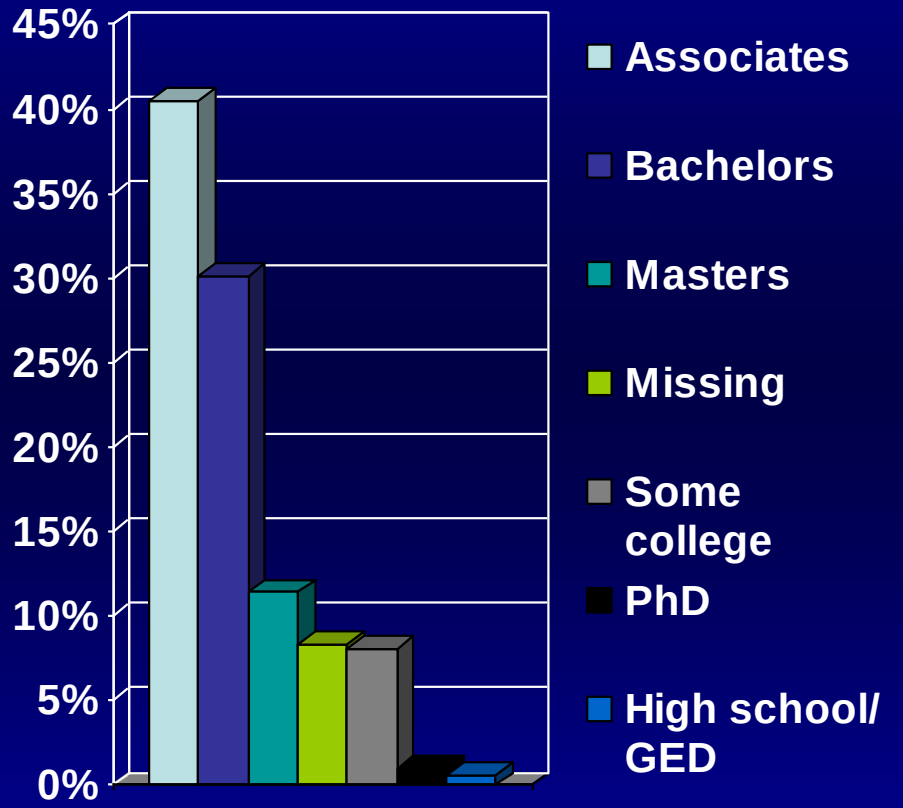
Moving towards BSRT



Degree earned becoming RT



Highest degree earned

Source: 2009 AARC Human Resource Study

Moving towards BSRT

- Where are the next educators coming from?

Table 76. Distribution by recruitment difficulty.

		Responses		Percent of Cases
		N	Percent	
What reasons contributed to the difficulty you experienced in recruiting faculty?	Applicants didn't meet academic preparation requirements	64	31.4%	69.6%
	Salary we could offer was not sufficient	63	30.9%	68.5%
	Applicants lacked teaching experience	58	28.4%	63.0%
	Other reasons for recruitment difficulty*	19	9.3%	20.7%
Total**		204	100.0%	221.7%

* 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

«« POSITION PAPER

November 2010

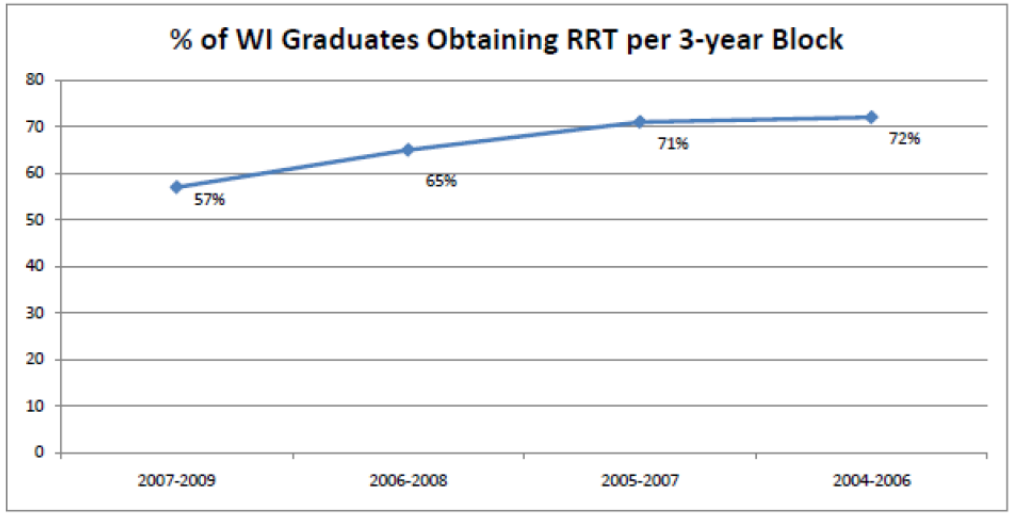
The Wisconsin Campaign to Promote the Applied Associate Degree as the Continued Career Entry Point for Respiratory Therapists

