AARC Human Resource Survey of Respiratory Therapists

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SUMMARIES

While the body of this report contains useful details, this section of the report is intended to summarize results and compare some results to past studies.

Limitations of Study Results

Although the sampling effort for this study was ample with 135,863 direct solicitations supplemented by additional snowball sampling, it remained possible that the observed responses were biased in one way or another. For example, we are confident in saying that four groups were oversampled – AARC members, Directors of respiratory care from acute care hospitals, therapists who primarily worked in education settings, and certified asthma educators.

Continuing the discussion about potential sample bias, we observed a population estimate of 204,191 but the size of the sample was 4,787, which was only about 2% of the population. There were many more who chose not to respond to the survey than did respond, which means that non-response bias remained as a possibility that could have influenced study results.

Population of Licensed Therapists

The population of therapists appears to have grown by 12,734 over the last six years to 204,191. A key point about these numbers is that they are based on the sum of counts kept by state licensing agencies except for Alaska. The count from Alaska was an estimate; plus, a small number of therapists were licensed in more than one state causing them to be counted twice, so we will characterize the population count as an estimate. There can be caution about claiming there are 204 thousand working respiratory therapists because one can hold a license while not working. When this is true and one is licensed in multiple states, then the discrepancy becomes exaggerated.

Geographic Characteristics

Each state within the United States plus Washington DC, Puerto Rico, and Guam were represented in the sample. We tended to observe the largest numbers of responses from those states that had large general populations. The South region yielded the largest number of responses followed by the Midwest, West, and then the Northeast regions of the United States.

Ages of Therapists and their Departure from the Workforce

The mean and median age of this sample was 49, which was older than six years ago when the mean and median ages were 46. A histogram of the age distribution showed that comparatively few therapists were in the sample beyond the age of 66. Our analyses of respondents' plans to depart the respiratory therapy workforce found that half of the sample expect to be out by the year 2034, which is two years further out than observed in the previous study.

Experience Level of Therapists

The typical respondent in this sample had a total of 18 (median) or 20 (mean) years of experience in respiratory therapy since professional training had been completed. The median value for the number of years respondents had worked for their current primary employer was seven years, so changing employers was typical behavior within this sample.

Primary Job Venues of Therapists

A majority (76.2%) of respondents indicated working their primary job in an Acute Care hospital which was a decrease from 2020 when 78.5% worked in a hospital. The remaining venues for primary position were Long Term Care (7.3%), Outpatient Facility (4.9%), DME/Home Care (4.5%), Education (3.3%), Physician's Office (2.4%), Manufacturing/Distribution (0.9%), and Trade / Professional Association (0.6%). Except for acute care hospitals, the percentage of therapists who worked primarily in each venue remained within a few percentage points of the 2020 results.

Base Wage at Primary Job, Differential Pay, Bonuses, and Raises

The mean wage value was $41.74/hour in 2023 (up from $33.56/hour in 2019). However, we encourage readers toward the multiple regression analyses of total compensation at the end of the report for a more nuanced representation of compensation, especially the variables that exerted systematic effects. As the name of the statistical model implies, the results account for the unique influence of several variables on total compensation so it is the most valuable benchmark this study can offer.

Median values for compensation differentials in 2023 were as follows:

- $2.25/hour for evening shifts
- $3.50/hour for night shifts
- $2.50/hour for weekends
- $18.00/hour for holidays
- $2.00/hour for on-call

Only 20% of respondents had received a bonus. The median value for a bonus was $1,500 while the mean value was $4,023.

The median value for the last raise received by sample members was 3.0% while the mean was 3.3%. A raise of more than 5% was rare.

Job Satisfaction

About 19% of therapists in this sample rated satisfaction with their jobs on the lower half of the scale ranging from 0 to 5 points. Typical responses fell between 3.5 (the mean) and 4 (the median).

Of those who responded, 30% indicated that **compensation and benefits** was an area that decreased their satisfaction. "**None of these [listed options]"** was cited by about 17%. When considering topics with which they were most satisfied, a quarter of respondents indicated their **involvement with patient care decisions.**

Among 47% of therapists who had changed jobs within the last five years, "**none of these [listed options]"** was the most frequently cited reason for the change, followed by 16% who indicated compensation and benefits, and 12% who were dissatisfied with department administration and supervision.

Kind of Shift

Respondents were allowed to indicate all of the options that applied to them. Nearly 70% selected 12-hour shifts followed by 30% who worked 8-hour shifts. Four years ago, 12-hour shifts were also dominant.

Job Titles

The largest subgroup (46.8%) of the sample were therapists working with the Staff Therapist job title. Although therapists working under this job title are likely a larger percentage of the population than this study had projected.

Credentials and Certifications

Among those who responded to a question about credential maintenance, 82% indicated that their employers did require that an employee maintain an active credential with the NBRC. Twenty-four percent (24%) of the sample did not respond to this question, which is nearly identical to the 23% of the sample who did not respond to this question four years ago.

Eighty-six percent (86%) of the sample reported that they had achieved the RRT credential compared to 83% in 2020 and 80% in 2014. Fourteen percent (14%) of the sample had achieved the CRT-NPS or RRT-NPS credential. Eleven percent (11%) of the sample had achieved a credential in pulmonary function testing.

BCLS certification was almost universal in this sample with 97% of therapists giving an affirmative response. Just over 80% indicated that they were ACLS certified. Fifty-eight percent (58%) of the sample had earned NRP certification while 64% had earned PALS certification.

Characteristics of Respiratory Therapy Training or Education

More than 80% of the therapists who responded to this question had received formal education in respiratory therapy that made them eligible to achieve the RRT credential. Those who had received CRT-level education or on-the-job training respectively constituted 13% and 5% of the sample.

Degree Earned from Respiratory Therapy Program

Around a quarter of this sample gave no response to this question. Among sample members who did respond, 77% had earned an associate degree compared to 82% six years ago while 16% had earned a bachelor's degree at the point that they completed their professional training compared to 17% six years ago. Less than 1% had earned a master's degree when they became eligible for a credential. The remaining indicated that a degree was 'not applicable' to their situation.

Highest Academic Level

Some therapists came to respiratory therapy with college degrees in-hand. Others sought degrees after they had completed their respiratory therapy education program. The survey asked for respondents' highest academic levels as a separate question from the one about the degree from the respiratory therapy program.

Just less than one quarter of the sample left this item without a response. Among those who did respond, 49% had completed an associate degree and 34% had earned a bachelor's degree. Again, 16% of respondents started with a bachelor's degree from their respiratory therapy program although a few could have had a bachelor's degree before starting their program. Twelve percent (12%) had completed a master's degree and 1% had completed a doctorate degree.

A follow-up question asked respondents whether they had completed a bachelor's or graduate degree in a health-related field. Around 26% gave an affirmative response which was similar to the quarter of responses from four years ago. The remaining respondents either did not respond (24%) or selected the negative (50%) response. About half of the group with a health-related degree cited respiratory therapy / cardiopulmonary sciences as their area of study.

Eighteen percent (18%) of therapists in this sample indicated they were pursuing a higher academic degree than the one they had earned compared to 17% four years ago. Within this group, 52% indicated they were doing so to advance their career in respiratory care. Almost 48% indicated that they intended to change their career, which we interpreted to imply that they had plans to leave the respiratory therapy workforce. We estimated that this could be a population of 13,388 people with plans to leave over the next few years.

Sixty-two percent (62%) of the therapists who responded in 2024 worked for an employer that offered tuition reimbursement/forgiveness/discount. Encouraging more employers to offer this benefit could only help encourage attainment of higher academic levels in the future.

Number of Patients Receiving Mechanical Ventilation Assigned to Each Therapist

Mean and median values were both 6 while the range of responses started at 1 patient per therapist and went up to 25. The mean, median, and range of responses is the same as it was four years ago.

Percentage of Time in Different Hospital Areas

Therapists spent 33% of their time in adult intensive care units in 2024, which was 4% less than four years ago. The next highest (22%) area was the general medical and surgical floors, which increased 2% from four years ago. The emergency department garnered 17% of therapists' time. The two areas related to the care of children, the Neonatal ICU (9%) and the Pediatric ICU (5%), bookended the Pulmonary Function Lab (6%). The areas that received the lowest percentages of time in this sample were other departments (5%), Pulmonary Rehabilitation (3%), the Sleep lab (1%) and Telemedicine/Telehealth (1%). There were individual therapists who specified spending from 0% to 100% of their time working in each department.

Percentage of Care by Disease/Disorders

Patients with pulmonary disorders were cited as the largest average percentage of time (53%) from therapists in this sample. Those who fell into the Cardiac category were next with an average of 17% of time. Patients with non-pulmonary conditions followed with 12% of therapists' time. Patients with sleep disorders and neuromuscular issues each consumed 6% of respondents time. Finally, patients with other diseases occupied an average of 5% of the time of therapists in this sample. Again, there were

individual therapists who specified spending from 0% to 100% of their time working with each population.

Some Employers Required Simultaneous Care to be Provided to Multiple Patients

The level of this activity has remained fairly stable over the past decade since 30% of the sample gave an affirmative response this time, which was similar to 28% in 2020 and 31% in 2014. There had been a steep decline from the 48% reported in 2009. The remainder of the sample gave no response (37%) or gave a negative response (33%).

Uncompleted Work Assignments During Recent Shifts

There has been no change in this activity over a decade since the typical response of 10% in 2024 was repeated in 2020, 2014 and 2009.

Employer Provided Work Prioritization System

The availability of a work prioritization system has fallen over the past several years, with about a quarter of the sample indicating that such a system was available. Just less than a third of the sample gave an affirmative response in 2020, while there were 39% such responses in 2014. When asked how often they used the prioritization system, 14% indicated that they use the system every day compared to 21% in 2020, 2% used the system once a week, 2% used it once a month, and 6% used it less than once a month.

Respiratory Care Delivery by Protocol

More than two thirds of those who responded to the question indicated that some respiratory care was affected by protocols where they worked. This proportion is the same as it was four years ago.

Gender

Forty percent of the sample either did not respond to this question or indicated that they preferred not to say. Among those who did respond, 68% were female, which was a decrease from the 70% observed in 2020. Small percentages (.2% and .9%, respectively) of the sample identified as non-binary and prefer to self-describe in 2024, which was the first opportunity they had to be recognized by this survey.

Race and Ethnicity

The majority of this sample was White (74% of cases). Black/African Americans and Hispanic/Latino/Spanish origin individuals each comprised 7% of the sample.

AARC Membership

Forty-two percent (42%) of the sample gave an affirmative response about being a member of the AARC. This was nearly identical to 43% four years ago.

Compensation Factors

Multiple regression and ANCOVA elements explained about 30% of variability in the total compensation of therapists who submitted responses. This was slightly more than what was reported in the last study.

We illustrated two compensation scenarios to demonstrate how the results of our analyses could be used by workers and employers. We encourage therapists and their employers who seek a benchmark for local compensation to use the spreadsheet file that will be provided with this report to run their own scenarios.

Introduction

The American Association for Respiratory Care (AARC) is the professional membership organization for respiratory therapists and has periodically conducted human resource studies of therapists and institutions that employ therapists. The intent behind this arm of the study was to gather information from individual therapists. The AARC prepared and made available a survey with the intent that individuals who were respiratory therapists would respond. Opportunities to respond to the survey were sent to the sample unsolicited by potential respondents who chose whether to respond.

The report that follows contains several statistical summaries. A brief guide to interpretation of these analyses is provided. The Results section follows the order of questions as presented in the survey. Where applicable, the specific survey question that pertained to the analysis is listed with the research question. The survey question is listed in bold type. The survey document is presented in Appendix A.

METHODS

A survey of the same scope of this population was last completed in 2020. The instrument from that study was the starting point for development of an instrument for this study. AARC executive office staff and board members revised and added items to the 2024 survey. Text of the survey document is shown in Appendix A. Respondents submitted their responses to an online survey.

Survey sampling came from the population of credentialed therapists. Emails were distributed to 135,863 therapists. Images of email messaging plus social media advertising are shown in Appendix B. All invitations encouraged a snowball sampling technique in which respondents were asked to encourage others to respond to the survey for individual therapists. Twenty-five (25) emails were returned to the monitored inbox as undeliverable, and 7 individuals sent an email to 'Opt Out' of responding (e.g., retired, unemployed, not working in respiratory care).

Other therapists were permitted to respond. They learned about the survey from information posted to the AARC website and emails distributed by the AARC. The addition of responses from therapists who were not directly solicited made it impossible to calculate a response rate.

Each study participant was limited to submitting a single set of responses. The survey was available between June 15 and September 6, 2024.

Not everyone from the population of credentialed therapists is still working in the field of respiratory care. The first survey question served as a screening tool asking respondents about the currency of their respiratory care work. Those who were more recently active were directed to the remaining survey questions, while those who had not been actively practicing as a paid respiratory therapist for at least six months were directed to the end of the survey.

The next question asked each respondent for his or her zip code. Using the zip code information from the survey, respondents were classified by census divisions and regions. These classifications were used for subsequent analyses in the report.

Through a combination of direct counts of the populations of license-holders from each state and proportions observed in results of this study, some projections have been estimated. We talked about study limitations in the Summaries section of this report, but it is worth highlighting again that these projections are only as good as the degree to which there was no sampling bias. Each instance in which there is a strong suspicion of sampling bias will be described as it is encountered in the body of the report.

Responses are summarized in the Results section of this report. The IBM SPSS Statistics Subscription version 29.0.2.0 software package was used to analyze survey responses for this study.

RESULTS

General Descriptions

Have you been paid for your work in the respiratory care profession within the past six months?

There were 5,610 therapists who submitted survey responses. Figure 1showed that 85% of respondents had been paid for work in the respiratory care profession recently. The 15% of respondents who did not meet this criterion were directed to the end of the survey. Analysis will be completed using responses from the remaining 4,787 therapists.

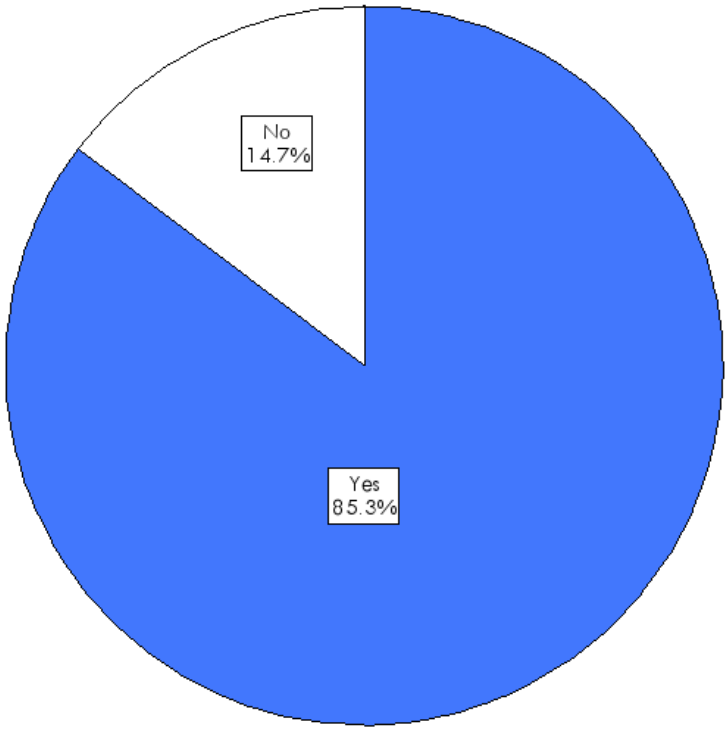

Figure 1. Paid for RT work in past six months

Frequency results that are shown in Appendix C, Table 49 had two inputs. In the summer of 2024, AARC staff solicited counts of licensed or registered therapists from state regulatory authorities. An AARC chapter representative from Alaska, a state that did not regulate respiratory therapy practice, estimated the therapist count since there was no regulatory authority. The sum of therapist counts among the states, the District of Columbia, and Puerto Rico was 204,191. While using the same method in 2020, the count was 191457, so this count has increased by 12,734 over four years.

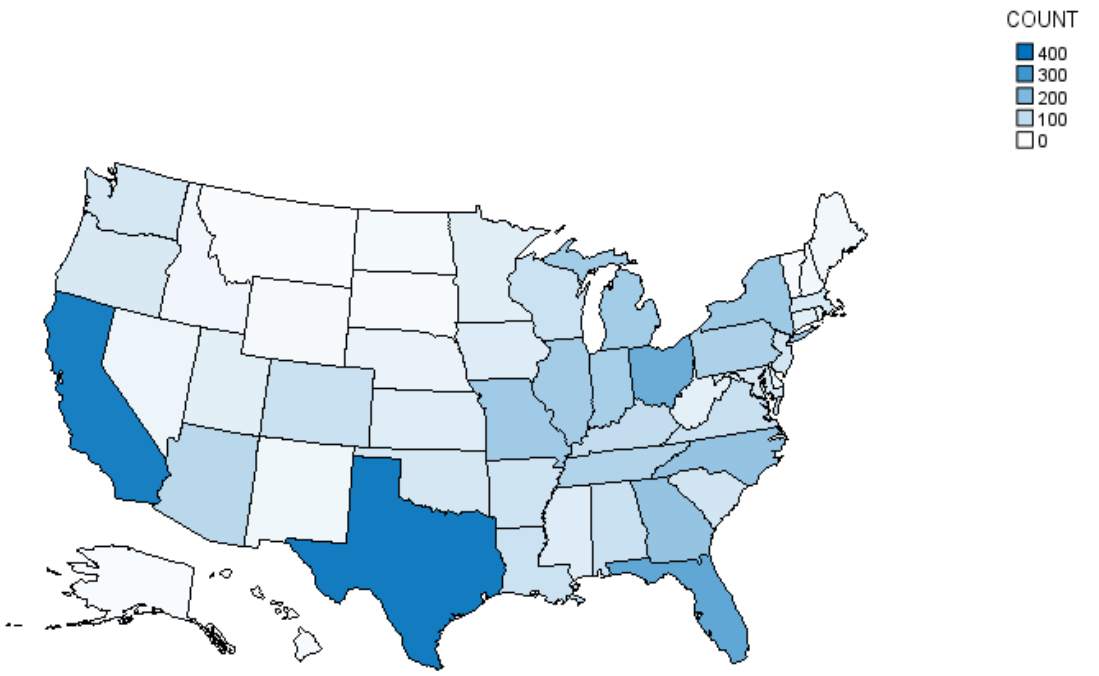

Figure 2. Choropleth of Active Therapists by State

Responses were combined into four regions so we could analyze variables by geography. Results are shown in Figure 3 and Appendix C, Table 50.

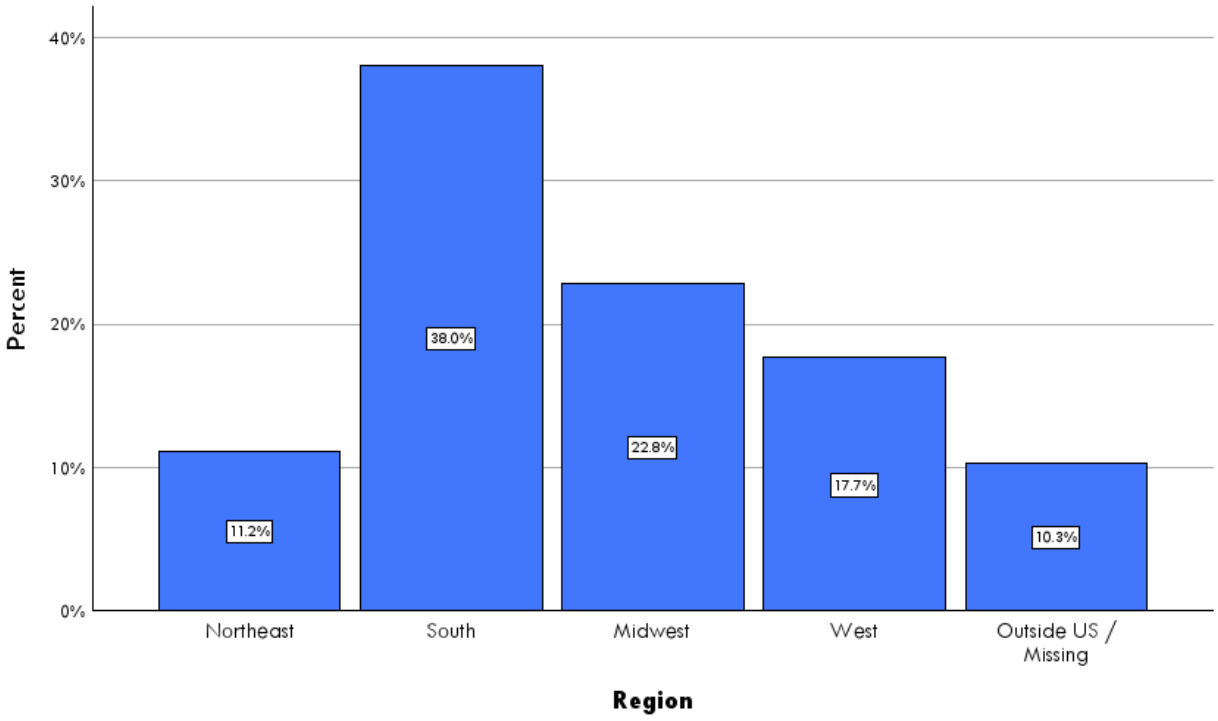

Figure 3. Distribution by region

Northeast – MA, RI, NH, ME, VT, CT, NJ, NY, PA
South – DC, DE, MD, VA, WV, NC, SC, GA, FL, AL, TN, MS, KY, LA, AR, OK, TX
Midwest – OH, IN, MI, WI, IL, IA, MN, SD, ND, MO, KS, NE
West – MT, CO, WY, ID, UT, AZ, NM, NV, CA, HI, OR, WA, AK

Survey responses were recompiled into the divisions shown in Figure 4 and in Appendix C Table 51 to coincide with groups defined by the United States census.

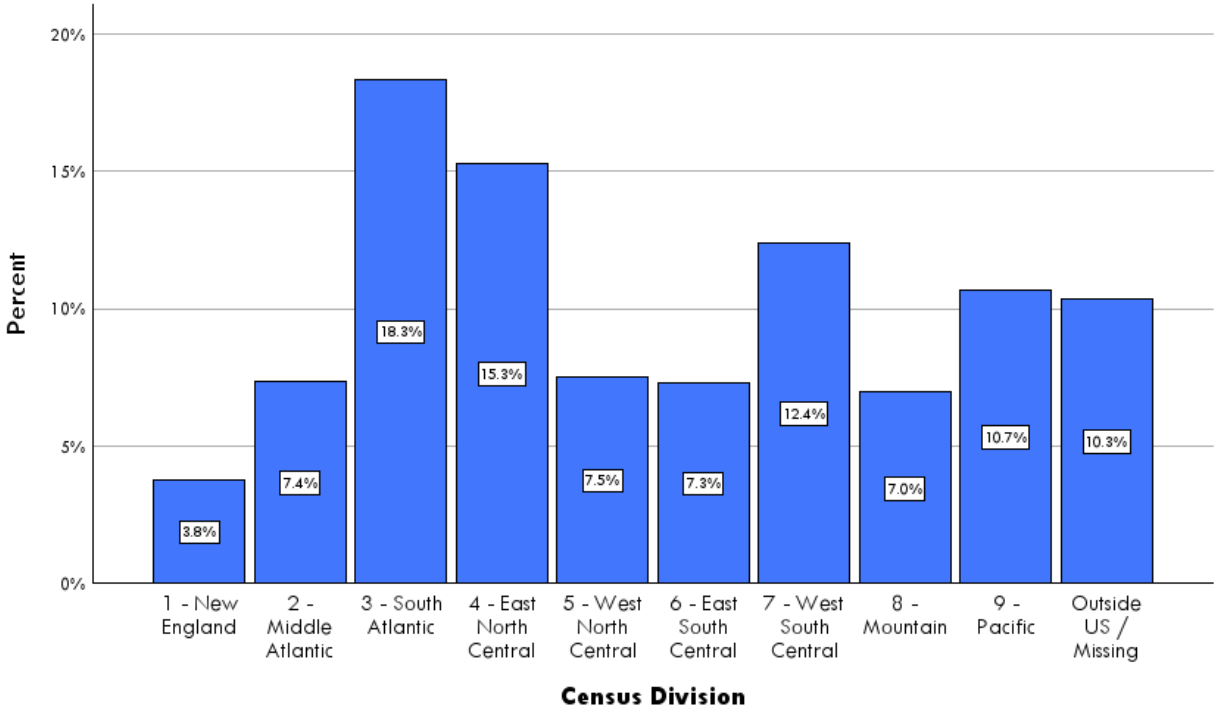

Figure 4. Distribution by division

1 – ME, VT, NH, MA, RI, CT
2 – NY, PA, NJ
3 – WV, VA, MD, DC, DE, NC, SC, GA, FL
4 – MI, OH, IN, IL, WI
5 – ND, SD, MN, NE, IA, KS, MO
6 – KY, TN, MS, AL
7 – OK, AR, LA, TX
8 – MT, ID, WY, NV, UT, CO, AZ, NM
9 – WA, OR, CA, AK, HI

Response Distributions

Survey questions are shown in bold type.

1. What is your age in years?

The typical survey respondent was a respiratory therapist who was 49 years old based on mean and median values. To the extent one is willing to generalize observations from this sample to the population, Figure 5 shows that respiratory therapists span the generations of people who work within the United States while tending to retire when in their 60s.

Table 1. Age of respondents in years

N*		Mean	Std. Error of Mean	Median	Std. Deviation	Minimum	Maximum
Valid	Missing						
4350	437	48.56	.19	49.00	12.27	19	81

*Excluded one response of 99

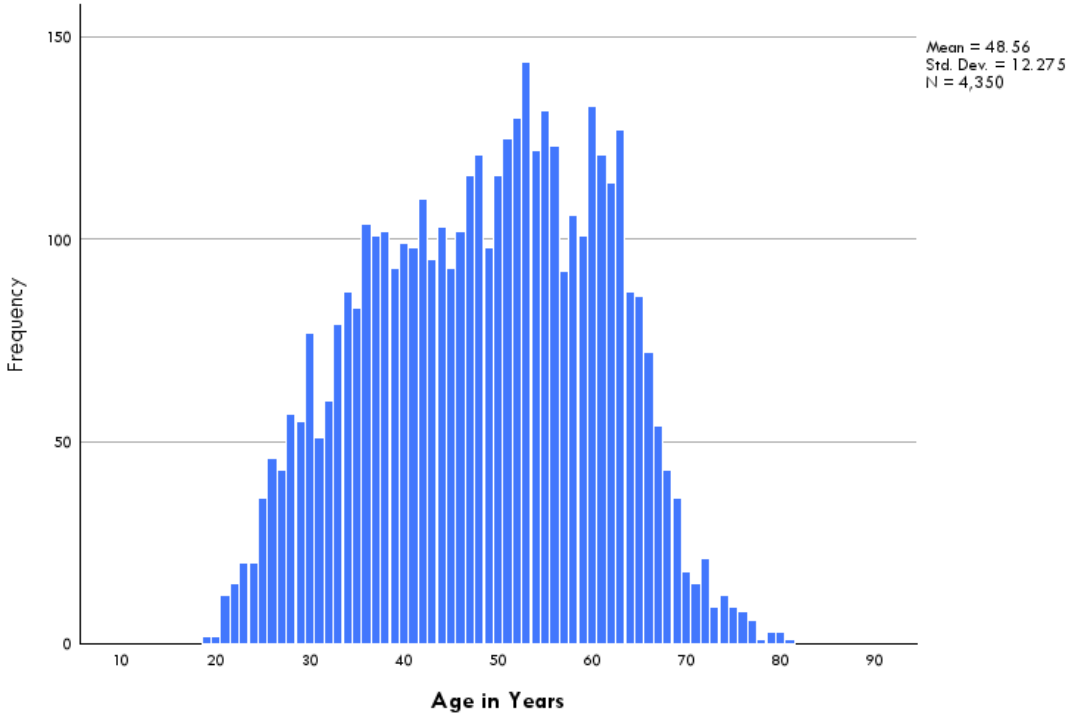

Figure 5. Age of respondents in years

2. For how many years have you practiced as a respiratory therapist since completing your training?

Figure 6 shows that the largest subgroup had about ten years of experience, so ten years is one way to describe what was typical. However, a mean value of 20 and a median value of 18 also describe typical experience levels.

