


Respiratory Therapy – Advancing Practice Beyond 2015

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Middletown, NY

AARC President – 2015-2016
Dallas, TX




A moment to remember someone special!



Objectives


- Review the AARC Mission and Vision Statement and how it impacts goals and movement of our profession.
- Use portions of the AARC's Strategic Plan as a guide to review the current state of health care and its impact on our profession.
- Bring the information presented to a local/state level to see the impact.



AARC Mission and Vision Statements

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

Vision Statement:
*The AARC encourages and **promotes** professional excellence, **advances** the science and practice of respiratory care, and serves as an **advocate** for patients and their families, the public, the profession and the respiratory therapist.*




PRESIDENT SALVATORE'S 2015-2016 GOALS:


- Continue to develop and execute strategies that will increase membership beyond 50,000 active members and participation in the AARC, both nationally and internationally.
- **Promote** activities to increase public awareness of respiratory therapists and their role in the diagnosis and treatment of respiratory disorders.
- **Advance** the concepts and initiatives brought about by the "Respiratory Therapist for 2015 and Beyond" conferences. Develop a toolkit to ensure the existing educational programs are able to move in a direction that will allow them to continue to develop our future students at a level that is consistent with them obtaining a bachelor's degree, which will eventually become the entry into our profession.
- **Promote and advocate** for appropriate patient and caregiver access to respiratory therapists in all care settings through local, state, and national legislation; regulation and/or policies including, but not limited to, recognizing respiratory therapists outside the traditional health care venues; and recognizing the credential of Registered Respiratory Therapist (RRT) as the minimum requirement for licensure.
- Continue to **advance** our international respiratory community presence through activities designed to address issues affecting educational, medical, and professional trends in the global respiratory care community and to advance advocacy for the patient.
- **Promote** the access of high-quality continuing education for development and enhancement of the skill base of today's practitioners to meet the current and future needs of our profession.
- Encourage the development of programs, accreditation, and credentialing of the Advanced Practice Respiratory Therapist (APRT) as a level of practice that will further improve the care given to our patients and **advance** the career track of our profession.
- Maintain and expand relevant communication and alliances with key allies and organizations within our communities of interest.
- Expand efforts to obtain research funding and develop the next generation of respiratory therapy researchers. The American Respiratory Care Foundation (ARCF) is an integral part of the funding/fundraising related to research; we will increase participation by our membership in ARCF fundraising activities through an educational effort that will increase awareness in the importance of the ARCF. ■■■


Strategic Objective 1:
 Refine and expand the scope of practice for respiratory therapists in all care settings.

- **Description-** Promote advanced practice and practice expansion for respiratory therapists. Assure that the science that demonstrates the value and role of the respiratory therapist is provided to those stakeholders whose decisions and actions need to be guided by that information.



Patient Protection and Affordability Care Act (PPACA/ACA/Obamacare):






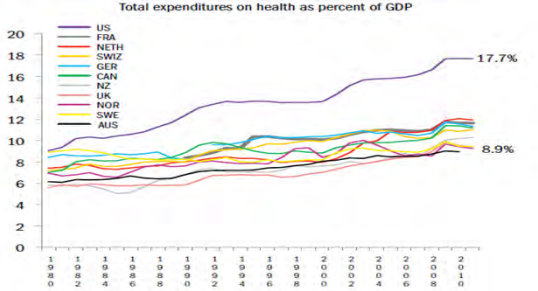
The Foundation: Why the 2,000+ Page Law??


The core issue was rising costs of health care.
How are we doing now with the ACA?

