M E M O R A N D U M

TO: Board of Directors

FROM: Sam P. Giordano, MBA, RRT, FAARC
Executive Director

RE: **RT 2015 and Beyond Final Report**

DATE: November 16, 2010

I am happy to inform the Board that the first phase preliminary information gathering has been completed. Our final conference in a series of three was convened along with a special community input section. The final conference manuscript has been drafted and has been submitted to our science journal *RESPIRATORY CARE* for consideration. Several recommendations were put forth by conferees and all will be shared with the Board later in this report.

Prior to the conference, the 2015 Planning Group adopted a series of transition plan attributes in order to assure that regardless of the approach undertaken by the profession's leadership, if the attributes are followed we should avoid unintended consequences, shortages of personnel, etc.

Since this will be the final report, I want to take this opportunity to provide the Board with a quick review of the project thus far. Several years ago I was asked to undertake the project and to plan and implement a conference or series of conferences organized for the purpose of answering 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?

The first two questions were established as the goals for Conference I. Conference I was convened in the spring of 2008. A manuscript was developed by a writing committee of the Planning Group. The manuscript was published in March of 2008 entitled "Creating

a Vision for Respiratory Care 2015 and Beyond". An abstract of the manuscript is included in this report.

The second Conference attempted to answer the question:

- What competencies will respiratory therapists need to succeed in the future roles and responsibilities as identified in Conference I?

This conference was convened in the spring of 2009 after the first manuscript was published. The results of this conference were developed into a manuscript and published in *RESPIRATORY CARE* in May of 2010. Please see the attached abstract of the manuscript for more details. The Planning Group consisted of physicians, employers, managers, educators, accreditation agencies, patients and payers. The Planning Group was fortunate to have the following individuals assist with the project.

Stakeholder	Stakeholder Representative
Respiratory therapy director	Robert Kacmarek
Respiratory therapy educator	Thomas Barnes
Administrator (acute care hospital)	Karen Stewart
Administrator (healthcare system)	John Walton
Healthcare workforce expert	Edward O'Neal
Patient/consumer	John Walsh
Physician (critical care)	Charles Durbin
Physician (chronic care)	Woody Kageler
2 year college representative	Jolene Miller
4 year college representative	David Gayle
Federal government representative	Judy Blumenthal
Military Representative	COL Michael Morris

All conferences consisted of an informational phase, which presentations were made related to the goals of the conferences. We did ask for feedback from the conferees and their agreement or lack thereof was duly noted.

We purposely waited for the proceeding conference's manuscript to be published and reviewed by participants and future conferees before convening the next conference. It slowed the process, but provided a series of manuscripts devoted to the topic which can be used as a resource by the Board and others as they consider next steps. In an effort to provide balance, co-chairs of the conference were identified in order to bring together a variety of viewpoints, i.e. The first conference was co-chaired by a RT manager and a hospital administrator. A second conference was co-chaired by a dean of allied health in a community college and a retired dean of a 4-year baccalaureate program, and a health care workforce expert, not affiliated with either level of RT program. These same co-chairs were asked to co-chair the third conference but the third co-chairman was a physician not affiliated with an RT program to assure even greater balance.

2015 and Beyond Abstracts Published in Respiratory Care Journal

1st Conference:

Creating a Vision for Respiratory Care in 2015 and Beyond

Robert M Kacmarek PhD RRT FAARC, Charles G Durbin MD FAARC,
Thomas A Barnes EdD RRT FAARC, Woody V Kageler MD MBA,
John R Walton MBA RRT FAARC, and Edward H O'Neil PhD

The respiratory care profession is over 60 years old. Throughout its short history, change and innovation have been the terms that best describe the development of the profession. The respiratory therapist (RT) of today barely resembles the clinicians of 60 years ago, and the future role of the RT is clearly open to debate. Medicine is continually changing, with new approaches to disease management emerging almost daily. Third-party payers are challenging payment for iatrogenic injury, manpower issues are affecting all disciplines in medicine, and the nonphysician and physician work force is aging. These factors make us question what the respiratory care profession will look like in the year 2015. To address this issue the American Association for Respiratory Care established a task force to envision the RT of the future. The goal is to identify potential new roles and responsibilities of RTs in 2015 and beyond, and to suggest the elements of education, training, and competency-documentation needed to assure safe and effective execution of those roles and responsibilities. We present the initial findings of that task force.

Key words:
respiratory care, respiratory therapist, iatrogenic injury, manpower, education, training, competency.

[Respir
Care 2009;54(3):375–389.

2nd Conference:

Competencies Needed by Graduate Respiratory Therapists in 2015 and Beyond

Thomas A Barnes EdD RRT FAARC, David D Gale PhD,
Robert M Kacmarek PhD RRT FAARC, and Woody V Kageler MD MBA

The American Association for Respiratory Care has established a task force to identify potential new roles and responsibilities of respiratory therapists (RTs) in 2015 and beyond. The first task force conference confirmed that the healthcare system in the United States is on the verge of dramatic change, driven by the need to decrease costs and improve quality. Use of evidence-based protocols that follow a nationally accepted standard of practice, and application of biomedical innovation continue to be important competency areas for RTs. The goal of the second task force

conference was to identify specific competencies needed to assure safe and effective execution of RT roles and responsibilities in the future. The education needed by the workforce to assume the new responsibilities emerging as the healthcare system changes starts with a close look at the competencies that will be needed by graduate RTs upon entry into practice. Future specialty practice areas for experienced RTs are identified without defining specific competencies. We present the findings of the task force on the competencies needed by graduate RTs upon entry into practice in 2015.