Table 2. Years respondents have practiced since completing training

N		Mean	Std. Error of Mean	Median	Std. Deviation	Minimum	Maximum
Valid	Missing						
4358	429	19.91	.20	18.00	13.09	.00	65.00

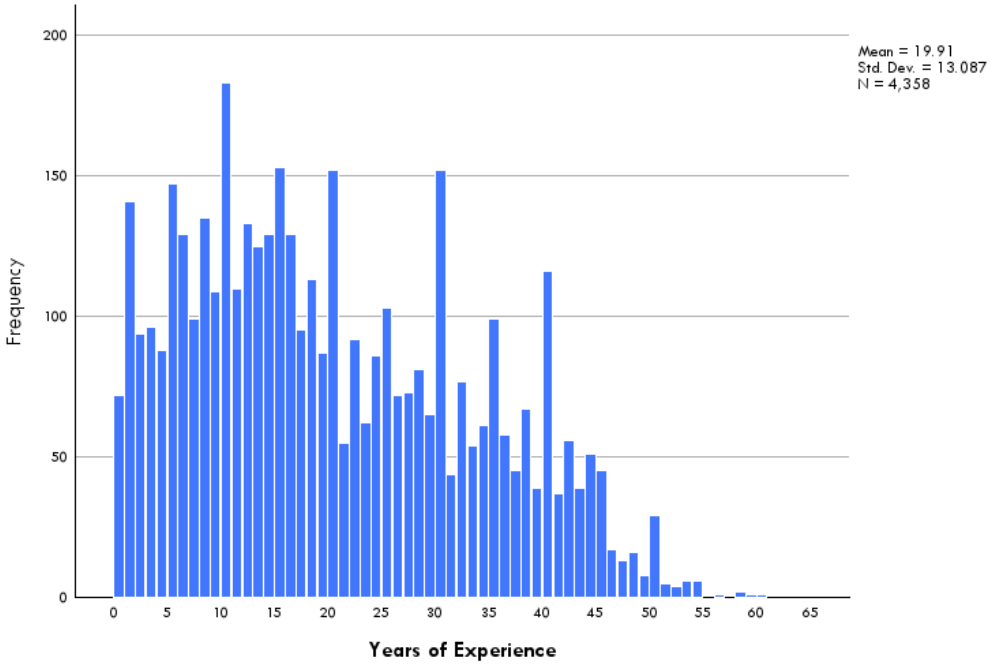

Figure 6. Years respondents have practiced since completing training

3. Which of the following best describes your military status?

As shown in Figure 7, about 9% of therapists have served or are serving in the military, which is a bit higher than the 7% of the United States population who have served (https://www.census.gov/content/dam/Census/library/publications/2020/demo/acs-43.pdf).

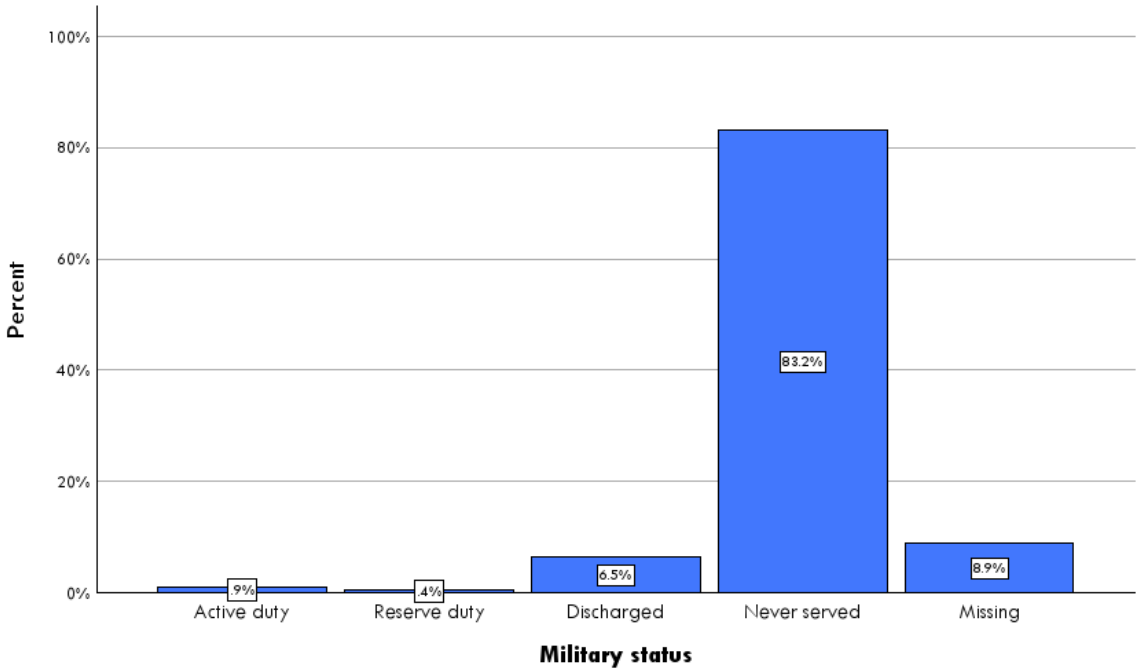

Figure 7. Military status

4. How many years have you worked for your primary employer?

Indicators of typical responses were expressed in a median value of 7 and a mean value of 11. Something else we noted was that the 10-, 20-, and 30-year points tended to be associated with upward spikes in the numbers. We infer from this behavior that some respondents submitted estimates.

Table 3. Years worked for current employer

N							
Valid	Missing	Mean	Std. Error of Mean	Median	Std. Deviation	Minimum	Maximum
4351	436	10.92	.16	7.00	10.62	.0	65.0

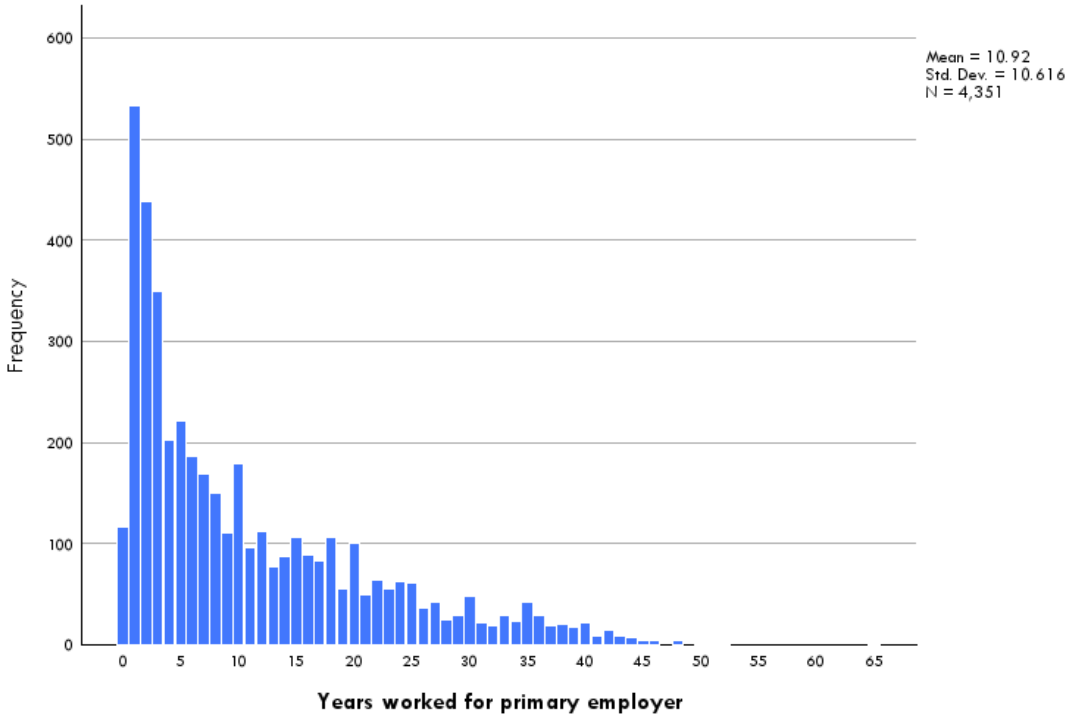

Figure 8. Years worked for Primary employer

5. What is your best guess about the year you will leave the respiratory therapy workforce?

The largest subgroup (9.6%) within this sample identified 2030 as the year they planned to leave the workforce of respiratory therapists. The year 2034 was the median point, which indicates that one-half of the sample intended to leave the workforce about 10 years into the future.

We suggest that the cumulative frequency column in Table 52 in Appendix C is helpful in making predictions and planning for the movement of individuals out of the workforce. We produced one set of predictions, which are listed in the column labeled "Projected." We calculated these numbers by multiplying the cumulative percent value by the 2024 population number, which was 204,191.

For example, we learned to expect that about 80,655 from the current population of therapists will have left the workforce by the end of the year 2030.

Something else we noted was that the 5-, 10- and 15-year points tended to be associated with upward spikes in the numbers. We infer from this behavior that some respondents expressed estimates.

Table 4. Descriptive statistics for year of intended departure from respiratory therapy workforce

N							
Valid	Missing	Mean	Std. Error of Mean	Median	Std. Deviation	Minimum	Maximum
4263	524	2037.1	.18	2034	11.51	2023	2100

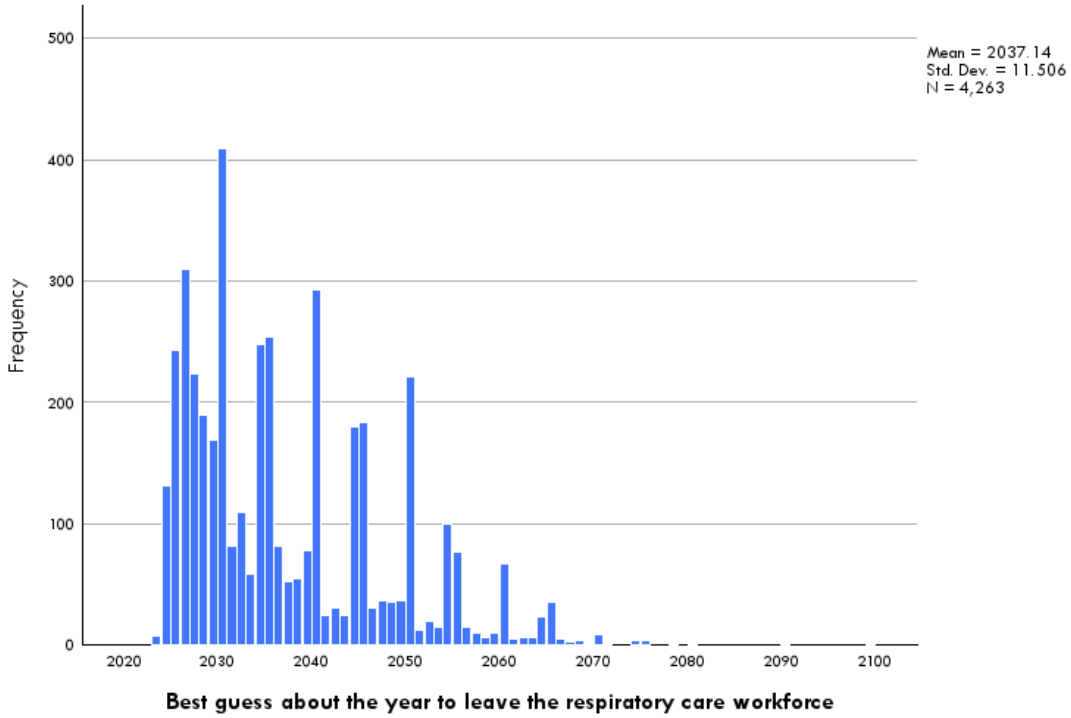

Figure 9. Year of intended departure from respiratory therapist workforce

6. At which of the following locations do you spend most of your respiratory care-related work time?

The largest group of respondents (76.2%) within this sample indicated their primary job was located at an acute care hospital.

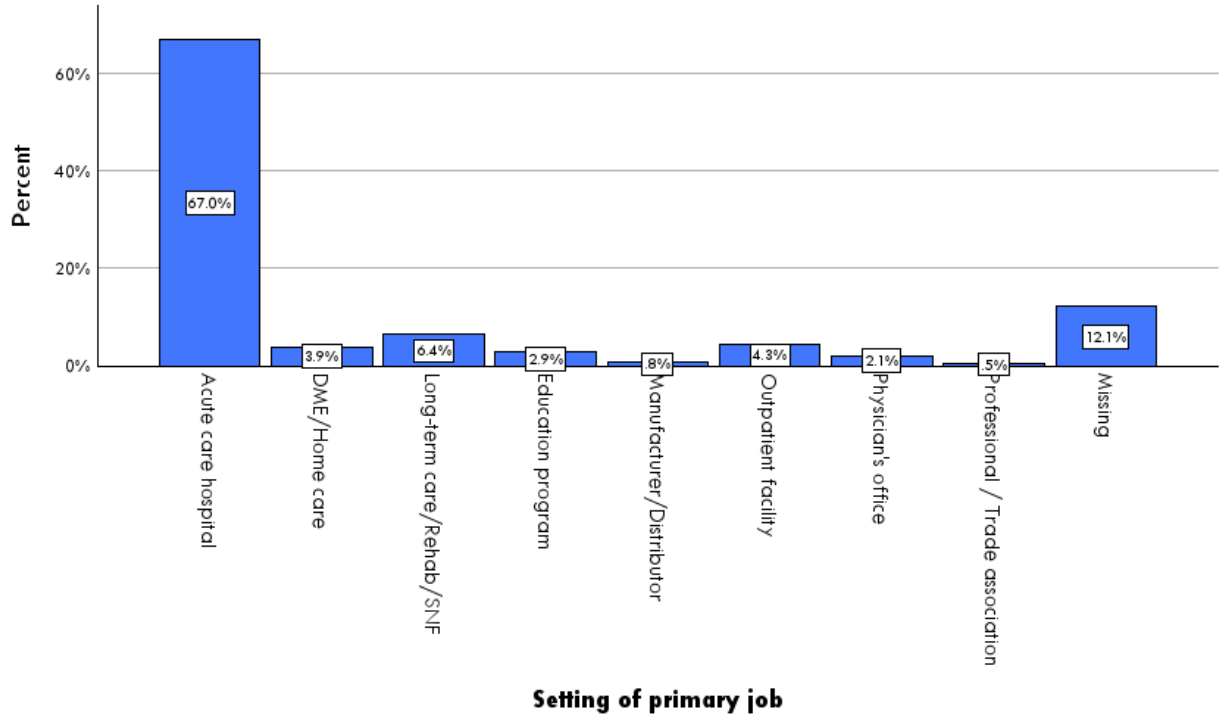

Figure 10. Setting of primary job

7. Approximately how many hours per week do you spend doing respiratory care-related work at this location?

Respondents were asked about hours spent at primary and, if one was held, secondary jobs. Survey functionality was set such that only responses between 1 and 90 were allowed. Submissions to those two questions were summed. Individuals specifying working more than 96 hours per week were removed. Ninety-six represented a breakpoint in the data because it duplicated a threshold used in the 2014 and 2020 studies of the same population and excluded still included 98% of the submitted responses.

The two largest groups indicated working 36 or 40 hours per week, likely indicating most respondents worked in a full-time role with three 12-hour shifts per week or a salaried position requiring 40.

Table 5. Approximate hours worked per week at primary job

N							
Valid	Missing	Mean	Std. Error of Mean	Median	Std. Deviation	Minimum	Maximum
4192	595	37.07	.168	36.00	10.86	1	90

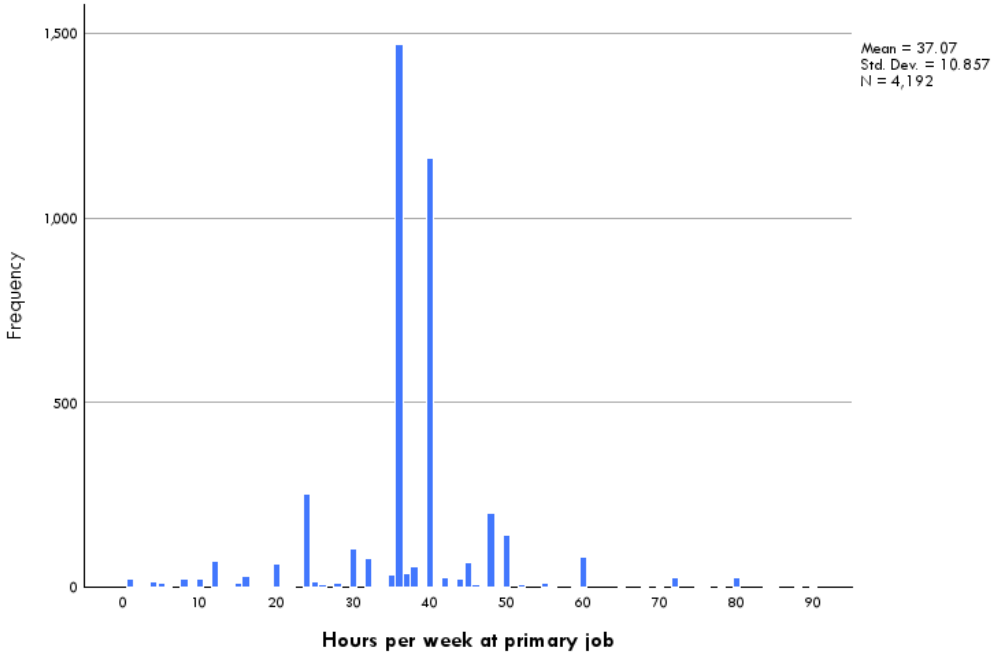

Figure 11. Approximate hours worked per week at primary job

Across all settings mean and median values fell between 34 and 40. As shown in Table 6 and Figure 12, responses from those who worked a primary job at an acute care hospital, DME/home care, and those from an LTC/Rehab/SNF showed a mean value higher than the median, indicating some respondents worked many more hours per week than most respondents from the setting. Conversely, the other locations show mean values lower than median, indicating that some are working less hours per week than most others, likely in part-time positions. Summaries of primary and secondary jobs worked in setting can be found on pages 11 – 19. Frequencies of hours worked per week by setting can be found in Appendix C, Tables 54 – 69.

Table 6. Approximate hours worked per week at primary job by setting

	N							
	Valid	Missing	Mean	Std. Error of Mean	Median	Std. Deviation	Minimum	Maximum
Acute care hospital	3188	0	37.39	.18	36.00	10.44	1	90
DME/Home care	187	0	37.29	1.01	40.00	13.80	1	80
LTC/Rehab/SNF	304	0	36.31	.60	36.00	10.41	1	80
Education program	136	0	36.54	1.23	40.00	14.40	1	80
Manufacturer/Distributor	36	0	37.31	2.22	40.00	13.34	5	60
Outpatient facility	205	0	35.39	.77	40.00	11.07	4	80
Physician's office	99	0	34.00	1.01	38.00	10.06	4	55
Professional/ Trade assn	26	0	34.96	2.77	40.00	14.14	1	59

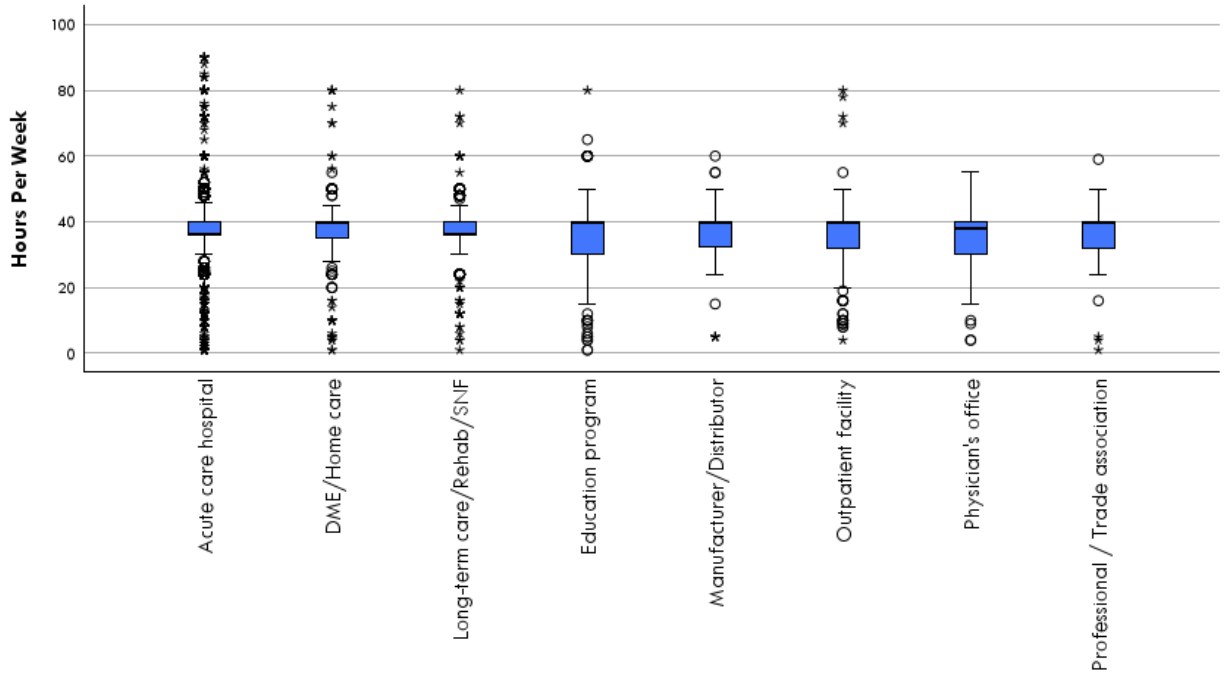

Figure 12. Approximate hours worked per week at primary job by setting

8. Do you work an additional respiratory care-related job?

Less than 20% of respondents indicated working at an additional respiratory care-related job.

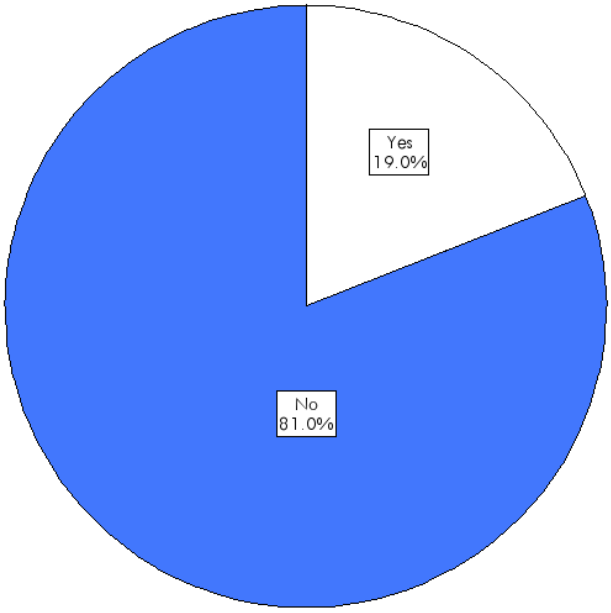

Figure 13. Work an additional respiratory care-related job

9. At which of the following locations do you work this additional job?

The 796 respondents who had responded positively to the previous question were asked to further describe their second respiratory-care related job. More than half of all secondary jobs were located at acute care hospitals.

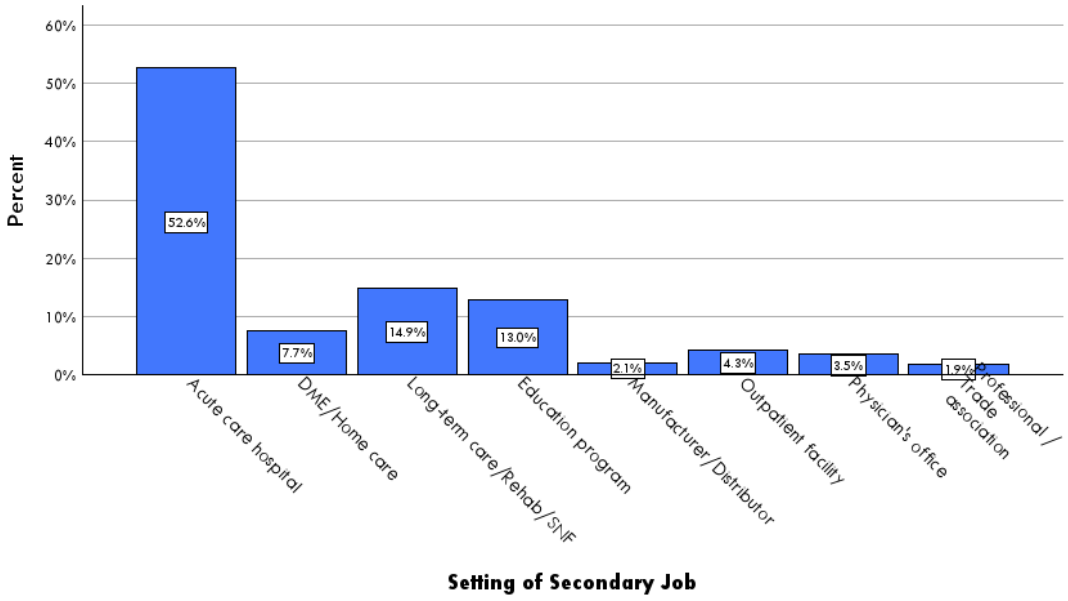

Figure 14. Secondary job setting

10. Approximately how many hours per week do you spend doing respiratory care-related work at this location?

Again, survey functionality was set such that only responses between 1 and 90 were allowed. The mean and median values indicate that the average individual working a secondary job spends between 12 and 15 hours per week working in that role.