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



Highest Expenditures on Health as % of GDP

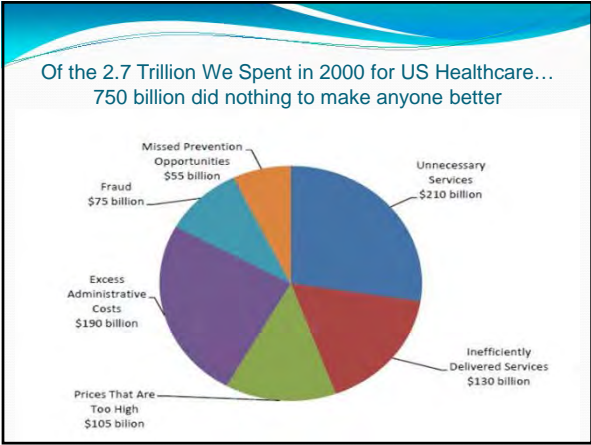




Most Expensive/Least Effective

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	9	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	\$3,800	\$4,522	\$4,118	\$4,495	\$5,099	\$3,182	\$5,609	\$3,925	\$5,643	\$3,405	\$8,508

Notes: * includes tax. ** Expenditures shown in BLS PPP (purchasing power parity). Australian & data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund National Scorecard 2011; World Health Organization; and Organization for Economic Cooperation and Development, OECD Health Data, 2012 (Paris: OECD, Nov 2013).
Source: <http://www.washingtonpost.com/news/health/wp/2014/04/16/once-again-us-has-most-expensive-least-effective-health-care-system-in-survey/>




Cost of Care...Cutting the Fat


- According to Premier Inc. the average hospital could cut millions of dollars in unnecessary care, staff productivity and prevention of readmissions
 - Labor productivity \$5.1 million
 - LOS \$3.1 million
 - Readmissions \$3.0
 - Employee skill mix \$1.8 million
 - Overtime costs \$1.8 million
 - Lab tests \$1.7 million
 - Respiratory therapies **\$1.5 million**

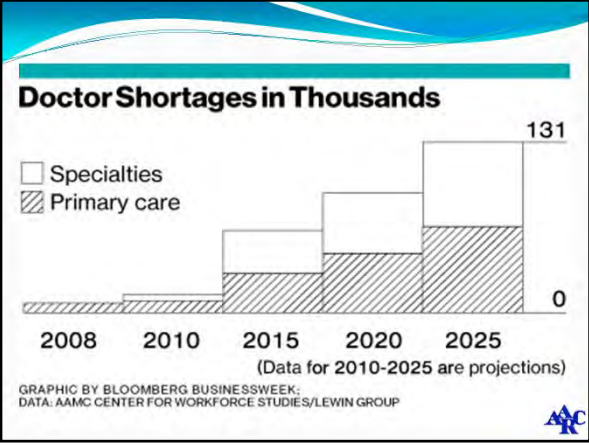
Hospitalizations for COPD in U.S. – The Numbers

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



<http://www.aacp.org/press-releases>
Wien, L.M. AHRQ HCUP Statistical Brief #66, 2011
Medicare Payment Advisory Commission. Payment policy for inpatient readmissions. In: Report to the Congress: Promoting Greater Efficiency in Medicare. Washington, DC: June 2007:93-100. Available at: www.medicare.gov/documents/lunarc_fairreport.pdf





CRITICAL CARE PERSPECTIVE

The Myth of the Workforce Crisis Why the United States Does Not Need More Internist Physicians

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Abstract
In the United States, more than 4 million patients are admitted to an intensive care unit (ICU) each year. ICU-related spending is projected to grow substantially and will soon be one of all health care's most rapidly growing costs. This gap has led to a number of proposals to increase the intensive care physician workforce. In addition, efforts to train more intensivists require us to consider issues that are not always addressed in these proposals, including the importance of interprofessional collaboration with nonphysicians and the impact of health policy on the demand for critical care physicians and other personnel providing healthcare services.

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

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Advanced Practice RT


- CoARC developed standards for accrediting Advanced Practice Programs in Respiratory Care
 - As a collaborating organization, the AARC consented to the standards.
- AARC created an Ad Hoc Committee on Advanced Practices, Credentialing and Education. Representatives from CoARC and NBRC are on the committee as well.
 - Committee will undertake a needs assessment for both the profession and the MDs.
- NBRC will be asked to begin the process of creating a credentialing program for APRT.
- AARC will need to take the lead on helping states get legislation/regulation to allow practice of APRT



Strategic Objective 2:


Advance the knowledge base and educational preparation of respiratory therapists to ensure competent patient care and to foster patient safety initiatives.

