

The Coalition Chronicle

Coalition for Baccalaureate and Graduate Respiratory Therapy Education

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Spotlight Article



University of Virginia Medical Center

Pulmonary Diagnostics and Respiratory Therapy Services

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The Pulmonary Diagnostics and Therapy Services department at UVA Health strives to provide exceptional patient care in a multi-disciplinary collaborative working environment. The department is organized on a discipline-specific, patient-focused model that provides our team members the opportunity to specialize in an area of clinical interest. These areas include general medicine, thoracic and cardiovascular, surgical/trauma and neurology, and pediatrics. UVA

Health also offers respiratory therapists the opportunity to further specialize and provide excellent patient care in our long-term care facility and outpatient diagnostic services, including a 6-lab pulmonary function testing center and an 8 bed AASM accredited sleep disorders center.

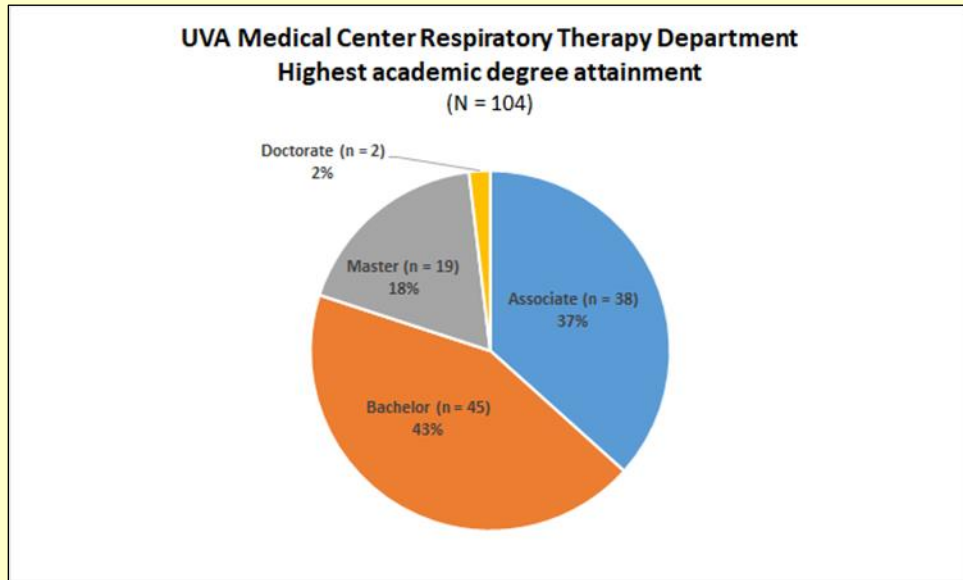
UVA Health Children's Hospital is ranked #1 in Virginia and consists of a level 4 neonatal ICU, newborn nursery, pediatric acute care, and pediatric intensive care services. The Children's Hospital respiratory therapists have the opportunity to work in all areas of the Children's Hospital and have obtained the RRT-NPS specialty credential. The home ventilator program provides comprehensive support to children that require tracheostomy and long-term ventilation. The program provides a standardized education program consisting of videos, mannequin demonstrations, and hands on practice. The respiratory therapist works with the complex care teams in each area of the Children's Hospital to develop a discharge plan to address all the needs of the child and family. The management of these patients continues to the outpatient setting where an interdisciplinary team, including respiratory therapists, specialize in continued management of these patients. The UVA Pediatric Home ventilator program is unique since it is non-integrated to the Children's Hospital. The program is successful due to the diligent hard work of respiratory therapists who ensure continuity from education to discharge to follow-up. The RT is present through all phases of education and builds a rapport with families that allows for great patient advocacy.

The academic atmosphere at UVA Health allows our team to participate in cutting edge clinical research that has had many positive impacts on improving patient outcomes and bedside practice. The department is a strong advocate of advanced degrees and recognizes that baccalaureate, master, and doctorate degree prepared respiratory therapists pave the way to the future of our profession. Our staff consists of 104 respiratory therapists, of which 63% have earned a minimum of a bachelor degree (Figure 1). We require all respiratory therapists to provide documentation of having earned the NBRC's RRT credential within 90-days of joining our team, and because our staff specializes in either



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(Educating family of pediatric tracheostomy patient for home respiratory care.)

neonatal/pediatrics or adult focused patient care we require respective NBRC specialty credential attainment within 2-years of employment. Eighty-seven percent (54 of 62) of our staff that work primarily with adult patients and who are eligible to take the NBRC's adult critical care specialist examinations have earned the RRT-ACCS credential, and 83% (29 of 35) of staff specializing in neonatal/pediatric respiratory care have earned the RRT-NPS credential.

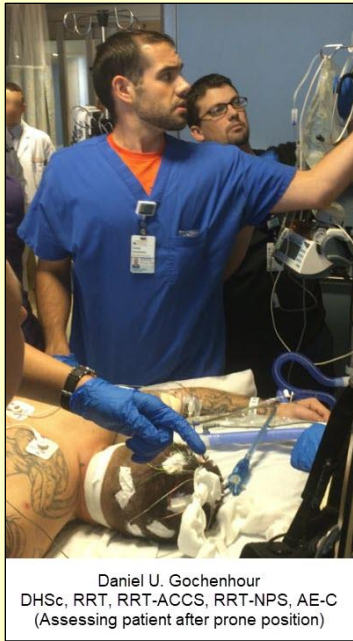


UVA Health encourages respiratory therapists to participate in the advancement of the profession through participation on health system, state, and national committees. Many of our team members participate in state and national professional organizations and have been recognized by the AARC, ARCF, and Respiratory Care Journal for significant and sustained contributions to the profession of respiratory care.