Table 7. Approximate hours worked per week at secondary job

N							
Valid	Missing	Mean	Std. Error of Mean	Median	Std. Deviation	Minimum	Maximum
776	3417	14.70	.38	12.00	10.61	1	60

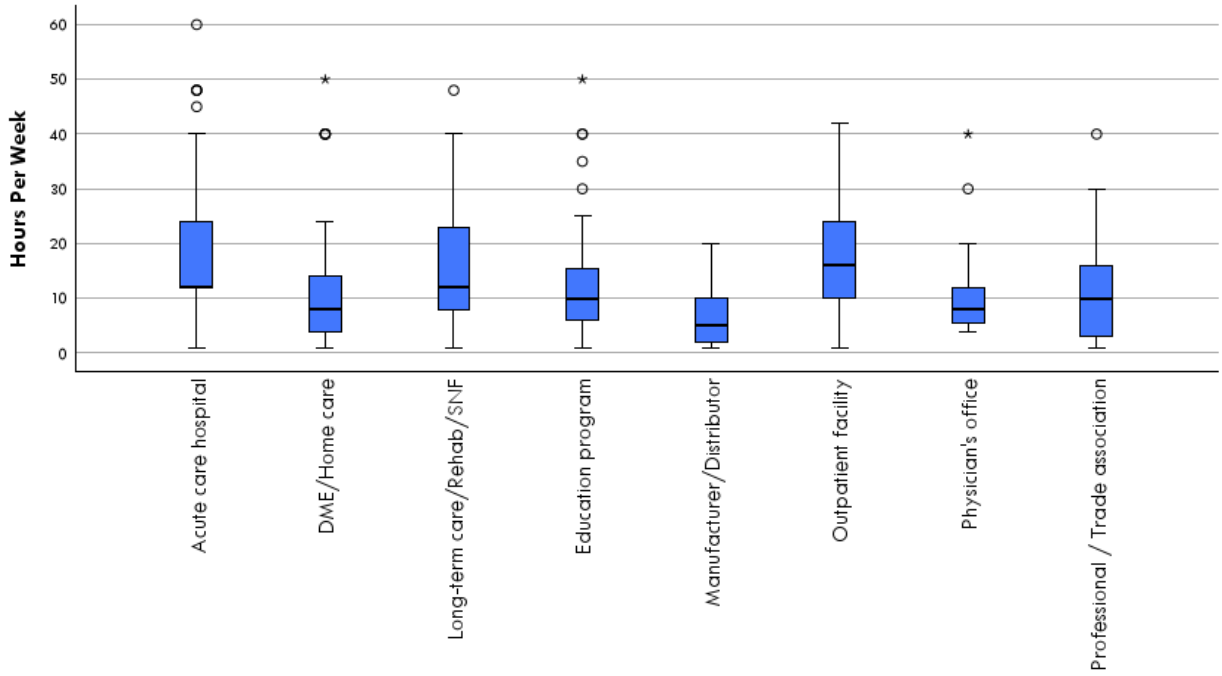

Figure 15. Approximate hours worked per week at secondary job by setting

Summaries of primary and secondary jobs worked in setting can be found on pages 11-19. Frequencies of hours worked per week by setting can be found in Appendix C, Tables 54 – 69.

Table 8. Approximate hours worked per week at secondary job by setting

	N		Mean	Median	Minimum	Maximum	Std. Error of Mean	Std. Deviation
	Valid	Missing						
Acute care hospital	406	11	16.38	12.00	1	60	.55	11.04
DME/Home care	61	0	10.90	8.00	1	50	1.42	11.08
LTC/Rehab/SNF	118	0	14.76	12.00	1	48	.81	8.76
Education program	99	4	11.72	10.00	1	50	.86	8.60
Manufacturer/Distributor	17	0	6.18	5.00	1	20	1.31	5.40
Outpatient facility	32	2	19.00	16.00	1	42	2.17	12.29
Physician's office	27	1	11.11	8.00	4	40	1.59	8.25
Professional/Trade assn	15	0	11.93	10.00	1	40	3.04	11.79

Acute Care Hospital

About 67% of therapists in this sample worked in their primary job at an acute care hospital, which extrapolated to a population of 136,753 people.

Among therapists whose primary job was in an acute care hospital, they typically worked for 36 to 37 hours per week (Appendix C Table 54). Those who had second jobs worked an average of 12 to 16 hours a week in acute care hospitals (Appendix C Table 55). We noted that among those who worked a second job, at least a few were putting in full-time hours. However, approximately two thirds of this group worked 12 hours or less, so that was a more typical scenario for second jobs.

Table 9. Hours worked per week at jobs at Acute Care Hospital

	N	Mean	Std. Error of Mean	Median	Std. Deviation	Minimum	Maximum
Acute care hospital - Primary	3188	37.39	.19	36.00	10.441	1	90
Acute care hospital - Secondary	406	16.38	.55	12.00	11.043	1	60

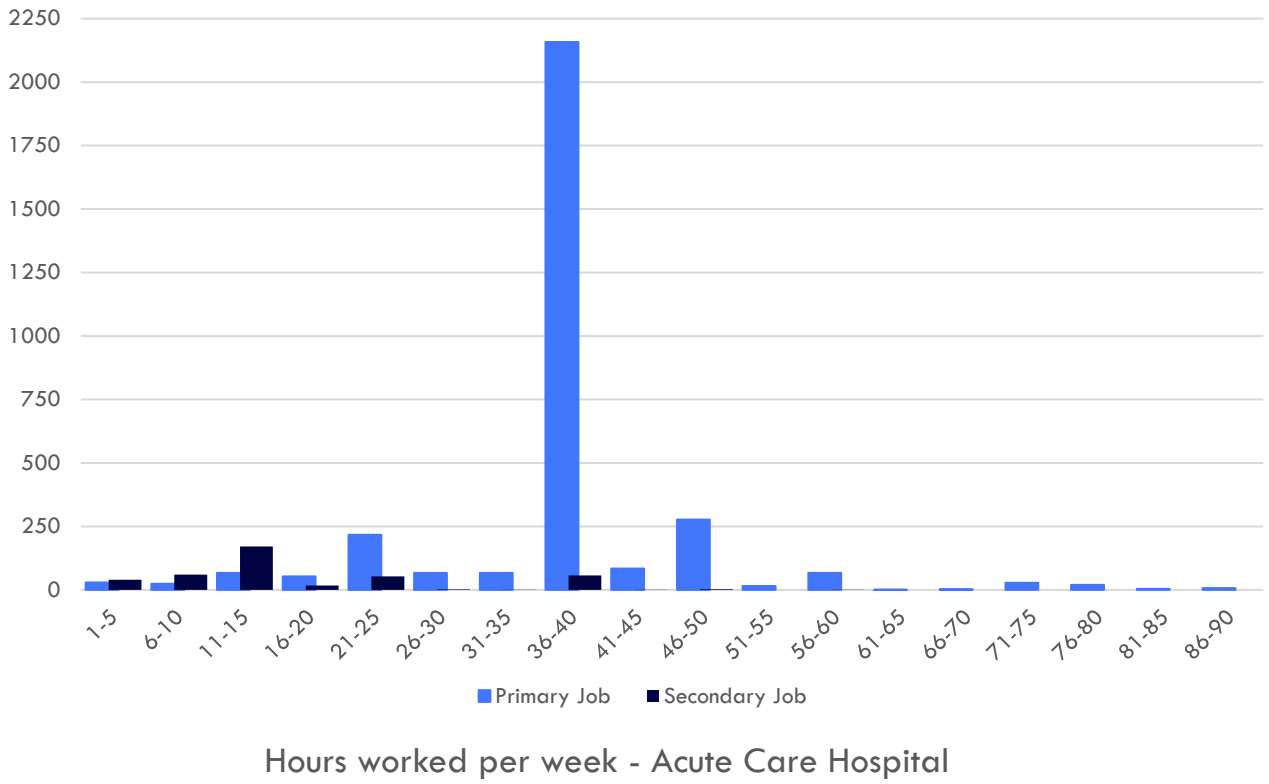

Figure 16. Hours worked per week at Primary and Secondary jobs in Acute Care Hospitals

DME/Home Care

Approximately 4% of the sample worked in the Durable Medical Equipment/Home Care setting as their primary job. This extrapolated to a population of 8,019.

When a respondent's primary job was in a DME/Home Care setting, typical therapists who worked full time put in 37 to 40 hours per week. The typical therapist working a second job in the DME/Home Care setting put in 11 hours or less, but a few indicated working 40 or 50 hours in their second job. Frequency tables can be found in Appendix C, Table 56 and Table 57.

Table 10. Hours worked per week in DME/Home Care

	N	Mean	Std. Error of Mean	Median	Std. Deviation	Minimum	Maximum
DME/Home care – Primary job	187	37.29	1.01	40.00	13.80	1	80
DME/Home care – Secondary job	61	10.90	1.42	8.00	11.08	1	50

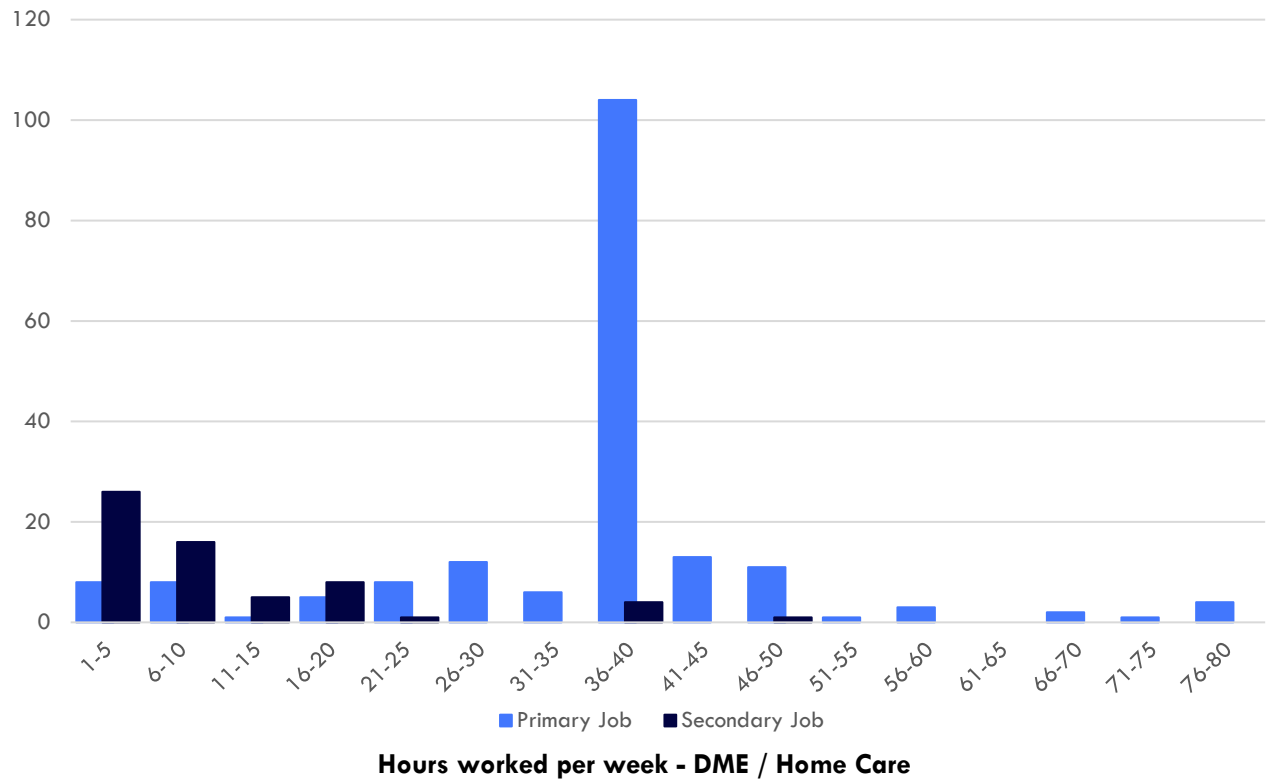

Figure 17. Hours worked per week at Primary and Secondary jobs in DME/Home Care

Long Term Care/Rehabilitation/Skilled Nursing Facilities

About 6% of the sample worked in Long Term Care/Rehabilitation/Skilled Nursing Facility settings for their primary job. We extrapolated a population of 13,138 from this percentage of the sample.

Average values for work hours among therapists in the Long-Term Care/Rehabilitation/Skilled Nursing Facility settings were around 36 hours. When therapists held a second job in one of these settings, they tended to work approximately 12 to 15 hours. Frequency tables can be found in Appendix C, Table 58 and Table 59.

Table 11. Hours worked per week in Long Term Care

	N		Mean	Std. Error of Mean	Median	Std. Deviation	Minimum	Maximum
	Valid	Missing						
LTC/Rehab/SNF - Primary	304	0	36.31	.60	36.00	10.41	1	80
LTC/Rehab/SNF - Secondary	118	0	14.76	.81	12.00	8.76	1	48

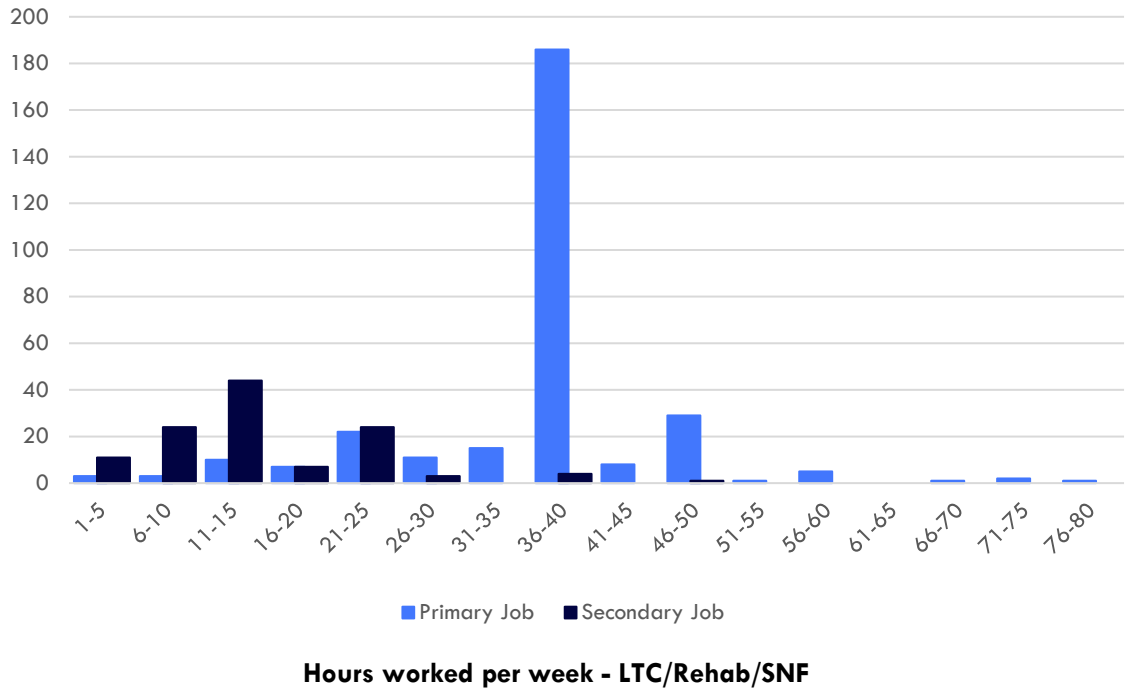

Figure 18. Hours worked per week at Primary and Secondary jobs in Long Term Care

Education Program

Three percent of the sample worked primarily in the education setting. We extrapolated a population of 5,844 from this percentage of the sample. However, we were reminded that there were 449 accredited programs and program options according to the 2023 CoARC Report on Accreditation. There would have to be 13 employees per program to reach more than 5,800 people. Therefore, this result revealed that people who primarily worked for education programs were overrepresented in this sample.

Therapists who worked in education settings as their primary job tended to put in around 36 hours per week according to the mean value in Table 12. However, the modal point in Figure 19 was 40 hours. These results indicate that some educators put in 40 hours a week at their primary jobs while others work less than 40 hours a week. When therapists worked second jobs in the education setting, they typically put in 10-12 hours. Frequency tables can be found in Appendix C, Table 60 and Table 61.

Table 12. Hours worked per week in Education

	N							
	Valid	Missing	Mean	Std. Error of Mean	Median	Std. Deviation	Minimum	Maximum
Education program – Primary	136	0	36.54	1.24	40.00	14.40	1	80
Education program – Secondary	99	4	11.72	.87	10.00	8.60	1	50

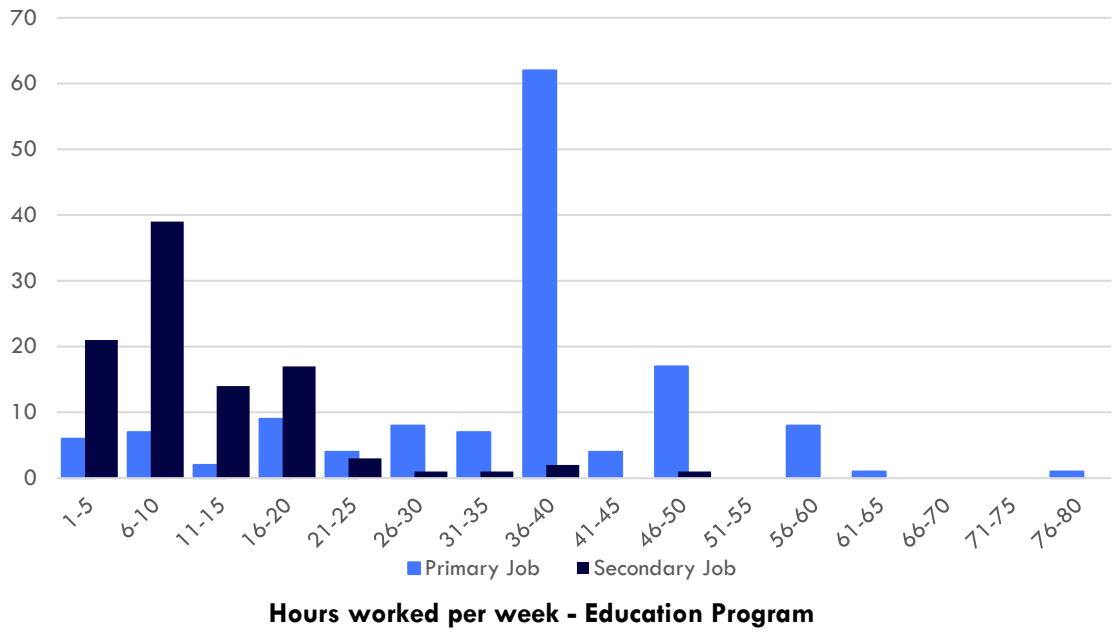

Figure 19. Hours worked per week at Primary and Secondary jobs in Education

Manufacturer/Distributor

Less than 1% of the sample worked primarily in this setting, which extrapolated to a population of 1,536. The few therapists who worked in the Manufacturing/Distribution setting tended to put in 37 to 40 hours. Those with second jobs in this setting were typically limited to 5 to 6 hours. Frequency tables can be found in Appendix C, Table 62 and Table 63.

Table 13. Hours worked per week in Manufacturing/Distribution

	N							
	Valid	Missing	Mean	Std. Error of Mean	Median	Std. Deviation	Minimum	Maximum
Manufacturer/Distributor - Primary	36	0	37.31	2.22	40.00	13.34	5	60
Manufacturer/Distributor – Secondary	17	0	6.18	1.31	5.00	5.40	1	20

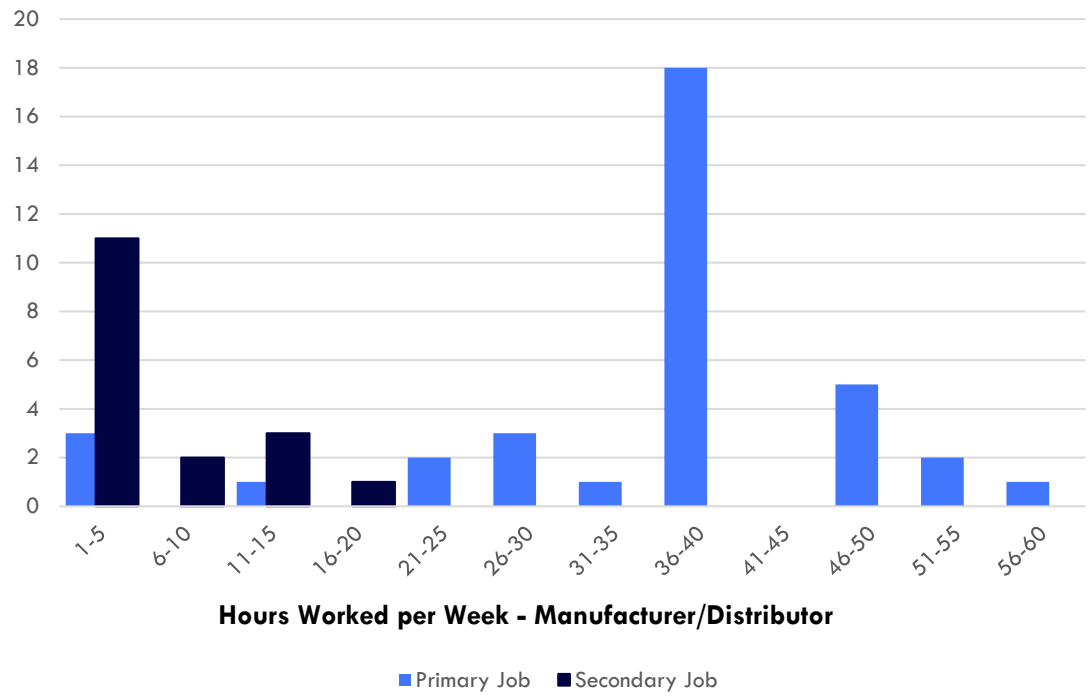

Figure 20. Hours worked per week at Primary and Secondary jobs in Manufacturing/Distribution

Outpatient Facility

Around 4% of the sample worked primarily at an outpatient facility, which extrapolated to a population of 8,830. Individuals in this setting tended to work between 35 and 40 hours per week. Therapists working a secondary job worked between 16 and 19 hours per week, though six indicated working a 40-hour work week or more. Frequency tables can be found in Appendix C, Table 64 and Table 65.

Table 14. Hours worked per week at Outpatient Facility

	N		Mean	Std. Error of Mean	Median	Std. Deviation	Minimum	Maximum
	Valid	Missing						
Outpatient Facility - Primary	205	0	35.39	.77	40.00	11.07	4	80
Outpatient Facility - Secondary	32	2	19.00	2.17	16.00	12.29	1	42

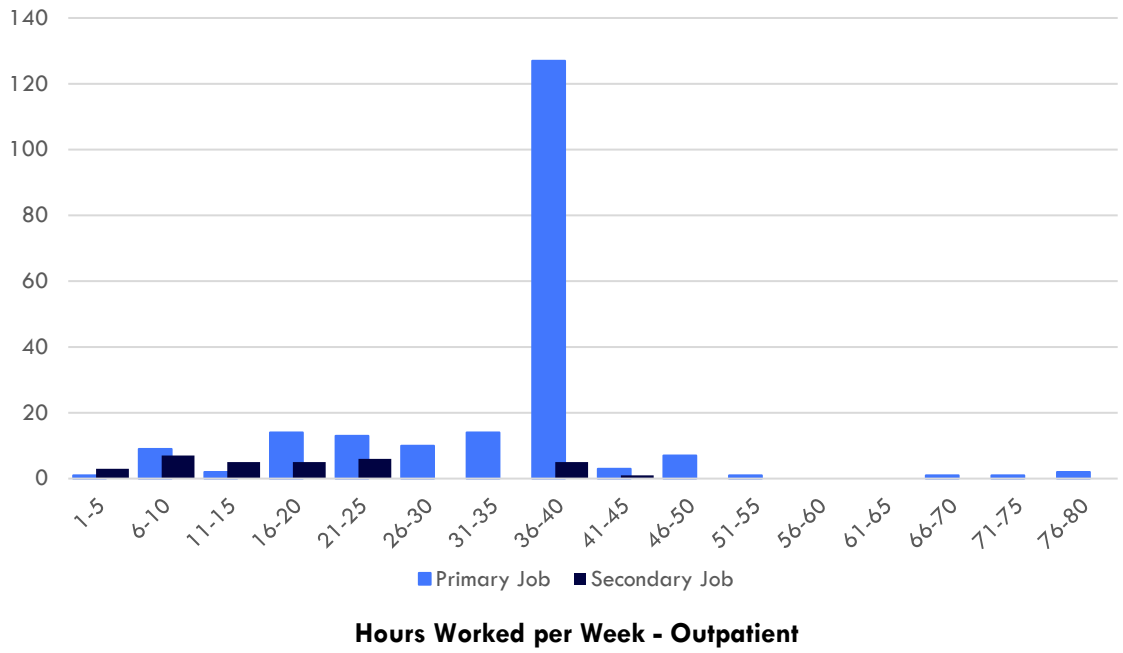

Figure 21. Hours worked per week at Primary and Secondary jobs at Outpatient Facility

Physician's Office

Just more than 2% of the sample worked primarily in this setting, which extrapolated to a population of 4,223. Among therapists whose primary job was in a physician's office, they typically put in 34 to 38 hours each week. However, the modal point was 40 hours per week. Those working a second job in this setting tended to work 8 to 11 hours. Frequency tables can be found in Appendix C, Table 66 and Table 67.

Table 15. Hours worked per week in a Physician's office

	N		Mean	Std. Error of Mean	Median	Std. Deviation	Minimum	Maximum
	Valid	Missing						
Physician's Office - Primary	99	0	34.00	1.01	38.00	10.06	4	55
Physician's Office – Secondary	27	1	11.11	1.59	8.00	8.25	4	40

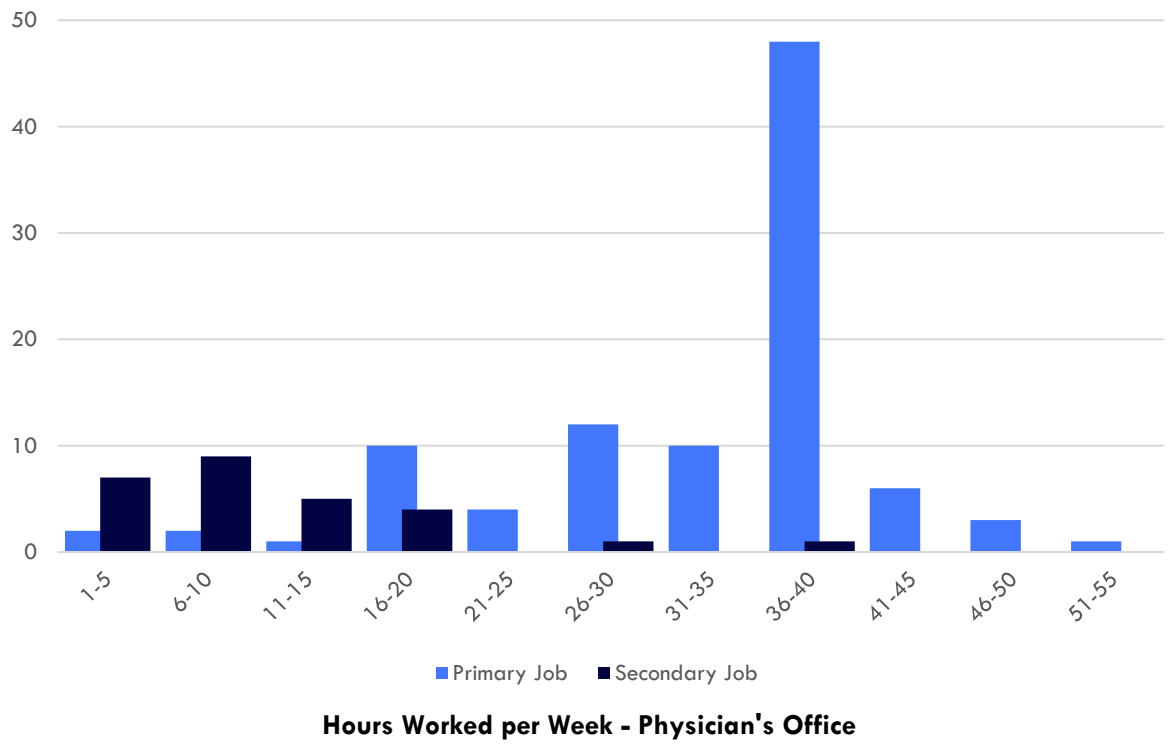

Figure 22. Hours worked per week at Primary or Secondary job at a Physician's office

Professional / Trade Association

Less than 1% of the sample worked primarily for a professional / trade association, which extrapolated to a population of 1,109. The therapists who worked for an association as their primary job tended to work between 34 and 40 hours per week. Those who worked at a secondary association job worked between 10 and 12 hours. Frequency tables can be found in Appendix C, Table 68 and Table 69.