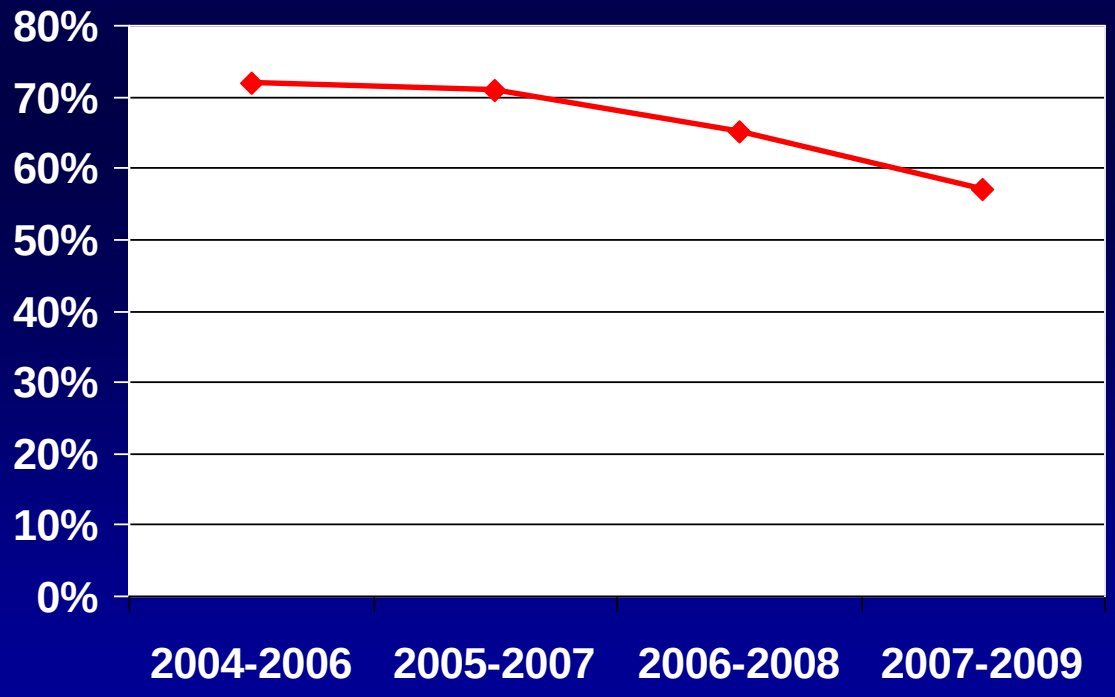
Background

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:

Wisconsin Technical College System: Position paper

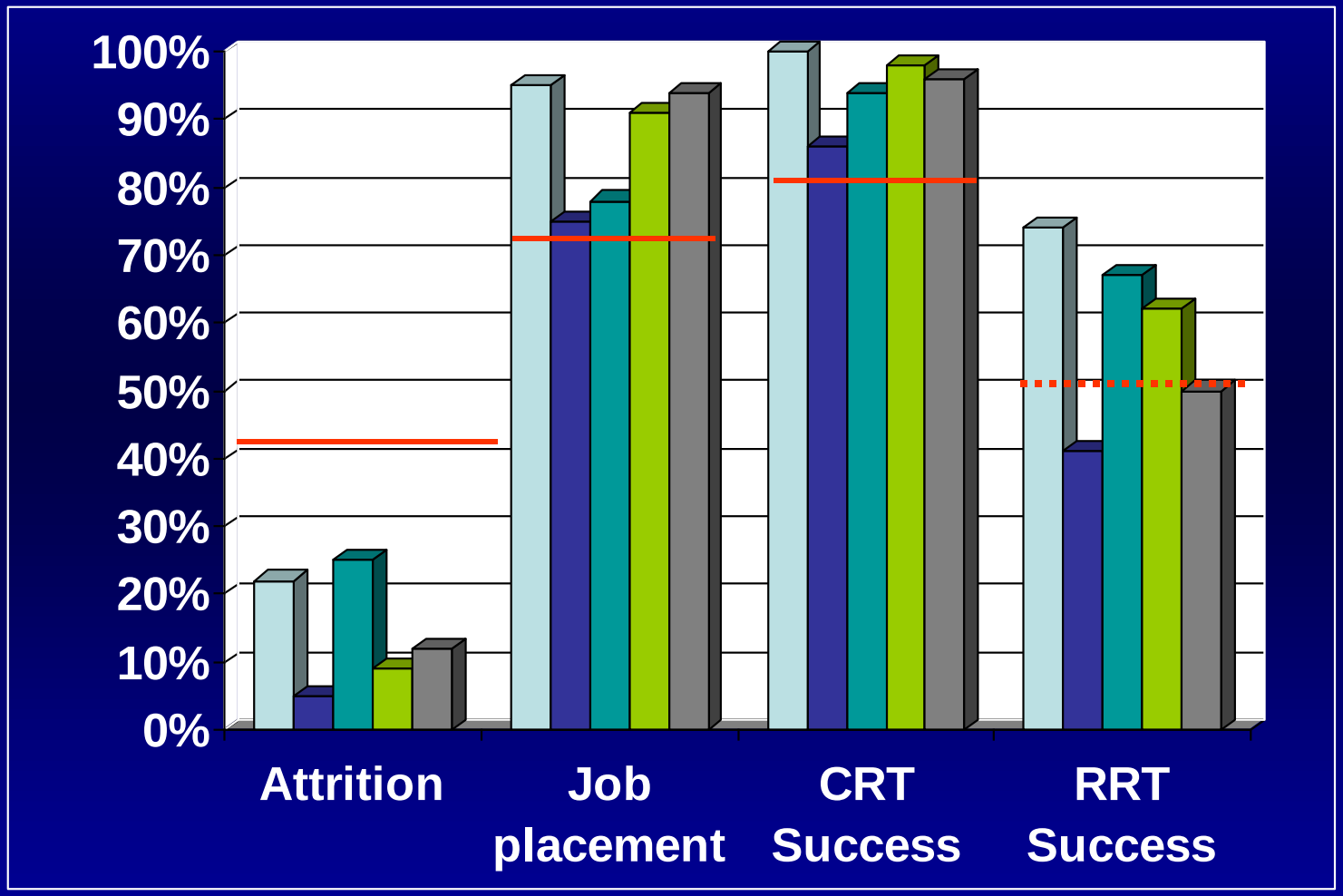
Table 2





Wisconsin Technical College System: Position paper

Washington State RT Schools

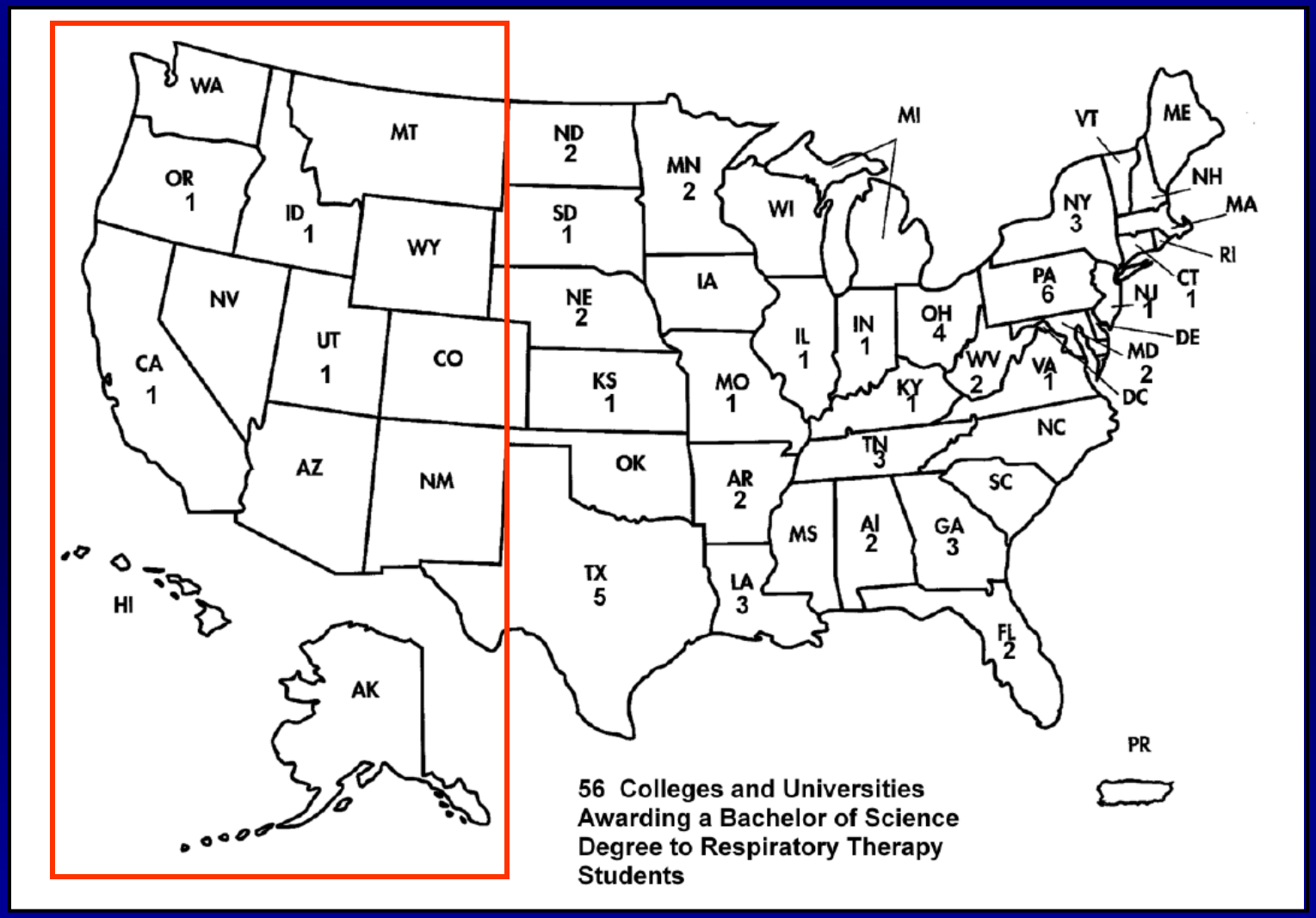


