The Coalition Chronicle

Coalition for Baccalaureate and Graduate Respiratory Therapy Education

December 27, 2017 Volume 6 (12)

Spotlight Article

UNIVERSITY OF CINCINNATI

AS to BS in Respiratory Therapy - Online

College of Allied Health

By Mark A Washam, RRT, CPFT, RN, FNP (CNP), MSN

Assistant Professor, Respiratory Care Program

The University of Cincinnati offers students a balance of educational excellence and real-world experience. UC is a public research university with an enrollment of more than 44,000 students and has been named "Among the top tier of the Best National Universities," according to U.S. News & World Report. More than a quarter-million living alumni count themselves as Bearcats — united not just by their loyalty to our nationally known sports teams, but by their common love of the place, the people and the ideas that make up the University of Cincinnati.

Having a bachelor's degree in respiratory therapy provides a pathway for respiratory therapists to move into leadership roles in education, research and management. The degree prepares them for coveted opportunities in graduate school and they will be in an excellent position to compete for leadership positions. The Bureau of Labor Statistics has estimated a 28% growth rate for respiratory therapists in the next 10 years, faster than the average occupational outlook.

The UC Respiratory Care Program, located in the College of Allied Health started in 2013 with Dr. Shane Keene, RRT, DHSc as its first director, who not only led the program but was an active instructor and mentor to students. Keene, a registered respiratory therapist and neonatal pediatric specialist, was recruited to lead the program from East Tennessee State University, where he was the program director for cardiopulmonary science and the assistant chair for the university's department of allied health. He is also a certified pulmonary function technologist, registered polysomnographic technologist, registered sleep technologist, and is a Fellow in the American Association for Respiratory Care. Under Dr. Keene's leadership the program grew quickly, and could add some unique programing. The UC Program is designed to challenge students and engage them simultaneously in preparation for leadership roles. The curriculum will enhance their ability to perform critical thinking in advanced practice clinical settings and facilitate their ability to conduct creative writing and pilot research. Students surveyed find the program challenging, and career building.

A unique offering of the UC Program was launched in 2015 putting an innovative spin on the Massive Open Online Course (MOOC) with a Targeted Open Online Course (TOOC), titled "Shared Air: A Collective Look at the Future of Respiratory Therapy." Like other MOOCs, the course is free, self-paced and online. However, it is targeted specifically toward working respiratory therapists and students currently enrolled in associate-level programs who may be interested in furthering their education and moving into advanced practice either within respiratory care or in an allied health profession. The TOOC gives interested Respiratory Therapists the opportunity to "try-out" on-line learning, gain new knowledge and reinforce things already learned in a self-paced no-pressure environment. In some select cases students accepted for the UC-Online program have credit applied for successful completion of the TOOC prior to their official start.

Exciting Changes

Under Dr Keene's leadership the program is well prepared to start graduate level courses in the 2018 academic year leading to master's degree in respiratory care. Our leaders, researchers and educators in respiratory care will need the advanced preparation to continue to serve patients and improve outcomes.

Dr. Keene announced that he was leaving the Respiratory Care Program in 2017 and after an extensive search, Dr. Nancy Colletti was offered the position and will start leading our program in early 2018. Dr Colletti is a registered respiratory therapist and holds a PhD in education with an emphasis on instructional design for online learning. She is currently the Program Director for the CoARC accredited Respiratory Therapy program at Kettering College. This is a role she has held for 17 years. She successfully transitioned their tradition classroom associate of science program to a bachelor of science program. More recently, she led her team in moving their BS completion program in health sciences to an online program. Prior to her time at Kettering College, Dr. Colletti was faculty at the State University of New York at Stony Brook. Dr. Colletti currently teaches online and assists faculty in online course and program development. She also serves as the Quality Matters Coordinator at Kettering College and is a quality matters peer reviewer and master reviewer. Dr. Colletti has served on many professional committees and boards and she currently, serves on the Ohio Respiratory Care Board. The University, College and program are excited to welcome her.

The College of Allied Health Sciences at the University of Cincinnati also is excited to have broken ground on a brand new $61 million-dollar Health Sciences Building in 2017. While most of our student don't visit campus until graduation this new building will allow our program to grow and develop opportunities for bench research in respiratory care. Get more information at: cahs.uc.edu/health-sciences-building.