Table 16. Hours worked per week for Professional/Trade association

	N		Mean	Std. Error of Mean	Median	Std. Deviation	Minimum	Maximum
	Valid	Missing						
Professional/ Trade Association - Primary	26	0	34.96	2.77	40.00	14.14	1	59
Professional/ Trade Association - Secondary	15	0	11.93	3.04	10.00	11.79	1	40

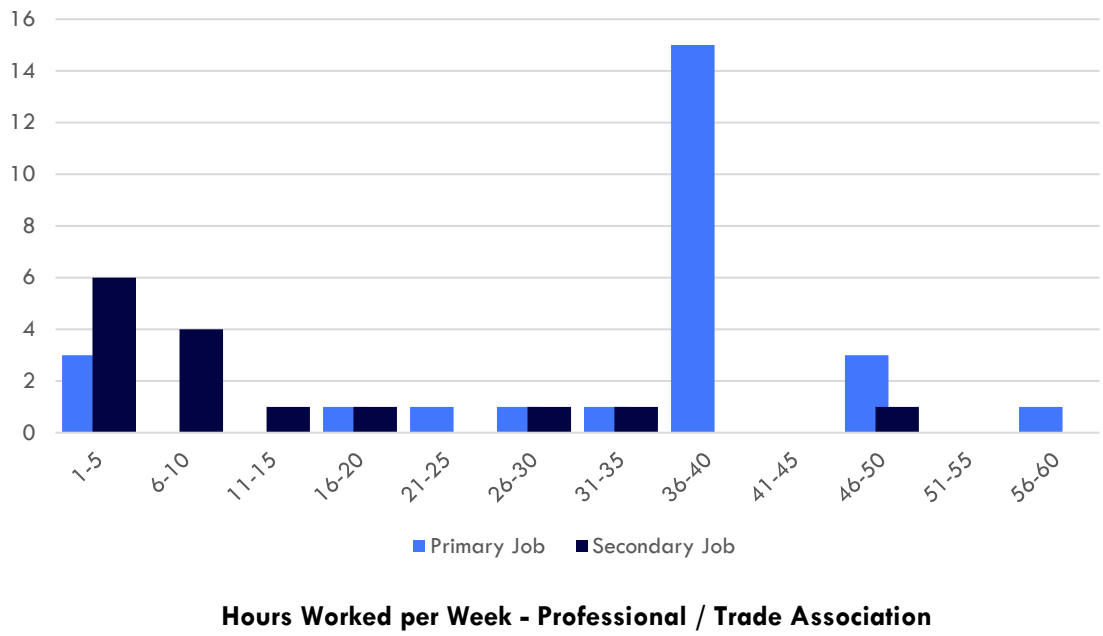

Figure 23. Hours worked per week at Primary and Secondary jobs for Professional / Trade association

Table 17. Descriptive statistics for hours worked per week for all employers

	N							
	Valid	Missing	Mean	Std. Error of Mean	Median	Std. Deviation	Minimum	Maximum
Acute care hospital – Primary	3188	0	37.39	.185	36.00	10.441	1	90
Acute care hospital - Secondary	406	11	16.38	.55	12.00	11.043	1	60
DME/Home care – Primary	187	0	37.29	1.01	40.00	13.80	1	80
DME/Home care – Secondary	61	0	10.90	1.42	8.00	11.08	1	50
LTC/Rehab/SNF – Primary	304	0	36.31	.60	36.00	10.41	1	80
LTC/Rehab/SNF - Secondary	118	0	14.76	.81	12.00	8.76	1	48
Education program – Primary	136	0	36.54	1.24	40.00	14.40	1	80
Education program – Secondary	99	4	11.72	.87	10.00	8.60	1	50
Manufacturer/Distributor - Primary	36	0	37.31	2.22	40.00	13.34	5	60
Manufacturer/Distributor - Secondary	17	0	6.18	1.31	5.00	5.40	1	20
Outpatient Facility – Primary	205	0	35.39	.77	40.00	11.07	4	80
Outpatient Facility - Secondary	32	2	19.00	2.17	16.00	12.29	1	42
Physician's Office – Primary	99	0	34.00	1.01	38.00	10.06	4	55
Physician's Office - Secondary	27	1	11.11	1.59	8.00	8.25	4	40
Professional/ Trade Association - Primary	26	0	34.96	2.77	40.00	14.14	1	59
Professional/ Trade Association - Secondary	15	0	11.93	3.04	10.00	11.79	1	40

11. Are you employed as a temporary / travel respiratory therapist at this location?

Survey respondents were asked if they were employed as temporary / travel RTs in their primary and, if held, secondary jobs. Analysis of the individuals working 96 or fewer hours per week suggests that approximately 5% of respondents are working as temporary / travel RTs in their primary job, which extrapolates to a population of 10,210. While there is a relatively small group working a secondary job, approximately 13% of those respondents indicated working in a temporary / travel role.

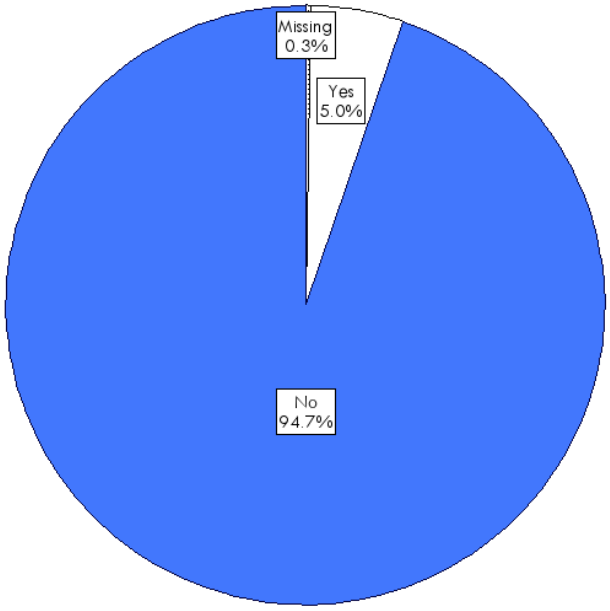

Figure 24. Employed as temporary / travel respiratory therapist at primary job

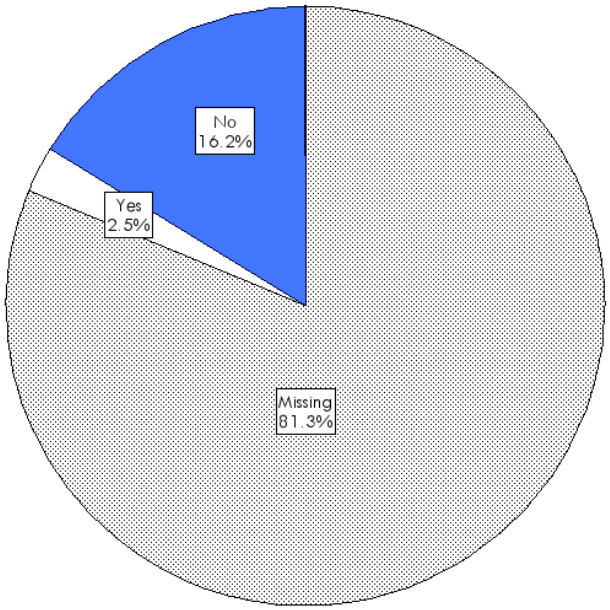

Figure 25. Employed as temporary / travel respiratory therapist at secondary job

The largest group who worked a primary job as a temporary / travel respiratory therapist were located at an acute care hospital, followed by LTC/Rehab/SNFs. Less than 10 respondents indicated working in travel positions at other locations. The settings for secondary jobs as a Travel RT were more varied as is seen in Table 18.

Table 18. Crosstab of employment as temporary/travel respiratory therapist by primary job setting

		Employed as a temporary/travel RT		
		Yes	No	Total
Acute care hospital	Count	181	3001	3182
	%	86.6%	75.8%	76.3%
DME/Home care	Count	6	181	187
	%	2.9%	4.6%	4.5%
Long-term care/Rehab/SNF	Count	11	292	303
	%	5.3%	7.4%	7.3%
Education program	Count	1	132	133
	%	0.5%	3.3%	3.2%
Manufacturer/Distributor	Count	1	35	36
	%	0.5%	0.9%	0.9%
Outpatient facility	Count	4	200	204
	%	1.9%	5.0%	4.9%
Physician's office	Count	5	94	99
	%	2.4%	2.4%	2.4%
Professional / Trade association	Count	0	26	26
	%	0.0%	0.7%	0.6%
Total	Count	209	3961	4170
	%	100.0%	100.0%	100.0%

Table 19. Crosstab of employment as temporary/travel respiratory therapist by Secondary job setting

		Employed as a temporary/travel RT		
		Yes	No	Total
Acute care hospital	Count	57	353	410
	%	54.8%	52.0%	52.4%
DME/Home care	Count	6	55	61
	%	5.8%	8.1%	7.8%
Long-term care/Rehab/SNF	Count	20	97	117
	%	19.2%	14.3%	14.9%
Education program	Count	6	96	102
	%	5.8%	14.1%	13.0%
Manufacturer/Distributor	Count	4	13	17
	%	3.8%	1.9%	2.2%
Outpatient facility	Count	3	30	33
	%	2.9%	4.4%	4.2%
Physician's office	Count	5	23	28
	%	4.8%	3.4%	3.6%
Professional / Trade association	Count	3	12	15
	%	2.9%	1.8%	1.9%
Total	Count	104	679	783
	%	100.0%	100.0%	100.0%

12. What do you estimate to be the total wages you earned in 2023?

Typical responses are summarized in Table 20. Detailed analyses of 2023 compensation will follow later in this report. Survey functionality was set to limit responses to a maximum value of $400,000.

Table 20. Descriptive statistics for estimated compensation from Primary and Second jobs in 2023

	N	Mean	Std. Error of Mean	Median	Std. Deviation	Minimum	Maximum
2023 Wages - Primary	3921	77241.18	532.44	75000.00	33340.48	1*	400000
2023 Wages - Secondary	687	25050.07	1003.68	1500.00	26307.11	1*	150000

*Fifty-nine values of 0 were excluded from analysis.
** Forty-three values of 0 were excluded from analysis.

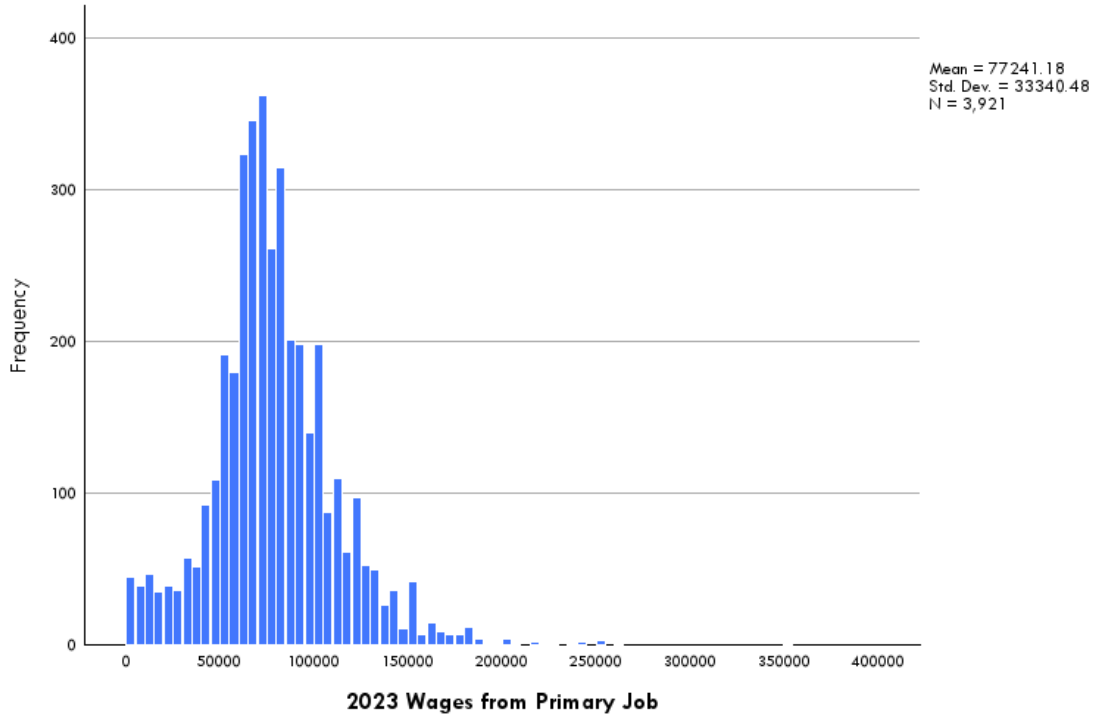

Figure 26. Estimated compensation from Primary job in 2023

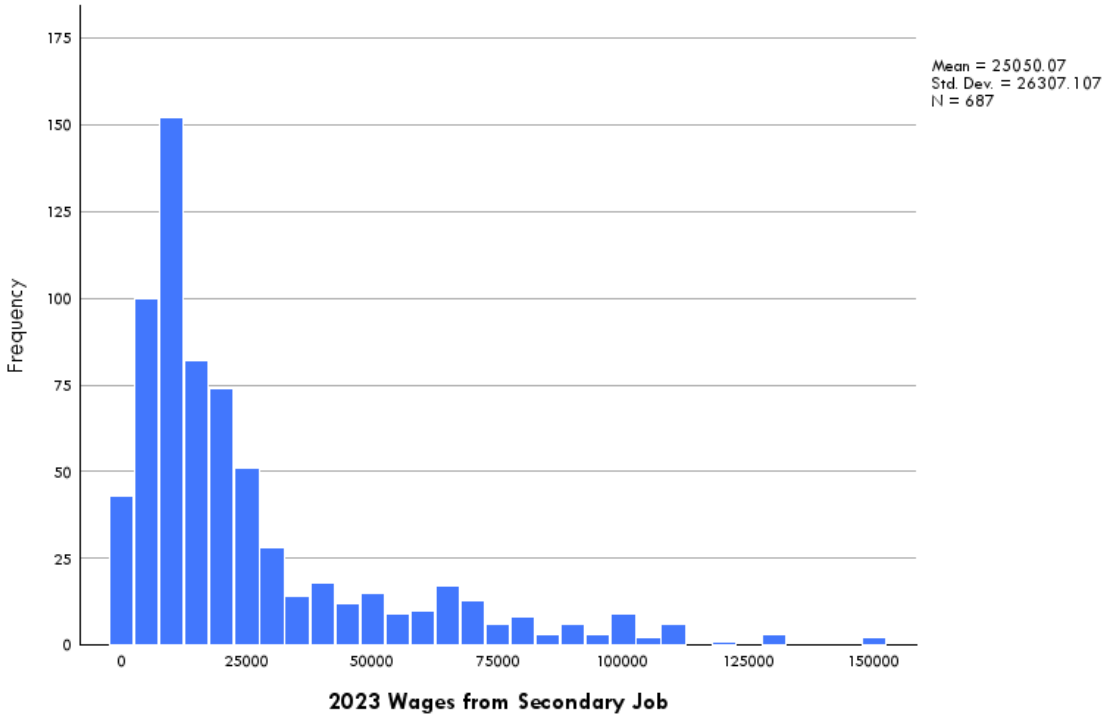

Figure 27. Estimated compensation from Second job in 2019

13. What is your hourly base wage at your primary respiratory care job?

Survey functionality was set to limit responses to $10 – 99. The typical respondent earned an hourly base (before differentials for evening and night shifts, weekends, holidays, and on-call) wage of $41.74 (Table 21). However, one-half of this sample earned less than $39.70/hour. Approximately 68% of the sample earned between $29.71/hour and $53.77/hour, a range defined by one standard deviation above and below the mean.

Because the shape of the histogram in Figure 28 indicates that the extreme values are on the upper end of the range, we recommend that the median value is a truer indicator of typical base wage than the mean in Table 21.

Table 21. Descriptive statistics for hourly base wage at Primary job

N							
Valid	Missing	Mean	Std. Error of Mean	Median	Std. Deviation	Minimum	Maximum
3668	1119	41.74	.20	39.69	12.03	10.00	99.00

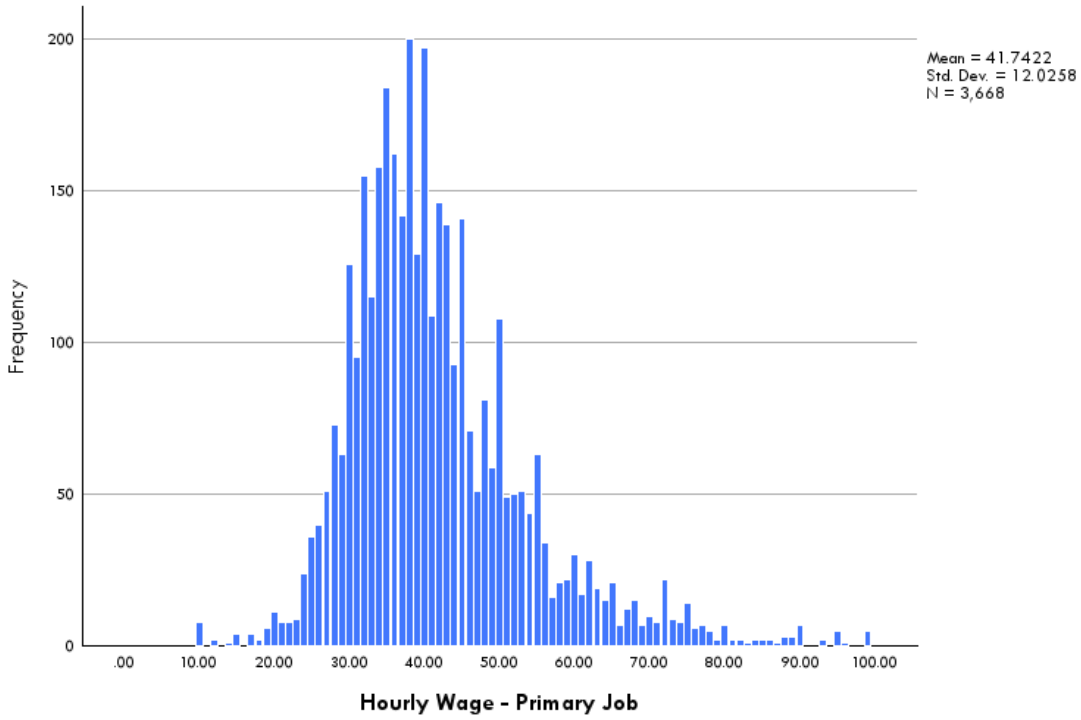

Figure 28. Hourly base wage at Primary job

14. Please specify the additional $ per hour differentials earned at your primary job.

Survey functionality was set to limit responses to $0-100. There were some settings where therapists worked in which they did not earn a wage differential. We inferred this from the minimum values of zero shown in Table 22. Because the sample included therapists working in some settings that did not require around-the-clock services, this was expected. Therapists in this sample who worked the evening shift typically earned an additional $2.25 to $2.87/hour, while those who worked the night shift typically earned an additional $3.50 to $4.13/hour as Table 22 showed. Those working on the weekend typically earned an additional $2.50 to $4.05/hour.

Stronger variability was observed in the differential for holiday and on-call work. On-call differential also showed a lot of variability with a range for the typical therapist between $2.00 and $7.27/hour. Holiday differentials showed the greatest variability ranging between $18.00 and $24.66 for the typical therapist in this sample.

Table 22. Descriptive statistics for differentials

	N							
	Valid	Missing	Mean	Std. Error of Mean	Median	Std. Deviation	Minimum	Maximum
Evening shift	1052	3735	2.87	.12	2.25	3.96	.00	60.00
Night shift	1408	3379	4.13	.14	3.50	5.17	.00	65.00
Weekend	1504	3283	4.05	.15	2.50	6.00	.00	75.00
Holiday	906	3881	24.66	.83	18.00	24.84	.00	100.00
On-call	641	4146	7.27	.55	2.00	13.88	.00	100.00

