The Coalition Chronicle

Coalition for Baccalaureate and Graduate Respiratory Therapy Education

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Spotlight Article



WEBER STATE UNIVERSITY
Ogden, Utah

Department of Respiratory Therapy

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Overview

The Respiratory Therapy Program at Weber State University (WSU) is a state, regional, and national advocate for respiratory care curriculum and education. The program maintains continuing accreditation by the Commission on Accreditation for Respiratory Care (CoARC). The mission of the Department of Respiratory Therapy is to prepare graduates for the practice of respiratory

therapy in a variety of health care settings such as clinics, extended and home care settings, emergency and life flight operations. Also provided are opportunities for interdisciplinary learning in graduate programs such as PA's, cardiopulmonary perfusionists, and future career opportunities as educators, technical sales representatives, and admission to medical and law schools.



The program offers career mobility through an articulated ladder approach to respiratory therapy education. WSU respiratory therapy faculty provides education to a hybrid population of students that match the diverse community for those residing in urban and rural areas through one base program in Ogden, Utah (selected and enrolled each year). There are two satellite locations; WSU-Davis cohort located in Layton, Utah (enrolled each odd year and taught thru to completion [18 months]) and Farmington/SLC cohort located in Farmington, Utah (enrolled each even year and taught thru to completion [18 months]). Alternate satellite cohorts graduate in August each year. At any given time, there are approximately 80 students enrolled in the program at various stages of completion, with 32-38 graduates each year. Its role is to build a foundation in the art, science, and practice of respiratory care and to provide for life-long personal and professional learning at the associate of applied science (AAS pre-professional), baccalaureate (BS) and master of science degree level (MSRT). Future incorporation of the



advanced practice emphasis into our master's degree preparation is the shared goal of the faculty.

The stated goals of the Department of Respiratory Therapy at WSU are to:

- 1) prepare competent graduates with demonstrated expertise in the cognitive (knowledge), psychomotor (skills), and affective (behavior) learning domains of respiratory care practice as performed by registered respiratory therapists (RRTs).
- 2) ensure credentialing success, and
- 3) demonstrate professionalism in respiratory care practices by preparing leaders for the field by including curricular content with objectives related to the acquisition of skills in one or more of the following: management, education, research and advanced clinical practice (which may include an area of clinical specialization).



Weber State's program utilizes rigorous selection criteria to admit students who have the technical, behavioral and communicative characteristics to succeed in the program. To its credit, attrition is less than 1%. Eighty-eight to 92% of graduates have apprentice or assistant licenses prior to graduation (implemented during the COVID-19 pandemic) and are working within 6 months of graduation or move on to graduate programs. Students enrolled in the program are continuously advised by an admissions advisor dedicated to the program and mentored by faculty through graduation from the program.

Distinguished RRT Credentialing Success

Following a CoARC site visit in 2009, the program re-formatted 11 credit hours in its curriculum to fulfill requirements for completing a baccalaureate degree for entry-level practitioners. One of the greatest rewards that appeared as a result of the curricular change was being recognized by CoARC for successful RRT credentialing for >90% of graduates over a three-year average. Indeed, it was never attained before baccalaureate implementation. The base program has achieved the honor every year since. Two satellite cohorts, one in Farmington/SLC have achieved Distinguished Credentialing Success 8 times over the last 12 years and Presidential Credentialing Success (100% RRT

credentialing) in 2020, and our WSU-Davis cohort in Layton has achieved Distinguished RRT Credentialing Success 6 times over the past 12 years. The distinction highlights each student's hard work in academics but further differentiates the program's reputation for preparing well-qualified practitioners for the workforce.

Recently, the program had a recruiting fair for anticipated graduates of the program hosted by the region's largest healthcare employer. We recognized that seven of the 8 department managers represented at the fair were Weber State past graduates. We're proud of our graduates.



Graduate Degree Offer Practitioners Multitude of Opportunities

The program has advocated for expanding opportunities, i.e., AS to BSRT completion, AS to MSRT, or MSRT degrees for academically prepared practitioners that parallel a workforce analysis that revealed a varied and growing demand for practitioners with advanced degrees. Professional positions are being realized with opportunities to expand our skills and expertise as department managers, caregivers in post-anesthesia assessment units, in health programs as Asthma Educators (AE-C), compliance and/or information officers, in sleep medicine, off-site telehealth consultants, and as "pulmonary navigators" in clinical practice. Further, advanced education fosters buy-in from employers that practitioners can be attained with clinical opportunities to offer hospitals and clinics practitioners with expanded roles thereby increasing job satisfaction as practitioners enjoy autonomous practices and increased clinical responsibility.



With three stated emphases in administration, research, and clinical and/or academic education opportunities, graduates fulfill roles as senior staff in administration or supervisory positions within the departments where they were originally hired although it is apparent that some have departed clinical practice for administrative or management roles within Utah or in states in the



surrounding area. Most students reside and practice locally in the area however national directives for educational advancement have been forwarded by the American Association for Respiratory Care (AARC) encouraging therapists to practice at the top of individual credentialing ability. Examples are furthering education to master's preparation, and advocating for the development of critical care consultants or "advanced practitioner" (APRT) roles. This group is understood to be a mid-level health provider under the direction of a physician supervisor at the master's degree level adding to the three-emphasis stated previously.

In consultation with the national advising group, the Coalition for Baccalaureate and Graduate Respiratory Therapy Education (CoBGRTE) the department is preparing meetings with area leaders, department managers, medical directors and physician partners, hospital groups (Intermountain Health, HCA, Steward Health, MountainStar Hospitals, University of Utah Medical group, and the Veteran's Administration) within the region and state to define job descriptions for advanced roles, determine scheduling needs, and plan to consult with credentialing organizers (National Board for Respiratory Care [NBRC]), and Utah legislative bodies seeking guidance for future licensing direction.





Currently, the master's degree pathway is tailored for advanced academic opportunities for practicing respiratory therapists emphasizing research, administration, and clinical and/or academic education roles in preparing graduates as hospital preceptors or academic faculty. To be sure, national discussion for career advancement centers on what an Advanced Practitioner's responsibilities will ultimately entail. One role is as a critical care practitioner credentialed (strategically planned and positioned as an advanced clinical practice arm of the MSRT degree) by a new examination matrix under development by the National Board for Respiratory Care (NBRC). Increasingly, respiratory therapists with a few years of experience seek out opportunities for increased responsibility and more autonomous practice within their individual circumstances. In that way, advanced education provides a way for personal growth that fosters developing professional positions that depend on that level of expertise.