The Respiratory Therapy Department at UVA Health prepares newly hired healthcare providers with a comprehensive 12-week orientation consisting of classroom, simulated skills demonstrations, and clinical mentoring. The orientation program strives to promote superlative patient care through the use of evidence-based literature and development of critical thinking skills that aim to personalize respiratory care to meet individual patient care needs.



To encourage an evidence-based approach to respiratory care practice, all respiratory therapy team members are assigned peer reviewed journal articles throughout clinical orientation. Clinical orientation includes a progressive curriculum that begins with an introduction to *Respiratory Therapy 2015 and Beyond* and then introduces referenced based literature that reviews and supports respiratory care interventions such as non-invasive positive pressure ventilation, high flow oxygen therapy, mechanical ventilation modes, lung protective mechanical ventilation strategies, assessment of pulmonary



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(Assessing patient after prone position)

mechanics, and ethical dilemmas encountered with the use of ECMO. For instance, Week 1 assigned reading includes *Competencies needed by respiratory therapists in 2015 and beyond* (Barnes et al., *Respir Care*, 2010) and Week 2 focuses on *Noninvasive ventilation for respiratory failure* (Hess, *Respir Care*, 2013) and *High flow nasal cannula oxygen therapy in adults* (Nishimura, *J Intensive Care*, 2015). Weeks 3 through 12 focus on critical care orientation. Readings



Laura Falls MPH, RRT, RRT-ACCS
(Inserting esophageal catheter to measure Ptp)

such as *Patient-ventilator interactions: Optimizing conventional ventilation* (MacIntyre, *Respir Care*, 2011), *Inhaled therapies for pulmonary hypertension* (Nicholas, *Respir Care*, 2015), *Driving pressure: A marker of severity, a safety limit, or a goal for mechanical ventilation?* (Bugedo, *Crit Care*, 2017), and *Ethical dilemmas encountered with the use of ECMO in adults* (Abrams, *Chest*, 2014) are paired with medical, heart center, and surgical/trauma/neuro ICU clinical rotations that are coupled with clinical preceptor skills demonstrations and discussion.

The Children's Hospital clinical orientation also encourages an evidence-based approach to practice and follows a similar progressive curriculum. Clinical orientation begins with an introduction to *Respiratory Therapy 2015 and Beyond* and progresses each week with literature and skills related to pediatric assessment, high flow nasal cannula and non-invasive ventilation, airway management, mechanical ventilation of pediatric and premature neonates, inhaled gases, tracheostomy care, ECMO, and advanced mechanical ventilation strategies with a focus on lung protective ventilation. Examples of assigned

readings included in Week 1 and 2, *Interpretation of the Pediatric Chest X-Ray* (Arthur, Pediatric Respiratory Reviews, 2000) and *Use of High Flow Nasal Cannula in Critically Ill Infants, Children, and Adults: A Critical Review of the Literature* (Lee, Intensive Care Medicine, 2012). Acute care orientation begins in Week 3 and includes the assigned article *Pediatric Airway Maintenance and Clearance in the Acute Care Setting* (Walsh et al., Respir Care, 2011). Weeks 4 through 12 focus on orientation to the Pediatric and Neonatal Intensive Care Units. Readings such as *Invasive and Noninvasive Pediatric Mechanical Ventilation* (Cheifetz, Respir Care, 2003), *Ventilator Induced Lung Injury: Similarity and Differences Between Children and Adults* (Kneyber et al., AJRCCM, 2014), *Tracheostomy: Pediatric Considerations* (Deutsch, Respir Care, 2010), *Neonatal Pulmonary Physiology* (Davis et al., Seminars in Pediatric Surgery, 2013), and *Mechanical Ventilation of the Premature Neonate* (Brown et al., Respir Care, 2011). These articles are paired with classroom didactic skills and clinical preceptor rotations to build up the skills and confidence of new clinicians.



Amanda Shaffer MSc, RRT, RRT-NPS, RRT-ACCS (Right)
Summer E. Daniels MSc, RRT, RRT-NPS, RRT-ACCS (Left)
(Discussing HFJV on premature newborn)

Our department offers respiratory therapy staff an opportunity to advance through a four level Respiratory Therapist (RT) clinical ladder. RT 1 designates a new graduate respiratory therapist with less than one-year of clinical experience. All RT 1s must ascend to RT 2 within one-year of their hire date, at which point they are recognized as a competent clinician with moderate level knowledge, patient assessment, and therapeutic skills for typical respiratory conditions. While not required, respiratory therapists that have worked clinically for greater than three years may apply to become a RT 3. The RT 3 is a skilled clinician with advanced knowledge and skills, has a minimum of a baccalaureate degree (Preferably BSRT), and actively participates in department initiatives and serves on department or professional society committees or workgroups. The RT 4 is recognized as an expert clinician by peers and others throughout the Health System. They have a minimum of five years clinical practice, BSRT/BSRC degree (Graduate degree preferred), and proficiency in quality improvement and root-cause analysis methodology.