Our Program

The entire UC Program is designed for working respiratory therapists. Professors teaching in our program take special care to build in some flexibility for these working professionals. The first-year focus on an integrated core of courses designed to enhance skills in critical thinking, reflective writing, problem solving, research methods and team building. In the second year, students take advanced courses in designated fields and specialty areas in respiratory care. They will complete the program with a capstone course and clinical practicum at a clinical setting close to home, and in many cases with their current employer giving them experiences. The program is completely online and can be completed in as little as 20 months with only part-time enrollment.

A sample or possible curriculum map appears below.

Semester	Term	Core Courses	Credits
Spring	Full Semester	RSTH 3002: Health Care Documentation & Communication	3
	1st Half Semester	RSTH 3001: Ethics in Respiratory Therapy	3
	2nd Half Semester	RSTH 3004: Community Health Problems & Practices	3
Summer	1st Half Semester	RSTH 3010: Integration of Delivery of Respiratory Therapy	3
	2nd Half Semester	RSTH 3040: Management in Respiratory Therapy	3
	1st Half Semester	RSTH 3065: Caregiving in the Respiratory Therapy Professions	3
Fall	1st Half Semester	RSTH 3050: Aging and Respiratory Therapy	3
	1st Half Semester	RSTH 3080: Disease Management/Patient Education	3
	2nd Half Semester	RSTH 4060: Introduction to Respiratory Therapy Research	4
		Advanced Courses 1st Semester	
Offered Each Semester	1st Half Semester	RSTH 4070: Advanced Respiratory Therapy/Clinical Internship	3
	Full Semester	RSTH 4001: Research Methods and Analysis	9
		Advanced Courses 2nd Semester	
Offered Each Semester	2nd Half Semester	RSTH 4050: Adv Respiratory Therapy/Leadership & Project Mgmt	4
	Full Semester	RSTH 5001: Capstone	6
		Total	50

Faculty

The UC program has a dedicated faculty, all of whom hold an advanced degree or degrees and all have worked as respiratory therapists. Most of the faculty also are certified in at least once specialty area within respiratory care.

Student Qualifications

We are actively seeking students with the following minimum qualifications. (Students seeking admission must also meet University of Cincinnati requirements as well.)

- Hold an associate's degree from a CoARC-accredited respiratory care/respiratory therapy program at a regionally accredited institution.
- Be credentialed by the National Board for Respiratory Care (NBRC) as a registered respiratory therapist (RRT) or a certified respiratory therapist (CRT) who is RRT eligible. *CRT's must be credentialed as a registered respiratory therapist (RRT) before matriculating into the capstone course
- Have earned a minimum GPA of 2.5

*Our program includes the Kettering RRT Home Study for CRTs as well as RRT exam reimbursement provided for CRTs. No additional cost is incurred by the student.

Contact Information

Rufan Li
Enrollment Advisor, College of Allied Health Sciences
Email: rufan.li@uc.edu
Phone: 513-558-4624

http://cahs.uc.edu/ClinicalHealthInformationSciences/academics/bs-in-respiratory-therapy/overview

So, what is a Bearcat anyway? (I mean besides being the best educated students in the world!) The bearcat (the animal!) is neither a bear or a cat! Its more closely related to The Mongoose Family. Depending on which reference you use its considered either a carnivore or an omnivore. Experts agree however that it eats mostly fruit, has a distinctive smell (like hot popcorn) and has a prehensile tail. Checkout this guy on-line and you will see an animal that looks a lot like a cat and a bear (in the face anyway).

So now you know!

"Listen, learn, and then lead."

An Interview with Robert L. Joyner, Jr., PhD, RRT, RRT-ACCS, FAARC

Special Assistant to the Provost for Healthcare Programming
Associate Dean - Richard A. Henson School of Science & Technology
Director - Respiratory Therapy Program
Salisbury University

Q. Tell us about your early days as a respiratory therapist. What brought you to the field?

A. From an early age, I knew that I wanted to work in medicine and specifically work with patients. I went to college with the intent to go to medical school. In my second year, I needed to provide additional support for schooling and began looking for jobs in hospitals nearby. It didn't matter what the job was, just that it was in a hospital. I came across an ad for a certified respiratory therapy technician (CRTT – it was 1987), and called for an interview. I didn't know what a CRTT was, but things like that had never stopped me before. A motto that I still have today is that the worst that can happen is that they can say no. And licensure did not exist in Maryland at that point.