Confirmed in the last year, WSU Master's degree graduates have secured management (department manager) positions at six area hospitals, two out-of-state health systems, secured two full-time WSU instructor positions in our undergraduate program. Plans are underway for a critical care specialist (University of Utah Medical Hospital), a tracheostomy specialist (Primary Children's Hospital), and three clinical "pulmonary navigators" for graduates taking mid-level provider roles in the Intermountain areas' "Wasatch Back" (east of the Wasatch mountains). This initiative was spearheaded by a 2019 student's master's capstone project on "innovative healthcare delivery." Respiratory therapists by their nature are innovative and have found ways to integrate their love of learning with new ways to move the profession forward by taking roles that were not necessarily evident when they graduated from their entry-level program.



Master of Science in Respiratory Therapy (MSRT) – Degree Map (2022-2023). This is a suggested plan, taking an average of 6 credit hours per semester facilitates timely graduation.

NAME: MSRT **Catalog Year: 2022-23** **Revised: 2022**

☑	Course Offering	Credit Hours	Semester Offered	Milestones & Notes
	Semester 1 Fall			
	MHA 6000; Managing Health Information	3	Fall	• Acceptance into MSRT program
	MSRT 6010; Medical Writing, Research Methods and Design	3	Fall	
	Total Semester Credits Taught	**6**		
	Semester 2 Spring			
	MSRT 6020; Medical Pathophysiology	3	Spring	•
	MSRT 6140; Applied Research in Respiratory Care	3	Spring	
	Total Semester Credits Taught	**6**		
	Semester 3 Summer			
	MSRT 6030; Adult Learning Theory and Simulation	3	Summer	• Meet with Advisor
	MSRT 6130; Evidence-Based Practice	3	Summer	
	Total Semester Credits	**6**		
	Semester 4 Fall			
	MHA 6100; Leading & Managing People in Healthcare	3	Fall	•
	MSRT 6040; RC Education	3	Fall	
	Total Semester Credits Taught	**6**		
	Semester 5 Spring			
	MSRT 6050; RC Curric & Course Design	3	Spring	• Apply for MS degree completion.
	MSRT 6150; Research Methods in RC	3	Spring	
	Total Semester Credits Taught	**6**		
	Semester 6 Summer			
	MSRT 6700; Capstone project	3	Summer	
	MSRT 6800; Capstone project	3	Summer	
	Total Semester Credits Taught	**6**		
	Total for Master's degree required	**36**		

For further information about the program that might be right for you, candidates can contact Alisa Kimball, enrollment manager @ (801) 626-7041, or additional resources/information can be found at: https://www.weber.edu/resptherapy/

As an Informatics Analyst-Senior at Intermountain Healthcare, graduate David Eitel, MSRT, MBA, RRT, ACCS-RRT, CPFT states:

> "I use my education every day. I always say it's not what you get from the degree but how you transform information to acquire knowledge and contextualize the material that matters. In the program, I had to assess processes and information better and learn to write and communicate highly complex information to others. I had to learn more about research and clinical processes and learn how to apply them to everyday work."

In that way, David uses his knowledge of practitioner responsibilities to process IT information in computer systems that serve to drive billing systems, initiate best practices, and to improve outcome-based measures in what they do every day. He goes on by commenting:

> "I know there are many talented RTs out there without a master's degree, but for me and for all my friends I've talked into getting a master's degree, none of them have regretted it. They have all found themselves in management or higher levels of work within healthcare. I don't think any of us knew exactly what we would get back from the degree, but we knew that getting one would help us be more attractive with a degree than without one. My horizons were broadened, and I've been a better person for it."

Adding to that sentiment, graduate Pam Barney, MSRT, RRT, NPS-RRT, AE-C, who began a new position last year as the Administrative Director of Clinical Education at Noorda College of Osteopathic Medicine suggests:

> "When I started the Master's program at Weber State, my motivation was to continue working in leadership roles in the hospital system setting where I worked. As I had more exposure, I quickly realized that my leadership skills and the type of leader that I am, wasn't going to thrive in that environment. My pivot to healthcare education was exactly what I was looking for. Having my Master's degree at the time when the new medical school hired new faculty was critical. I am so grateful for my advanced degree, the flexibility it gives me, and the ability I have, and the privilege to help shape a new generation of physicians."

Pam's anecdotal story, coupled with others suggested that advanced education is worth the effort and that with all practical skills and knowledge being equal as new practitioners enter the workforce, employers have overwhelmingly hired practitioners that were determined to persevere to higher educational standards. Certainly, there are stories that counter this narrative but continuing to learn and

grow personally and professionally forwards an attitudinal characteristic that employers appreciate and increasingly embrace.



Program Faculty



Mich Oki, MPAcc, RRT, RRT-NPS, RPFT, RPSGT, is an associate professor & department chair.He is in his 30th year of teaching at Weber State University. He received his AAS in respiratory therapy in 1982, a BS degree in accounting in 1987, and has completed a Master's degree in Accountancy in 1989. Mich worked as an auditor for the Department of Defense for two years before returning to practice respiratory therapy. He has been in respiratory therapy since 1981 specializing in the areas of adult critical care, newborn intensive care, newborn ground transport, pulmonary function testing, and most recently in sleep medicine. His present interest is in sleep medicine and believes that the first step to health is to get eight hours of sleep every day.



Sarah Allred, MSRT, RRT, RRT=ACCS, RRT-NPS is an assistant professor. She graduated from Weber State with her bachelor's of science in respiratory therapy in 2019. Shortly after graduation, she began practicing at Tampa General Hospital. Within a year of beginning work, the Covid-19 pandemic broke out and she began working in the Covid ICU. Throughout the pandemic, she gained experience working with critical adult patients, neonates, and those impacted by Covid-19. She also became involved in training healthcare workers internationally the principles of neonatal care and mechanical ventilation. In 2021, she graduated from Weber State with her masters of science in respiratory therapy with an emphasis in

education. She began teaching as an adjunct instructor and was recently hired as an assistant professor. She is committed to improving international healthcare, addressing the compassion crisis in our healthcare system, and providing quality education to students.



Sherri Vasas, MSRT, RRT, RRT-NPS, RRT-ACCS graduated from Weber State's program with her BS degree in 2000. She began her career with an internship at Primary Children's Medical Center, and worked there full-time for 2 years after completing the internship. She transferred within Intermountain Healthcare to McKay Dee Hospital to work in the NICU where she spent the next 16 years in her dream job working with newborns. Sherri began teaching as adjunct faculty for Weber State in 2016 and fell in love with it, motivating her to return to school. She graduated with her masters of science in respiratory care with an emphasis in education in 2018 from Weber State University. She was hired as a full-time instructor in 2018 and made an assistant professor in 2021. She has a passion for teaching and continuing to learn.