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



Respiratory Care 2015 and Beyond

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



Respiratory Care 2015 and Beyond

The transition plan must:

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

- The Board Unanimously Accepted as amended.




Actions on Conference Recommendations:

- The board recently pushed forward some 2015 and Beyond initiatives that came directly from committees/groups that addressed recommendations. Two such initiatives addressed are:
 - **Conference Recommendation #4:** The AARC, CoARC and NBRC are putting together a task force on competencies for Entry into Respiratory Care Professional Practice that will address 2015 and Beyond.
 - **Conference Recommendation #5:** That AARC encourages clinical department's educators and state affiliates' continuing education venues to use clinical simulation as a major tactic for increasing competency levels for the current workforce. - A Clinical Simulation Brief from a sub-committee was approved by the AARC BOD and put up on www.aarc.org.
 - **Conference Recommendation #8:** That the AARC BOD explores development and promotion of career ladder education options for the member of the existing workforce to obtain advanced competencies and the baccalaureate degree. A Clinical Ladder Document was approved by the AARC BOD in April 2015 and placed up on www.aarc.org.

Respiratory Care 2015 and Beyond

- The 2015 ad hoc committee recommended increased access to baccalaureate degrees (either Bachelors Science Respiratory Therapy {BSRT} or Bachelors Science Health Sciences {BSHS}), for both respiratory therapy students enrolled in associate degree granting programs and for associate-prepared respiratory therapists who are already in the workforce, be readily available to access by established articulation or transfer agreements by 2015.



AARC BOD Action July 2015

- The AARC in 2012 created a goal to increase by 25% the number of RTs with a B.S. degree or higher by 2020.
- When the 2020 AARC Human Resources Survey is done, we want 80% of the respondents to have or be actively working on their Bachelor's Degree or higher.
 - The AARC will work to provide tools for schools to make the move if they can.
 - We'll perform a mid-way survey to see if we're moving the needle on our goal.

AARC BOD Action November 2015

American Association for Respiratory Care
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Position Statement

Respiratory Therapist Education

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

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

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

Effective 1998
 Revised 03/2009
 Revised 04/2012
 Revised 07/2015
 Revised 11/2015

AARC BOD Action November 2015

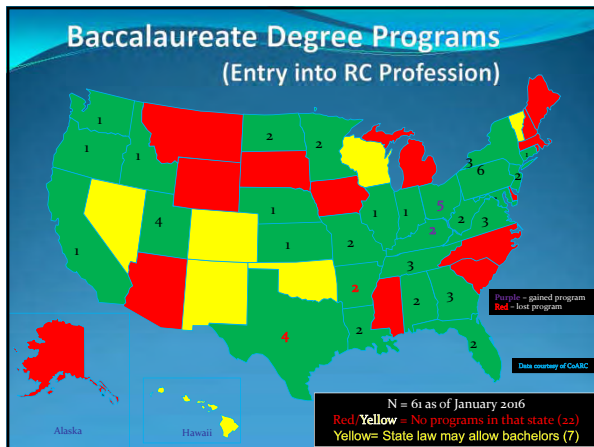
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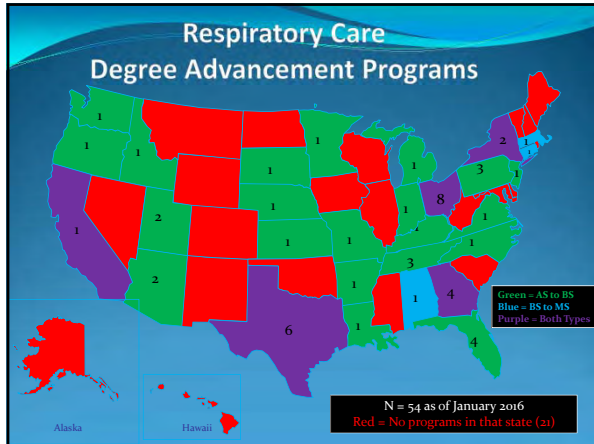
AARC BOD Action November 2015