Key words: respiratory care; respiratory therapist; manpower; education; training; competency; licensure; credentialing; accreditation; credentials; specialty; protocols. [Respir Care 2010;55(5):601–616. © 2010 Daedalus Enterprises]

After the third conference last July, the Planning Group convened a community input session open to the public. It received quite good feedback from the group with regard to recommendations that were presented by conferees during Conference III. Incidentally, all conferees invited were asked to submit recommendations relating to the transition if they desired to do so. All recommendations were presented and discussed as part of the conference. The Planning Group did not consider the recommendations nor take a position related to them. We felt this was beyond the scope of our charter. The Planning Group did, however, develop a set of "transition plan attributes" prior to the last conference. These were presented during the conference and comments were received from those in attendance. While there was some wordsmithing, the intent and substance of the attributes did not change. Even though you will see several recommendations, you will not be asked to take action on the majority of these items.

The Planning Group also decided several months ago that a period of time after adjournment of the final conference and publication of the resultant manuscript be utilized to conduct a briefing/listening tour by AARC leadership for our stakeholder community. We believe that this additional communication effort will assist stakeholders in understanding all three conference proceedings as well as provide them with an opportunity for additional input to our leadership.

I therefore have four recommendations for your consideration:

Recommendation #1

"That the 'transition plan attributes' be approved by the Board."

Justification:

These attributes will provide assurance to the profession, then stakeholders, that as we move forward, we will not create new problems to solve old ones. We will not create a new system which cannot adequately provide adequate numbers of RT graduates (8,000 to13,000) and that we consider virtually all tactics and strategies put forth while providing assurance of goal-directed change which will not only move the profession forward but also address the many challenges manifest in such a transition.

Transition Plan Attributes

The transition plan must:

- Maintain an adequate respiratory therapist workforce throughout the transition.
- Address unintended consequences such as respiratory therapist shortages.
- 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.
- Assure that emerging conference recommendations must be supported by a plurality of the stakeholders in attendance.
- Reflect the outcomes of the previous two 2015 and Beyond conferences
- Identify the agencies most appropriate to implement identified elements.

Recommendation #2

"That AARC Leadership after reviewing recommendations generated in Conference III identify additional research, additional communication needs, legal issues, including but not limited to legal credentialing, feasibility and other potential impact brought about by implementation of the recommendations."

Justification:

Even though we conducted several pre-Conference III surveys, the statistical power of many of these surveys does not permit generalization across the population being surveyed. While the surveys were useful in giving us a feel for certain issues, these surveys should in no way be considered as the ultimate research required in order to responsibly consider the recommendations.

Recommendation #3

"That if the transition plan attributes are approved by the Board, that it conduct at minimum a cursory crosswalk of Conference III recommendations with the attributes."

Justification:

This will permit the Board to know how realistic some of these recommendations are at this point in time. It will also serve to inform the Board of all potential consequences, both negative and positive, as further consideration is given in the future.

Recommendation #4

"That AARC's leadership use the next year to conduct a briefing/listening tour to provide key stakeholder groups with an opportunity to better understand the project and allow AARC to gain additional input before it takes action on the remaining recommendation."

Justification:

The Association needs to carefully assess the impact of each potential approach to transition. Also, it is reasonable to assume that other ideas, tactics, and strategies will be generated by these groups. Moreover, we recognize the concerns of all stakeholders and should do everything possible to promote clarity and understanding by all parties.

Summary

I want to take this opportunity to thank the voluntary members of the Planning Group. They contributed to every aspect of the project. Minutes were taken of every meeting and all was transparent. The Planning Group identified all conference agenda items, topics and speakers. Indeed many provided presentations as well as participating as members of the writing committee. I want to provide a special thank you to Bob Kacmarek and John Walton who co-chaired Conference I and were lead authors for the first manuscript. I also want to thank Tom Barnes and Woody Kageler who co-chaired Conference II and participated as lead authors in its manuscript development. Also, Charlie Durbin, Tom Barnes and Woody Kageler for their efforts in planning, implementing and co-chairing Conference III, and moreover, for their participating as members of the writing committee.

I'll be happy to entertain any questions you may have concerning any of the foregoing. Attached you'll find a list of the organizations that have been invited to the conferences and the list of the Planning Group along with their organizations. Finally, I want to recognize Bill Dubbs here in the Executive Office who did much of the heavy lifting and coordinating all these activities. We hope this project will assist the profession as it moves forward in a careful and thoughtful way that assures respiratory therapists in the future will tie into the values of our nation's health care delivery system and its stakeholders. This exercise does not mark the end of the process, but as Winston

Churchill said, “It is not the end; it is not even the beginning of the end. But, it is the end of the beginning.”

Thank you.