Laurel K. Duncan, BSRT, RRT, RRT-NPS, CPFT is an instructor and honors graduate of the WSU Respiratory Therapy program in 2019. She is currently enrolled in the WSU Respiratory Therapy MSRT program researching EVALI and ENDS use among adolescents. Her studies include an educational emphasis, and expects to graduate in April 2023. She began adjunct teaching for the WSU Respiratory Therapy program in 2020 with full faculty status as of January 2022. Ms. Duncan continues employment with Intermountain Health at McKay-Dee Hospital specializing in neonatal and emergency care.



Janelle Gardiner, DHSc, RRT, AE-C is an associate professor and in her 19th year at Weber State. Janelle is a graduate of Weber State's AS program in 1997, completing her BS degree in 1998. Dr. Gardiner received a master of science in respiratory care leadership from Northeastern University in 2009. She went on to receive a Doctor of Health Sciences degree from A.T. Still University in 2015. She has been employed with Intermountain Health for the last 32 years. She currently works PRN as a staff therapist at Intermountain Health in Park City, Utah. She has worked in adult critical care, on the assessment and RSV teams, and taught smoking cessation. Most recently, as Vice President of Clinical Operations at Neonatal Rescue, Janelle worked to assist newborn health in low-

resource countries. Dr. Gardiner is passionate about the respiratory care profession and loves being involved with the Utah Society for Respiratory Care. She is currently serving as the USRC's Delegate to the AARC. She is also the Vice President of Internal Affairs on CoBGRTE's Board of Directors.



Paul Eberle, PhD, RRT is a tenured professor and program director, and has served as the department's chairperson for the program from 2007-2022. He is in his 36th year of teaching for Weber State University focusing on patient assessment, physiology, and pathology of cardiopulmonary diseases. The program has increasingly implemented technology and simulation to prepare students for their clinical rotations and focuses on "lifelong learning" strategies and opportunities for advanced degrees to encourage practitioners to continue to grow personally and professionally. He completed a bachelor's degree in zoology from Weber State in 1984, studied and credentialed in respiratory therapy at the University of Chicago Hospitals and Clinics, 1985, completed a Master's degree in curriculum design from Weber State in 1993, and a PhD in Education from the University of Utah in 2008. Dr. Eberle's interests include advanced degree preparation, participating in CoBGRTE activities, and he has helped graduate students in the Master's co-hort's from respiratory therapy, radiology, and physician's sssistant studies.He serves as a guest lecturer for the doctorate of nursing practice and advocates for advanced practice opportunities for healthcare practitioners.

Graduation April 2020



Covid-19 Graduation April 2021





Graduation April 2022



Contact Information

Alisa Kimball, enrollment manager @ (801) 626-7041
additional resources/information can be found at:
https://www.weber.edu/resptherapy/

INTERVIEW



William L. Croft, EdD, PhD, RRT, RCP, FAARC
Executive Director
North Carolina Respiratory Care Board

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

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

In 1982, I began working as a central supply technician (CST) at Moore Regional Hospital in Pinehurst, North Carolina. I loved the hospital environment and wanted to do more, so I had the opportunity to talk to a variety of medical professionals. Eventually, I started dating a respiratory therapist on staff. She convinced me that it was a worthwhile career choice, but at that time I was not ready. I was on the college transfer track at Sandhills Community College (SCC). I later left SCC after my first year to attend University of North Carolina Greensboro (UNCG) to major in communications. After 18 months, I left UNCG without completing my degree because I felt communications had no future for me. I was always health and wellness-minded from my early days in 4-H, and been interested in nutrition and weightlifting since I was 12, then I began competing in powerlifting at 16. My powerlifting career ran parallel with my career in respiratory care, as it spanned 44 years of competition at the state, national, and world levels. Eventually, those early interests and experiences were blended into how I saw the profession.

During my first year at UNCG, I began working for a large fitness chain and quickly became a manager and then an area manager. A few years later, the company ran into legal issues and in 1986 it went bankrupt; I saw the writing on the wall. In early 1987 I began looking at other career opportunities. I remembered that I always wanted to do something in the medical field, so I volunteered at Rex Hospital in Raleigh for about six months. I was placed in the ER, which was perfect. I could help where needed but also observe. I spent my weekends volunteering and spending time in the NC State University Library reading about different professions. I rediscovered respiratory therapy after speaking to some of the staff members, who convinced me that it was a good choice. I returned home to attend the RT program at SCC. It was here that I met a

future mentor, Dan Grady. Of course, I had no idea how he would continue to impact my life.

When a RT position opened at the local hospital after my first quarter, Dan encouraged me to apply. I officially began working in the field in February 1988 as an OJT while enrolled at SCC. I earned my RRT soon after graduation in 1989 and passed the NPS exam in March 1992. During my first four years in the profession, I was employed in several hospitals in the ICU and ER while working on my bachelor's degree. By my second year, I became a supervisor and a year later took a position as a NICU therapist. I wanted to learn everything I could. Of course, learning could not happen fast enough. I became a clinical educator in my third year and continued as a NICU therapist for another year. Both positions were some of the best clinical experiences. The clinical educator position was officially the beginning of my career in education. It was a perfect fit for me. I continued working in a clinical environment for 12 years to maintain my skills until my primary responsibilities required otherwise. I learned I could not do everything without compromising something else, like family time. Family time was too important.

Currently, I am the Executive Director of the North Carolina Respiratory Care Board (NCRCB). In my job, I have been afforded the opportunity to expand my knowledge in the ethical, legal, and regulatory aspects of the respiratory care profession. In this role, I conduct research and analysis on various issues relative to the Board's mission to produce state-formatted rules, declaratory rulings, interpretative letters, or position statements for the Board's consideration. As a result, I have to tie the clinical and legal aspects together in these various documents. In addition, I serve as the Board Liaison (Lobbyist) to the North Carolina General Assembly and the North Carolina Rules Review Commission. These responsibilities necessitate understanding existing laws and rules with significant detail to mitigate the consequences of any proposed initiative. In public outreach, the role requires consultation with affected individuals, legal counselors, legislators, and professional groups to ensure effective implementation. This role includes serving as Chair of the BSRT and MSRC Advisory Committee at UNC-Charlotte and MSRC Advisory Committee at Boise State University.

