Respiratory Therapy: Advancing Practice Beyond 2015

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AARC Vice-President for Internal Affairs– 2015-2016
Disclosures

- National Asthma Educator Certification Board
- Coalition for Baccalaureate and Graduate Respiratory Therapy Education
- Georgia Society for Respiratory Care
Objectives

- Review the **AARC Mission and Vision Statement** and how it impacts goals and movement of our profession.

- Use portions of the **AARCs Strategic Plan** as a guide to review the current state of health care and its impact on our profession.

- Bring the information presented to a local/state level to see the **impact**.
AARC Mission and Vision Statements

**Mission Statement:**
The American Association for Respiratory Care (AARC) will continue to be the leading national and international professional association for respiratory care.

**Vision Statement:**
The AARC encourages and promotes professional excellence, advances the science and practice of respiratory care, and serves as an advocate for patients and their families, the public, the profession and the respiratory therapist.
PRESIDENT SALVATORE’S 2015–2016 GOALS:

• Continue to develop and execute strategies that will increase membership beyond 50,000 active members and participation in the AARC both nationally and internationally.

• Promote activities to increase public awareness of respiratory therapists and their role in the diagnosis and treatment of respiratory disorders.

• Advance the concepts and initiatives brought about by the “Respiratory Therapist for 2015 and Beyond” conferences. Develop a toolkit to ensure the existing educational programs are able to move in a direction that will allow them to continue to develop our future students at a level that is consistent with them obtaining a bachelor’s degree, which will eventually become the entry into our profession.

• Promote and advocate for appropriate patient and caregiver access to respiratory therapists in all care settings through local, state, and national legislation; regulation and/or policies including, but not limited to, recognizing respiratory therapists outside the traditional health care venues; and recognizing the credential of Registered Respiratory Therapist (RRT) as the minimum requirement for licensure.

• Continue to advance our international respiratory community presence through activities designed to address issues affecting educational, medical, and professional trends in the global respiratory care community and to advance advocacy for the patient.

• Promote the access of high-quality continuing education for development and enhancement of the skill base of today’s practitioners to meet the current and future needs of our profession.

• Encourage the development of programs, accreditation, and credentialing of the Advanced Practice Respiratory Therapist (APRT) as a level of practice that will further improve the care given to our patients and advance the career track of our profession.

• Maintain and expand relevant communication and alliances with key allies and organizations within our communities of interest.

• Expand efforts to obtain research funding and develop the next generation of respiratory therapy researchers. The American Respiratory Care Foundation (ARCF) is an integral part of the funding/fundraising related to research; we will increase participation by our membership in ARCF fundraising activities through an educational effort that will increase awareness in the importance of the ARCF.
Strategic Objective 1: Refine and expand the scope of practice for respiratory therapists in all care settings.

- **Description** - Promote advanced practice and practice expansion for respiratory therapists. Assure that the science that demonstrates the value and role of the respiratory therapist is provided to those stakeholders whose decisions and actions need to be guided by that information.
Patient Protection and Affordability Care Act (PPACA/ACA/Obamacare):
The core issue was rising costs of health care.

How are we doing now with the ACA?

1. In 2014, health care was 17.5% of US GDP. (Was 17.6% in 2000)
2. In 2014, US spent $3 trillion overall on healthcare. (Was $2.7T in 2000)
3. Insured share of population rose:
   - 2013 (86%)
   - 2014 (88.8%)

Source: http://www.beckershospitalreview.com/finance/healthcare-spending-hits-3-trillion-under-a... 12/3/2015
Highest Expenditures on Health as % of GDP

### Most Expensive/Least Effective

#### Overall Ranking (2013)

<table>
<thead>
<tr>
<th></th>
<th>AUS</th>
<th>CAN</th>
<th>FRA</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
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<td>Quality Care</td>
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<td>Effective Care</td>
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<td>Access</td>
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<td>Cost-Related Problem</td>
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<td>Timeliness of Care</td>
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<tr>
<td>Healthy Lives</td>
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<td>7</td>
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<td>Health Expenditures/Capita, 2011**</td>
<td>**$3,800</td>
<td>$4,522</td>
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Notes: * Includes ties. ** Expenditures shown in US PPP (purchasing power parity); Australian $ data are from 2010.