I met with the manager, and his words to me were, "Well, you've taken an A&P class and did pretty well. You are really young (I was 20). Let's give it a shot and see how this works out." I started a few days later, attending my first code within minutes of clocking in. I was mortified and troubled for about a week. I had a talk with my mom about my experience and she told me that I had never let difficulty stop me before and asked if I liked what I was doing. She had me verbalize that yes, I did, and I was hooked. Shortly after that, I was asked by a physician to set up an external IMV bag with a Hudson H-valve to a patient who was receiving ventilation from a Puritan Bennett MA-1. The patient was obviously air-hungry. I had to tell the physician that I didn't know how. He said, "Then – I don't need you here." My honest statement let me to understand that I was no help to the patient or the physician. I was just a spectator to the events that were occurring, and I did not like that feeling. I wanted to help.

I swore to myself that I would never again be in a position where I couldn't do the best for the patient. I learned of California College for Health Sciences and started the program immediately. I began the program in January of 1988, completed the program in April of 1988, and was enrolled at Salisbury University to get a baccalaureate degree in respiratory care by September 1988. I graduated in 1991 with a BS in respiratory care. I travelled with my wife (Lisa) who is also a respiratory therapist to Tulane University Medical Center in New Orleans, LA for a single

assignment. I very quickly recognized that I wanted and needed to go back to school. I did not know enough to be involved with some of the patient care I was doing (e.g., pressure control-inverse ratio ventilation, neonatal and pediatric heart defects, etc.). I applied and was turned down from Dartmouth in 1991. We moved to New Hampshire to work at Dartmouth-Hitchcock Medical Center and the following year I applied again. I was accepted into the Department of Physiology at Dartmouth Medical School and studied pulmonary hypertension. Mostly I learned how much I don't know. I graduated with a PhD in physiology in 1998.

Q. Who were your mentors? What did they contribute to your career?

A. Wes White, the manager who hired me first taught me that you need to give people a chance. He is a wonderful person and I will forever be indebted for the opportunities that he provided me.

Hal Manning, MD – A mentor from Dartmouth who taught me to critically think and ask thoughtful questions. He is forever in my thoughts when I read papers or listen to a discussion.

Jay Leiter, MD – My thesis mentor. Likely the smartest, most thoughtful person I have ever met. He plays more of a parental roll for me than he will ever know. He taught me not only how to learn, but how to be kind to others who are going through their own struggles.

Given this opportunity to write about my experiences I would like to thank them for everything they have done for me. I would not be who I am without their guidance.

Q. What prompted you to move into a leadership/education position?

A. I got into patient care because I wanted to help patients. 20 years into my professional practice I became concerned with the knowledge of some leaders and began to realize that I needed to participate in their education. Being in higher education allows an individual's influence to be exponential and that is what I am currently hoping that is happening.

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

A. Honestly, I would like to state this question a different way. My education did not cause my career path. It opened doors that I wanted to open and has facilitated my involvement in decision making that I would not have otherwise been able to do. Without my education, I would be left to criticizing others without the opportunity to participate in the decisions that are being made. I have a healthy respect for difficult decisions and I am much less likely these days to complain without also forwarding a

solution. Decisions are the result of problems and constraints on solutions. There are no perfect solutions. The best that can be offered are solutions that come from a team of experienced people.

I suggest rewriting this question in the reverse. "How did your desired career path affect the education you sought?"

Always start from the point of view that you need more knowledge to understand a problem. Stephen Covey said it best, "seek first to understand, then to be understood."

Everyone has a reason to feel the way they do. Sometimes the expressions that offend the most are just symptoms of the bigger problem. My education has taught me to try and understand the bigger picture and not get plagued by the emotion of it all. Solving problems sometimes requires leaders to endure difficult conversations and circumstances to bring about an acceptable solution. The many aspects of my education have allowed me to be where I am today. Just where I want to be.