All these roles have been made possible through higher educational levels and the influence of strong mentors, friends, and great parents. I learned early in life that any achievement is never achieved completely alone. You need to rely on the counsel and advice of others such as mentors, friends, and parents. You never know who will spark an idea in you that will change your course in life.

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

As mentioned, Dan Grady was a key mentor. He had been in respiratory care for about nine years when we met 1987. He was a 1978 graduate of SCC, and over his 39 year career in the profession he had earned his bachelor's and master's degrees and received the recognition FAARC from the AARC. I was fortunate to also have him as a friend and colleague. I watched him serve in many leadership positions as an educator, manager, administrator, and inventor. He served as President of the NCSRC from 1993-1994, so I had the opportunity to work with him within that organization. By this time, I was the Program Director at Robeson Community College in Lumberton, NC, and Dan had just taken a new job as the Director of Neurodiagnostic and Cardiopulmonary Care at Moore Regional Hospital.

Dan was one of the first people I called for advice before I took the Program Director position. When I asked him if I should take the job, he was adamant that I would do great. I took the job, and it afforded me the opportunity to serve on various North Carolina Society for Respiratory Care (NCSRC) committees over the years, with Dan as the leader. Later in 1998, I called him again for advice about an open position as Program Director at SCC. He had worked for the current director, who was stepping back into the DCE position. He had been my former professor, so I would be supervising my Program Director and professor. Once again, Dan encouraged me by saying that it would be a challenge for anyone, but I could do it.

When Dan developed an inoperable brain cancer in 2014, everyone who knew him was devasted. The disease progressed; eventually, treatments did not work, then he suffered a stroke in late 2017. When I received this news, I remembered a discussion that I had with him in April of that year about how he was doing. In his usual chipper tone, "I am doing fairly well with some good days and bad, but overall, I am keeping busy." I discussed my graduate dissertation and comprehensive exams with him, and he assured me, as he always did, that I would do great. It hit me hard at that moment, so I said, “Dan, I just want you to know how much I appreciate all that you have done for me over the last 30 years. You have always inspired me to do more. He chuckles…" He responded with, “Well, you did the work…I am just glad I was around to see you do great things." Hearing that from a long-time mentor, friend, and colleague was surreal, but I was thankful I had the opportunity to thank him.

The irony is that Dan hired me into my current position as the NCRCB Chair in 2014. In my first official meeting with him as Executive Director, he gave me the news that he had to resign because of his diagnosis. Dan was the

quintessential motivator. He was a humble servant leader who gave everything to the profession and was a natural mentor. He mentored by example. He spent his last days wanting to see our profession grow and progress. He even led the UNC-Charlotte BSRT/MSRC Advisory Committee until 2017. I took over as vice-chair following his passing. I am now Chair of the committee. It is my hope that I am living up to the standard Dan set for all of us.

As I reflect upon Dan's influence, I would be remiss to mention three other people. Kelly McClure, Rick Sells, and Floyd Boyer. Kelly hired me in 1991 as a clinical educator for the Southeastern Regional Medical Center in Lumberton, NC. He took me to my first NCSRC meetings when he was President-Elect in 1991-1992, including the newly formed educator-manager meeting. The NC Respiratory Care Educators (NCARE) still meets on an annual basis.

A few years later, Rick Sells became President, and I was elected to the NCSRC Board. Rick was so helpful in guiding and encouraging me throughout his tenure and far beyond. For Dan and Rick, I worked on various committees, including public relations, hospital restructuring, education, publications, nominations, and professional network. Like Dan, Rick was a true servant leader and mentored me to do more. I took him up on the challenge. I served as a Board member until 2000; then, I became President of the NCSRC. My election coincided with our licensing passage, so I was encouraged to apply for the new Board to be formed, but I had to wait. At the time, I did not understand the process. I missed the opportunity until 2002. In 2002, Floyd Boyer rotated off the NCRCB as Chair and was hired as the first Executive Director. I was appointed by the Speaker of the House to the NCRCB to replace Floyd. I served two more terms and rotated off in 2009.

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

My early educational endeavors did not start out so positively. I remember in high school taking the SAT® to enter college. I never shared my scores because they were not very good. I remember feeling terrible. I thought I had been a good student, but the test showed otherwise. As always, my mother had the right touch. She reminded me of my successes and gave me a hug and kiss. I did not want anything said to my sisters, and I do not think she did.

Nevertheless, it was hard to shake off. I really could care less about knowing my peer's scores because I was not sharing mine. I remember those who did well sharing their scores, and I just shrank when they asked mine. I had no answers. I did not think I was intelligent enough to go to college. I was an A-B student in high school but never at the top of my class. My early struggles were linked to hearing issues which were corrected late into my junior year. I had my right

eardrum rebuilt since 95% of it was gone. It is why I considered community college when I did decide. I felt if I could be successful there that, I might have a chance.

As many do after high school, I floundered for a while until I landed at Sandhills Community College. I learned that I was not as stupid as a single test made me feel. It also meant the people who told me I was not the sharpest knife in the draw were wrong. As I had one success after another, I learned that hard work pays off. I had to work harder than everyone else, but it was worth it.

I had no idea how much I missed because I could not hear well. I was behind, but I performed much better with less frustration during my senior year. Once at SCC, I had to make up ground. Eventually, I was successful at earning two degrees. Of course, many people still looked down on community college degrees at the time. They were lesser degrees than university degrees. I was not deterred because my second degree was in respiratory therapy, which turned out to be the best decision ever.

By the time I completed my AAS in respiratory care, I had caught the learning bug. I had proven to myself that I could be successful with hard work. Of course, it helps when you can hear. Along the way, I had the help of some great educators and mentors who would later become my colleagues. I pursued several more university degrees and credentials until I earned my doctorate while maintaining a 4.0 GPA at each level. I became a certified nutritionist and a certified whole health educator because of my interest in health and wellness. All of this is from a kid with poor SAT scores.

The irony is that my graduate research focused on those SAT entrance tests that help determine the success or failure of future academic performance, at least in theory. I found they do not determine either. They are not designed to assess either very well, but they were often used to help students decide whether to select a trade school or a university. Score low and your guidance counselor might pull out trade school information. Score high, and they might give you university-level material. I remember walking out of my high school counselor's office feeling more conflicted and with no direction. I always kept this in the back of my mind when advising students at the college level. I even created alternative pathways of program entry for students with unrealized potential. It eventually became a departmental standard once I was a health science department chair.

For these reasons, my research seemed to focus naturally on self-directed learning (SDL) based on the work of Malcolm Knowles. Knowles describes "SDL as a process in which individuals take the initiative, with or without the help of others, in diagnosing their learning needs, formulating learning goals, identifying resources for learning, choosing and implementing appropriate learning

strategies, and evaluating learning outcomes." In other words, like many other adult students, I had learned that I was a high SDL student who charted his own path. Many of our colleagues fall into this category.