Of the 2.7 Trillion We Spent in 2000 for US Healthcare… 750 Billion did nothing to make anyone better
Cost of Care...Cutting the Fat

According to Premier Inc. the average hospital could cut millions of dollars in unnecessary care, staff productivity and prevention of readmissions

- Labor productivity  $5.1 million
- LOS  $3.1 million
- Readmissions $3.0 million
- Employee skill mix  $1.8 million
- Overtime costs  $1.8 million
- Lab tests  $1.7 million
- Respiratory Therapy  $1.5 million
Hospitalizations for COPD in U.S. – The Numbers

- 822,000 Hospitalizations
- Average LOS 4.7 days
- $7,500/hospitalization
- Annual cost for COPD continues to grow
  - $49.9 billion (direct & indirect)
  - 40% of costs could be avoided with prevention of complications and reducing hospitalizations
- 17.6% of Medicare patients readmitted to hospitals within 30 days of discharge
- Avoidable readmissions account for $17.5 billion additional Medicare expenditures annually

http://www.ncbi.nlm.nih.gov/pmc/
Wier, L.M., AHRQ HCUP, Statistical Brief #106, 2011
Doctor Shortages in Thousands

<table>
<thead>
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<th>Year</th>
<th>Specialties</th>
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<tr>
<td>2020</td>
<td></td>
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<tr>
<td>2025</td>
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<td>131</td>
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</table>

(Data for 2010-2025 are projections)

GRAPHIC BY BLOOMBERG BUSINESSWEEK;
DATA: AAMC CENTER FOR WORKFORCE STUDIES/LEWIN GROUP
The Myth of the Workforce Crisis
Why the United States Does Not Need More Intensivist Physicians

Jeremy M. Kahn1,2 and Gordon D. Rubenfeld3,4

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Abstract

Intensivist physician staffing is associated with lower mortality in the intensive care unit (ICU), yet many ICUs are not staffed by trained intensivists. This gap has led to a number of proposals intended to increase the intensivist supply in the United States. In this perspective we argue that such efforts would be both ineffective and ill-advised. Because many ICU patients are not critically ill, workforce models that base demand projections on ICU admission rather than true critical illness substantially overstate the workforce gap. Even in the presence of a workforce gap, training new intensivists would not place them in hospitals where they are needed most, would not mitigate the shortage of nonphysician critical care providers, and would require an unrealistic increase in spending on physician training.

In addition, efforts to train more intensivists require us to prioritize intensive care over other specialties that are also in short supply, without clear justification for why intensivists are more important. Rather than continuing an unwarranted push to increase the intensivist supply, we suggest alternative workforce policies that emphasize novel interprofessional care models (to improve ICU quality in the absence of intensivists) combined with limitations on the future growth of ICU beds (to reduce demand through implicit rationing of care). These policies offer opportunities to reduce the mismatch between critical care supply and demand without an unnecessary expansion of the intensivist supply.

Keywords: intensive care units; critical care; hospital personnel; patient selection; healthcare rationing

In the United States, more than 4 million patients are admitted to an intensive care unit (ICU) each year, ICU-related spending approaches $80 billion annually, and one in five of all deaths occurs in a hospitalization involving the ICU (1, 2). Data such as these have prompted health care administrators and policy makers to search for ways to improve the quality and efficiency of critical care (3). Increasing the number of patients receiving care by a trained intensivist physician is one such strategy (4). Most studies suggest that intensivist staffing is associated with lower mortality in the ICU (5). However, only a minority of ICUs in the United States are staffed by trained intensivists (6), creating a workforce gap that is expected to widen as the population ages and the incidence of critical illness rises (7).

Labeled a “crisis” by the major critical care professional societies (8), the workforce gap has led to a number of calls to increase the intensivist supply (9). Suggested strategies include increasing graduate medical education (GME) training slots for intensivists; expanding the J-1 visa waiver program, which would allow physicians from other countries to train as intensivists and practice in the United States; creating economic incentives for physicians to enter the specialty through increased reimbursement and loan repayment; and even developing novel training pathways so that practicing hospitalists can become board-certified intensivists through a shortened fellowship (10–12).