Q. What are some key leadership lessons you have learned?

A. Emotional preparedness is imperative. In every situation do your best to understand who you are in a discussion with. Are you teaching individuals who are going through a developmental process, are you working with peers with equivalent responsibilities, or in a discussion with a mentor and should be spending time learning?

Listen, learn, and then lead.

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

A. Take a good accountability of what you don't know. It's vast and as you learn more it's like peering over the mountain to see the limitless valley on the other side. Learn everything you can. Everything is your job. From making adjustments on the mechanical ventilator to helping clean a room just after a code. Always be respectful and have some understanding of how the words you are using will be received. Will they portray the correct sentiment or are you responding in the heat of a moment?

Never allow yourself to be put in a position where you must say I don't know what the next step is. Even if that next step is "I need to do some additional reading." Your patients and other caregivers depend on your knowledge. Take responsibility for it and work at it every day.

The Importance of Infrastructure

Erna Boone, DrPH, RRT, CTTS, FAARC
Chair, Department of Respiratory and Surgical Technologies
Tobacco Treatment Specialist, Nursing ICE

I began my second career as a tobacco treatment specialist nearly seven years ago. Most of my counseling time has occurred in the thoracic surgery oncology clinic (SONC) in the Winthrop P. Rockefeller Cancer Institute (WPRCI) at the University of Arkansas for Medical Sciences (UAMS). During this time, I have come to appreciate the importance of having an infrastructure that supports the program as my colleagues and I continue to build the scope of services available to patients and providers. Infrastructure is the basic physical and organizational structure and facilities needed for operation of almost any program or organization I can imagine. Accordingly, almost all of the problems our team has encountered originate from a weak infrastructural element preventing us from doing the best work possible. Conversely, the successes we have achieved can be attributable to a strong infrastructural element.

I have almost memorized the *2008 Update to Treating Tobacco Use and Dependence*, a Public Health Service-sponsored Clinical Practice Guideline! I depend upon it a lot. One of the most important conclusions of the guideline update is that the way to motivate clinicians to intervene with tobacco users. This provides information about multiple effective treatment options and helps to ensure they have adequate institutional support (infrastructure). A major goal of any tobacco treatment program is to encourage a culture in which failure to intervene with a tobacco user is seen as inconsistent with the standard of care (infrastructure). In fact, there is increasing evidence that success of a comprehensive tobacco program cannot be divorced from the health care system in which it is embedded (infrastructure). The health care administrator, insurer and purchaser must ensure that tobacco dependence treatment is an integral element of health care delivery (infrastructure). Clinicians must receive adequate training with institutional support and systems that ensure consistent identification, intervention and follow-up with patients who use tobacco (infrastructure). The purpose of this article is to share some of the infrastructure elements that I have experienced during my time as a tobacco treatment specialist in hopes it can help readers who are contemplating the implementation of a tobacco treatment service at their institution.

Executive Leadership

Implementation of a high quality, effective tobacco treatment program requires the strong support of the institutional leaders. The guidelines discuss three “systems strategies” for a “top down” approach from the executive leadership. As continues to be the case at UAMS, the culture may need still need to be shifted.

First, there must be a "system" ensuring every patient at every clinic visit or hospital admission is asked about their tobacco use and offered cessation counseling (infrastructure). This can be incorporated as the "sixth" vital sign through modification of the EMR, ideally. Individuals should be identified as responsible for recording the tobacco status of every clinic patient and hospital admission, regardless of the reason for the visit or whether it is the first or hundredth visit (tobacco dependence is a chronic, relapsing disease).

When our team began in SONC, it took a year or so to get the medical assistants (MA) and registered nurses (RN) to do this. Now, "asking the question" is rarely missed and the MA or RN frequently seek us out to meet with a new patient that has been identified as a tobacco user. This has been a dramatic change, but we are now able to counsel with the majority of tobacco-using patients and we operate like an interprofessional team should (infrastructure), as roles are known, trust has been built and we work together as a team to make sure each tobacco user is offered quitting assistance.

In my experience, many healthcare providers do not feel comfortable asking a patient about their tobacco use. But, asking this question is now integrated into the care rendered at the SONC. I have learned that approaching patients with the intent of having a conversation and truly listening to what they say is the optimal strategy. I introduce myself as a respiratory therapist and say "Dr. S. has asked me to talk with you about your tobacco use. Is that OK with you?" (I rarely have a patient refuse to talk to me!) Making it an integrated part of the visit has been important to changing the culture in SONC (infrastructure).