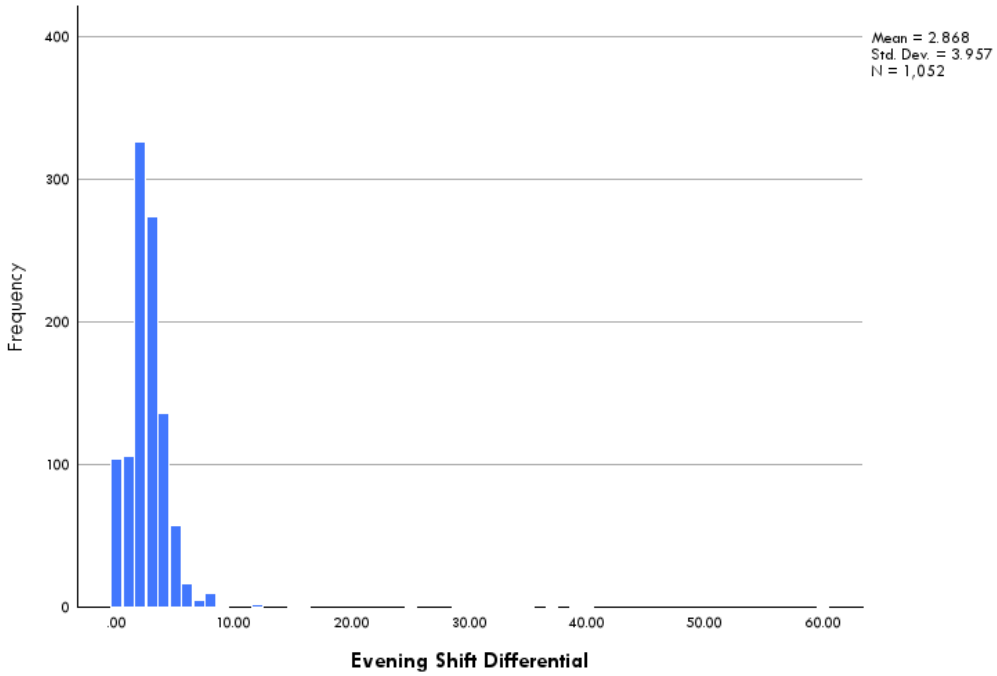

Figure 29. Hourly Evening shift differential

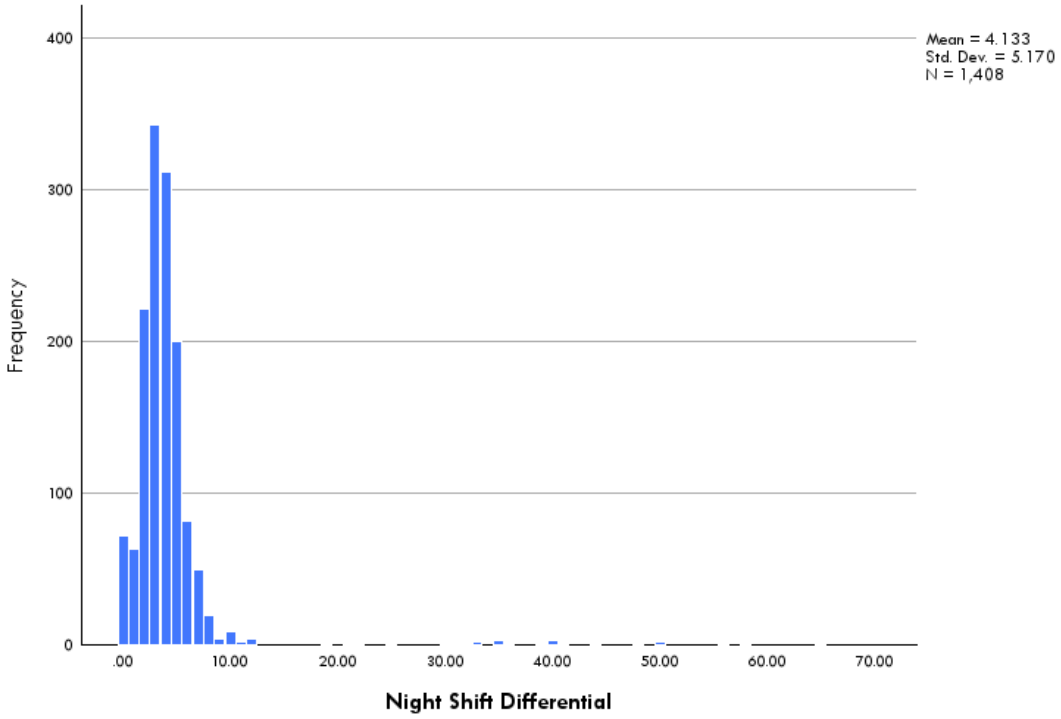

Figure 30. Hourly Night shift differential

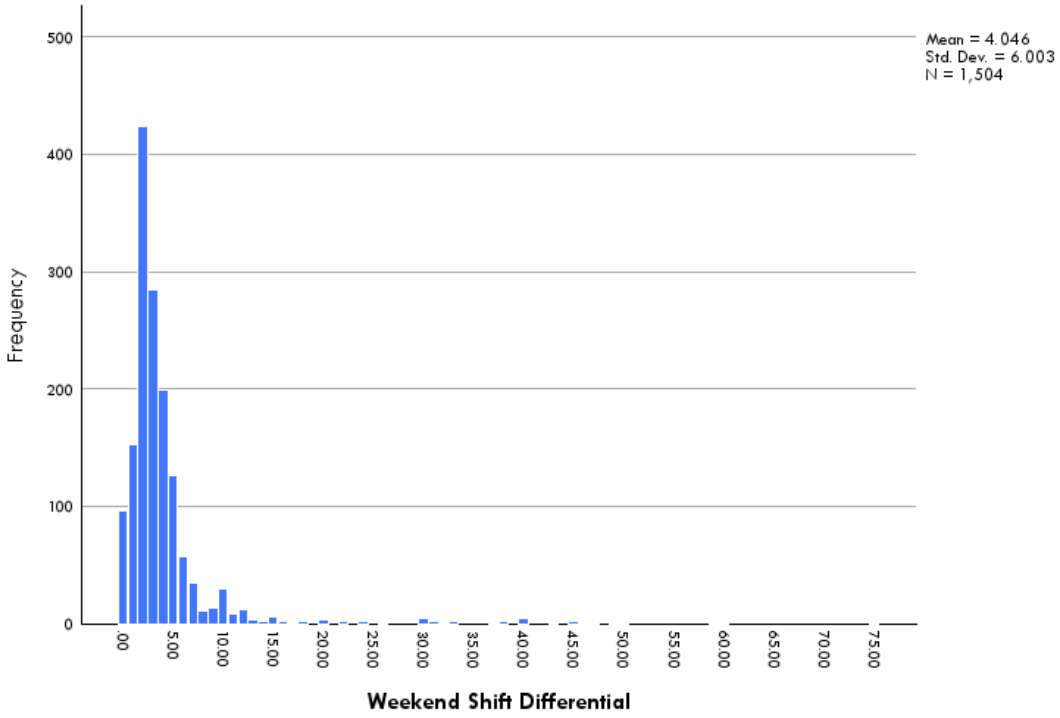

Figure 31. Hourly Weekend shift differential

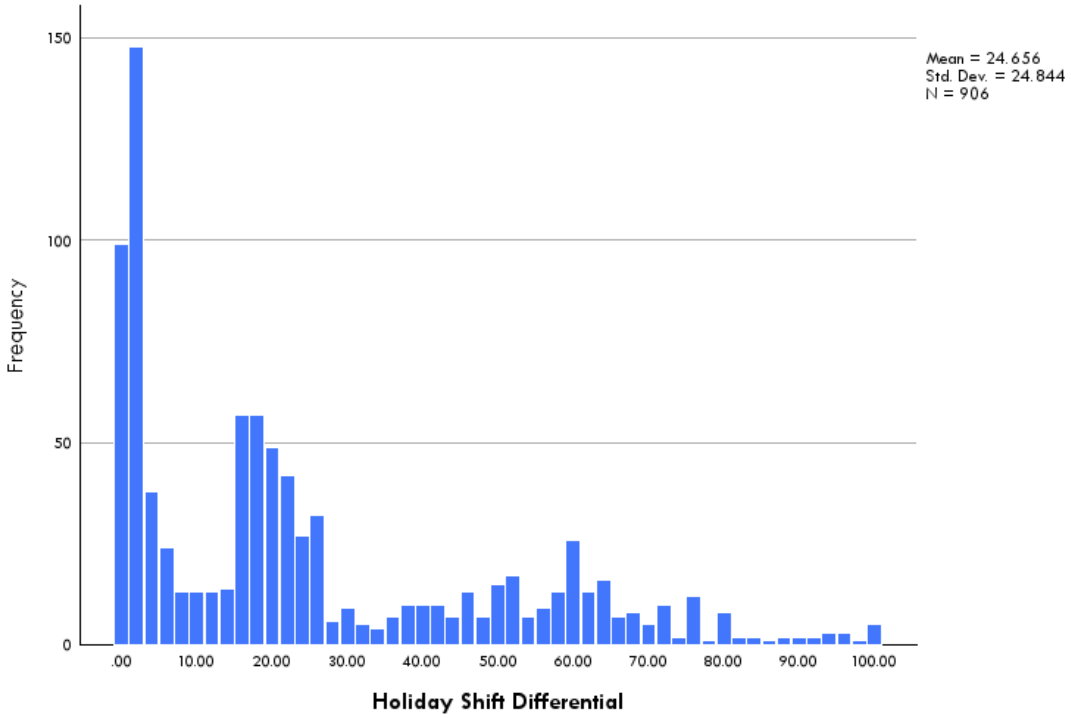

Figure 32. Hourly Holiday shift differential

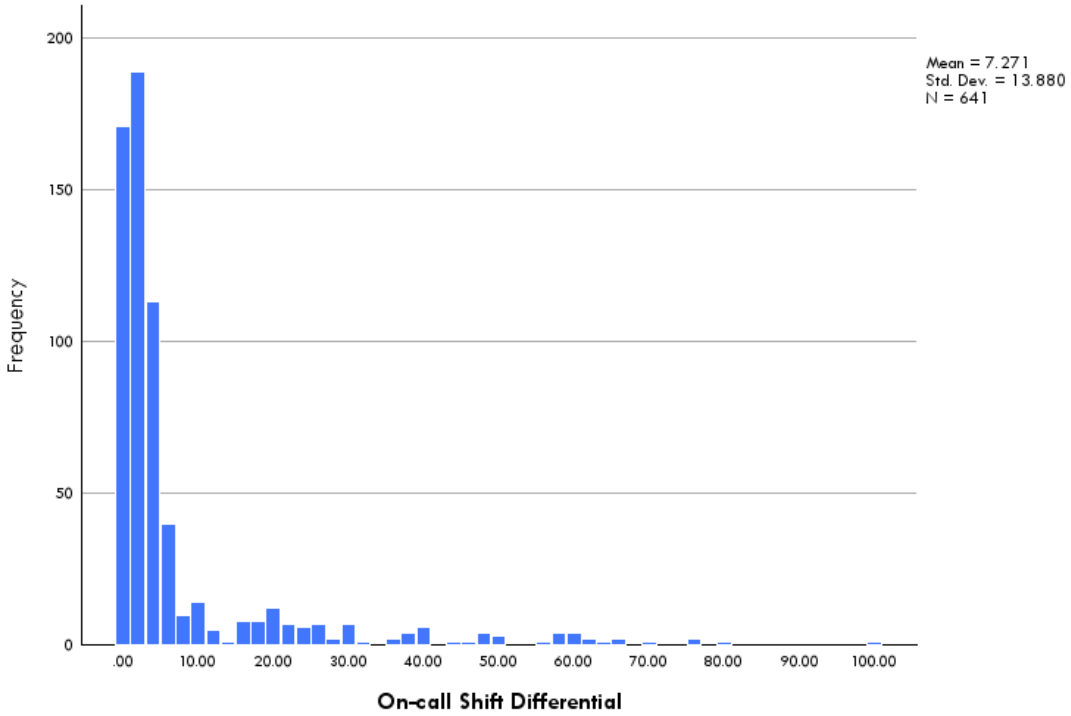

Figure 33. Hourly On-call shift differential

15.If you received a bonus last year, what was the amount?

The first thing to understand about bonus compensation was that only 20% of respondents received a bonus. Among those who did, the mean was $4,023 and the median was $1500 as Table 23 showed.

Table 23. Descriptive statistics for most recent bonus amount

N			Std. Error		Std.		
Valid	Missing	Mean	of Mean	Median	Deviation	Minimum	Maximum
952	3835	4022.59	184.70	1500.00	5698.91	1.00	47000.00

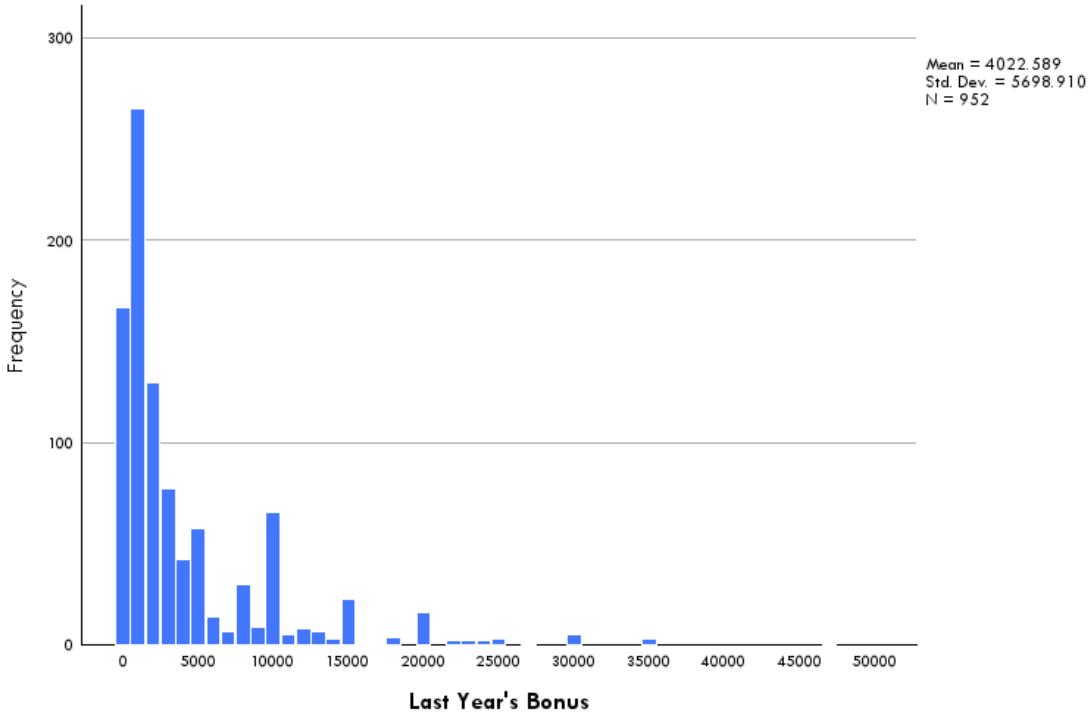

Figure 34. Bonus Received Last Year

16. By what percentage was your base wage increased when you last received a raise for your current position?

Most respondents' last raises were between 2.91% and 3.34%. Two hundred fifty-one respondents were excluded from this analysis after submitting a value of zero.

Table 24. Descriptive statistics for percentage increase of last raise

N							
Valid	Missing	Mean	Std. Error of Mean	Median	Std. Deviation	Minimum	Maximum
2780	2007	3.34	.06	3.00	2.91	.003	25.000

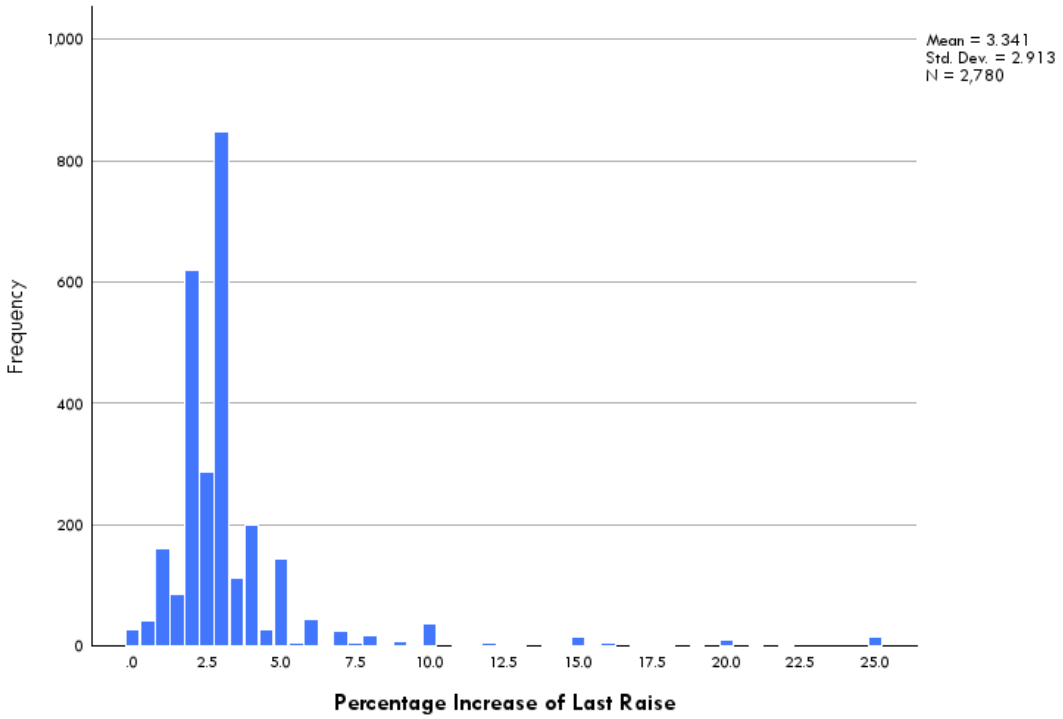

Figure 35. Percentage increase of last raise

17. Using the following scale (0 – Unsatisfied, 5 – Completely Satisfied), please indicate your satisfaction with your primary job.

We first noted that one-quarter (1,276) of the sample did not respond to this question (Table 25). A median value of 4 and mean of 3.50 indicated that the typical therapist who did respond was satisfied with his or her job. About 20% of the sample indicated that they were completely satisfied.

Among those who responded to this question, 18.8% were on the lower half (0, 1, or 2) of the satisfaction scale (Appendix C Table 70). Conversely, 81.2% were more satisfied than dissatisfied having given responses of 3, 4, or 5).

Table 25. Descriptive statistics for job satisfaction

N							
Valid	Missing	Mean	Std. Error of Mean	Median	Std. Deviation	Minimum	Maximum
3511	1276	3.50	.023	4.00	1.37	0	5

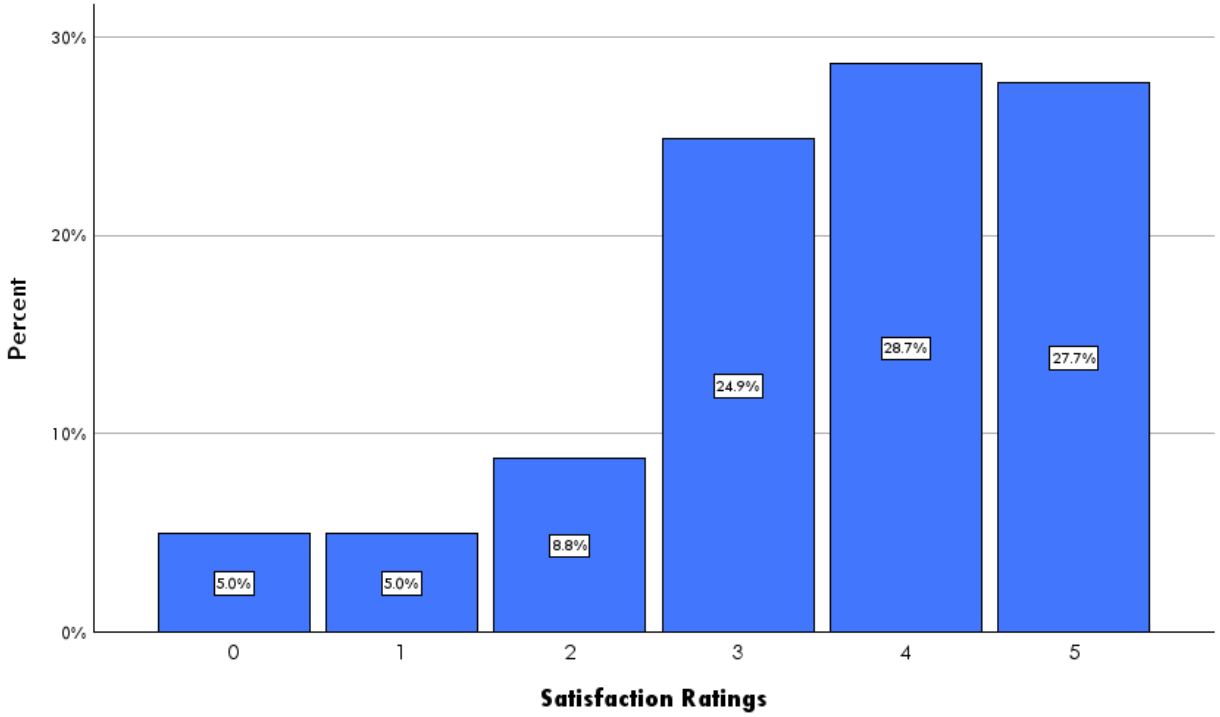

Figure 36. Job satisfaction

18. With which of the following are you LEAST satisfied about your primary job?

While the typical therapist in the sample was well satisfied with his or her job, the element about which his or her satisfaction was lowest was in the area of compensation and benefits (Figure 37). According to Appendix C Table 71, just less than one-quarter of respondents chose not to respond to this question. "None of these" followed as the second most selected option.

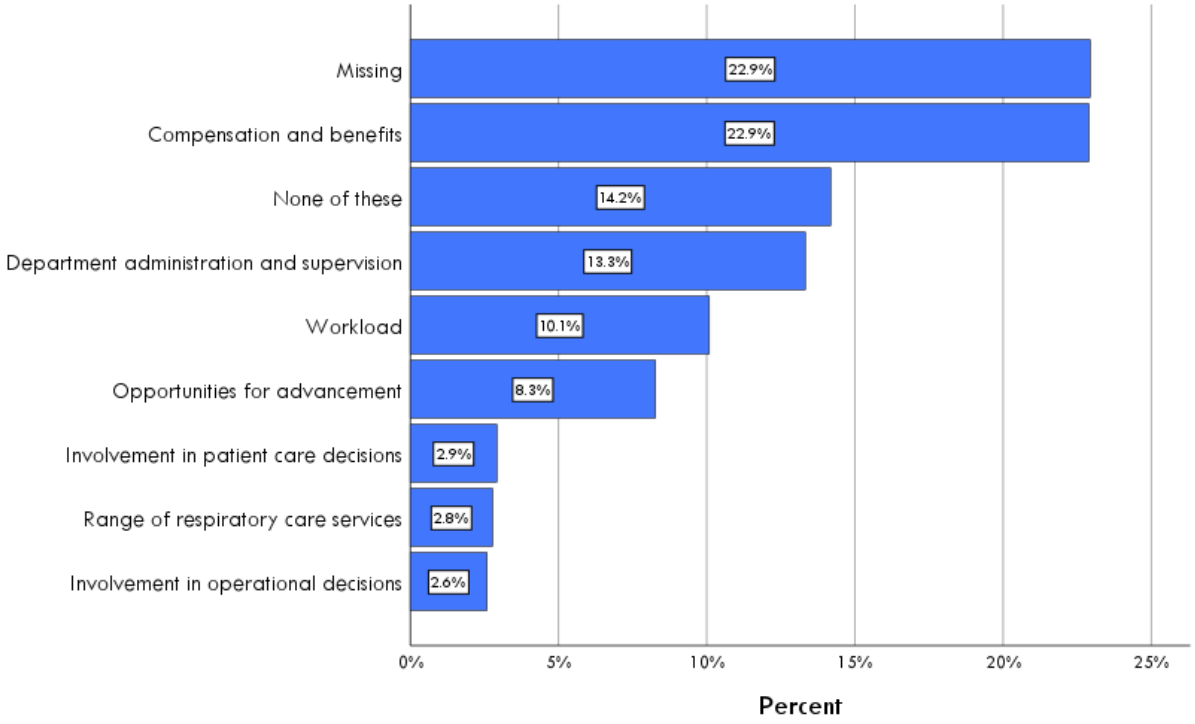

Figure 37. Area of lowest job satisfaction

19. With which of the following are you MOST satisfied about your primary job?

Again, as shown in Appendix C Table 72, just less than one-quarter of respondents chose not to respond to this question. Involvement in patient care decisions was the point of greatest satisfaction for respondents.

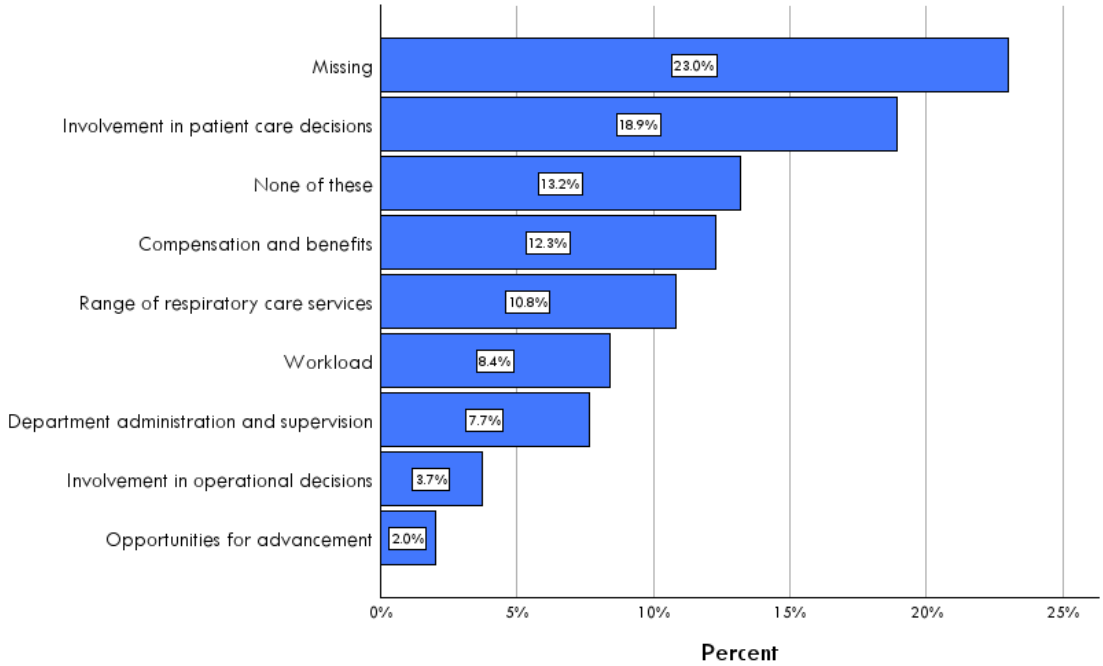

Figure 38. Area of highest job satisfaction

20. If you have changed employers within the last five years, what was the strongest reason?

Sixty percent of respondents answered this question indicating they had changed employers in the last five years. This was a big increase from the 35% of therapists who responded to this question in the 2020 study. Among those who did change jobs, the issue cited most often was a reason that wasn't listed (Appendix C Table 73). Compensation and benefits were the second most cited reason.

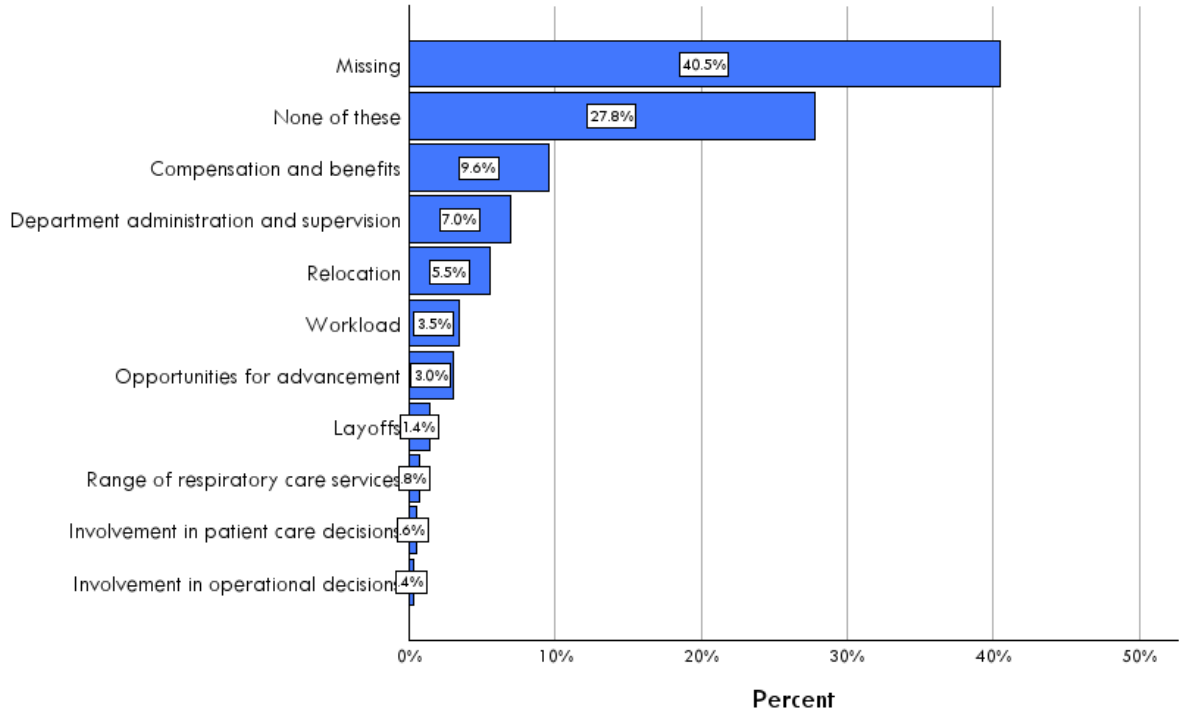

Figure 39. Strongest reason for employment change

21. Which of the following shift durations do you work?

Respondents were able to indicate all that applied. Among those who worked in shifts, the largest subgroup said they worked 12-hour shifts. Eight-hour shifts were also common. The "Salaried/Not Shift work" option was created based on clusters of free text provided after a respondent had selected the 'Other' response. Other responses can be found in Appendix D.

Table 26. Descriptive statistics for job satisfaction

		Responses		Percent of Cases
		N	Percent	
	4-hour	90	2.1%	2.4%
	8-hour	1094	25.5%	29.7%
	10-hour	330	7.7%	8.9%
	12-hour	2556	59.5%	69.3%
	16-hour	84	2.0%	2.3%
	Salaried / Not shift-work	21	0.5%	0.6%
	Other	120	2.8%	3.3%
Total		4295	100.0%	116.5%

22. Which of the following is *closest* to the title for your primary job?

An option was provided for survey respondents to type an 'Other' job title that was not included among the list of other choices. On review of the free responses, it was concluded that many individuals wrote in 'Other' responses that belonged among the provided options. NBRC staff reviewed and recategorized such responses to fit within the existing job title options.

While the Staff Therapist job title described the largest subgroup in the survey sample in Figure 40 and there was oversampling of therapists from other job titles. As a result, the population projection Appendix C Table 74 was probably low for the Staff Therapist group. Those who indicated they occupied Manager, Director, Instructor, or Educator positions particularly stood out as oversampled.

Technical directors of respiratory therapy in 4,934 acute care hospitals were directly solicited with a postcard. Even allowing that directors of departments from other hospitals could have become aware of the study and responded to this survey, we know that at most there were about 6,000 hospitals of any type in the American Hospital Association database. Projecting a population of nearly 15,000 Director level therapists would have meant that there were more than two directors in each hospital. Results of the acute care hospital study showed that there was typically just one director of respiratory therapy, which is why we are confident about the oversampling assertion.

There were 486 accredited practice education programs. Observing a population projection of 3,583 would mean that there were more than 7 faculty per program. Results of the education program study indicated that the typical number of education staff was far fewer than 7 per program. In fact, some programs operate with only a program director and director of clinical education, so educators were oversampled.

These were important characteristics for us to manage for other analyses in this study, particularly those related to compensation. We want to emphasize that we included projected populations in Table 74 in Appendix C to illustrate evidence of oversampling, not to assert that these were accurate representations of the sizes of these populations. We suggest that more accurate information will be found in the reports about acute care hospitals and education programs.

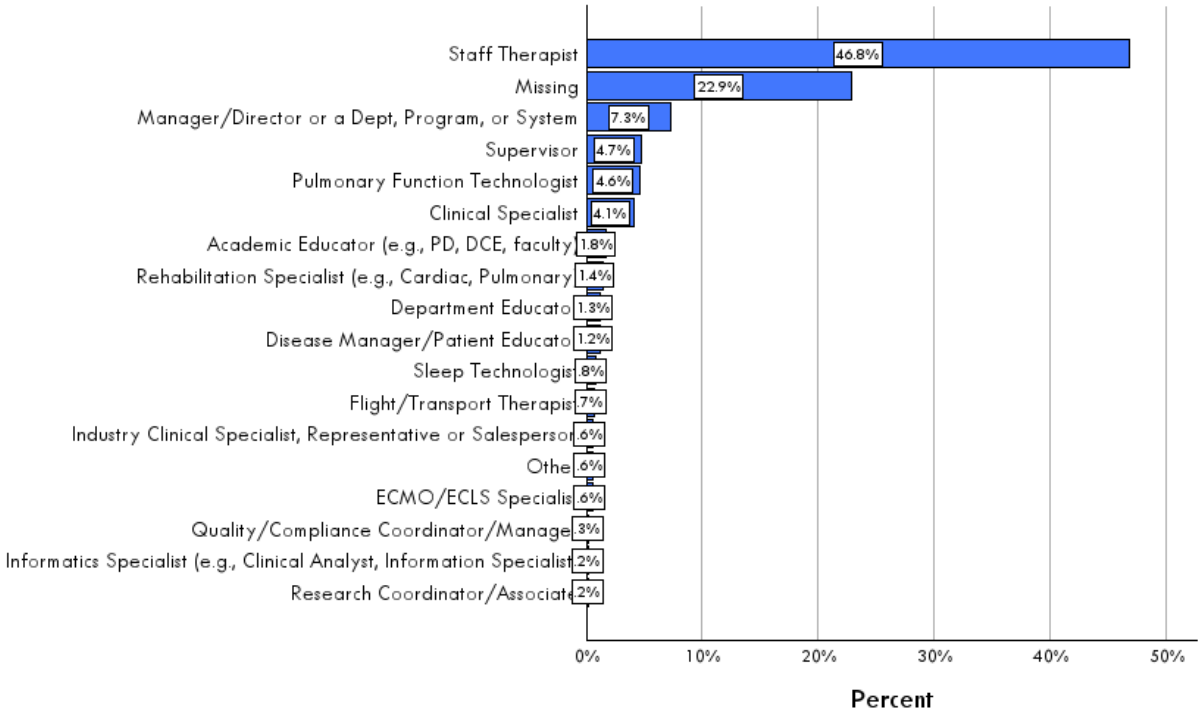

Figure 40. Job Titles

23. Does the employer for your primary job require that you maintain an NBRC credential as a condition for employment?

The number of missing responses was notable in Appendix C Table 75 and Figure 41. Some respondents may have skipped this question because they were uncertain about whether credential maintenance was required by their employers. Other respondents may have withheld a response because the answer was really "no."