The clinical ladder focuses on demonstrated excellence in patient care while also encouraging team members to identify areas of interest for professional

growth, such as by participating in department and health system committees, clinical research, and professional society volunteerism. We pride ourselves as effective multidisciplinary team members who are valued by the health care team and hospital administration for our specialized knowledge and skills that improve respiratory care delivered to patients. The University of Virginia Medical Center's



Joseph L. Di Peppe BS, RRT, RRT-ACCS
(Using EIT to evaluate distribution of ventilation during PEP therapy)

respiratory therapists have a long history of service excellence and have received local and national recognition for their significant and sustained contributions to the profession of respiratory care. Many have been elected or appointed to serve on the Virginia Society for Respiratory Care, American Association for Respiratory Care, Cystic Fibrosis Foundation, Society for Critical Care Medicine, International Council for Respiratory Care, and the Commonwealth of Virginia Board of Medicine's Board of Directors,

committees, and workgroups. Others have conducted research and presented their findings at the AARC Congress' Open Forum, in addition to having full manuscripts published in peer reviewed journals.

UVA Health welcomes new graduate and experienced Respiratory Therapists who are motivated to advance the practice of Respiratory Care and actively contribute to the multidisciplinary care team environment supported in the health system. Come join our team of professionals and share our commitment to lifelong learning and passion for providing the best patient care to diverse patient populations.



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Interview

Republished as a tribute to the late Professor Bud Spearman

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Charles B. (Bud) Spearman, MEd, RRT, FAARC
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School of Allied Health Professions,
Department of Cardiopulmonary Sciences
Respiratory Care Programs

By Jeff Ward, MEd, RRT, FAARC

Mayo Clinic Multidisciplinary Medical Simulation Center
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1. Tell us about your early days as a respiratory therapist.

What brought you into the profession?

In 1968, at the suggestion of a friend, I applied for a job in the inhalation therapy department of Tucson General Hospital. That friend is Harold McAlpine, RRT, one of the first registered respiratory therapists in Arizona. I had no previous background in this type of work, so I was trained on the job by Harry's own mentor Otis Brown. I was instructed in basic oxygen therapy for wall and portable gas cylinders, adult and pediatric oxygen tents, intermittent positive pressure breathing (IPPB) treatments with Bird and Bennett pressure ventilators, self-inflating resuscitators, ECGs, as well as some physical therapy procedures. The latter included simple traction and diathermy. I guess you could say that what brought me to the profession was the need of a job and what kept me in it was enjoying the responsibilities of taking care of patients.

2. Who were your mentors?

How did they contribute to your career?

About 18 months later, I entered the first formal respiratory therapy program in Tucson located at Tucson Medical Center (TMC). I changed jobs and began working evening shift in TMC's respiratory therapy department. That's where I met my second important mentor Steven P. McPherson, RRT. I attended classes during the mornings on the TMC campus then walked to the RT department to work. This program soon was subsequently affiliated with a new community

college, and I earned my associate of science in respiratory therapy from Pima Community College.

I gained experience quickly since I was working and attending the program at the same time. I learned a lot from Steve McPherson and found that I liked the way he explained the technical aspects of the equipment and how it actually worked. He could make devices make sense so that applying them to patients correctly could be better understood. He encouraged me to complete the national Certified Inhalation Therapy Technician (CITT now the CRT) exam after my first year of school (1970) so that I could be credentialed. After graduation and passing the American Registry of Inhalation Therapy (ARIT, now the NBRC), I became RRT number 1646. Steve then asked me to help teach some of the courses. That was my introduction to education. Steve's confidence in me and his availability to me as an encouraging leader gave me confidence in myself. Steve was on the editorial board for the Respiratory Care Journal and encouraged me and others to get involved in professional journalism. I then coauthored a Letter to the Editor with TMC therapist, Ray McCrea, RRT. I then contributed a couple of Teacher Features and two brief articles on technical aspects of respiratory care equipment. *The game was afoot.*

My writing took a quantum leap when Steve asked me to write in one of the first comprehensive books specifically devoted to equipment. I contributed to five editions of *Respiratory Therapy Equipment*. That experience led to an opportunity to work on several editions of what became *Egan's Fundamentals of Respiratory Care*.

In the 1970s, I was fortunate to meet Glen Gee, RRT, Richard L Sheldon, MD, FAARC, Ray Masferrer, RRT, FAARC and each contributed to my professional development through their support and encouragement. I worked in the Loma Linda University/Loma Linda University Medical Center system from the mid-1970s until I retired in 2014. During those years I had the privilege of working with colleagues Howard G Sanders, MA, RRT and David Lopez, EdD, RRT who were examples for me as well as many others including many AS and BS students.

3. How did furthering your education contribute to your career path?

What got you on your path as an educator?

In the early 1970s I enjoyed teaching in the program in Tucson but began to understand that my lack of former training as an educator was hindering me and that there were some respiratory therapy programs offering BS degrees. I also realized that if I were ever to leave my hometown of Tucson and seek a teaching job in another program, I had better get at least a bachelor's degree. Respiratory

therapy was really the only college teaching I enjoyed, so I looked for such programs. At that time there were very few RT programs offering a BS degree, and the only one in the western US was Loma Linda University (LLU) in Loma Linda, California. Not only could I study respiratory therapy in greater depth and breadth, but the program also offered an area of emphasis in education. While enrolled in the BS program at the University, I worked in the respiratory care department of Loma Linda University Medical Center (LLUMC) under director Glen Gee, RRT. My classmates and co-workers at LLU included Rick Meyer, MS, RRT and Terry Krider, BS, RRT. We developed strong friendships while challenging each other during our various classes.