We believe that these calls for more intensivists, although well intentioned, are also misguided. In this perspective, we advance the argument that expanding the intensivist supply is not a practical solution to the workforce problem. First, we explore the underlying reasons for the workforce gap in critical care. Second, we discuss why efforts to expand the intensivist workforce will not close this gap and in fact may have unintended harmful consequences for the healthcare system as a whole. Finally, we outline policy alternatives that can meaningfully address the dual problems of deficient quality and excess spending in critical care without an unnecessary...
Advanced Practice RT

- CoARC developed standards for accrediting Advanced Practice Programs in Respiratory Care
  - As a collaborating organization, the AARC consented to the standards.

- AARC created an Ad Hoc Committee on Advanced Practices, Credentialing and Education. Representatives from CoARC and NBRC are on the committee as well.
  - Committee will undertake a needs assessment for both the profession and the MDs.

- NBRC will be asked to begin the process of creating a credentialing program for APRT.

- AARC will need to take the lead on helping states get legislation/regulation to allow practice of APRT
Advanced Practice RT

Objective 1:
  - Refine and expand the scope of practice for respiratory therapists in all care settings.
Strategic Objective 2:
Advance the knowledge base and educational preparation of respiratory therapists to ensure competent patient care and to foster patient safety initiatives.

- Description - The AARC will promote the continuing development of the respiratory care workforce both nationally and internationally by promoting formal educational programs and continuing education in order to ensure competent, safe, and effective patient care, and to provide for the transfer of new knowledge to clinical practice.
Respiratory Care 2015 and Beyond

- In 2007, President Toni Rodriguez directed the AARC Executive Director to organize a series of conferences to address the following questions:
  - What will the future health care system look like?
  - What will the roles and responsibilities of respiratory therapists be in the future?
  - What competencies will be required for RTs to succeed in the future?
  - How do we transition the profession from where it is today to where we need to be in the future?

- Key Stakeholders of the profession were selected to plan and implement a series of three conferences.
The transition plan must:

- Maintain an adequate respiratory therapist workforce throughout the transition.
- Require multiple options and flexibility in educating both students and the existing workforce. (e.g. affiliation agreements, internships, special skills workshops, continuing education, etc.)
- Require competency documentation options for new graduates.
- Support a process of competency documentation for the existing workforce.
- Assure that credentialing and licensure recommendations evolve with changes in practice.
- Address implications of changes in licensing, credentialing and accreditation.
- Establish practical timelines for recommended actions.
- Reflect the outcomes of the previous two 2015 and Beyond conferences
- Identify the agencies most appropriate to implement identified elements.

The Board Unanimously Accepted as amended.
Actions on Conference Recommendations:

- The board recently pushed forward some 2015 and Beyond initiatives that came directly from committees/groups that addressed recommendations. Two such initiatives addressed are:
  - **Conference Recommendation #4**: The AARC, CoARC and NBRC are putting together a task force on competencies for Entry into Respiratory Care Professional Practice that will address 2015 and Beyond.
  - **Conference Recommendation #5**: That AARC encourages clinical department’s educators and state affiliates’ continuing education venues to use clinical simulation as a major tactic for increasing competency levels for the current workforce. – A Clinical Simulation Brief from a sub-committee was approved by the AARC BOD and put up on www.aarc.org.
  - **Conference Recommendation #8**: That the AARC BOD explores development and promotion of career ladder education options for the member of the existing workforce to obtain advanced competencies and the baccalaureate degree. A Clinical Ladder Document was approved by the AARC BOD in April 2015 and placed up on www.aarc.org.
The 2015 ad hoc committee recommended increased access to baccalaureate degrees (either Bachelors Science Respiratory Therapy {BSRT} or Bachelors Science Health Sciences {BSHS}), for both respiratory therapy students enrolled in associate degree granting programs and for associate-prepared respiratory therapists who are already in the workforce, be readily available to access by established articulation or transfer agreements by 2015.
AARC BOD Action July 2015

- The AARC in 2014 created a goal to increase by 25% the number of RTs with a B.S. degree or higher by 2020.