Among those who responded to the question, 82% indicated that their employers did require that they maintain an NBRC credential as a condition for employment. There are still therapists in the population with credentials that were earned for a lifetime, but that percentage will shrink going forward since every therapist credentialed since July 2002 must renew his or her credential every five years.

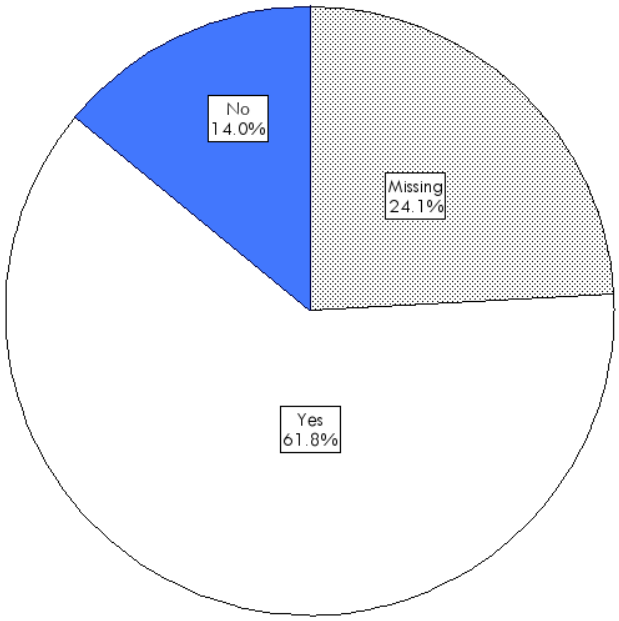

Figure 41. NBRC credential maintenance requirement

24. Which of the following NBRC credentials have you earned that are not expired? (Select all that apply.)

The oversampling of directors from hospitals and faculty from education programs that we documented earlier should be considered when interpreting results shown in Table 27. We particularly expected that the AE-C and ACCS groups were larger as a percentage of the sample than as percentages of the population.

Table 27. NBRC credentials earned

	Responses		Percent of Cases*	Population Projection**
	N	Percent		
Adult Critical Care Specialist (RRT-ACCS)	332	5.4%	9.2%	14,162
Certified Asthma Educator (AE-C)	116	1.9%	3.2%	4,948
Certified Respiratory Therapist (CRT)	1670	27.1%	46.2%	71,234
Certified Pulmonary Function Technologist (CPFT)	241	3.9%	6.7%	10,280
Neonatal Pediatric Specialist (CRT-NPS or RRT-NPS)	500	8.1%	13.8%	21,328
Sleep Disorders Specialist (CRT-SDS or RRT-SDS)	55	0.9%	1.5%	4,030
Registered Pulmonary Function Technologist (RPFT)	154	2.5%	4.3%	2,346
Registered Respiratory Therapist (RRT)	3099	50.3%	85.8%	132,188
Total***	6167	100.0%	170.7%	

* The percentage value was based on the number of people who responded to this question.
** Projected certification = (Frequency/4,787) x 204,191, where 204,191 = number of active therapists in total population.
*** Respondents were allowed to select each option that applied. Respondents who earned the CRT and RRT credentials selected both options. Therefore, the sum of row frequencies exceeds 4,787

25. If you hold an unexpired nursing credential, which of the following is it? (Select all that apply.)

Therapists who had achieved a credential in nursing in addition to respiratory therapy were summarized in Table 28.

Table 28. Unexpired NCLEX credentials

	Responses		Percent of Cases*	Population Projection**
	N	Percent		
Licensed Practical Nurse (LPN)	21	38.9%	38.9%	896
Registered Nurse (RN)	33	61.1%	61.1%	1,408
Total***	54	100.0%	100.0%	

* The percentage was based on the number of people who responded to this question.
** Projected certification = (Frequency/4,787) x 204,191, where 204,191 = number of active therapists in total population.
***Respondents were allowed to select all that applied.

26. What additional certifications have you completed?

The degree to which therapists had achieved certifications related to lifesaving and tobacco-related procedures was summarized in Table 29.

Table 29. Certifications completed

	Responses		Percent of Cases*	Population Projection**
	N	Percent		
Advanced Cardiac Life Support (ACLS)	2913	27.1%	83.5%	124,255
Basic Cardiac Life Support (BCLS	3380	31.4%	96.8%	144,175
Neonatal Resuscitation Program (NRP)	2012	18.7%	57.7%	85,822
Pediatric Advanced Life Support (PALS)	2233	20.7%	64.0%	95,249
Smoking Cessation or Tobacco Treatment specialist	224	2.1%	6.4%	9,555
Total***	10762	100.0%	308.4%	

* The percentage was based on the number of people who responded to this question.
** Projected certification = (Frequency/4,787) x 204,191, where 204,191 = number of active therapists in total population.
***Respondents were allowed to select all that applied.

27. Which of the following other credentials have you earned that are not expired?

The largest subgroup within the sample was therapists who were also credentialed as Smoking Cessation specialists (Table 30). This group represented nearly one quarter of the sample. We cautiously offer population projections for these subgroups because oversampling is again likely.

The categories of CCSH, VA-BC, and FACHE were added based on review of the free responses. It was also concluded that some individuals wrote in 'Other' responses that belonged among the provided options. NBRC staff reviewed and recategorized such responses to fit within the existing job title options.

Table 30. Other credentials earned

	Responses		Percent of Cases*	Population Projection**
	N	Percent		
Certified Cardiographic Technician (CCT)	17	3.6%	4.1%	725
Certified Case Manager (CCM)	4	0.9%	1.0%	171
Certified Hyperbaric Technologist (CHT)	13	2.8%	3.1%	555
Certified Neonatal-Pediatric Transport (C-NPT)	31	6.6%	7.5%	1,322
Certified Procurement Transplant Coordinator (CPTC)	3	0.6%	0.7%	128
Emergency Medical Technician (EMT)	70	14.9%	16.9%	2,986
Paramedic	31	6.6%	7.5%	1,322
Registered EEG Technologist (R.EEG.T)	7	1.5%	1.7%	299
Registered Electrophysiology Technologist (R.EP.T)	1	0.2%	0.2%	43
Registered Polysomnographic Technologist (RPSGT)	68	14.5%	16.5%	2,901
Registered Vascular or Cardiac Ultrasound Credential (RDMS, RDCS, RVT, RVS)	4	0.9%	1.0%	171
Smoking Cessation specialist	95	20.3%	23.0%	4,052
Certified in Clinical Sleep Health (CCSH)	5	1.1%	1.2%	213
Vascular Access - Board Certified (VA-BC)	5	1.1%	1.2%	213
Fellow of the American College of Health Care Executives (FACHE)	4	0.9%	1.0%	171
Other certification	111	23.7%	26.9%	4735
Total***	469	100.0%	113.6%	

* The percentage was based on the number of people who responded to this question.
** Projected certification = (Frequency/4,787) x 204,191, where 204,191 is the number of active therapists in total population.
*** Respondents were allowed to select all that applied.

28. Which of the following best describes how you entered and became licensed to be employed in the respiratory care field?

Most sample members had graduated from an education program that made them eligible for the RRT credential (Figure 42 and Appendix C Table 76). Here again, oversampling among hospital director and educator groups likely skewed population projections upward for the advanced level group and downward for the other groups. Likewise, the high percentage of missing responses is notable because the other options should have covered most of the possibilities.

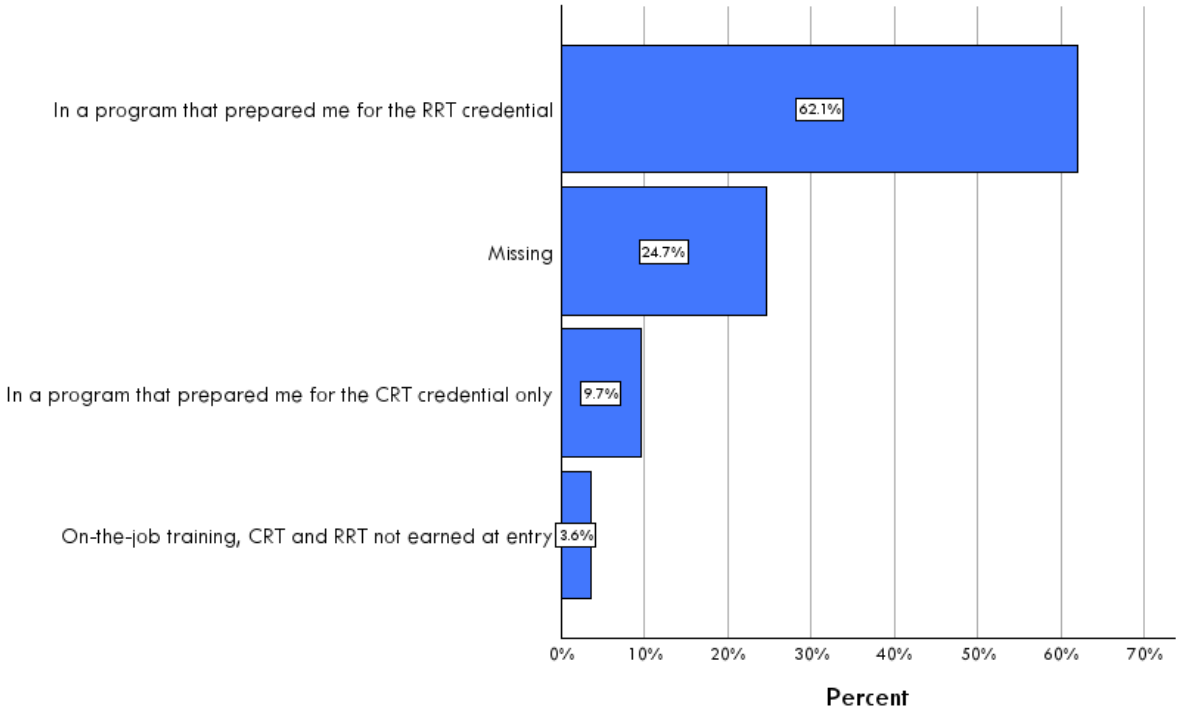

Figure 42. Respiratory therapy training/education

29. If you earned a college degree when you became eligible for your respiratory therapy credential, what type of degree was it?

The spike in missing responses to this question caught our attention as well. We observed that a growing number of respondents had stopped submitting responses entirely by the time they had arrived at this point in the survey.

As shown in Figure 43 and Appendix C Table 77, there were more than four therapists who graduated with an associate degree for every therapist who graduated with a bachelor's degree from their respiratory therapy programs.

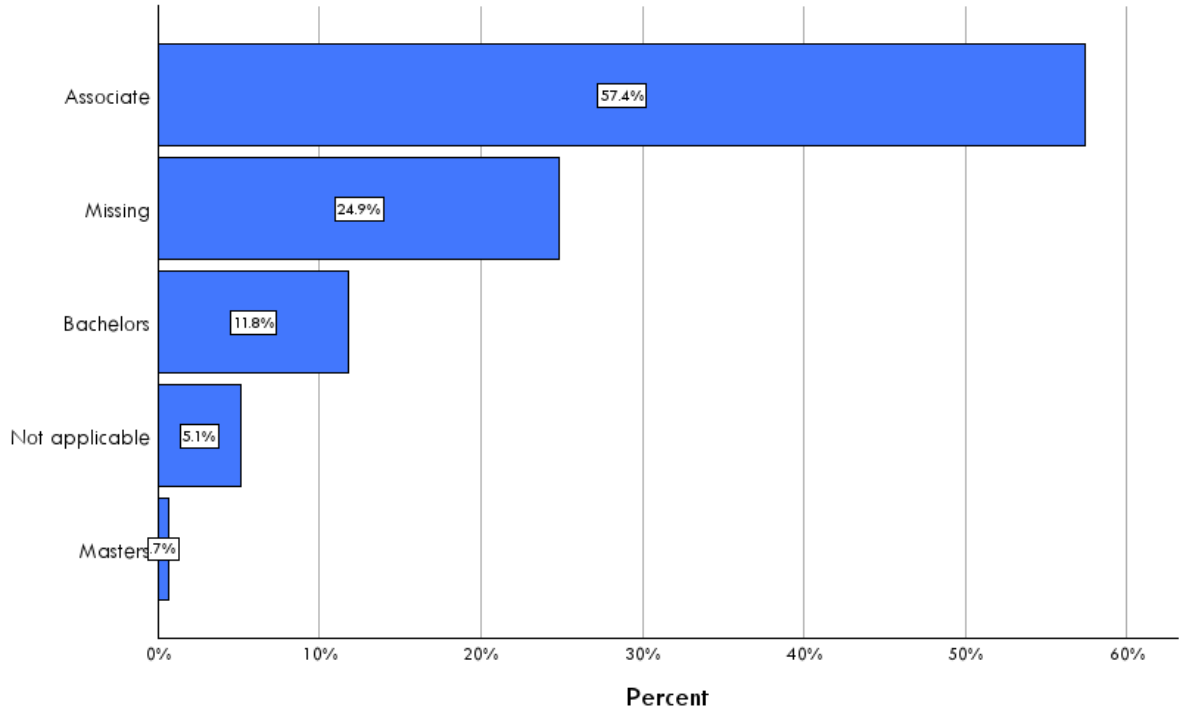

Figure 43. Degree earned when eligible for credential

30. What is the highest academic level you have achieved?

The first thing we noted about Figure 44 and Appendix C Table 78, was the slight decrease in missing responses. Some therapists within this sample indicated the highest academic degree they had earned but did not give the type of degree they had earned from their respiratory education program.

We added Table 31 to the report to illustrate that substantial numbers of respiratory therapists in this sample had achieved academic degrees that were more advanced than the degree they earned from their original respiratory therapy education program.

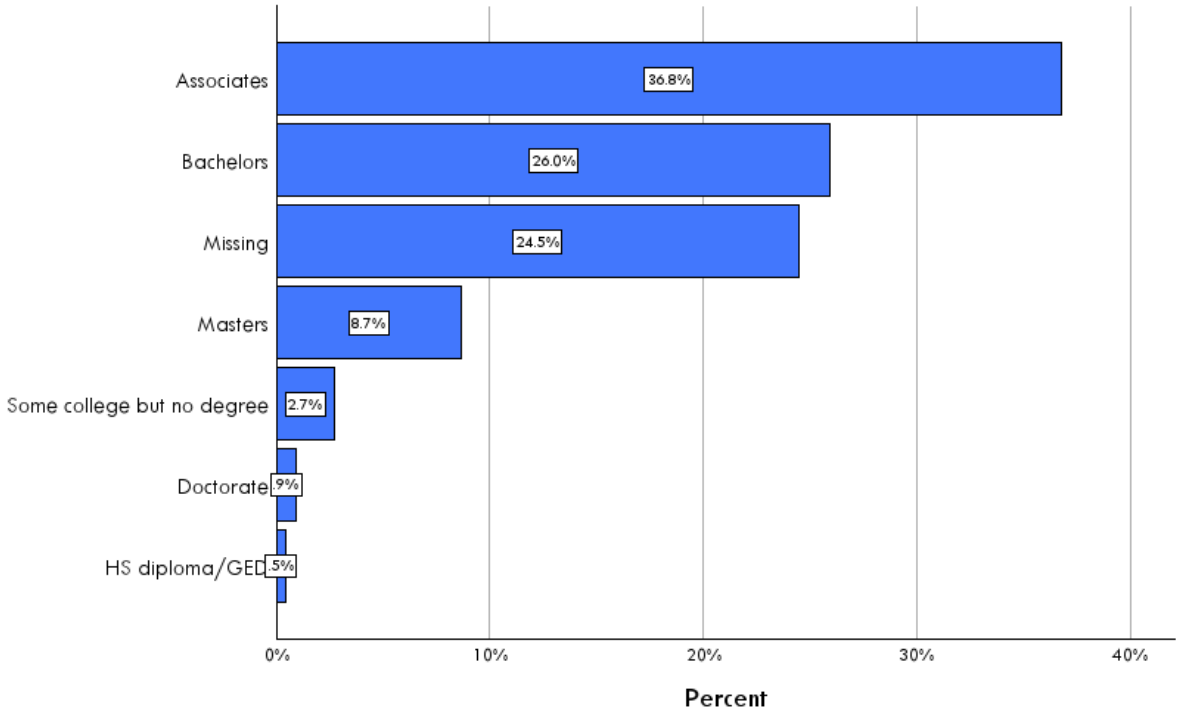

Figure 44. Highest academic level achieved

Table 31. Comparisons of the valid percentages of degrees earned from the respiratory therapy program and the highest academic degree

	Initial degree	Highest degree
Associates and lower	82.1	52.9
Bachelors	16.9	34.4
Masters / Doctorate	1.0	12.7

31. Do you hold a Baccalaureate or graduate degree in a health-related field?

About one quarter of the sample indicated that they had achieved a baccalaureate or graduate degree in a health-related field. The oversampling of department directors and educators should be recalled when interpreting the projected population of therapists with a baccalaureate degree. In other words, there are likely fewer than the 53,404 described in Appendix C Table 79.

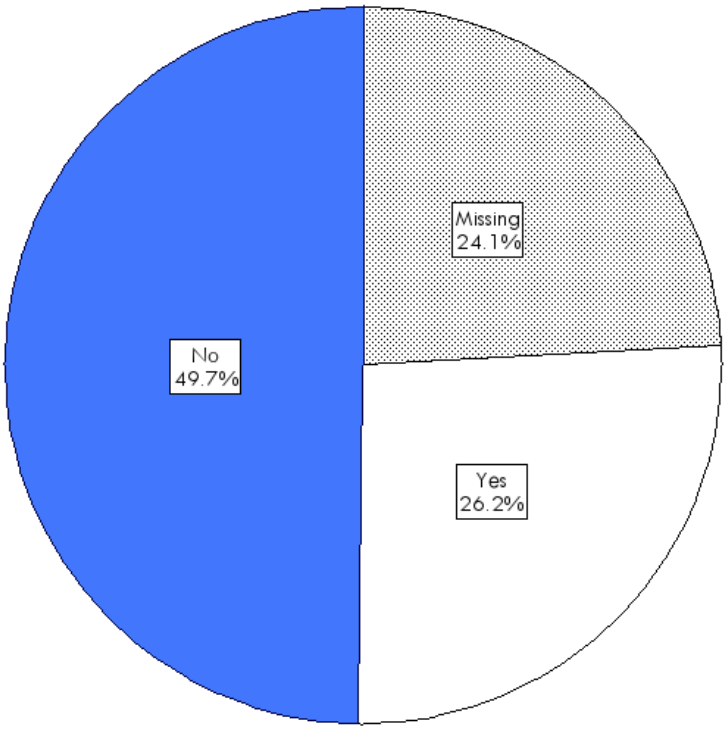

Figure 45. Baccalaureate or Graduate degree in health-related field

32. In what field of study is your highest health-related degree?

Respondents who had selected "Yes" for the previous item were directed to this follow-up question. For every respondent who achieved at least a baccalaureate degree in respiratory therapy, there was another respondent who had achieved a degree in another health-related domain.

An option was provided for survey respondents to type an 'Other' field of study that wasn't included among the list of other choices. Again, upon review of the free responses one additional category was created (Health Education) and the Respiratory Therapy descriptor was expanded to include Cardiopulmonary Sciences. Frequencies can be found in Appendix C Table 80.

Some respondents indicated holding a science-related baccalaureate or graduate degree but listed an 'Other' degree that was not science-related, like Law and English. Other responses can be found in Appendix D.

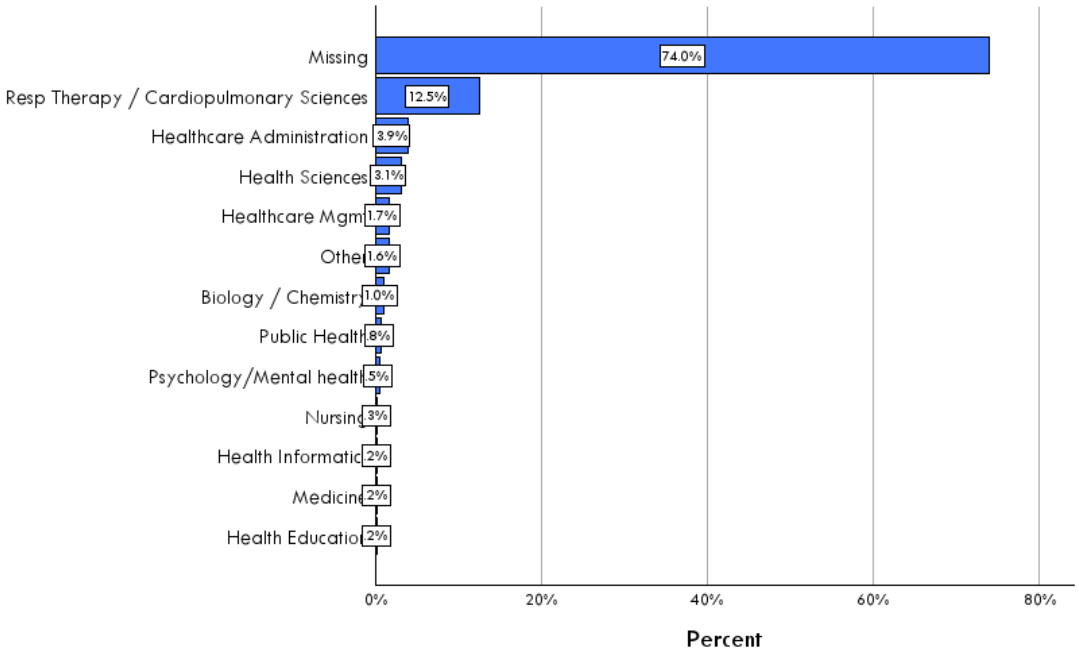

Figure 46. Field of health-related Baccalaureate/Graduate degree

33. Are you pursuing an academic degree that is higher than one you have already earned?

Assuming that most of the 24% of the sample who skipped this item did so because they determined the question did not apply to them, we concluded it was most likely that about 18% of therapists in this sample were pursuing a higher academic degree at the time this study was done. Frequencies can be found in Appendix C Table 81.

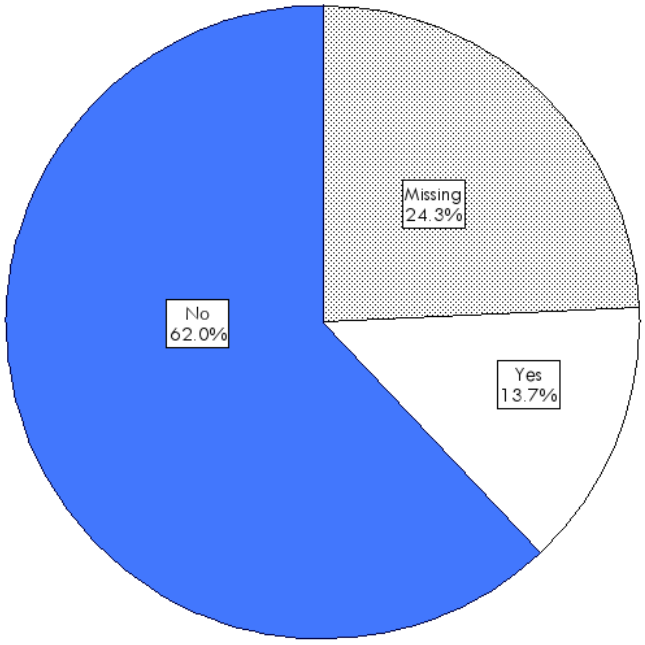

Figure 47. Presently pursuing higher academic degree

Additional Analyses

Responses to the respondents' highest degree were recoded to make it easy to see the percentage who had already achieved at least a bachelor's degree.

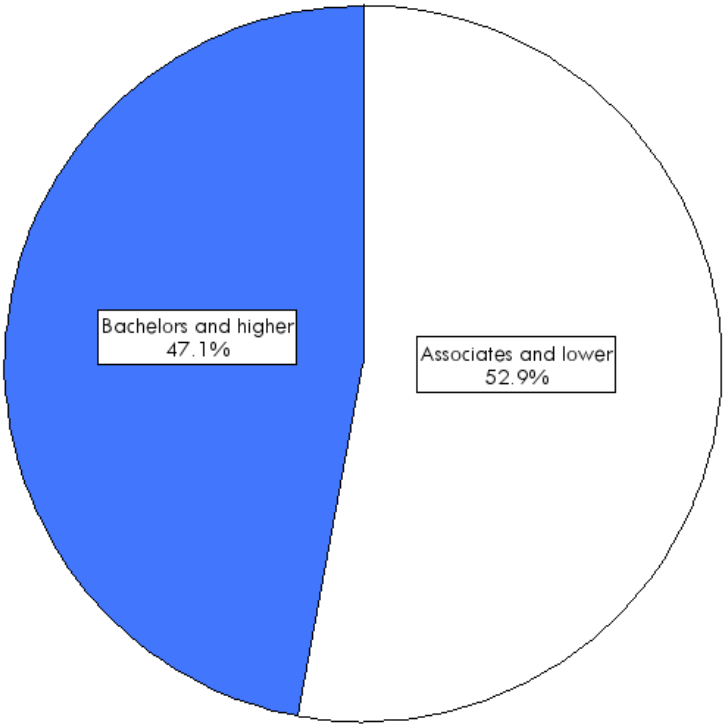

Figure 48. Highest academic level combined

Information cross tabulated below is based on responses from two items. There were 10.0% of the sample in the group called Associate and lower who also indicated that they were pursuing a higher academic degree. There were 47.1% of all respondents from the group called Bachelor's and higher. After summing these two values (10.0% + 47.1%), one could say that 57.1% of the study sample had at least achieved a bachelor's degree or were working towards their next degree.

Table 32. Highest academic level subgroups by pursuing a higher academic degree

		Are you pursuing an academic degree that is higher than one you have already earned?		
		Yes	No	Total
Associates and lower	Count	359	1550	1909
	% of Total	10.0%	43.0%	52.9%
Bachelors and higher	Count	296	1401	1697
	% of Total	8.2%	38.9%	47.1%
Total	Count	655	2951	3606
	% of Total	18.2%	81.8%	100.0%

However, there were some in the group labeled Associate and Lower who had not yet achieved an Associate degree, so for them the next degree was an Associate degree. The survey did not ask respondents to identify the next degree on which they were working. Table 33 was produced to tease out information from the available responses. Summing the percentages linked to bachelor's = 34.4%, master's = 11.4%, doctorate = 1.2%, and Associate-working-on-the-next-degree = 9.5%, showed that 56.5% of the study sample had achieved a bachelor's degree or were working to achieve one.