After graduating in 1975, I returned to Tucson and once again taught in our RT program there before returning to the LLU/LLUMC system in 1977. I was fortunate to be able to attend AARC annual conventions yearly starting around 1975 and that led to networking with other educators and therapists. The privilege of attending those and other meetings also enhanced my growth through continuing education not only in therapy approaches, new devices and assessment techniques but also in research and education methods. I feel those experiences meant more to my professional growth after I completed my bachelors' program than those before that degree was completed.

I guess what really got me started on my path as an educator was that first teaching responsibility given to me by Steve McPherson in Tucson. He took a chance on me and I couldn't let him down. At LLU/LLUMC I was also asked to present to physicians, nurses and other respiratory therapists as part of the continuing education section of the respiratory care department. I really enjoyed teaching both seasoned practitioners and beginning students. The BS RT students I taught were generally working therapists while the AS RT students were in their first professional program. I had the best of both worlds. Later, the AS RT program was closed in favor of a BS level program. The original BS RT program remained so I still had a blend of both novice students and experienced practitioners in my classes and labs.

When the dean of the LLU School of Allied Health Professions offered to provide tuition assistance to the faculty wanting advanced degrees I found a Master's degree program in health professions education at the University in Southern California (USC) in nearby Los Angeles (UCLA), that I could attend part time with afternoon and evening classes. That program helped me be a better educator and to change the way I approached my courses. It built on the education courses in my BS RT program and workshops I had attended and gave me a broader understanding of both education theory and techniques.

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

One of the important lessons I learned as a clinician was the importance of being part of a collaborative team with health care providers such as physicians, nurses and others. To do this well, respiratory therapists must not only be skilled and knowledgeable but also be able to communicate effectively. When I started in the late 1960s as an on the job trainee, we functioned primarily as technicians receiving orders and applying treatments as directed. Most of the communication with physicians was done through nurses and patient assessment was mostly based on safety rather than therapy success. Formalizing respiratory therapy education raised the level of the therapist's ability to provide safe and effective care which was based on more thorough patient assessment. My experience as a therapist at LLUMC showed me how that could be done. While working in the ICU of the respiratory unit, I was expected to participate with the physicians, medical students, residents and nurses during rounds each day. George Burton, MD and John Hodgkin, MD were key pulmonary physicians that I was fortunate to work with and learn from both in the ICU as well as in the classroom as a BS RT student. On rounds, they would ask the therapist to provide any suggestions and questions about the patient's care. They expected the therapist to be able to explain the rationale for changes requested. This was a quite different work environment than being a technician.

I was introduced to research studies briefly in my AS in RT degree but much more in both the BS RT and MS education degrees including both research design and statistics courses. This helped me interpret the literature better as well as design some projects which evaluated equipment used for respiratory care. While at LLU, I was able to present my research poster format at the Respiratory Care Journal's Open Forums sessions. This provided a chance to interact with other researchers, most of whom were doing higher level clinical research than I was. These sessions at the AARC International Congresses were particularly important for both professional growth but also for networking with others.

I was fortunate to have attended nearly all the AARC national Congresses and several Summer Forums and various state annual meetings over a 40 plus year period. That was important to developing course curriculum, contributing to textbooks, presenting lectures and workshops at national, international and state meetings. Some of the meetings required speakers to provide an article based on the presentation given. It was my privilege to have several articles published in the Respiratory Care Journal.

I believe that taking advantage of opportunities relatively early in my career led to even more possibilities. Contributing to the Respiratory Care journal in the 1970s led to an invitation to present a workshop with another therapist, Bob Demers, BS, RRT at the AARC Congress in 1977. Contributing to one textbook development and writing chapters for others led to an opportunity to work as an editor and contributor to another text. Again, these activities helped me in my primary role as an educator in my “day job”.

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

Here are some recommendations I have for new graduates:

The first thing I recommend to new graduates after acquiring your RRT credential is to find a job that will give you a broad, sort of generalist patient care experience if possible. I believe that most new graduates are not quite ready for specialty areas and will benefit from a range of experiences with adults in general care and also rotations through ICUs. After honing your skills in patient assessment, therapy application, airway care, mechanical ventilation etc. you then might consider being assigned to specialty areas such as adult, pediatric and neonatal critical care, home care, rehabilitation, and sleep labs etc. Assisting in departmental business aspects or staff education are also considerations.

You should seek out any of the specialty credentials that you feel will help in your work and professional development. Memberships in the AARC, your state societies and CoBGRTE are highly recommended as is volunteering for these organizations when possible. You should continue reading and researching best care methods, seek out the best continuing education information for your credentials and your practice areas. You should seek out and be available to mentors whenever possible whether they are at the workplace, professional meetings or elsewhere.

Consider what the next level of formal education might do for you. Graduates with an AS degree should look for a bachelor’s program as soon as possible and BS RTs should investigate graduate degrees that might apply to your professional development plan.

Take advantage of chances to contribute to your profession whenever possible. You never know where it might lead. Here is an example.

In the early 1980’s then president of the AARC Glen Gee, RRT asked if I would consider an appointment to the NBRC and I accepted. There I was able to help create and modify credentialing exams along with leaders in the profession such as Fred Helmholtz, MD, Robert Kacmarek, PhD, RRT, FAARC and many others

that also served as mentors to me in their own way. Work for the NBRC at that time also included helping states that wanted to use an NBRC's exam for state licensing.