One of the behavior traits identified was the level of desire someone had for success, so I looked for these attributes in students, such as their GRIT scores. Someone testing high on the SDL scale would also have high GRIT scores, as defined by Dr. Angela Duckworth. She defines someone with GRIT as having mental, physical, and emotional resilience, with passion and perseverance toward long-term goals. I developed this approach with the help of my mentors, and Dr. Duckworth put this into words.

I should mention at this point that my mentor Floyd Boyer and I went way back to 1992 when he was the Advisory Committee Chair for the AAS Respiratory Care Program in Lumberton, NC. The program was not doing well, with only two students in the graduating class and 12 in the upcoming senior class. The JRCRTE accreditation site visit had been a disaster, and he asked if I would be willing to move from the hospital to the college. One faculty member had resigned, and the other was to be terminated. With the encouragement of Kelly McClure, Dan, and Floyd, with a strong push from Dr. Thomas DeKornfeld, I took the position. I was just hoping that I would live up to their expectations, but I agreed to "fill in" until they could hire someone. I guess things went well. I ended up working for the NC Community College System for 21 years, with my last post as Program Director, Professor, and Health Science Department Chair at my alma mater, Sandhills Community College. In 2014, I left the college with another push from my long-time mentors and friends.

Once again, enter Floyd Boyer and Dan Grady. They invited me to apply for Floyd's position at the NCRCB since he was retiring. I was among many who interviewed, but I was offered the job. Most people do not know that I turned them down three times, then I received a call from Dan. He was once again understanding about my reluctance but encouraged me to take the job. I took the position. It was the right thing to do because Dan highlighted how I could advance the profession even more than I was. Floyd was also adamant that I should take the job. I trusted both Dan and Floyd on this matter as in the past, so the rest is history.

While my mentors encouraged me to pursue higher education, higher education, it was already my passion. After earning my AAS, I completed my bachelor's, master's, and doctorate because I wanted to better myself. I did not complete each advanced degree because it was required but because I could see how each one could enrich the lives of those around me. I knew if I could enhance my skills and knowledge, that it would benefit me, my family and students, our

profession, and the patients who would be impacted. It is all connected. When you are better yourself, you can better serve others.

For these reasons, I would give this advice to any new respiratory therapist starting out in the field. Surround yourself with like-minded people. When you are ready, your mentor will appear in the form of an educator, manager, friend, or colleague. In my case, it was all the above.

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

I admit that none of the opportunities I experienced would have been possible without elevating my educational level; higher education requires higher and higher levels of critical thinking. Respiratory therapists are surrounded by highly educated people in both clinical and academic settings. As professionals, we must reach a level comparable to the others sitting around the decision-making table. Otherwise, we will likely not get an invitation to the party. Advancing the profession requires us to show up and prove ourselves as valuable team members. We have to work harder in many cases because of the view many have of our profession. The question is where to begin if just starting out.

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

I love teaching, and I would encourage anyone to consider it, even if just part-time. You learn so much about yourself and what you know about respiratory care. As they say, you do not know what you do not know. Study, read, write, and teach to learn, so you can help others along the way. During my career, I also volunteered for countless committees within the college and community, so I would suggest seeking out volunteer service as an essential piece of your career. I learned from my parents and examples set by my mentors the importance of volunteerism. It is a way to give back to the community, but it can also be a good way to represent the respiratory therapy profession in other organizations. It does not always need to have a direct application to the profession, but it helps. For example, I ended up serving on the Regional Health Services Board for First Health of the Carolinas. As a group of health professionals and public members, we brought health services to the local community in clinics, physician offices, and mobile units.

Since I was also the Health and Wellness Committee Chair at SCC during my tenure, we brought those mobile services to campus to serve the community with a campuswide health program every year. My respiratory students were front and center in the community project, so the profession had a great deal of exposure through their participation. It was one way to promote the profession in a subtle manner while serving others. It was the best of both worlds. As a result, we were

able to have the hospital adopt a pulmonary screening program for their mobile visits across the service area. For me, the possibilities are endless. Look for those types of encounters to put the profession in a positive light.

Through all these experiences, I learned that although you might think that you know enough, there is always something more to learn. I learn every day in my current position. I owe this mindset to my mentors, who were fierce promotors of our profession. I am also fueled by the influence of my mother and father, who have since left this world as well. My dad retired as a senior Navy chief gunners mate after serving in WWII, Korea, and Vietnam. My mom started out working for the CIA but gave it up to be a Navy wife and mother. They both believed in John F. Kennedy's charge to the nation in 1961: "Ask not what your country can do for you — ask what you can do for your country."

Parents are your first mentors, but along the way, you find other like-minded people to guide you, like Dan, Rick, Floyd, and Kelly. They all put others first, which is the attribute of a good leader. Although they never said it, I believe they lived a version of JFK's charge. It begins with getting a good education.

My siblings often asked me when they thought I would have enough education. Given my start, I would laugh. Does anyone know when enough is enough, whether it is money, material goods, or education? Enough is ambiguous at best. It has no end point to measure. After years of work, I completed my fifth degree in my lifetime at age 55. After hundreds of hours of writing and reading, this journey ended when I defended my work to the dissertation committee. My advisor told me over those five years that we would read and write until we knew it was enough. You will just know. I have to say she was so right with that advice.

You intuitively know how it feels. You also know when you have not done enough. When I reflected on her words, I thought of Dan, who had just passed away. He worked until it was time to go. Along the way, he invented a lifesaving device that hyperoxgenates the blood to save cardiac arrest victims! I say a crowning achievement in a long career. Many may know the device as intracoronary hyperoxemic supersaturated oxygen therapy (SSO_2) which is used the commercially developed TherOx® system. Dan began developing the idea while still teaching at Sandhills Community College and continued working on it until he was able to sell the patent.

He knew when it was enough and left this world a better place. He left our profession in a better place. My advice to anyone in this profession is to find your Dan. Dan always said we could all contribute in our own way, so just find your way by finding your "why". Once you define your "why", it all makes sense. For me, advancing my education was fundamental to finding "my why". It is not about the credential but the journey toward greater knowledge. Along the way,

you will meet people who will enrich your life. You may meet someone like Dan. May best advice is be like Dan and advance the profession in your own way.