Using the same method of teasing out information from subgroups, a 2020 study had showed that 56.2% of the study sample had achieved a bachelor's degree or were working to achieve one. The difference between the 56.2% result in 2020 and the 56.5% result in 2024 was +0.3%. There had been +1.1% growth between 2020 and 2017. This followed a +1.6% growth between 2017 and 2014 so there has been a persistent, small gain in the percentages but it has fallen over time.

Figure 49 illustrates future contingencies, which includes the time it will take to be able to say that 80% of respiratory therapists have a bachelor's degree. Based on samples from 2017, 2020, and 2024 the general inference is that the percentage of therapists who have at least the bachelor's degree continues to grow. The pace of growth has been small, but it is growth rather than contraction. However, the point at which it will be said that 4 out of 5 therapists have achieved a bachelor's degree remains many years away.

The last point that Figure 50 illustrates is that small changes in the rate of growth would have large effects on the amount of time it would take to achieve the 80% threshold. A 0.3% rate of growth adds decades to the projection when compared to the projection in 2017 when the rate of growth was observed to be 1.6%. A short-term goal of moving the rate of growth back toward 2% could steepen the slope enough to hit the 80% threshold many years sooner.

Table 33. Highest academic level by pursuing higher academic degree

			Are you pursuing an academic degree that is higher than one you have already earned?		
			Yes	No	Total
Highest academic level	HS diploma/GED	Count	1	21	22
		% of Total	0.0%	0.6%	0.6%
	Some college but no degree	Count	15	114	129
		% of Total	0.4%	3.2%	3.6%
	Associates	Count	343	1415	1758
		% of Total	9.5%	39.2%	48.8%
	Bachelors	Count	236	1005	1241
		% of Total	6.5%	27.9%	34.4%
	Masters	Count	57	355	412
		% of Total	1.6%	9.8%	11.4%
	Doctorate	Count	3	41	44
		% of Total	0.1%	1.1%	1.2%
Total		Count	655	2951	3606
		% of Total	18.2%	81.8%	100.0%

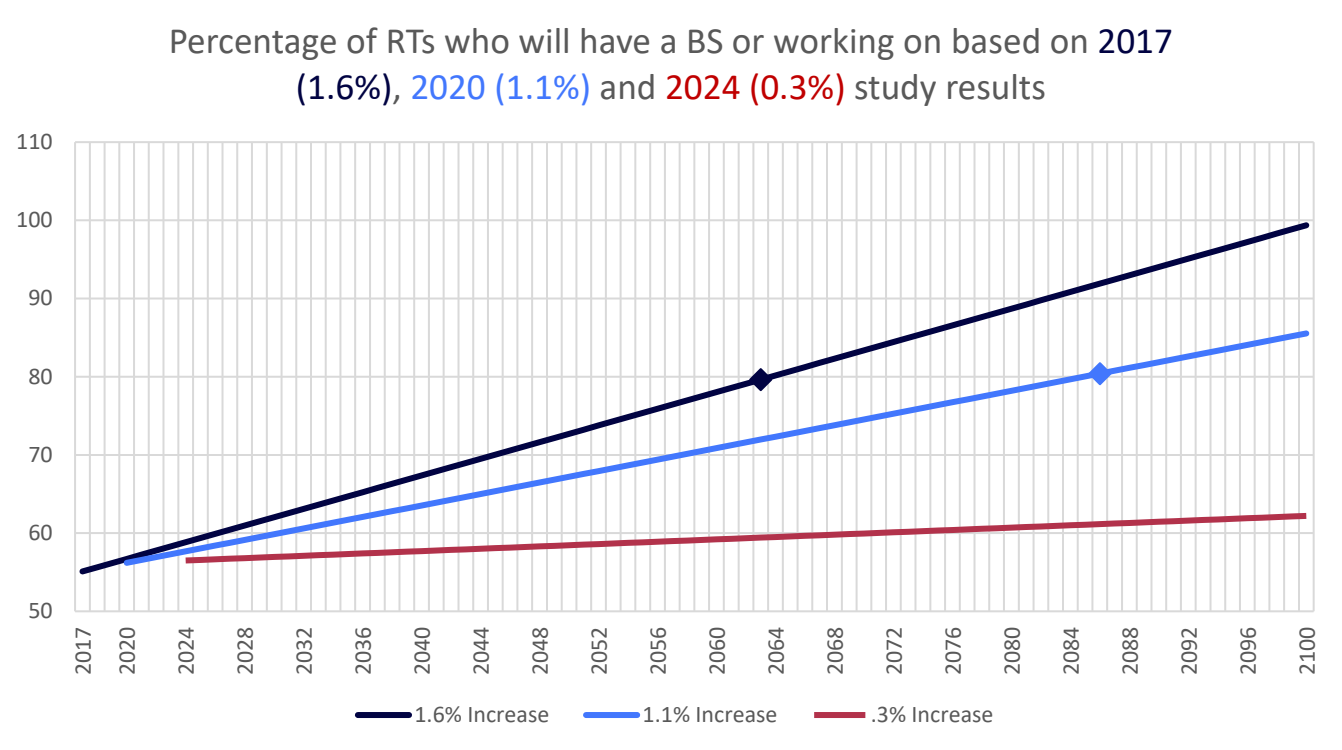

Figure 49.Baccalaureate Degree Acquisition

34. If you are pursuing a higher academic degree, which of the following best describes your goal?

Among those who were pursuing a higher academic degree, about 18% of respondents, more than 50% intended to advance their career in respiratory care while the rest intended to change their careers.

One important bit of information revealed by Figure 50 was that 6.5% of respiratory therapists in this sample were actively working to take their careers away from respiratory care. For every respondent who was looking for a career change, there was one respondent who intended to advance their careers within respiratory care. Frequencies can be found in Appendix C Table 82.

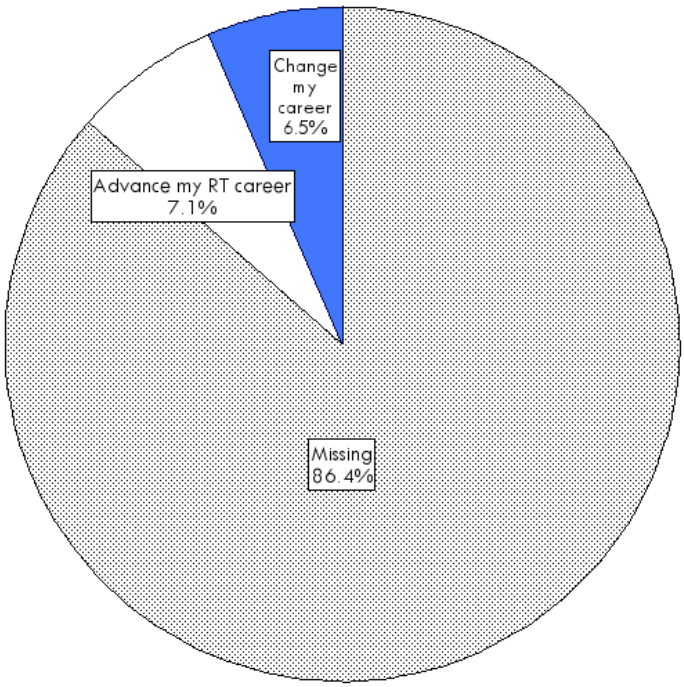

Figure 50. Goal for pursuing higher academic degree

35. Does your employer offer a program that discounts, reimburses, or forgives tuition?

Most respondents were aware that their employer offered tuition assistance. Although it was the smallest group, approximately 12% of the sample was unsure whether their employers offered tuition reimbursement, forgiveness, or discounts so the percentage of the population with access to tuition assistance from their employer could be higher. Frequencies can be found in Appendix C Table 83.

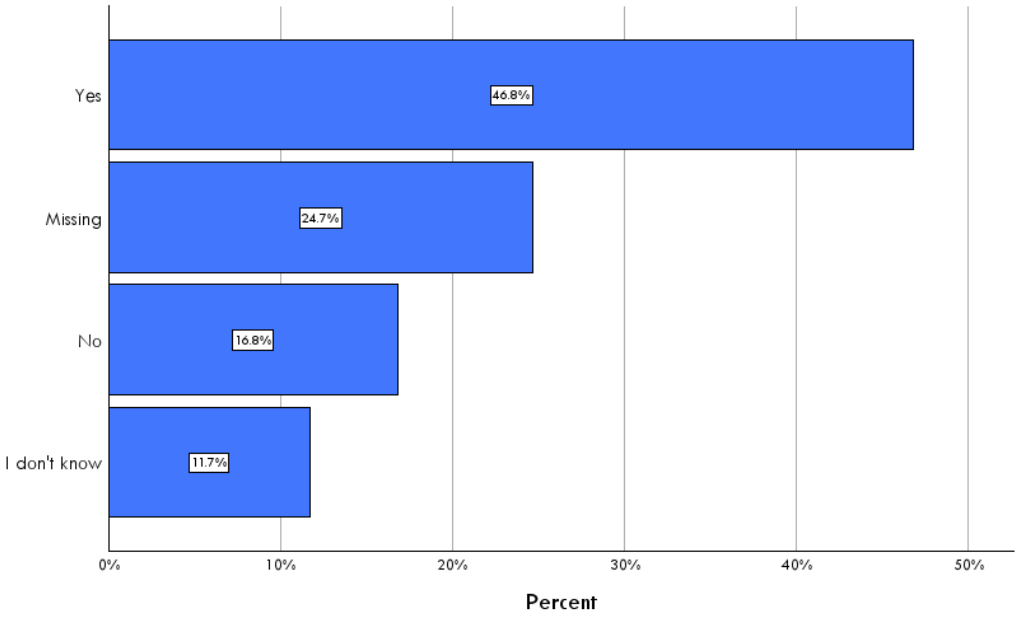

Figure 51. Employer offers tuition reimbursement

36. Do you provide direct patient care?

The next several questions, #37 – 41, were addressed to those who provided direct patient care. To filter out individuals who were not providing patient care respondents answered Question #36. Individuals who responded "No" were immediately directed to Question #42. The number of people who did not provide a response to the questions that followed was expected to increase when compared to other survey items.

Respondents overwhelmingly (90%) provided direct patient care in their roles. Frequencies can be found in Appendix C Table 84.

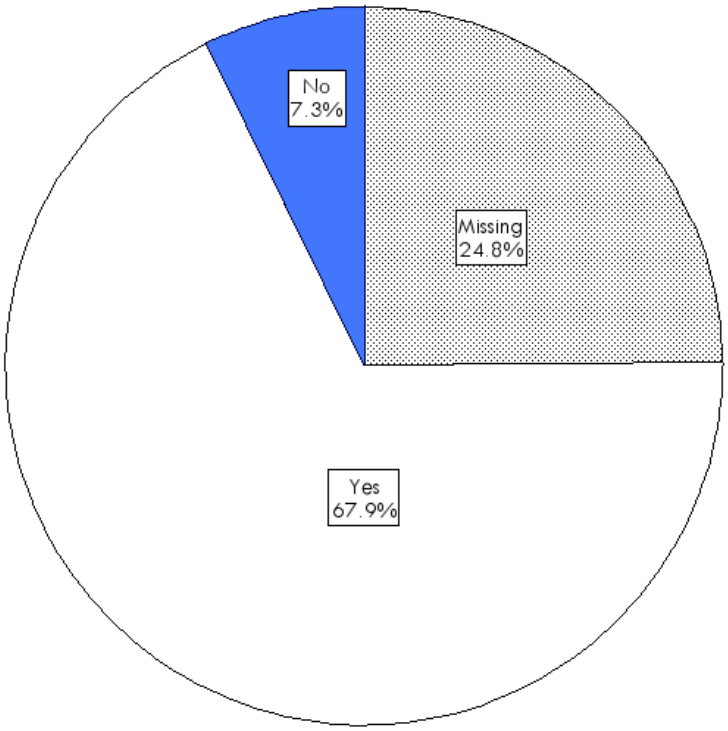

Figure 52. Provide Direct Patient Care

37. If you work in a setting where therapists are assigned to the management of mechanical ventilation, approximately how many patients receiving mechanical ventilation are assigned to each therapist?

The typical respondent among those who answered this question indicated that therapists were assigned six patients who were receiving mechanical ventilation. Frequencies can be found in Appendix C Table 85. Survey functionality limited responses to values less than or equal to 25.

Table 34. Descriptive statistics for patients receiving mechanical ventilation assigned to therapists

N			Std. Error of		Std.		
Valid	Missing	Mean	Mean	Median	Deviation	Minimum	Maximum
2503	2284	6.31	.068	6.00	3.420	1	25

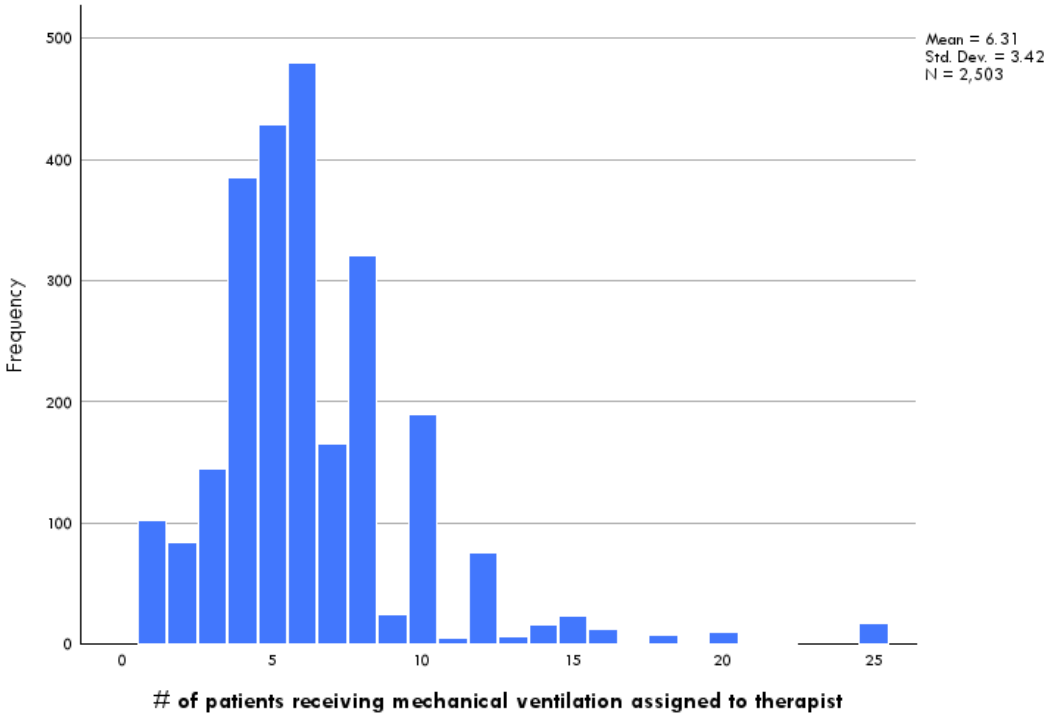

Figure 53. Patients receiving mechanical ventilation assigned to therapists

38. If you work in an acute care hospital, please indicate the typical percentage of time you spend in each area when providing direct patient care.

Table 35 showed that at least some respondents in this sample spent all their time in one area. Among those who divided their time, a typical respondent spent the most time in adult ICUs followed by another unit.

Telemedicine/telehealth and sleep lab required the smallest percentage of therapists' time within the whole sample. However, we expected that this was because some hospitals did not have such areas of specialization. We reached this conclusion by observing that the median value for those settings was zero, respectively, which meant that less than one-half of this sample worked in hospitals with those locations.

Table 35. Percentage of time spent in hospital units

	N			Std. Error		Std.		
	Valid	Missing	Mean	of Mean	Median	Deviation	Minimum	Maximum
Adult ICU	2586	2201	32.67	.60	25.00	30.67	0	100
General medical and surgical floor	2586	2201	21.77	.45	20.00	23.05	0	100
Emergency department	2586	2201	16.63	.39	10.00	19.77	0	100
Neonatal ICU	2586	2201	8.90	.42	.00	21.45	0	100
Pulmonary function lab	2586	2201	6.00	.40	.00	20.29	0	100
Pediatric ICU	2586	2201	4.80	.31	.00	15.67	0	100
Other department	2586	2201	4.60	.33	.00	16.53	0	100
Pulmonary rehabilitation	2586	2201	2.46	.26	.00	13.42	0	100
Sleep lab	2586	2201	1.19	.19	.00	9.67	0	100
Telemedicine/telehealth	2586	2201	.97	.11	.00	5.52	0	100