Second, the leadership must ensure that clinicians are adequately prepared to treat tobacco dependence, have sufficient resources to conduct counseling and receive feedback about their practices (infrastructure). There are several effective models for tobacco dependence intervention. Two A's and an R (Ask, Advise and Refer) includes asking about tobacco use status, giving strong advice to make a quit attempt and faxing a referral form to the state quit line to follow-up with the patient. This model can be easily done at the bedside and requires the smallest amount of practitioner training and resources. The five A's (Ask, Advise, Assess, Assist and Arrange) require slightly more time, training and resources. In the SONC, we use an in-take form that is completed during and after the visit. We conduct an in-depth assessment (CO level, readiness stage, etc.) and spend time talking with the patient and family about practical strategies that can be used to assist in the quit attempt and help prevent relapse. This level of counseling takes considerably more training, including learning how to use motivational interviewing. Training to implement these services is available from accredited training programs found here: www.ctttp.org. A core group of employees should complete an accredited training program and become certified as a tobacco treatment specialist (CTTS) to ensure the vitality and sustainability of a tobacco treatment program.

Last, the guidelines recommend communicating the importance of providing tobacco treatment services to all staff. It is also important to designate a person or team to be responsible at every clinical site. On our team, we all have tobacco treatment responsibilities for patients in the SONC and when tobacco-using patients are referred for low dose computerized tomography (LDCT) imaging. We are also responsible for following up with each of these patients. Other functions are assigned to each team member, depending upon their interests, strengths and time commitment to the program. We strive to communicate the importance of tobacco services to providers in our institution, where the tobacco use is about 25% of our patient population. For example, the team was very visible leading up to the Great American Smoke Out day and during our university benefits fair. It is important to have an approved implementation plan that is aimed at reaching staff and providers and starts small and builds over time.

Dedicated, Knowledgeable Tobacco Treatment Staff

Effective tobacco treatment is an interprofessional competency that numerous health care disciplines can and should possess. The guidelines recommend that treatment delivered by a variety of clinician types increases abstinence rates. They also conclude that all clinicians should provide cessation interventions. Moreover, treatment delivered by multiple types of clinicians are more effective than interventions delivered by a single type of clinician. To our team, this means we had to have a training program that will lead to certification and place multiple types of clinicians in settings where they would come in contact with tobacco users (infrastructure).

I received my tobacco training through an Arkansas Department of Health grant that brought a marvelous trainer from University of Massachusetts (UMASS) to Little Rock. The UMASS curriculum is excellent, up-dated twice per year and it is accredited by the Council for Tobacco Treatment Training Programs (CTTTP). Program "graduates" are eligible to earn the Certified Tobacco Treatment Specialist (CTTS) credential. Not only did I receive face-to-face tobacco training, but I also became certified to teach the UMASS curriculum to others. We offer this training twice each year on-site and respiratory therapists, nurses, pharmacists, dental hygienists, physicians and substance abuse counselors have completed the training and are working on earning their CTTS credential. Honestly, any profession that has direct patient contact should be able to offer effective tobacco treatment counseling after receiving the appropriate training and experience (infrastructure).

After training, documentation of counseling experience is required to earn the credential. We use faculty practice plans from the colleges at UAMS to place a faculty member in a clinical setting to provide tobacco counseling on a part-time basis or to help with follow-up phone calls (approximately 4-8 hours/week or 0.1 - 0.2 FTE). These faculty may serve as a preceptor for students as well as conduct scholarly activities concurrent with the tobacco interventions they provide to patients. Thus, meeting the UAMS mission of improving the health, health care and well-being of Arkansans and of others in the region, nation and the world by (1) educating current/future health care professionals, (2) providing high quality, innovative, patient- and

family-centered health care and (3) advancing knowledge in order to accelerate health improvements, is met. This can be a selling-point to administrators who remain reluctant to support an institution-wide tobacco treatment program.