Perspectives on Medical Simulation

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

I began my journey in respiratory care in 1970 when I was hired as an on-the-job trainee (OJT) inhalation therapist in a Denver medical center. It was intended to only be a summer job as I'd just completed a BS in biology and planned to start graduate school in the fall. It turned into a 53-year career. I'd become familiar with inhalation therapy during a previous summer job as an orderly in a Chicago hospital. I became friends with therapists as I watched them care for mechanically ventilated patients in ICUs. Like my former training as an orderly, the OJT strategy as a therapist followed the apprentice model: see one; assist one; do one; and then teach one. The only simulation-like activities were CPR training on a Resuci-Anne© and testing out mechanical ventilators with a sponge-filled rubber bag "test lung" prior to patient use.

Medical education only began to embrace simulation after its well-established practice used by the military and commercial aviation. That largely changed with the 1999 publication *To Err is Human,* which implicated medical errors as a significant source of mortality.[1] The purpose of this article is to review my past and present perspectives with simulation-based education and emphasize the importance of standardized patients (SPs). I hope to encourage *Chronicle* readers to further embrace medical simulation, recognize the importance of SPs and consider participating as SPs themselves.

After a period as a clinician, I quickly realized how much more I needed to learn if I was to be *all-in* my new career. I went back as an "adult student" in a university medical center's BSRT program and its graduate college of education; that was a decision I've never regretted. Besides RT technical courses, I was able to study educational theories of Kolb[2], Dewey[3], Knowles[4] and make connections to my recent clinical experiences. I scrutinized all my courses' educational strategies and tactics. I found the most valuable learning in the RT program occurred during bedside patient rounds conducted by the program's medical director. It was a real but a guided and slowed-down version of what therapists'

care involved. The doctor carefully selected our patients. After review of the chart, chest radiographs and interview/examination of the patient, we adjourned for a debriefing; that's where I found the learning really took hold. We could go further than just technical procedures and dig into pathophysiology and evidence for therapy. It was also very powerful in terms of the humanistic component of care; I can still recall some of the patients' stories and faces after 40+ years. I also relished morning coffee & donuts in the medical center's student lounge which was shared by medical- nursing- and allied health students. At first, I wondered why the multiple TVs were always tuned to the recently developed new pre-school *Sesame Street*. I soon figured out that the insightful educational techniques used by the Children's Television Workshop were also appropriate for adults in advanced medical studies.[5]

Years later the table was turned as I became a RC faculty and program director. Besides the traditional didactic curriculum, I replicated the physician-supported bedside teaching that I had found so valuable. When physical facilities permitted, I assembled a lab and rudimentary simulation resources to allow students to practice hands-on skills in a safe setting. I quickly appreciated how this helped both student skills and my ability to more objectively assess technical competency beyond reports from a cadre of clinical instructors. Simulated events were concocted using techniques from *Mister Wizard* and *MacGyver* with help from task trainers including Resuci-Anne©, intubation manikins, arterial arms, ECG dysthymia simulators and more comprehensive lung simulators. I created homemade scenarios using the lab's 1-bed ICU and experimented by using patients who were disguised RT faculty or emeritus MDs. The audio-video recording was very basic but facilitated replay debriefing ……and provided some laughs. But it worked. Students found that simulated interactions were fun, boosted skills, and confidence. The faculty could be assured that all students had the same exposure to some common and unusual clinical situations.

Following five years of preparation, in 2005 my institution established a multidisciplinary medical simulation center. Like many other institutions investing in a center was in response to several factors including more complicated medical technology, compacting of training timeframes and pressure for increased safety and quality.[1,6,7,8,9,10,11,12] The scope of the project was comprehensive in terms of both the physical and educational infrastructure. The cadre of administrators and faculty had a formidable task in incorporating a plan for simulation courses to include undergraduate allied health, nursing, medical students, residents/fellows and physician staff. The need also included evaluation/documentation of learners' competency.

The simulation center's medical director was a pulmonologist and intensivist who knew of the RT program's interest in simulation, and I was asked to join a group of support faculty. That new responsibility required additional study of the theories and techniques of simulation especially the skills required for debriefing.[13,14,15] In that capacity I developed a more organized and thoughtful series of RT simulations to incorporate into the curriculum. I also assisted others in writing and producing scenarios including the physical therapy program, medical school, and critical care fellowship. This work included working with a cadre of SPs. That process reinforced my understanding of the importance and advantage of having live subjects involved as patients, family members or other medical staff (confederates). I still believe the most difficult task for medical educators is to help learners develop human caring behaviors and attitudes. I observed how direct and well-conducted feedback from standardized patients could help learners more clearly see themselves as patients did. The SPs made that experience much more robust than watching video replay or hearing critiques from faculty.[16,17,18]

Ten years later I retired from my roles as faculty in RT education and simulation. I began doing volunteer clinical care in a free clinic and signed on as a SP at the simulation center. Now I was on the other side of the one-way glass. Instead of writing scripts and briefing SPs, now I had to prepare for roles by memorizing my lines, donning moulage, getting into character and developing improvisational skills. I was also responsible for delivering verbal or written feedback of learners' performance. My SP roles included almost every physical, emotional and mental condition imaginable. The SP supervisor often assigned me to scenarios which required some medical background and I frequently played dyspneic patients. The impact of being a SP really hit me when I portrayed the father of a young woman who was the victim of a motor vehicle accident. I was prompted to enter the ED just as the trauma team's resident was "calling" the code resuscitation. The resident had to tell me that my daughter was dead. My role was to beg the team to continue…through sobbing tears; their challenge was to explain in an empathetic manner, the futility based on her extensive injuries. I then participated in the teams' debriefing and conveyed how I felt the resident did based on content and behaviors of the interaction. After two sessions I was exhausted. This job was not just acting; the significant responsibility to the ED residents and team was only overshadowed by its value for future family members who would receive similar tragic news.

The literature on use of standardized patients in simulation education became of greater interest. I soon learned of the Association of Standardized Patient Educators (ASPE). In 2017 the organization published best standards of practice (SOP) for SPs.[19] These standards related to five domains: safe work environment,

case development, SP training, role portrayal and training for feedback. Although many simulation centers may recruit SPs from the actor pools of local theaters, medical simulation events are more complex and go well beyond theatrical acting. This includes SPs understanding the learning context, perceiving the emotional state of their role, and providing objective feedback to learners.[20] The literature has described the benefits of incorporating an SP in simulation. A profound advantage of a real person (vs. manikin) is suspending reality that it's a simulated event. Human communication is dynamic with subtle changes of voice and non-verbal nuances. SPs are trained in improvisational skills to be able to alter the flow of interactions based on the learner's responses. SP-based scenarios can better portray emotions of difficult human situations that are better learned in a simulated setting. These might include scenarios with a dying patient, a frantic parent of a sick child or patients with cognitive, behavioral or psychological issues. SPs can also portray certain physical findings (e.g. neuromuscular deficits) that manikins cannot convey.