Source: 2011 Annual Report of Current Status Outcomes; available at www.coarc.com

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

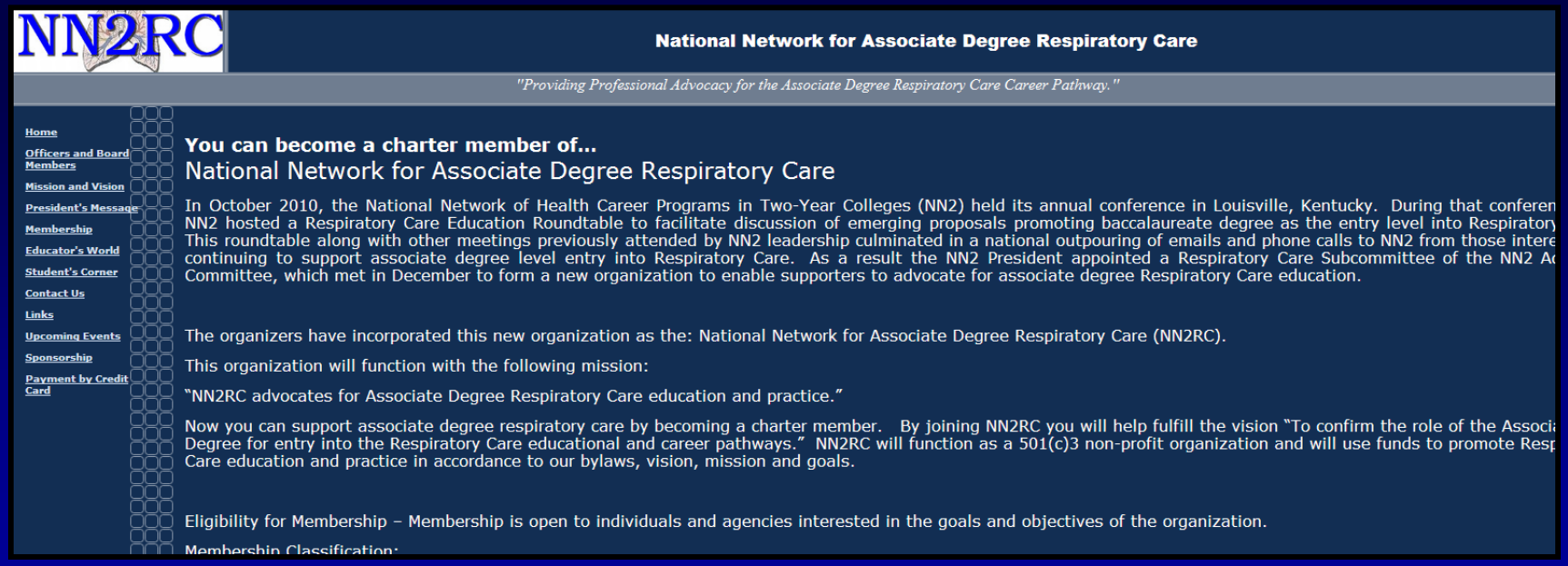
Moving towards BSRT



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