- When the 2020 AARC Human Resources Survey is done, 80% of the respondents to have or be actively working on their Bachelor’s Degree or higher.
  - The AARC will work to provide tools for schools to make the move if they can.
  - We’ll perform a mid-term survey to see if we’re moving the needle on our goal.
American Association for Respiratory Care  
9425 N. MacArthur Blvd., Suite 100, Irving, TX 75063  

Position Statement  

Respiratory Therapist Education  

Respiratory therapists provide direct patient care, patient education, and care coordination. They practice in acute care facilities, long-term acute care facilities, skilled nursing facilities, assisted-living centers, subacute care units, rehabilitation centers, diagnostics units, and in the home. Their clinical decisions are increasingly data-driven by scientifically supported algorithms (protocols) to deliver respiratory care. They are involved in research and need to be adept at understanding the practical ramifications of published research. Respiratory therapists use sophisticated medical equipment and perform complex therapeutic procedures and diagnostic studies. They also provide education to patients and other members of the public. Respiratory therapists must possess an in-depth understanding of human physiology and apply that knowledge in the clinical setting.  

The continually expanding knowledge base of today’s respiratory care field requires a more highly educated professional than ever before. Factors such as increased emphasis on evidence-based medicine, focus on respiratory disease management, demands for advanced patient assessment, and growing complexities of American healthcare overall, clearly mandate that respiratory therapists achieve formal academic preparation commensurate with an advanced practice role.  

The primary purpose of a formal respiratory care educational program is to prepare competent respiratory therapists for practice across multiple health care venues. Respiratory care educational programs are offered at technical and community colleges, four-year colleges, and universities. Training and education for entry-to-practice as a respiratory therapist should be provided within programs awarding a bachelor’s or master’s degree in respiratory care (or equivalent degree titles) and all newly accredited respiratory care educational programs must award, as a minimum, the bachelor’s degree in respiratory care (or equivalent degree title). Associate degree respiratory care programs which are currently accredited by the Commission on Accreditation for Respiratory Care (CoARC) should be allowed to continue in good standing as long as they remain in compliance with all other CoARC policies and standards. The AARC supports existing and future articulation agreements between associate and baccalaureate respiratory therapy programs. Respiratory therapists seeking to practice in advanced clinical settings, leadership roles, research, and in professional educator roles should seek higher education at the masters or doctoral levels.
Training and education for entry-to-practice as a respiratory therapist should be provided within programs awarding a bachelor’s or master’s degree in respiratory care (or equivalent degree titles) and all newly accredited respiratory care educational programs must award, as a minimum, the bachelor’s degree in respiratory care (or equivalent degree title). Associate degree respiratory care programs which are currently accredited by the Commission on Accreditation for Respiratory Care (CoARC) should be allowed to continue in good standing as long as they remain in compliance with all other CoARC polices and standards.
Training and education for entry-to-practice as a respiratory therapist should be provided within programs awarding a bachelor’s or master’s degree in respiratory care (or equivalent degree titles) and all newly accredited respiratory care educational programs must award, as a minimum, the bachelor’s degree in respiratory care (or equivalent degree title).  **Associate degree respiratory care programs which are currently accredited by the Commission on Accreditation for Respiratory Care (CoARC) should be allowed to continue in good standing as long as they remain in compliance with all other CoARC polices and standards.**
CoARC has posted accreditation standard changes

- Standard 1.01 -
- A Except as provided in the following sentence, an educational sponsor must be a post-secondary academic institution accredited by a regional or national accrediting agency that is recognized by the U.S. Department of Education (USDE) and that is must be authorized under applicable law or other acceptable authority to award graduates of the program an associate baccalaureate or graduate degree upon at the completion of the program.† For programs that were accredited prior to January 1, 2018, an educational sponsor must be a post-secondary academic institution accredited by a regional or national accrediting agency that is recognized by the USDE and that is authorized under applicable law or other acceptable authority to award graduates of the program an associate or equivalent degree upon completion of the program.
Baccalaureate Degree Programs
(Entry into RC Profession)