There are also benefits, demands and risks of being a SP. Many have reported improvement and being more articulate in their own communication skills both verbal and non-verbal. They felt they became less quick to judge others and more open-minded about their own prejudices and factors that cause problems in patients' lives.[21] Some SPs reported changes in how they perceived their own health care providers; a number changed their personal practitioners. Negative effects included anxiety, exhaustion and fatigue following simulation scenarios. These tend to be short-term.[22,23] There is also stress that they feel their feedback may cause if it is used in "high stakes" simulations which determine advancement, remediation, or independent practice.[24]

With much emphasis on the use of high-fidelity manikins, some readers may question whether there is evidence whether use of standardized patients actually influences simulation education. That evaluation does depend on the goals of the simulation in terms of technical, cognitive skills versus practitioner-patient communication and physical exam. A study of 4th year medical students in emergency management noted a small but statistically significant improvement during objective structured clinical examinations (OSCE) when standardized patients were used.[25] A scoping review found that 24 out of 33 studies reported that use of SPs facilitated competence in technical, non-technical (communication) and cognitive skills. It should be noted that in hybrid simulations, a SP can be aligned with a simulation task-trainer to support procedural skill development or a more complex clinical scenario.[26]

A recent survey of respiratory care has noted varied uses of simulation based on the program's degree level. The majority reported that they wished to increase

utilization but cite a lack of faculty development.[27] Canadian respiratory therapy education appears to be actively working to embrace simulation as part of clinical competency assessment recommendations.[28,29]

When I reflect on my own past education: OJT, clinical experience gained in the hospital, work as an educator and simulation SP, the quote from Confucius comes to mind.

> ***"By three methods we may learn wisdom: first, by reflection, which is the noblest; second by imitation which is the easiest; and third by experience, which is the bitterest."***

There appear to be multiple benefits in simulation education based on its focus on the power of reflection through thoughtful debriefing.[30] There is growing evidence that SPs enhance learning not only for participants in scenarios but for the SPs themselves. A qualitative yet comprehensive study from Australia provides an excellent perspective on both issues. That article is recommended reading for both respiratory therapy program staff who wish to enhance the use of SPs in simulations as well as RT students and faculty who may find benefit by serving in that role.[31]

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CoBGRTE Scholarships: Application Ready

José D. Rojas, PhD, RRT, RPFT, FAARC

The Coalition for Baccalaureate and Graduate Respiratory Therapy Education (CoBGRTE) was formed to help students, faculty, and the public learn about baccalaureate and graduate respiratory therapy education in the United States of America. To that end, the CoBGRTE Board of Directors, with steadfast tenacity, continues to make scholarship money available to help support school expenses for members pursuing baccalaureate, graduate, or doctoral degrees. Since 2012, CoBGRTE has supported students and faculty with over $80,000 of awards. The faculty support has been made possible through the generosity of the NBRC, who realizes that the future of our profession lies not only in training the next generation of therapists, but in also increasing the number of therapists with doctoral degrees. Thus, the NBRC has continued to support faculty development in 2023 with another $20,000 investment.

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 materials will be posted on the CoBGRTE website starting April 1, 2023. The cycle will remain open until October 1, 2023, and the hope is to make announcements and presentations at the AARC Congress. Monthly reminders will be posted in the Coalition Chronicle.

1. The scholarship cycle for all awards (NBRC supported, Merit, Malinowski, and Smallwood) opens April 1, 2023 and closes on October 1, 2023.

2. The application link will be posted on the CoBGRTE website and monthly in *The Coalition Chronicle*.

3. There are four award categories:

a. Merit Scholarships (8)

-eligibility (BS and MS entry-level CoBGRTE member, BS and MS degree advancement members; Propose to allocate 4 scholarships for entry-level and 4 scholarships for degree advancement depending on number of applications)

-required materials (letter of support from faculty/PD/DCE, professional resume, completed application, unofficial transcript, essay describing how CoBGRTE can accomplish its goal of increasing the number of graduates from baccalaureate and graduate respiratory care educational programs.)

b. Smallwood Research Scholarship (1)

-eligibility (BSRC and MSRC entry-level CoBGRTE member, BSRC and MSRC degree advancement CoBGRTE member)

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

c. Malinowski Leadership Award (1)

-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

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

Members of the CoBGRTE Scholarship Committee:

Bruce Adcock, MEd, RRT, RRT-NPS, CHSE — Assistant Professor
University of Texas Medical Branch at Galveston

Brian Cayko, MBA, RRT, FAARC — Clinical Assistant Professor
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International Spotlight



Lydia Piechnik

Pediatric Respiratory Therapist-German Society for Nursing Further Education
Respiratory Therapist-German Society for Pneumology
Specialist Nurse for Anesthesia and Intensive Care

CHARITÉ - UNIVERSITY MEDICINE BERLIN
CC17- Clinic for Pediatrics with a focus on Pneumology, Immunology and Intensive Care Medicine
Pediatric Intensive Care unit 25 I
Campus Virchow Clinic, Berlin, Germany

By Wendy Castro, MS, RRT, RRT-NPS

Chair, CoBGRTE International Outreach Committee

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

There is no such thing as a typical working day with routines. The only routine I have is the start at 7:30 a.m. (from Tuesday to Friday) with participation in rounds at the pediatric intensive care unit (PICU). After that, there is a separate patient "priorities" handover for me with the senior physician on duty. Thereby, I can estimate which tasks await me at the PICU that day and whether I have time to care for patients with respiratory difficulties/problems on other wards of our pediatric clinic. After all that talking, I go from patient to patient, check mechanical ventilator settings, optimize ventilation parameters if necessary, and create individual weaning plans, inhalation, and positioning plans.

My work also includes plans for secretion management e.g., percussion therapy and in- exsufflator therapy. I like to meet with our physical therapists, to work together on our patients to gain the most success. For young patients receiving a tracheostomy tube in the pediatric ITS, I coach them in tracheostomy tube selection and training with the speech valve to phonate as quickly as possible (if possible) or to maintain ventilation of the oropharyngeal area. Before I leave in the evening, there is another handover with the senior physician in charge, where I report on the successes and treatment plans of the patients under my care. As part of secretion management, on Tuesdays (9:00-11:00) I care for young patients with spinal muscular atrophy (SMA) in the neurological department of our Social Pediatric Center to adapt them to an in- and exsufflator

(Cough Assist®). In addition, together with one of our senior physicians at our PICU, we run a pediatric pneumology consultation clinic every Friday (9:00-13:00). Here we follow up on children who have been ventilated for more than 5 days. in the pediatric intensive care unit or who have received a tracheal cannula. Children, who need support in secretion management, adaptation to home ventilation, polygraphy, etc., also come to us for consultation. As you can see, there is no room for boredom.