As I worked teaching at LLU in BS RT programs I had an interest in promoting the development of other bachelor's level and graduate degrees in respiratory care. So, when Tom Barnes, EdD, RRT, FAARC was looking for people of like mind to join a professional association called CoBGRTE I signed on. Currently I am finishing my last year on the Board of Directors of CoBGRTE. It has been my honor to serve with the leaders of respiratory care education and management on this board.

In the early 2000's, I had the opportunity to accept an appointment to the Respiratory Care Board of California (RCB) which is the licensing board for respiratory care practitioners in the state. My past medical director, co-editor and friend Richard Sheldon, MD, FAARC was also on the RCB at the time and encouraged me to accept the appointment which I did. I served eight years on that board from 2006-2014 serving as president from 2013-2014. During my time on the RCB we were successful in changing the minimum entry credential needed for a license from the CRT to the RRT. I was fortunate to represent the RCB and LLU at each of the 2015 and Beyond workshops presented by the AARC in 2008, 2009 and 2010.

So, to new graduates as you settle into the respiratory care profession, think of how you can serve your patients by expanding your knowledge, experiences, credentials, education and membership in professional organizations. Volunteer and take advantage of opportunities that come your way. Invest in yourself and your profession and you will reap benefits for yourself and your patients.

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Ultrasound Education at Collin College

Araceli Solis, MA, RRT

Kelley A. Reynolds, RRT, RRT-NPS, RRT-ACCS, AE-C, TTS

The Respiratory Care Program at Collin College is a 22-month program where students earn an Associate of Applied Science in Respiratory Care. Through a partnership with Midwestern State University, students can begin taking upper-level courses while enrolled at Collin College and be one step closer to earning their Bachelor of Science in Respiratory Care.



In 2017, the Texas Medical Board and Respiratory Care Board confirmed PICC Line, Peripheral Line, and Venipuncture as part of the respiratory care scope of practice. Soon after, Collin

faculty attended a Peripheral Access Training Course offered by the Texas Society for Respiratory Care. Program faculty discussed the need for ultrasound equipment to begin training students as select respiratory care departments were already starting to train their staff to be on PICC line teams. The program's advisory committee provided information that solidified the need for purchasing training equipment for our lab. More trainings were attended by program faculty in 2019 specific to lung ultrasound. We obtained information from various vendors and decided to purchase an ultrasound device that was used widely in our service area, where our students gain



employment. Our program applied for Carl D. Perkins funding in 2019 and funds were awarded later that year. We developed skills and activities within select respiratory care courses:

- Recommend and perform basic bedside ultrasound procedures to find appropriate vessels for venous and arterial cannulation.
- Recommend and perform basic lung ultrasound procedures. Identify placement of an endotracheal tube using bedside ultrasound techniques.

Specific student learning outcomes were kept simple: 1) define terminology, 2) name specific uses, 3) identify vessels, 4) identify normal lung anatomy, 5) explain the indications for lung ultrasound, 6) describe various probes and uses, 7) identify the appearance of normal structures/tissue, 8) define A lines, B lines, and lung sliding, 9) describe the use of lung ultrasound to determine diaphragm excursion and confirmation of endotracheal tube placement, and 10) describe the use of ultrasound to perform arterial sticks and PICC/mid-line placement.



Students practiced using the ultrasound during class. They identified vessels and normal lung and diaphragm excursion on themselves and others. Students were quizzed and tested on content covered. Faculty were able to utilize the online resources available through the vendor to supplement learning.

Student feedback was positive. Only one group of students was able to benefit from this education (the Class of 2020). As a result of the pandemic, limited lab time and online instruction posed challenges in getting students the hands-on experience that the previous cohort had. We are back on track to educate our two current cohorts.

All major facilities in our area are utilizing point-of-care ultra sound (PoCUS). We have three facilities that have RT-Driven Vascular Access Teams. Graduates have an advantage if they are familiar with the technology. Several Collin College alumni are on vascular access teams. The program plans on purchasing phantoms to supplement lab activities going forward.

*“**Imaging phantom**, or simply **phantom**, is a specially designed object that is scanned or imaged in the field of [medical imaging](#) to evaluate, analyze, and tune the performance of various imaging*

devices. In the case of ultrasonography, a phantom with similar [rheological](#) and [ultrasound](#) scattering properties to real tissue would be essential, but x-ray absorbing properties would not be needed.” (from https://en.wikipedia.org/wiki/Imaging_phantom accessed 8/28/21).

Our program plans on using ultrasound as a means to recruit students to the program. In recent years, recruitment has been challenging for us. Our PR department routinely develops videos for us to use for promotion and



recruitment. This year we had them incorporate our newer equipment in their filming, which included our new ultrasound machine. We plan on attracting more students to the profession of respiratory care by demonstrating multiple aspects of the profession that involve technology. We have identified several recruitment strategies which we will

implement this academic year. Recruitment is a priority for us, and our profession is in need, now more than ever.

[ASRT to BSRT & MSRC Degree Advancement Programs](#)

[BSRT and MSRT Entry Programs](#)

[Graduate Respiratory Therapist Programs](#)

www.CoBGRTE.org

Recruiting Entry-Level Respiratory Therapy Students: Three Strategies to Implement Now

Sarah Pehlke, MHS, RRT

Randy Case, PhD, RRT, RRT-NPS

Lee Wisdom, MHS, RRT, RRT-ACCS, RRT-NPS

For several years, recruitment into respiratory therapy has been a growing point of focus for leaders and educators across the profession. Since the onset of the COVID-19 pandemic, and the growing awareness of respiratory therapy's role in patient care, recruitment has now been catapulted to a top priority for healthcare and academic organizations alike. Conversations regarding the “how” of recruiting into respiratory therapy is a subject focus for many. Successful recruitment will require efforts from academics, managers, front-line workers, students, retirees, and more. Strategies should not only focus on increasing incoming student numbers now, but also prepare our programs for continued growth over time.