Physician Champion

Our team began because of an outstanding thoracic oncology surgeon who observed one of my team members counseling his patient. They became acquainted and collaborated to write a grant to make counseling possible in SONC for the first four years. This excellent surgeon clearly recognizes the important role tobacco plays in the lives of the patients and their families. He also teaches residents and medical students about the importance of helping patients quit using tobacco, as well. Of utmost importance, he understands integrating this service with all the other services provided during a SONC visit is critical. As an example, if I am in the exam room with a patient and he walks in, he says to the patient "Oh good! I am so glad you are speaking with Dr. Boone. She has a lot of important information for you. I'm just going to step out and take a look at your scans and I'll be back in a moment." See how he has incorporated tobacco treatment into his clinic? I find a stopping place, let the patient know I'll be back and find Dr. S so that I'm not slowing down the clinic flow (infrastructure).

IT support

As the guidelines allude to, it is vitally important that your EMR can be up-dated, if needed, to retain information about tobacco dependence services that are provided to patients – especially the tobacco status at admission and the offer to provide assistance to quit. As an example, a hospital "across town" had help from their IT department to document tobacco counseling of hospitalized patients, meeting the criteria for the tobacco quality incentive measure for Medicaid in Arkansas (infrastructure). This accomplishment plus a similar quality incentive measure met in their NICU earned the hospital $800,000 last year in incentive payments! This is a great (and memorable) example of how respiratory therapists can add value (and revenue) to a health care system! The worth of a streamlined system such as the one I just described is infinite. Although we use the same EMR at UAMS, we have struggled to make this happen. However, recently we have been able to partner with the "across town" hospital and there is a plan to move UAMS in this direction (infrastructure).

Outcome Management Tool

Closely related to the EMR is the existence of a "tool" that can be used to capture and report the outcomes of a tobacco dependence program. The guidelines don't explicitly discuss the importance, but to meet several of their recommendations, it is critical to have this data. It can identify strengths, limitations, gaps, need for policy change, need for personnel additions, etc. An extremely effective tobacco treatment program may not be able to continue or certainly grow without the ability to demonstrate their outcomes to administrators (infrastructure).

At UAMS, we have grown considerably in our ability to capture this data. Initially, we used a paper and pencil in-take form. Then we added an excel file, which quickly became a nightmare. Then we were approached by the tobacco research side of our campus, who wanted to partner with us to collect, interpret and disseminate data. This led to access to a new database, which is easier to use. Although we are still collecting patient data using paper and pencil, a smart phrase will soon be available in our EMR so that we can add notes after the initial counseling session, as well as at the follow up sessions directly into the patient's chart (infrastructure).

Understanding Insurance and Billing

How to navigate the different insurers and how to bill for services are currently being worked through at UAMS. We have limited understanding about what insurance covers what medications and services. This is because 1) it is hard to identify and 2) it frequently changes. We have a fairly large Medicare population, but Medicare does not pay for NRT (nicotine-replacement therapy) medications (unbelievable!). Medicaid will pay for all stop smoking medications, but some pharmacists do not realize that it does not take a medication "slot", and are refusing to fill the prescription. Other insurers have "rules", such as one that requires the patient to contact their "health coach" and enroll in their preventive program in order to be covered for a recommended medication. As if this isn't enough, there is confusion surrounding who can bill and for what service. It is definitely not clear. This tells me there is a huge gap that needs to be filled through provider education and changes in policy that will allow tobacco treatment specialists to recommend medications (not prescribe, necessarily) and bill for the appropriate counseling service. I have recently learned that the Board of Directors of the Association for the Treatment of Tobacco Use and Dependence (ATTUD) has formally begun to advocate for recognition of the CTTS as independent providers by the Center for Medicare & Medicaid Services (CMS). This is great news and should greatly increase the number of patients seen by a CTTS.

I hope this description of a few of the infrastructure elements that I have encountered, some with solutions and some without, will assist readers in preparation for offering similar services in their institutions. In any case, the development of a mindset that understands the complexity and importance of infrastructural elements is critical to the development of any health program.

Strong leadership, approved implementation plans, outcome tools that work, support of a physician champion and from the IT department and making friends with the people in your institution who know about insurance and billing are some universal elements that are likely to be needed. The AARC Tobacco Roundtable and the ATTUD listserv are two great resources. Indeed, the majority of content discussed on these fora have something to do with the importance of infrastructure and one can learn a lot by "listening in."