N = 61 as of January 2016
Red/Yellow = No programs in that state (22)
Yellow = State law may allow bachelors (7)

Purple – gained program
Red – lost program

Data courtesy of CoARC
Respiratory Care
Degree Advancement Programs

Green = AS to BS
Blue = BS to MS
Purple = Both Types

N = 54 as of January 2016
Red = No programs in that state (21)
N = 115 as of January 2016
Red = No programs in that state (10)
Green = Entry Only
Blue = DA Only
Purple = Both Types
Yellow = State law may allow bachelors (7)
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<tr>
<th>Baccalaureate Degree Eligibility Category</th>
<th>Maximum Enrollment Capacity as of 12/31/13</th>
<th>Total Graduates as of 12/31/13</th>
<th>% of maximum enrollment 2013</th>
<th>Maximum Enrollment Capacity as of 12/31/14</th>
<th>Total Graduates as of 12/31/14</th>
<th>% of maximum enrollment 2014</th>
<th>Maximum Enrollment Capacity as of 12/31/15</th>
<th>Total Graduates as of 12/31/15</th>
<th>% of maximum enrollment 2015</th>
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<tr>
<td>I. Sponsoring institution currently offers a baccalaureate degree RC</td>
<td>1,395</td>
<td>813</td>
<td>58.3%</td>
<td>1,478</td>
<td>790</td>
<td>53.5%</td>
<td>1,310</td>
<td>693</td>
<td>52.9%</td>
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<tr>
<td>II. Sponsoring institution offers baccalaureate degrees in other disciplines</td>
<td>3,339</td>
<td>1,841</td>
<td>55.1%</td>
<td>3,308</td>
<td>1,954</td>
<td>59.1%</td>
<td>3,342</td>
<td>1,232</td>
<td>36.9%</td>
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<td>III. Sponsoring institution located in a state that authorizes community colleges to award bachelor's degrees under</td>
<td>2,006</td>
<td>1,145</td>
<td>57.1%</td>
<td>2,183</td>
<td>1,272</td>
<td>58.3%</td>
<td>3,049</td>
<td>1,577</td>
<td>51.7%</td>
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<td>IV. Sponsoring institution cannot offer a</td>
<td>7,159</td>
<td>4,129</td>
<td>57.7%</td>
<td>6,477</td>
<td>3,691</td>
<td>57.0%</td>
<td>5,274</td>
<td>2,417</td>
<td>45.8%</td>
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Ohio was the first state to adopt
California signed RRT entry 1/1/15
Six States have dual licensure rules in place already
Looking at another ½ dozen states moving in the same direction
Credential and Education and

**Strategic Objective 2:** Advance the knowledge base and educational preparation of respiratory therapists to ensure competent patient care and to foster patient safety initiatives.
Strategic Objective 3:
Support research and scientific inquiry to strengthen the scientific foundation and promote best practice for patient care.

- **Description** - Demonstrate the value of the respiratory therapist in providing respiratory care by supporting, conducting, and publishing research information. Research should compare the value of the respiratory therapist to others who may provide respiratory care services. Information generated should consider the needs of employers, legislators, regulators, other health professionals, and patients. Research efforts will, when appropriate and possible, be conducted in collaboration with other health care stakeholders.
Research and Scholarship

- Journal Conferences – last one totally funded by ARCF
- Funding - Advanced Practice Scholarships for RTs who will get an advanced degree and work in the field of Alpha-1 and respiratory (1st time ever at a significant funding level)
- Annual Research Fellowships
- International Fellows – 4 in 2015
Strategic Objective 3:
Support research and scientific inquiry to strengthen the scientific foundation and promote best practice for patient care.

- Respiratory Therapy Journals
- Respiratory Care
- Respiratory Care Education Annual
Strategic Objective 4:
Establish professional standards and outcomes that are supported by scientific evidence.