The CoBGRTE Marketing Committee supports recruitment efforts into bachelors and graduate respiratory therapy programs. In addition to the production of content for prospective students, the marketing committee hopes to share information that may be useful to programs seeking growth in student recruitment. Consider implementing the following three strategies for recruiting entry-level students into the profession and into your respiratory therapy program.

1. Ensure accurate information is accessible to prospective students.

When making career decisions, prospective students, and in many cases, their parents, seek information about the profession. Mean salary and projected job growth are often factors taken into consideration when making career decisions. Although the Bureau of Labor Statistics (2021) projects a 19% job growth in respiratory therapy through 2029,¹ Google currently cites 2014 data, in which the projected job growth was 12%. Google's top referenced questions include “Is respiratory therapy a growing field?” and “Will respiratory therapy be phased out?” Out-of-date information about our profession can be found in quick search responses on Google, Yahoo, Bing, and other major search engines.

Did you know, you can solicit engines to update inaccurate information?

Recently, a member of the CoBGRTE Marketing Committee provided feedback leading to updated responses in Google to the questions “Is respiratory therapy a growing field?” and “Will respiratory therapy be phased out?” The new and accurate information reflects a more positive perspective of the profession. The search engine, however, continues to note the projected job growth at 12%. To update this statistic, we should continue to submit feedback. The process is quick! First, go to www.google.com. Search “respiratory therapy job growth.” Below the answer, click “Feedback” and “Something is wrong.” In the comment box, cite the U.S. Bureau of Labor Statistics projection of 19% (Much faster than average).¹ The process is similar for other search engines. Continue to watch for inaccurate information about respiratory therapy and provide real-time feedback. Together, we can ensure that accurate, up-to-date, and encouraging information is shared about our profession.

2. Catch prospective entry-level students as soon as you can.

Student recruitment is an essential component to most respiratory therapy programs, and reaching individuals interested in pursuing a career in the health sciences as early as possible is a critical step. In many situations, students wanting to pursue careers within the health sciences turn to the most visible professions, such as nursing. The respiratory therapy community must develop and implement strong recruitment strategies to engage more students early on. The middle to late stages of high school are often considered the most influential decision-making times in one’s life. This is the time recruitment could potentially find the most benefit in attracting prospective students to the field of respiratory therapy. One method many have found tremendously successful has been collaborating with local high schools to reach students enrolled in health education courses. Recruiters will have an inquisitive audience whose members already expressed an interest in health care.

What should I say?

Students are typically more engaged through interaction and activities versus traditional communication. The more bells and whistles you can produce, the more captivated they will be. Several recruiters for respiratory therapy programs and members of the CoBGRTE marketing committee use their high school recruitment demonstrations as a time to showcase cutting-edge and advanced respiratory care equipment. Students

in this age category are heavily influenced by technology. What better method to introduce prospective students to the technology utilized by respiratory therapists than with a high-tech ventilator? In many instances, the equipment and technology will speak for themselves; however, simply talking about the roles and responsibilities of respiratory therapists will also prove to be beneficial. This method will at minimum, plant the seed and introduce the students to the profession of respiratory therapy. Recruitment of future respiratory therapists is a complicated task, however, targeting young high school students and those entering college is a key element to a positive and beneficial recruitment effort.

3. Increase your program's online visibility.

Once you've ensured your information is up to date, share information with as many individuals as possible. In addition to partnering with high schools across your state, consider utilizing electronic communication to reach those who may not be as close geographically, or may not be present during your high school visit. Leveraging the power of social media is one technique for sharing information regarding the profession with potentially large numbers of people. Create and maintain pages specific to your program and invite current students, faculty, and those interested to join or follow the page via a dedicated link or QR code. This could be done while visiting high schools, meeting with prospective students, and sharing page content. Keep in mind, when utilizing social media, posts may be seen by individuals of various ages and different education backgrounds. Keep things simple, use combinations of graphics and text, and share key points in your posts or advertisements, with links to more detailed information. In addition to routine informative posts specific to the profession and your program, consider asking students to share their favorite thing about your program/the profession, positive experiences in the clinical setting (with respect for privacy, of course), and more.

How can you “connect” with prospective students through a screen?

Some examples include:

- a.** Brief demonstration videos (less than 2 minutes) on various skills respiratory therapists have and procedures we may do. This provides an opportunity to show off program technology, such as mechanical ventilators and simulation equipment.
- b.** Go Live! If you're utilizing a platform such as Facebook or Instagram and have followers, take the opportunity to “go live” to

share information about your program, take questions, or do live-demonstrations via simulation.

- c. Ask followers what they are interested in, and tailor the content on your social media platform to their interests, OR, ask current students to create demonstrations to show skills they are learning at various points in the program.
- d. Share content and materials created by CoBGRTE specific to respiratory therapy.
- e. Use hashtags! This will allow your content to be reached through searches and personal algorithms. Consider using general terms, such as #healthcarejobs, #careers, and #healthcareheroes. Select a few well-researched hashtags to increase the visibility of your posts.