CoBGRTE Scholarship Recipients

Nicholas Henry, MS, RRT-ACCS, RRT-NPS, AE-C
Chair-CoBGRTE Scholarship Committee

The CoBGRTE Scholarship Committee has finished the review of applications submitted for the 2017 CoBGRTE Merit and Research Scholarships. The committee received many qualified applications and selection of the recipients is never an easy task. The committee is happy to announce the 2017 recipients of CoBGRTE Research and Merit Scholarships.

2017 CoBGRTE Research Scholarship Recipient

Corey David Noles - Samford University

Upon graduating my program, I plan to begin work and research with infants and neonates, to enhance the quality of care of which therapists and practitioners provide, and expand the respiratory therapist's role within the healthcare team

2017 CoBGRTE Merit Scholarship Recipients

Gabriela Avila – Georgia State University

Since a young age, I've envisioned myself becoming a leader in the respiratory care community to help those in need. After completion of the program, I plan to utilize my skills as a respiratory therapist to fulfill my aspiration of caring and nourishing for the people that find themselves needing the extra assistance either in my local community or outside the country.

Nicole Baucum – Texas State University

I am a senior at Texas State in the Bachelor of Science in Respiratory Care Program. I hope to follow my passion in Pediatric Care and get my specialization in neonatal and pediatric respiratory care and work at a local children's hospital. In 2-3 years, I would like to enter the master's program at Texas State and focus on leadership and management. I love working with people and can't wait to enter the respiratory care field!

Edward Besse – Georgia State University

I am a second-year master's student in Georgia State University's respiratory therapy program in Atlanta. Since beginning the respiratory therapy degree, I have particularly enjoyed working in pediatrics during my clinical rotations. After graduation, I hope to work in a cardiovascular unit at a children's hospital with patients suffering from congenital heart defects. I would like to thank my professors and preceptors for giving me a chance to succeed in this career, and my classmates at Georgia State for their exceptional kindness and support.

Jennifer Cruz-Galera – Texas State University

I am a senior pursuing a bachelor's degree in respiratory therapy at Texas State University. After graduating and earning my RRT, I plan on moving back to Houston, Texas, and work at a children's hospital, gain experience, and after a few years get a job on the NICU transport team. As a way of giving back to our profession, I plan on going in medical missions to educate patients and healthcare providers about respiratory therapy. Furthermore, this will not only be my accomplishment, but as my mom says, "I'll be making her dream come true!" I can't wait to impact lives one breath at a time!

Ashley Dahl – Texas State University

I will graduate in May 2018 with a bachelor of science in respiratory care. My goal is to pursue a career in the pediatric unit and further my education by attending a master's program in respiratory care.

Jennifer Kotara – Texas State University

I am a senior at Texas State University studying respiratory care. Following graduation, I plan to move to Houston, Texas and would like to gain experience in an adult intensive care unit. Following graduation, I am also interested in pursuing a graduate degree and become a clinical director for rotation sites for future students.

Jasmine Danae Moore – Midwestern State University

I am a senior expecting to graduate with my bachelor of science in respiratory care (BSRC) from Midwestern State University, Wichita Falls, Texas. This past fall semester I worked as an extern in respiratory care at Children's Medical Hospital, Dallas, Texas where I have graciously been afforded the opportunity to gain a lot of practical experience. My interest in health care field stems from my lifelong desire to serving people in need of care in a global setting. My absolute passion is serving children, and once I graduate I aspire to work in a Children's Hospital.

Linda Sandate – Texas State University

I am currently a senior in the respiratory care program at Texas State University, and I am eagerly working towards obtaining my bachelor of science in respiratory care. I aspire to become a registered respiratory therapist next year and will strive to earn credentials in both Neonatal-Pediatric Specialist and Asthma Educator-Certified. As for the future, I plan to pursue a master of science in respiratory care with a concentration in leadership to further myself professionally.