- **Description** - The AARC will continue to develop and disseminate position statements, issue papers, consensus conference reports, evidence-based Clinical Practice Guidelines and other professional standards that promote safe and effective care, and provide guidance on all aspects of respiratory care.
Strategies for Objective 4:

1. Created a taskforce to work with UHC to develop a "Issues Paper" on Safe Initiation and Management of Mechanical Ventilation

2. Continue to review validity and accuracy of AARC Issue Papers and Position Statements

3. Appointed a taskforce to determine the competencies needed by entry level respiratory therapists
Strategic Objective 5:
Advocate for federal and state health care policies that enhance patient care, patients’ access to care, and professional practice.

- **Description** - Advocate at the federal and state level for health care policy that promotes access to appropriate, safe, and effective respiratory care for patients and the public. Develop and implement promotion/marketing of the respiratory therapist targeted to legislators, policy makers, and payers. Messages will emphasize the value of the respiratory therapist in controlling the utilization of services, creating cost savings, improving outcomes and patient safety, and increasing access to respiratory care as provided by a respiratory therapist.
What about the States...De-licensure

- State tactic to reduce the size of government
- Many states have had issues:
  - Michigan, Indiana, Texas.....
- Many states also have sunset laws that will bring this up:
  - Illinois......
- State Societies need to be vigilant and stay on top of this issue
- AARC will provide muscle, but can’t be the face of the fight!
Strategic Objective 6: Partner with governmental agencies, community organizations, third party payers, professional societies and the public to promote healthy behaviors and prevent cardiopulmonary disease.

Description - Promote partnerships with interested stakeholders to improve lung health, prevent cardiopulmonary disease, and identify and maximize the care of patients with chronic disease.
State Based Medicaid Initiative

- The goal of this project is to engage in a collaborative effort with state Medicaid Programs to use and assess alternative care services for the Medicaid COPD patient utilizing Respiratory Therapists in a way we are not currently being used.
Strategic Objective 7: Broaden consumer and health care providers’ knowledge and understanding of the value of respiratory therapists in providing safe, competent, and evidence-based care.

- **Description** - Develop and implement promotion/marketing of the respiratory therapist targeted to health care providers, patients, and the public. Educate respiratory therapists on the importance of health promotion, effective smoking-cessation and tobacco-control programs, pulmonary health screenings, patient education, and disease management.
Changing the Way We Think About Prevention... One Notable Study

- Disease Management Program for Chronic Obstructive Pulmonary Disease: A Randomized Controlled Trial
  - n = 743 patients
    - Hospitalization within 12 months
    - Oxygen Dependent
    - Corticosteroid use
  - Elements of DM program
    - 1 – 1.5 hour education session
    - Individualized action plan
    - Monthly phone calls for RT case manager
- Results
  - 31% fewer hospital visits
  - 34% fewer ED visits

Rice, KL et al. Disease Management Program for Chronic Obstructive Pulmonary Disease: A Randomized Controlled Trial. Am J Respir Crit Care Med. 2010 Jan 21
Strategic Objective 8:
Assure the Association has the resources to meet the mission and strategic goals of the organization.

- **Description** - Assure that the AARC has the financial, volunteer, and staff resources needed to accomplish the implementation of the strategic plan of the Association. It is necessary to have sufficient income to support the ongoing and new initiatives of the Association if we are to accomplish the goals of the AARC. In addition to financial resources, it is essential that there be active participation of sufficient numbers of effective leaders and an effective and efficient Executive Office to support the efforts to be a leader in health care.
Benefit of AARC Membership

- Need to continue to show value to current members.
- Need to get leadership of RT engaged
- Stop “Professional Welfare”
- Membership initiatives 2015:
  - Student Membership campaign. - Alpha
  - Senior Memberships - Omega
  - Win Back Program
- Dues increase....
Exciting Possibilities

- Move to Respiratory Disease Management
  - In Hospitals and alternative care settings!
- Time to advance the degree and credential needed to enter into the profession educationally and regarding licensure.
- Need to make sure we move purposefully, and in a manner that doesn’t hurt our profession.
What **WE** need to do!!!

- “Status Quo”
- “Status Quo”

- Respiratory Therapists at all levels must get involved!!
- State Societies need to be more stronger than ever!
“If You’re Not at the Table, You’re on the Menu”

Respiratory Therapy Department... $ No Value $
Which way do we go?
Is this more poignant?.....Which way do you want to go?
Thank YOU!!

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