We all know that recruitment is essential to growing and maintaining a strong respiratory profession. Now more than ever, respiratory therapists are in the spotlight for their vital role relative to the COVID-19 pandemic, and we can leverage the increased awareness to recruit entry-level students to our programs. The CoBGRTE Marketing Committee is here to help, and we hope you will consider implementing these three strategies to strengthen your recruitment efforts. Look to future Coalition Chronicle issues for continued support for respiratory therapy program marketing. Do you have ideas you would like to share about recruitment? We would love to hear them! Email your suggestions to Sarah Pehlke at spehlke@bellarmine.edu.

REFERENCE

1. Bureau of Labor Statistics, U.S. Department of Labor. (2020). Employment projects – 2019-2029. <https://www.bls.gov/news.release/pdf/ecopro.pdf> accessed 8/28/21.

Professional Positions Posted

***University of Missouri, *Liberty University, *St. Catherine University, *University of North Carolina-Wilmington, *Augusta University, *Upstate Medical University-Syracuse, *Norton Healthcare, *University of Virginia Health System**

Advocacy - Crossing the Finish Line

Gary Wickman, MSc, RRT, FAARC

I have written about advocacy in the past detailing how meaningful and rewarding it can be to our patients, our profession, and ourselves. The Respiratory Care Society of Washington, RCSW, has been working to further define our scope of practice to current standards and linking licensure to the registered respiratory therapist credential. We began by trying to work with our Department of Health, DOH, which had limited success.

The RCSW advocacy team met with the Washington State DOH to develop working relationships with the people there, following the enactment of the respiratory care licensure law. The RCSW lobbyist guided us through the legislative processes. We started working with them to allow respiratory therapists (RTs) to provide ECMO and ECLS more than 20 years ago. RTs had been performing this procedure in some NICUs for more than 10 years before that. Again, RCSW had limited success in getting this recognized in our scope of practice. This was due to a number of issues. First, RTs had to provide knowledge and expertise to people who were not familiar with this procedure and to relate it to our existing law and scope of practice. This can be challenging but providing the science behind it and having physician and other allied health partners to corroborate what RTs were trying to convey helped. Second, RTs had to abide by existing laws and rules. Sometimes, this was put to the Attorney General to provide the legal answer to proposals that were governed by existing law. Third, the personnel at the DOH changed and then we would have to start the process over with the new people. In the end, after many years of trying, it was determined that actually taking the legislative route, amending the law through our legislative process was the best way to affect these changes. RCSW had been hesitant to do this because we were taught that opening up our law would provide room for other stakeholders to make changes that we may not want.

The keys to success in changing legislation are:

1. Have the support, both financial and with personnel from the State Affiliate.
2. Know what you want to change specifically and be able to articulate why the changes are needed to legislators. You need to articulate how it will help patient care and safety.
3. Have a lobbyist who knows the players and can help facilitate the process.
4. Be willing to work with groups and stakeholders who have an interest in the changes you are proposing.

5. Develop an advocacy team that is willing to put the time in to make it happen.

The RCSW used all of these strategies to change RCSW licensure law in the 2021 legislative session. Groundwork was planned prior to 2021 by educating and then polling the respiratory therapists, the employers, and our key health care partners in the state on what RCSW were proposing. RCSW also used the 2015 and Beyond Consensus Conferences findings to help guide the changes wanted.

Our lobbyist helped us find the right legislator to sponsor our bill. RCSW also had the support of the DOH to use the legislative route to make the needed changes. Then a list of needed items was developed and included in changes to our current licensure law for the new bill. RCSW worked with the legislative aids of the legislator who sponsored the new bill to put the list into legislative language. It also helped that the Chair of both the House and Senate Health Care Committees had worked with us in the past.

Once the new bill was written and submitted, then RCSW had to work with stakeholders who either wanted clarification about the new bill language or wanted changes to be made from their perspectives. This is where the fun begins, RCSW had to be ready to work with these stakeholders in order to try to get them to support our bill.

Here are some of the highlights RCSW was able to include in our bill:

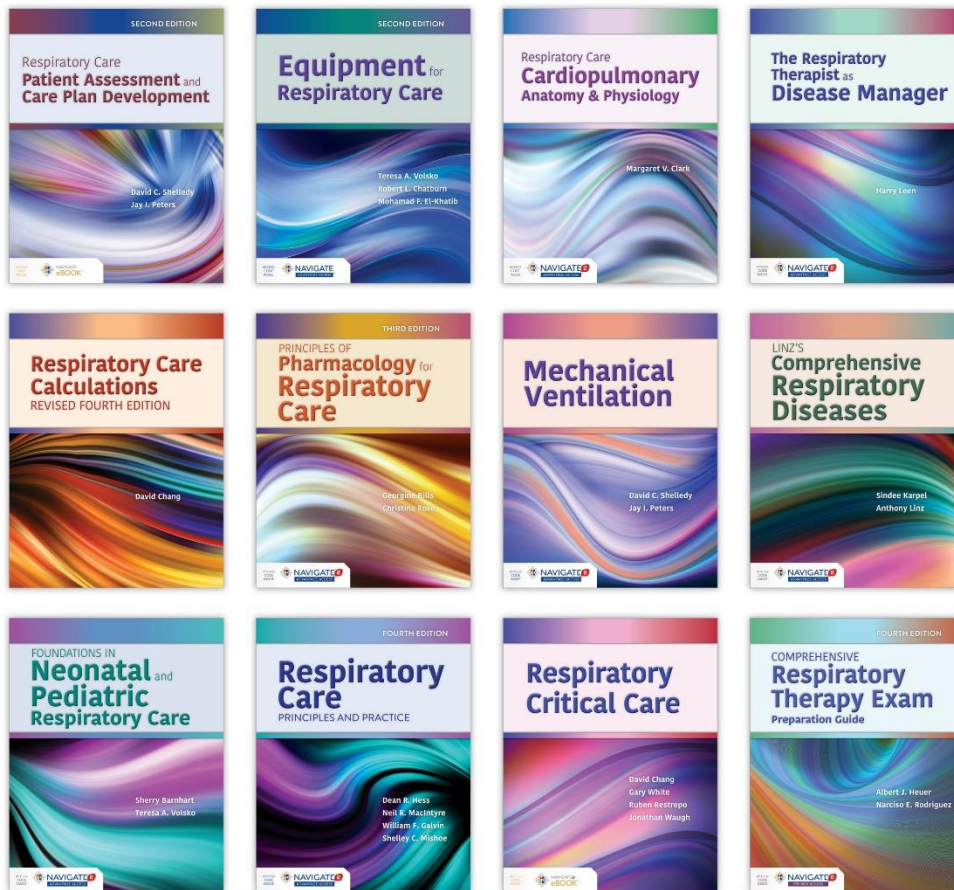
1. We changed the exams for licensure for those leading to the registered respiratory therapist credential, including both the Therapist Multiple Choice and the Clinical Simulation portions. The strategy was to have the wording just say that a person needed to have an active registered respiratory therapist credential. The legislators balked at using a specific agency like the NBRC in the legal language. However, they did include it as an acceptable example.
2. Changed the scope of practice to include:
 - a. Administration of nitrous oxide for analgesia
 - b. Performing cardiac stress testing including administration of medications needed for that test.
 - c. Providing ECLS or ECMO
 - d. Being able to administer any medication that is nebulized. The goal was to make the wording broad so we could add medications to this list as changes happened.
 - e. Provide disease prevention services
 - f. Can administer medications related to cardiopulmonary medicine
 - g. Can take written, telephone, or verbal orders
 - h. Can provide Telemedicine services

We had to work with the state nursing association because of many of the scope of practice items. They were mainly interested in how RTs were taught to do things like administer medications for cardiac stress testing, assessing responses to those medication, etc. Our educators and managers stepped up and provided thorough resources for this and that detail convinced the nurses that we should be able to provide these services. The nitrous oxide administration was questioned by the anesthesiology group. RCSW was ready for that with our own anesthesia experts who helped us write the policy around this procedure. The dental hygienists questioned this procedure as well. We were able to work with them to include language that worked for them and allowed us to provide the service. Lastly, the perfusionists came in at the last minute as the bill was going to be voted on in the Senate and had already passed the House. They wanted some changes to the language around ECLE/ECMO. Mostly they did not want RTs to do the things they do in cardiac surgery. They also wanted to have language around training included in the law. RCSW included our own RTs who were already providing this procedure to help in the negotiations with the perfusionists. We were able to work through the issues and allow RTs to safely provide this service to our patients. The bill passed and was signed into law in June.

Now comes the rest of the process to enact this law. RCSW will be working with the DOH and other stakeholders to write rules that will help to interpret and enact the changes that this bill provided. In the end, the legislative process was good for our patients, our profession, and RCSW RTs. We considered but did not include changing the educational level to a bachelor's degree even though 3 out the 4 state schools already provide baccalaureate level educational programs and the fourth is moving there. Our legislators were not willing to go there yet. That will come in the future. One lesson we learned was that it is okay to open up your law in order to make needed changes that will improve patient care and support our profession and RTs. We also learned to be proactive with our stakeholders and be willing to listen and negotiate. I am hopeful that more states will make the change to use the RRT Exam for licensure and will also take a look at their scope of practice as well. In this way we can continue to improve our profession in order to provide safe, effective care into the future as medicine evolves.



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If you haven't already decided to become a CoBGRTE member after visiting www.cobgrte.org, the following are 14 reasons why you should join the coalition.

Reasons Why You Should Become a CoBGRTE Member

1. Award scholarships to baccalaureate and graduate respiratory therapy students.
2. Assist in the development of ASRT to BSRT Bridge Programs.
3. Collectively work towards the day when all respiratory therapists enter the profession with a baccalaureate or graduate degree in respiratory care.
4. Support a national association, representing the 70 colleges/universities awarding baccalaureate and graduate degrees in respiratory care, to move forward the recommendations of the third 2015 conference.
5. Help start new baccalaureate and graduate RT programs thus leading to a higher quality of respiratory therapist entering the workforce.
6. Work to change the image of the RT profession from technical-vocational-associate degree education to professional education at the baccalaureate and graduate degree level.
7. Mentoring program for new graduates as well as new faculty members.
8. Join colleagues to collectively develop standards for baccalaureate and graduate respiratory therapist education.
9. Develop public relations programs to make potential students aware of baccalaureate and graduate respiratory therapist programs.
10. Help to publicize, among department directors/managers, the differences between respiratory therapists with associate, baccalaureate and graduate degrees.
11. Access to over 75 Spotlight articles on BSRT and RT graduate programs, and major medical centers.
12. Round table discussion dinners and Meet & Greet member receptions held in conjunction with the AARC Summer Forum and the International Congress.
13. Help to support maintaining a roster and web site for all baccalaureate and graduate respiratory therapist programs.
14. Collaborate with CoARC and AARC to improve respiratory therapy education.

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