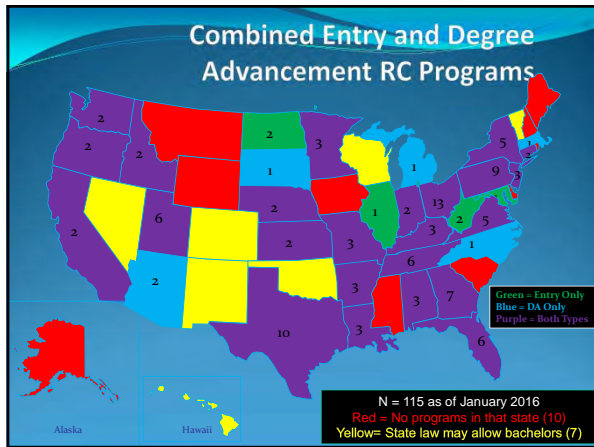
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CoARC has posted accreditation standard changes

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







Baccalaureate Degree Eligibility, Enrollment Capacity and Graduates for 2013 (N=441), 2014 (N=381), and 2015 (N=427)									
Baccalaureate Degree Eligibility Category	Maximum Enrollment Capacity as of 12/31/13	Total Graduates as of 12/31/13	% of maximum enrollment 2013	Maximum Enrollment Capacity as of 12/31/14	Total Graduates as of 12/31/14	% of maximum enrollment 2014	Maximum Enrollment Capacity as of 12/31/15	Total Graduates as of 12/31/15	% of maximum enrollment 2015
I. Sponsoring institution currently offers a baccalaureate degree RC	1,395	813	58.3%	1,476	790	53.5%	1,310	801	61.1%
II. Sponsoring institution offers baccalaureate degrees in other disciplines	3,339	2,841	85.1%	3,308	1,954	59.1%	3,342	1,212	36.3%
III. Sponsoring institution located in a state that authorizes community colleges to award Bachelor's degrees under	2,006	1,145	57.1%	2,183	1,272	58.3%	3,049	1,577	51.7%
IV. Sponsoring institution does not offer a	5,189	4,129	79.4%	6,477	6,083	94.0%	5,274	2,417	45.8%

Table 52 – Baccalaureate Degree Eligibility by State and District of Columbia								
# of Programs as of 12/31/15 (N=427)	Category I		Category II		Category III		Category IV	
	# of Programs as of 12/31/15	Max Enroll Capacity	# of Programs as of 12/31/15	Max Enroll Capacity	# of Programs as of 12/31/15	Max Enroll Capacity	# of Programs as of 12/31/15	Max Enroll Capacity
Kansas (n=9)	1	24	2	38	0	0	6	155
	Baccalaureate degree RC Program		Inst. Offers baccalaureate degrees in other disciplines		Inst. Located in state that auth. CC to award Bachelor's degr. Under certain circumstances		Not able to offer a Baccalaureate Degree	

RRT Entry - Licensure


- Ohio was the first state to adopt.
- California just signed it into law effective 1/1/15.
- Six States have dual licensure rules in place already.
- Looking at another ½ dozen states moving in the same direction.




Strategic Objective 3:


Support research and scientific inquiry to strengthen the scientific foundation and promote best practice for patient care.

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






- Journal Conferences – last one totally funded by ARCF.
- Funding 2 Advanced Practice Scholarships for RTs who will get an advanced degree and work in the field of Alpha-1 and respiratory (1st time ever at a significant funding level)
- Annual Research Fellowships
- International Fellows – 4 in 2015.




Strategic Objective 4:
Establish professional standards and outcomes that are supported by scientific evidence.