Francis Wen – Georgia State University

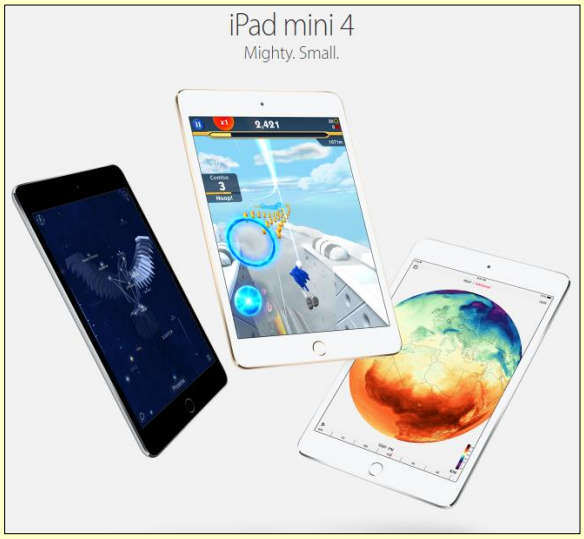
I am currently an integrated master's student finishing out my degree at Georgia State University in Atlanta, Georgia. I am a first-generation Taiwanese-American student and I will be the first in his family to complete a master's level degree. My future plans in respiratory care will be to obtain my adult critical care specialty certification to work in some of the larger hospitals in Atlanta and to work in some sort of educational capacity within the respiratory care field after building up my experience.

Just a few days remaining!

Christy Kane, PhD, RRT-NPS, RRT-ACCS, AE-C, FAARC
Chair, CoBGRTE Membership Committee

Don't miss out! Please join me in renewing your CoBGRTE membership for 2018! Active members, if you renew or join by December 31, 2017, your name will be placed in a drawing for an iPad Mini 4 (128 GB). Please go to http://www.cobgrte.org/membership.html and renew or join today! CoBGRTE continues to be a strong organization, but we will be stronger with you. Renew today for your chance to win.

A special note to program and department directors – Institutional Membership dues remain at $125 for 2018 and includes one active membership. **Institutional Membership invoices were mailed out in early December. Please let me know at ckane@bellarmine.edu if you need me to resend the invoice.**



Professional Positions Posted at http://www.cobgrte.org/professionalpositions.html
*Georgia State University, *University of North Carolina – Charlotte, *East Tennessee State University, *University of Virginia Health System, *Texas State University, *University of Texas Health Sciences Center – San Antonio, *The University of Toledo, *Salisbury University, *Skyline College, *Boise State University, *Canisius College, *Boston Children's Hospital, *Nova Southeastern University, *Northern Kentucky University, *Iman Abdulrahman Bin Faisal University.

CoBGRTE Institutional Members

Indiana Respiratory Therapy Consortium
Georgia State University
Weber State University
Boise State University
Bellarmine University
Rush University
Salisbury University
University of Toledo
The Ohio State University
State University of New York Upstate Medical University
Northeastern University
University of Texas Medical Branch - Galveston
Wheeling Jesuit University
Texas State University
University of South Alabama0
Long Island University
University of North Carolina – Charlotte
Louisiana State University Health Science Center – New Orleans
Midwestern State University
Jefferson College of Health Sciences
Youngstown State University
Rutgers University - North
Nova Southeastern University
Loma Linda 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
Highline College
University of Akron
Oregon Institute of Technology
Augusta University
CHI St. Alexius Health-University of Mary
Valencia College

CoBGRTE Institutional Members – Continued

Kettering College of Medical Arts

Shenandoah University

Middle Georgia

State University

York College of Pennsylvania

Respiratory Care Board of California

Texas Southern University

St. Catherine University

Armstrong State University

Cincinnati Children's Hospital Medical Center

University of Virginia Medical Center

Iman Abdulrahman Bin Faisal University

Seattle Central College

Florida Southwestern State College

Utah Society for Respiratory Care

Intermountain Healthcare

Southern Connecticut State University

Washington Adventist University

Rutgers University - South

Northern Kentucky University

Boston Children's Hospital

California Society for Respiratory Care

Respiratory Care Society of Washington

Samford University

Canisius College

Carlow University

University of Washington Medical Center

Jacksonville State University

Modesto College

Newberry College

Eastern Tennessee State University

University of Cincinnati

University of Michigan – Flint

Liberty University

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 63 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 45 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.

Become a CoBGRTE member by completing the application on the Membership Page: http://www.cobgrte.org/membership.html

Editorial Board

www.cobgrte.org

Find us on Facebook

Follow Us

"Dedicated to Improving Respiratory Therapy Education"