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

Over the years as a pediatric nurse, I became acquainted with respiratory therapists (RTs) from adult medicine and was fascinated by this job profile. Since there was no RT in pediatrics until recently, I wanted to change that. I have been fascinated from the beginning how small, targeted techniques, e.g., contact breathing can make a big difference. Doctors often lack time to adapt the respirator to the patient and quite often this results in just more and deep sedation. I however, can help to prevent that and achieve a better adaption with the respirator and individualized respirator/ventilation settings. It is interesting what you can read from flow curves on the respirator. I love to see how, with my help (using individually created weaning plans), the little patients get to breathe on their own.

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

There were no obstacles to getting my degree even though it was a hard time studying part-time. However, practicing on the ward where I previously worked as a pediatric nurse for 18 years was more of a problem. Being the first pediatric RT in Berlin, none of my colleagues (medical as well as nursing) knew what to do with my new field of practice. It took almost 2 years for my recommendations to be heard and accepted. My patience paid off, and now I have so much work that I hardly know how to manage it all.

What formal education did you have?

I trained for 3 years as a pediatric nurse at the Charité in Berlin. For RT, I trained for 2 years through the German Respiratory Society (DGP)- German Society for Pneumology in Heidelberg. Immediately afterward, I trained as a pediatric RT via the General Directorate of Public Works (DGPW)- German Society for Nursing Sciences. Since 2001 I have been working at the Charité - Virchow-Klinikum on the pediatric intensive care unit 25 I.

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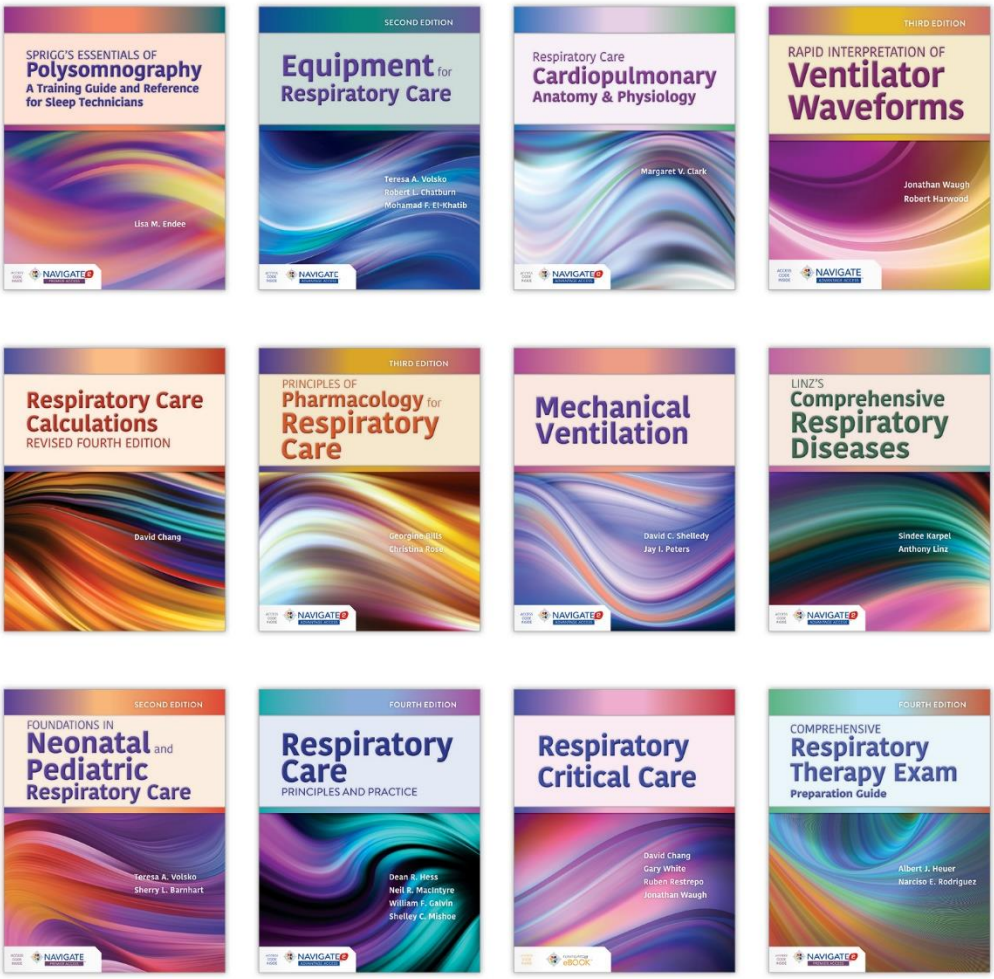

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Rush University
Salisbury University
The Ohio State University
Northeastern University
University of Texas Medical Branch - Galveston
Texas State University
University of North Carolina – Charlotte
Louisiana State University Health Science Center – New Orleans
Midwestern State University
Radford University
Youngstown State University
Nova Southeastern University
University of Arkansas for Medical Sciences
State University of New York at Stony Brook
University of Texas Health Science Center – San Antonio
University of Hartford
University of Kansas Medical Center
College of Southern Nevada
University of Akron
CHI St. Alexius Health-University of Mary
Valencia College
Middle Georgia State University
University of North Carolina - Wilmington
Respiratory Care Board of California
St. Catherine University
Georgia Southern University
University of Virginia Medical Center
Utah Society for Respiratory Care

CoBGRTE Institutional Members - Continued

Southern Connecticut State University
Boston Children's Hospital
Carlow University
Jacksonville State University
Yosemite College
Newberry College
East Tennessee State University
University of Cincinnati
Liberty University
Ozarks Technical College
North Carolina Respiratory Care Board
Vidant Medical Center
University of Pennsylvania Health System
Loma Linda University
California Society for Respiratory Care
Southern Illinois University Carbondale
University of Missouri
Massachusetts College of Pharmacy and Health Sciences
Rowan University
Children's Hospital Colorado
Texas Southern University
Tennessee State University
SUNY Upstate Medical University
Spokane Community College
York College of Pennsylvania
Northern Kentucky University
Florida Southwestern State College
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.

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