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



Strategies to meet Objective 4:

1. Created a taskforce to work with UHC to develop a White Paper on Safe Initiation and Management of Mechanical Ventilation
2. Continue to review validity and accuracy of AARC White Papers and Position Statements.
3. Appointed a taskforce to determine the competencies needed by entry level respiratory therapists.




Strategic Objective 5:
Advocate for federal and state health care policies that enhance patient care, patients' access to care, and professional practice.

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


What about the States...De-licensure.

- State tactic to reduce the size of government.
- Many states have had issues:
 - Michigan, **Indiana**, Texas.....
- Many states also have sunset laws that will bring this up:
 - Illinois.....
- State Societies need to be vigilant and stay on top of this.
- AARC will provide muscle, but can't be the face of the fight!



Strategic Objective 6:
Partner with governmental agencies, community organizations, third party payers, professional societies and the public to promote healthy behaviors and prevent cardiopulmonary disease.

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




State Based Medicaid Initiative

- The goal of this project is to engage in a collaborative effort with state Medicaid Programs to use and assess alternative care services for the Medicaid COPD patient utilizing Respiratory Therapists in a way we are not currently being used.




Strategic Objective 7:
 Broaden consumer and health care providers' knowledge and understanding of the value of respiratory therapists in providing safe, competent, and evidence-based care.

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




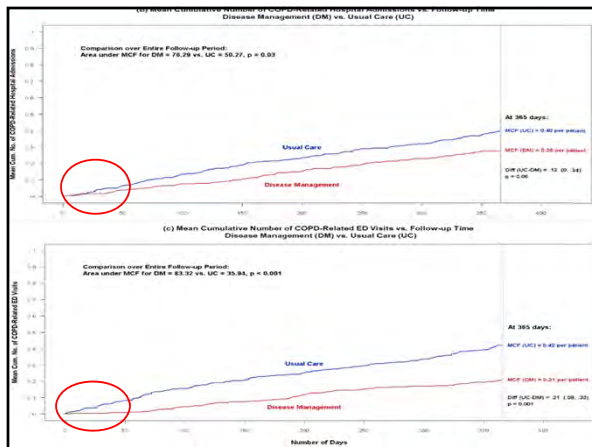
Changing the Way We Think About Prevention...One Notable Study

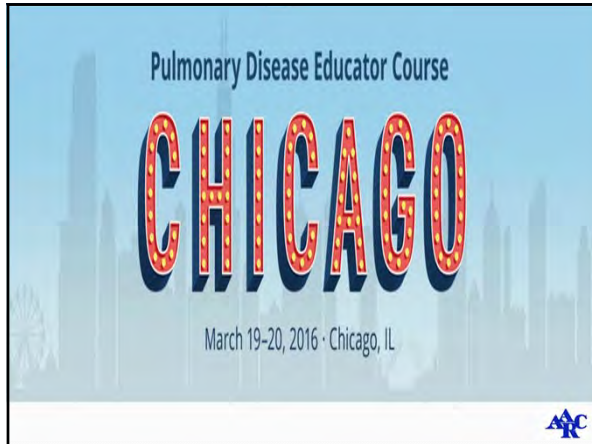
- Disease Management Program for Chronic Obstructive Pulmonary Disease: A Randomized Controlled Trial**
 - n = 743 patients
 - Hospitalization within 12 months
 - Oxygen Dependent
 - Corticosteroid use
 - Elements of DM program
 - 1 - 1.5 hour education session
 - Individualized action plan
 - Monthly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



Rice, KL et al. Disease Management Program for Chronic Obstructive Pulmonary Disease: A Randomized Controlled Trial. Am J Respir Crit Care Med. 2010 Jan 21








Strategic Objective 8:
Assure the Association has the resources to meet the mission and strategic goals of the organization.

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




Benefit of AARC Membership

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


Exciting Possibilities

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



What WE need to do!!!

- "Status Quo"
- ~~"Status Quo"~~
- Respiratory Therapists at all levels must get involved!!
- State Societies need to be more stronger than ever!



"If You're Not at the Table,
You're on the Menu"