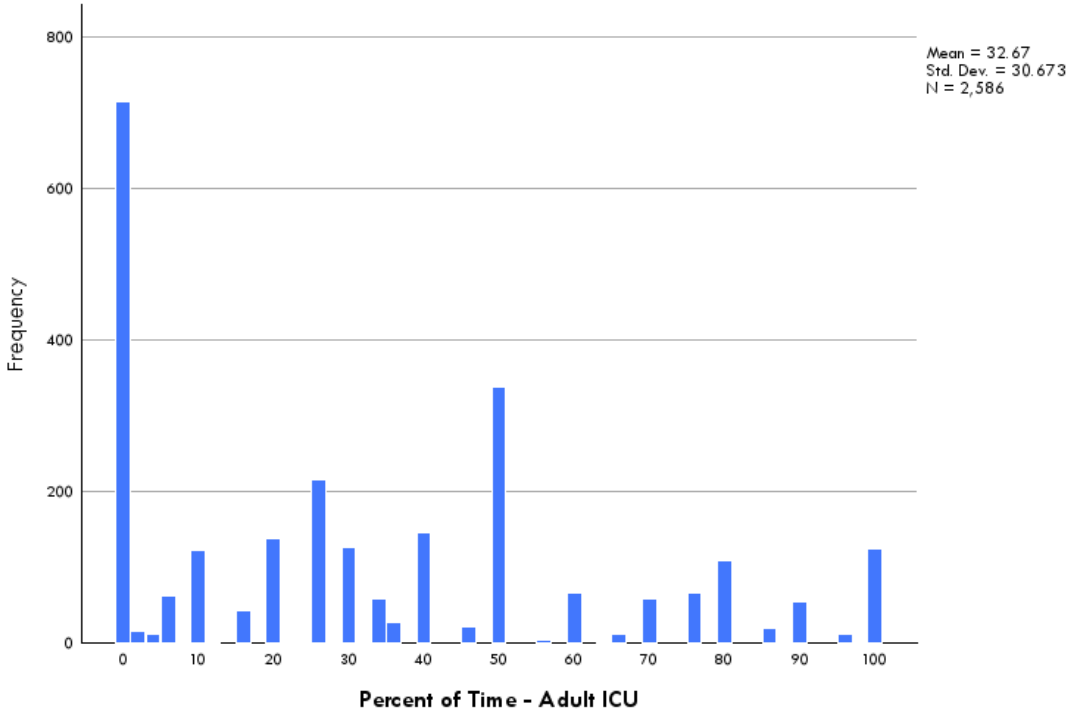

Figure 54. Percentage of time spent in Adult ICU

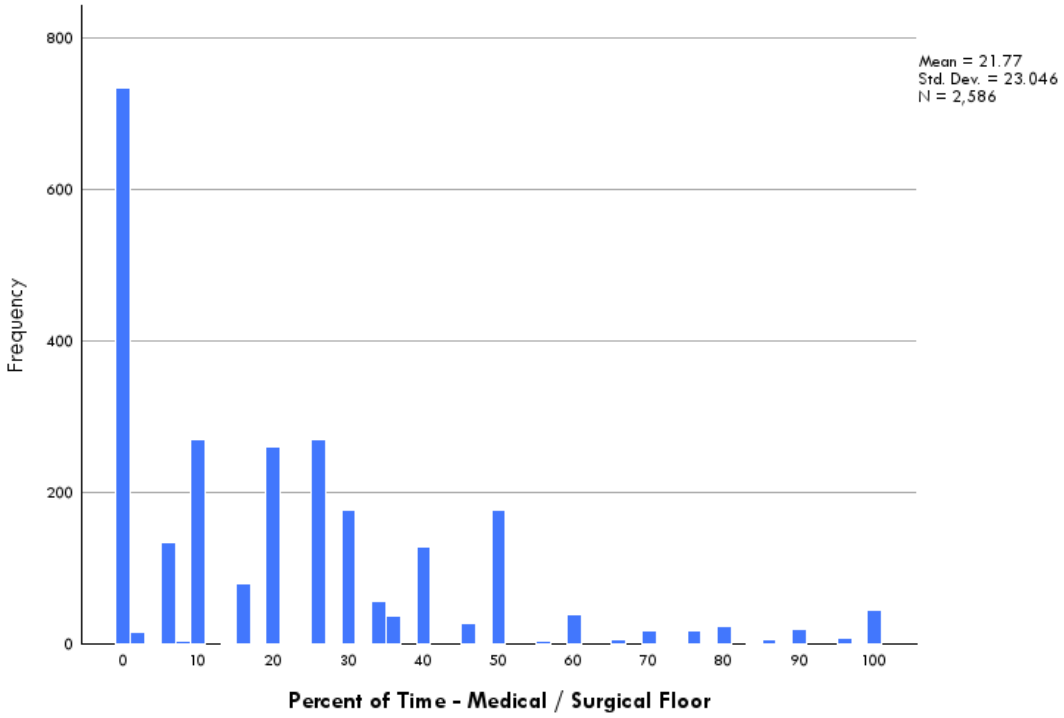

Figure 55. Percentage of time spent in General Med/Surg floor

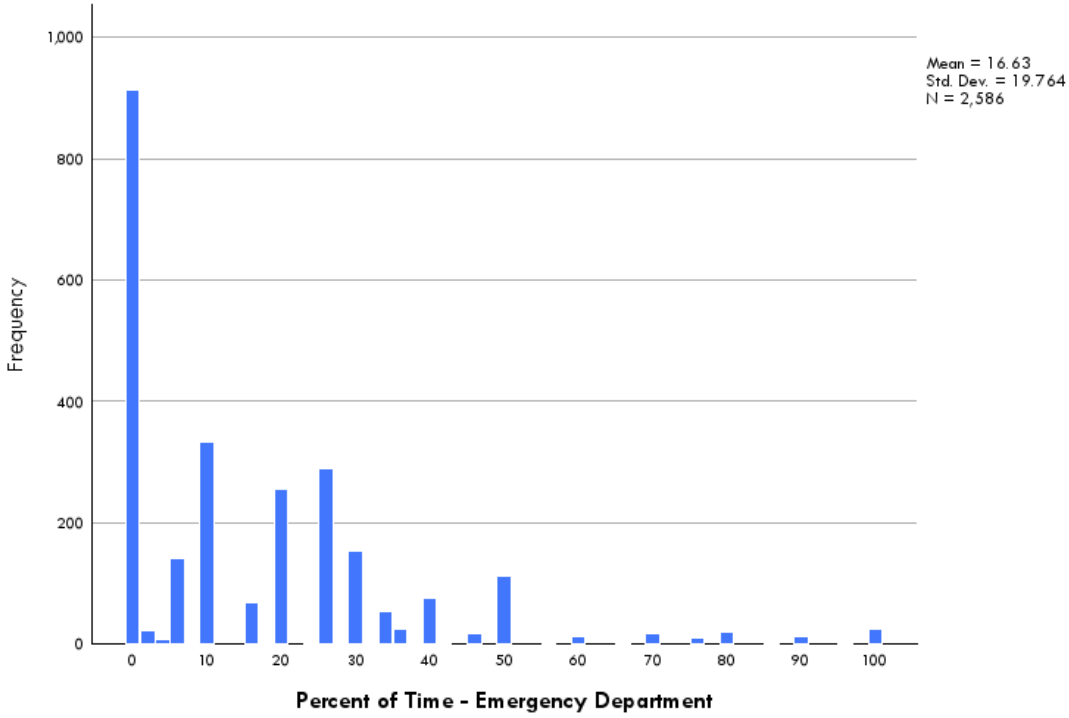

Figure 56. Percentage of time spent in Emergency Department

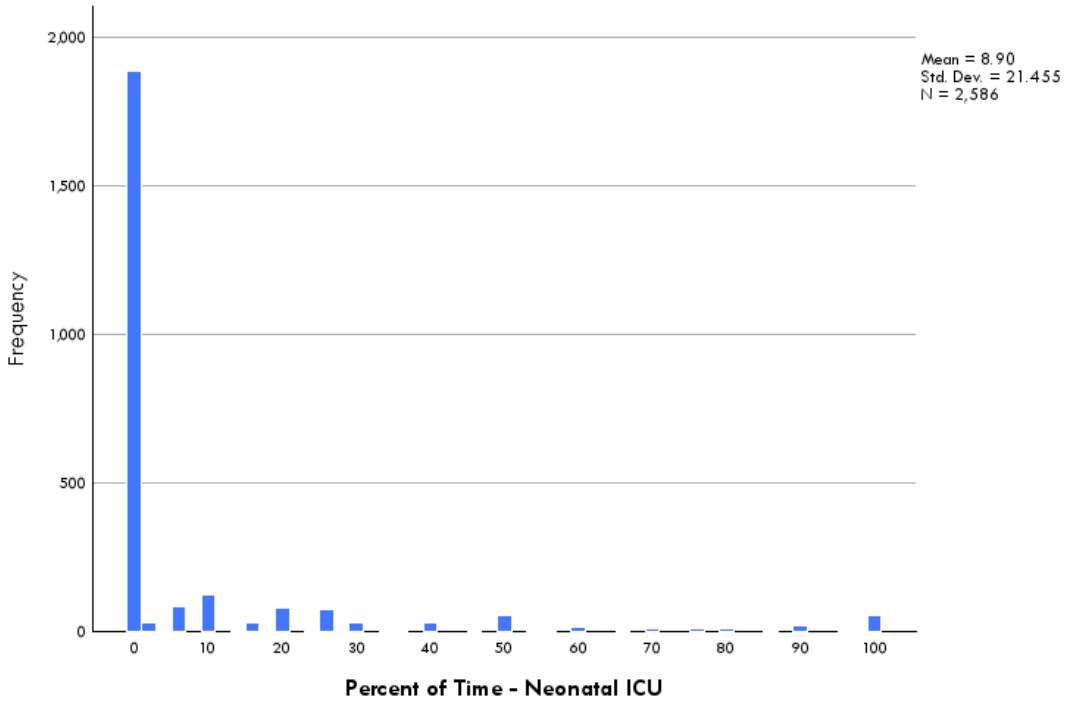

Figure 57. Percentage of time spent in Neonatal ICU

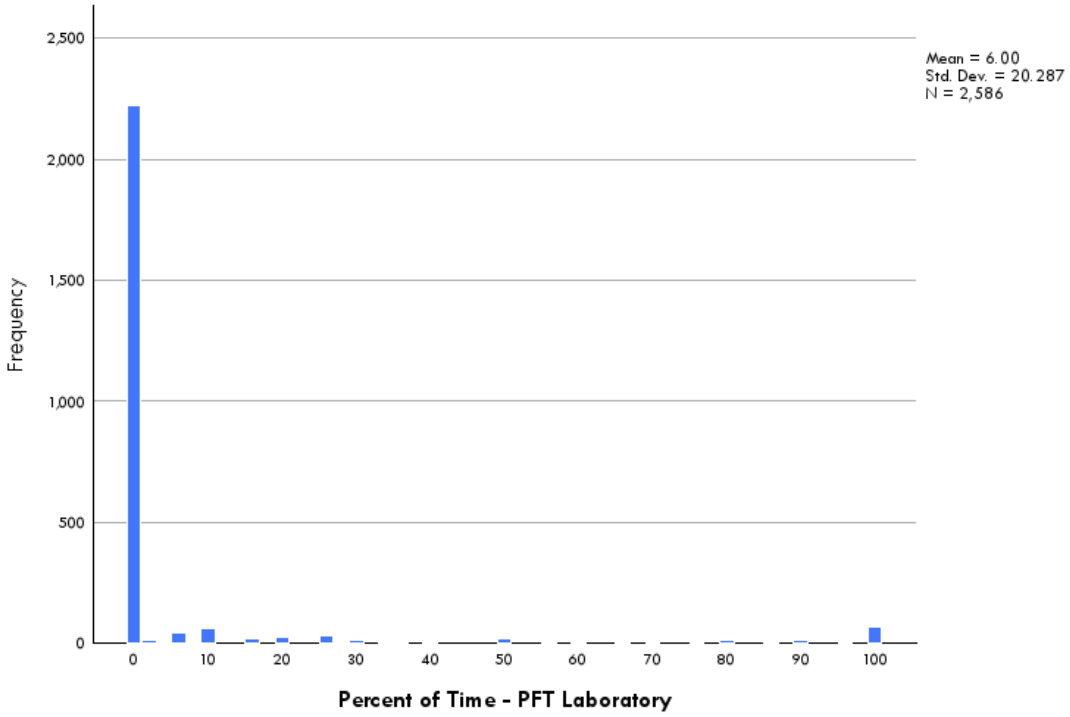

Figure 58. Percentage of time spent in Pulmonary function lab

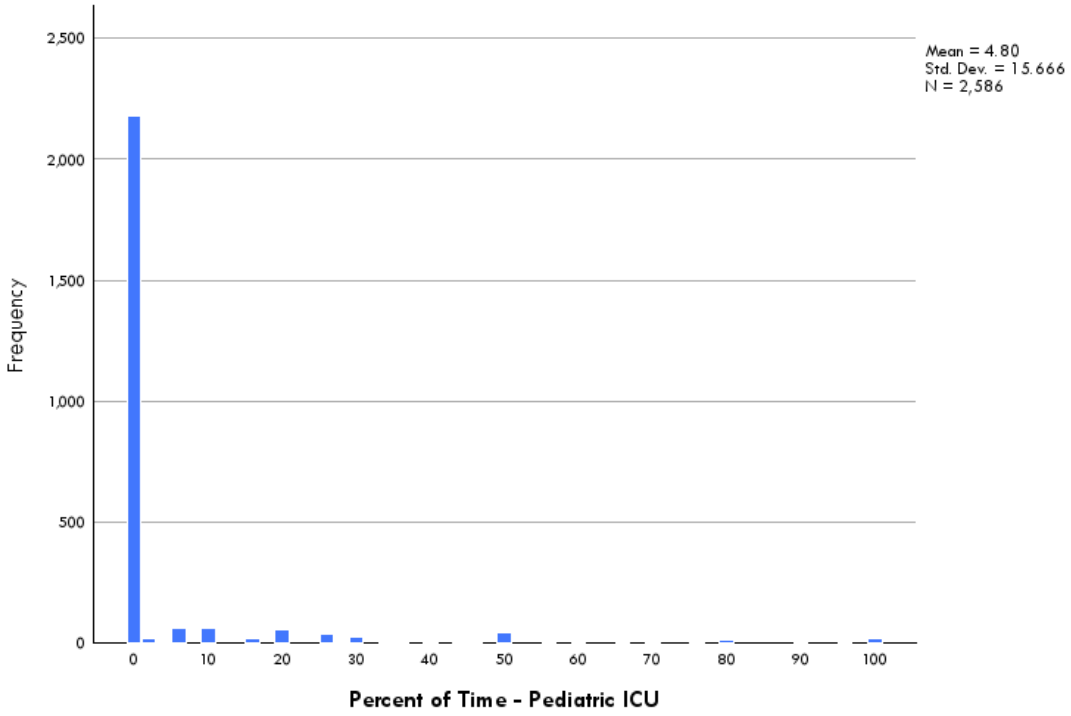

Figure 59. Percentage of time spent in Pediatric ICU

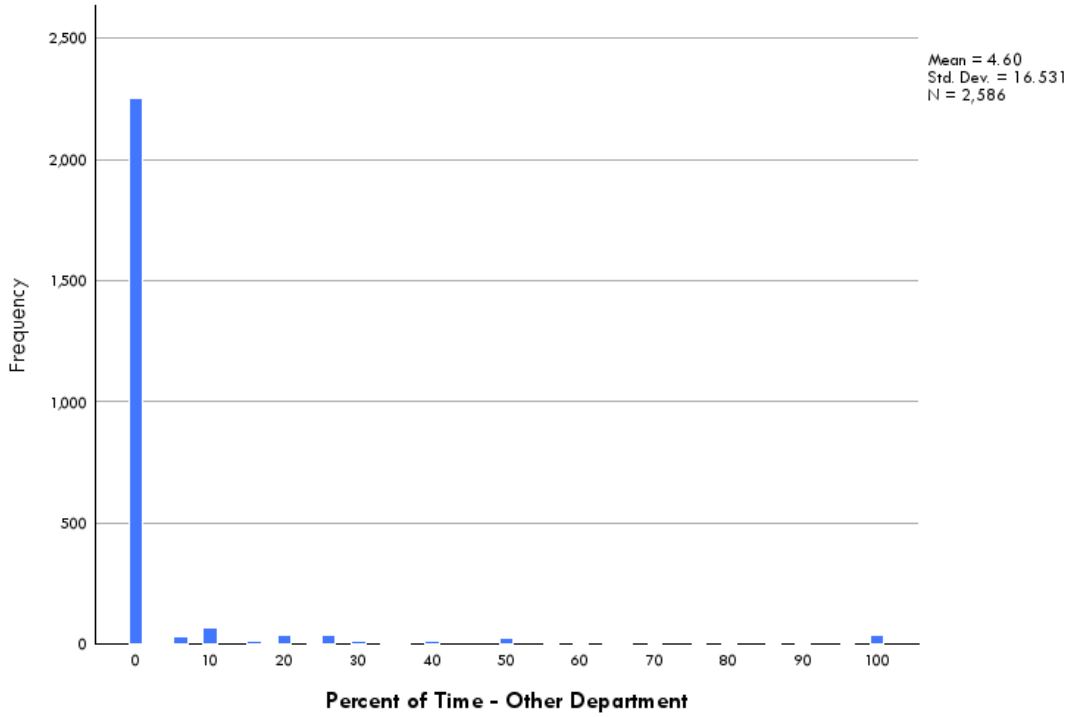

Figure 60. Percentage of time spent in Other area

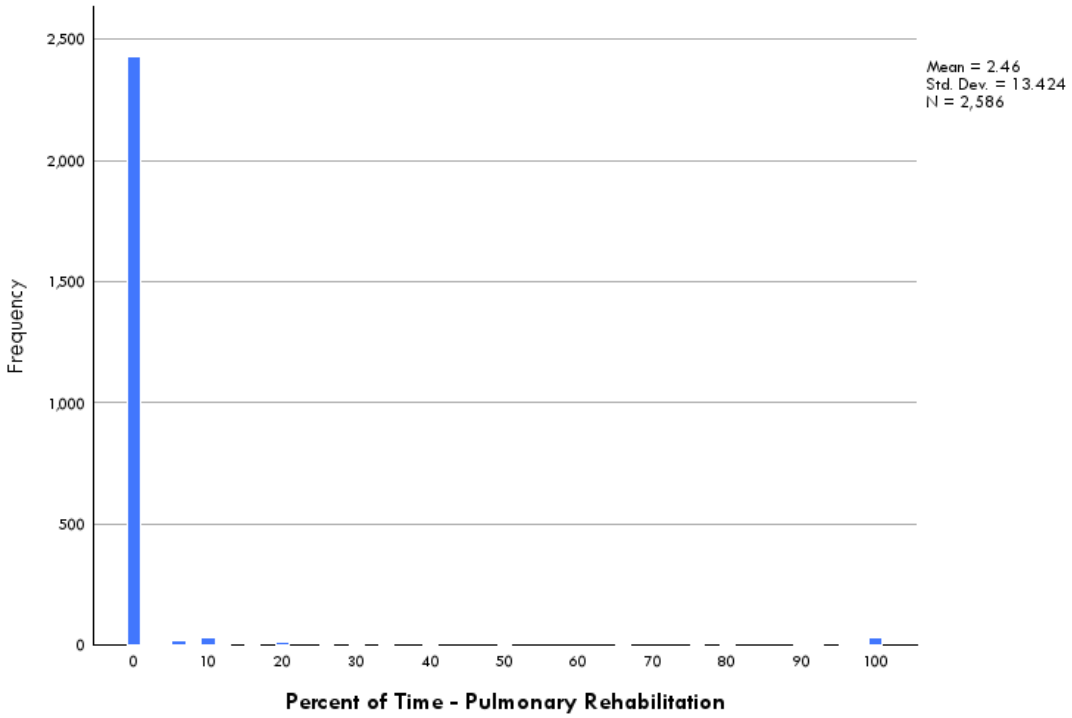

Figure 61. Percentage of time spent in Pulmonary rehabilitation

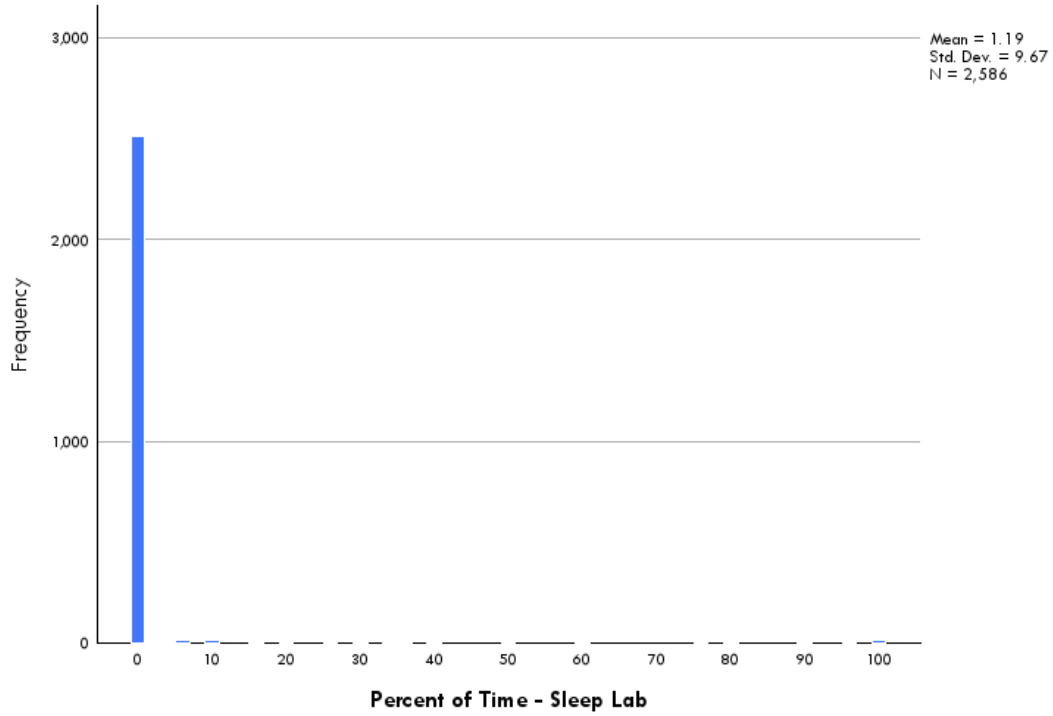

Figure 62. Percentage of time spent in Sleep lab

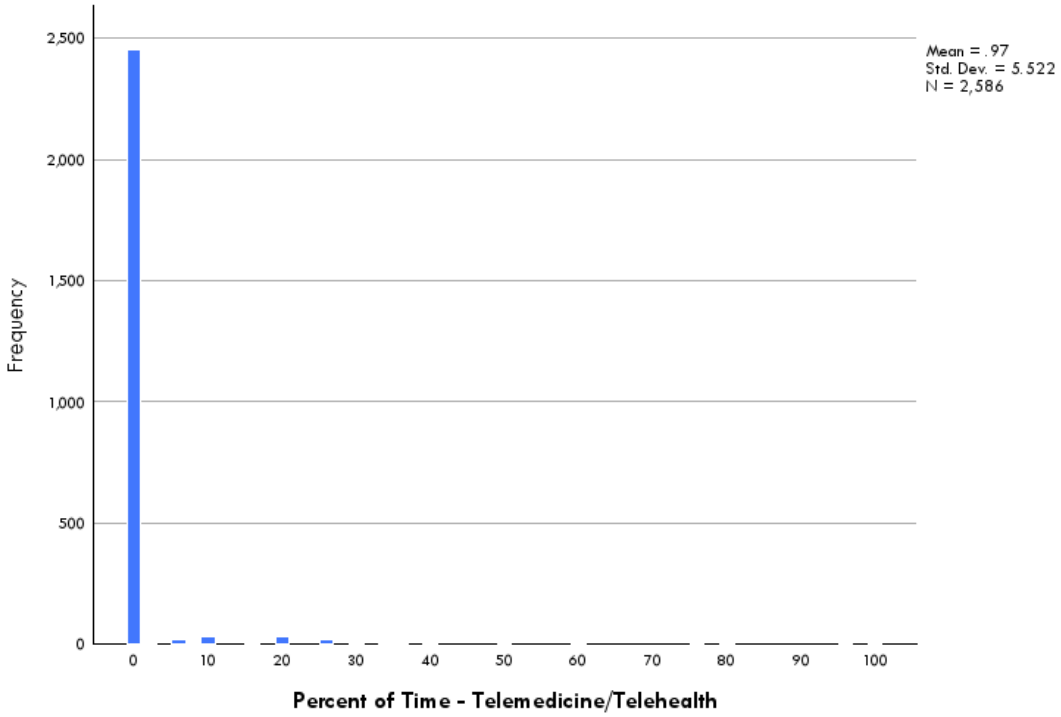

Figure 63. Percentage of time spent in Telemedicine/telehealth

39. What percentage of your time do you spend caring for patients with the following diseases/disorders?

Except for the asthma group mean as compared to the mean for the other chronic pulmonary diseases group, each mean value shown in Table 36 was significantly ($p<.05$) different from each of the other mean values as Table 37 showed. Pulmonary patients took over 50% of the time of therapists in this sample.

Table 36. Percentage of time spent caring for patients with diseases/disorders

	N							
	Valid	Missing	Mean	Std. Error of Mean	Median	Std. Deviation	Minimum	Maximum
Pulmonary	2700	2087	53.45	.53	50.00	27.62	0	100
Cardiac	2700	2087	16.77	.32	15.00	16.75	0	100
Non-pulmonary	2700	2087	12.49	.30	10.00	15.51	0	100
Sleep disorders	2700	2087	6.31	.32	.00	16.71	0	100
Neuromuscular	2700	2087	6.04	.19	.00	10.08	0	100
Other disease	2700	2087	4.95	.32	.00	16.43	0	100

$F(5,16199) = 2893.33$, $p<.000$, eta square = .472

Table 37. Mean differences in percentage of time spent caring for patients with diseases/disorders

(I) Disease	(J) Disease					
	Pulmonary	Sleep	Cardiac	Neuromuscular	Non-pulmonary	Other Disease
Pulmonary		47.14*	36.68*	47.41*	40.97*	48.50*
Sleep	-47.14*		-10.46*	.27	-6.18*	1.36*
Cardiac	-36.68*	10.46*		10.73*	4.28*	11.82*
Neuromuscular	-47.41*	-.27	-10.73*		-6.45*	1.09*
Non-pulmonary	-40.97*	6.18*	-4.28*	6.45*		7.54*
Other Disease	-48.50*	-1.36*	-11.82*	-1.09*	-7.54*	

*. The mean difference is significant at the 0.05 level.

40. Within the last year, has your employer expected you to deliver therapy to multiple patients in different rooms or locations simultaneously?

Among those who did respond, less than one-half indicated that their employer did expect them to deliver therapy to different patients at the same time. Frequencies can be found in Appendix C Table 86.

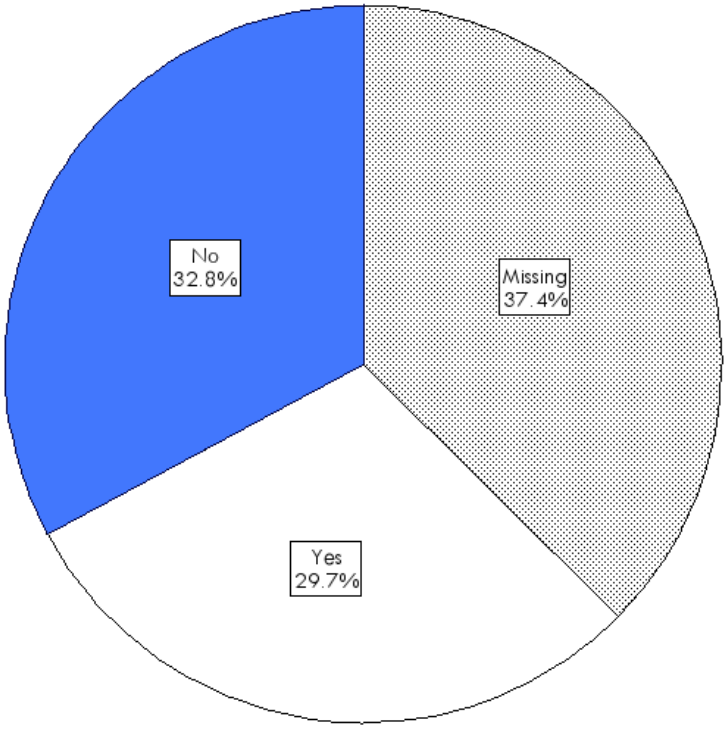

Figure 64. Expectation to deliver therapy to multiple patients in different locations simultaneously.

41. For approximately what percentage of recent shifts have you been unable to complete all work assigned to you?

Figure 65 revealed an important result. The most frequent response we received to this question was the omission of a selection followed by a selection of zero. Some of those who left the question blank may have also been indicating that no work was missed. More than two-thirds of the sample were associated with those who were able to complete all assigned work and those who skipped the question. When work was missed, the typical response indicated that 10% of shifts had unfinished work. Frequencies can be found in Appendix C Table 87.

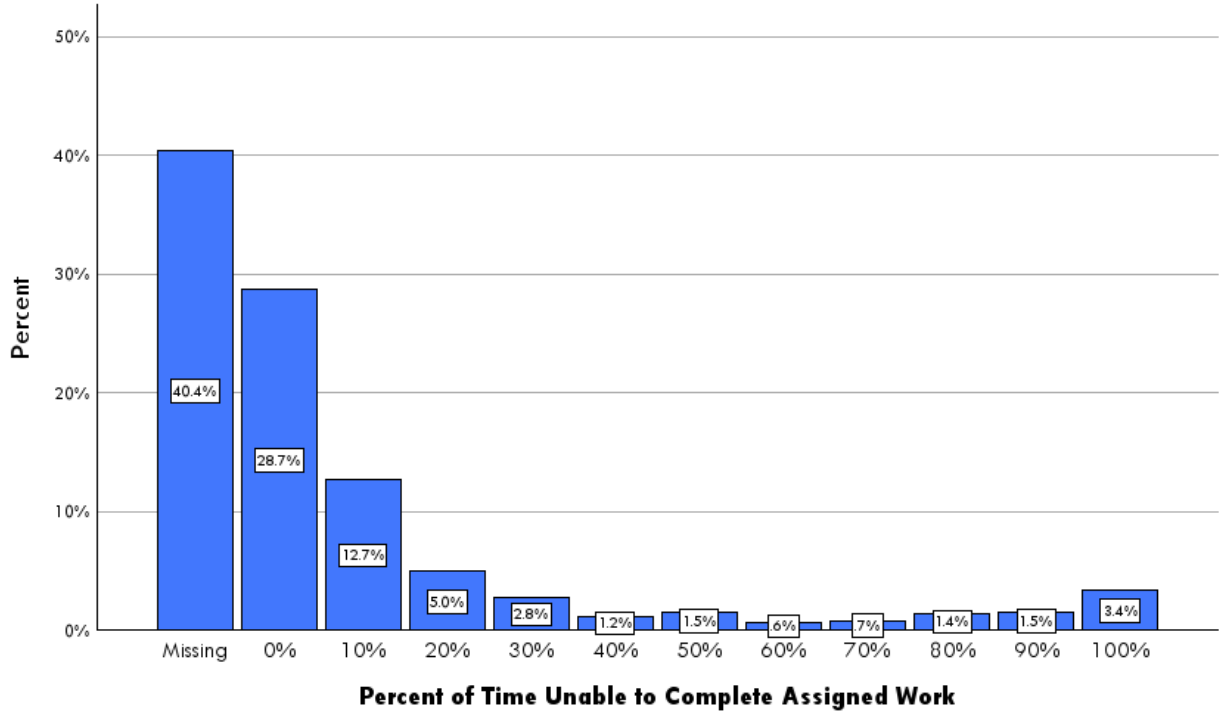

Figure 65. Percentage of recent shifts respondents have been unable to complete all assigned work

42. Does your employer provide a system that helps you to prioritize your work assignments when providing direct patient care and there is not enough time to complete them all?

Even though Question #42 appeared on a page that was only shown to respondents who had indicated that they provided direct patient care, a small group responded to this question by saying that they did not. Among respondents who provided patient care, more often a work prioritization system was not available. Frequencies can be found in Appendix C Table 85.

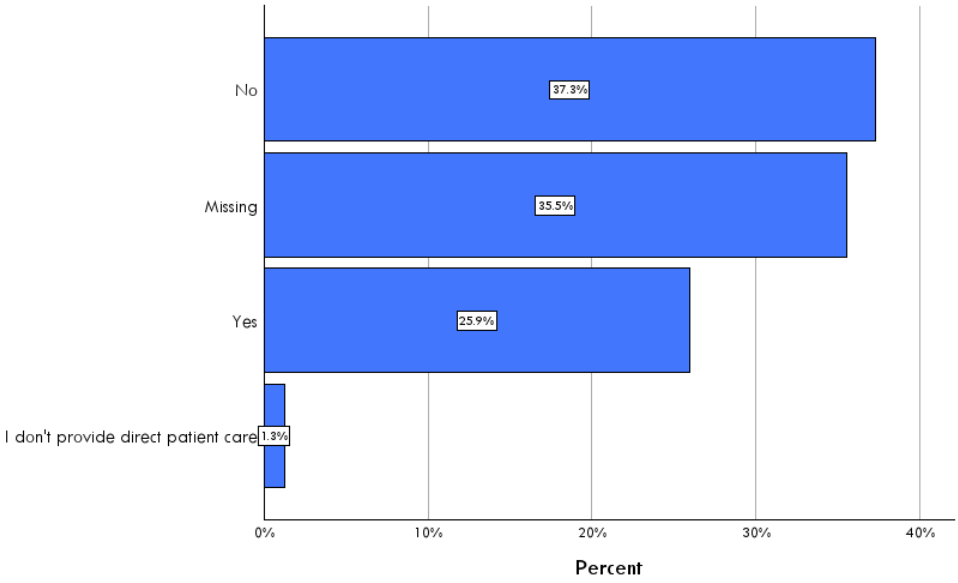

Figure 66. Availability of a work prioritization system

43. Briefly describe the prioritization system, including whether it involves software.

Descriptions of the prioritization systems can be found in Appendix D.

44. When providing direct patient care, how often do you use the prioritization system?

Among those who gave an affirmative response to the previous item, around 60% used an employer-provided prioritization system every day. Frequencies can be found in Appendix C Table 89.

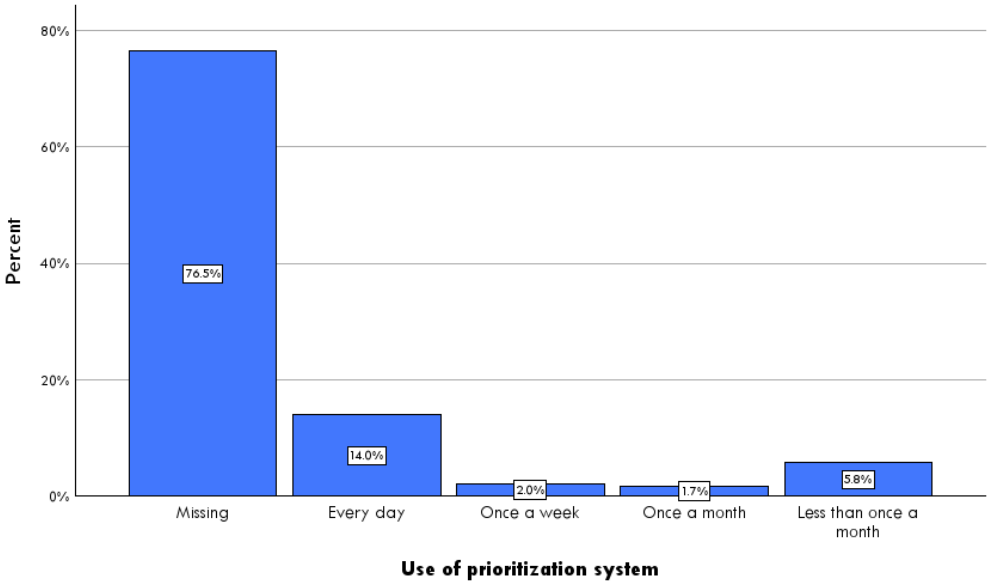

Figure 67. Use of prioritization system

45. Do you deliver respiratory care by protocol when providing direct patient care?

About half of the sample indicated that they used protocols during delivery of respiratory care to patients. Frequencies can be found in Appendix C Table 90.

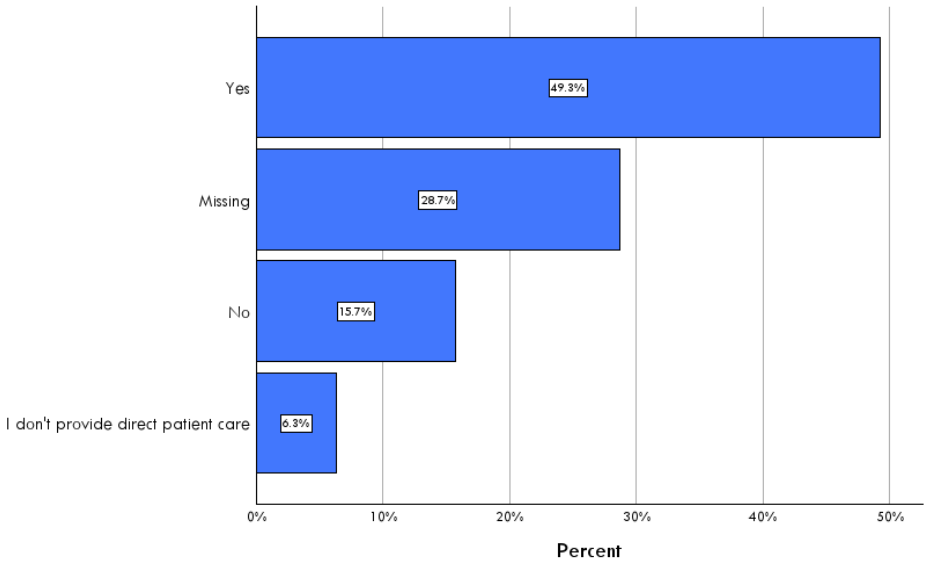

Figure 68. Use of protocols to deliver patient care

46. With which of the following do you identify?

Females outnumbered males among respondents. Frequencies can be found in Appendix C Table 91. Free responses to this question can be found in Appendix D.

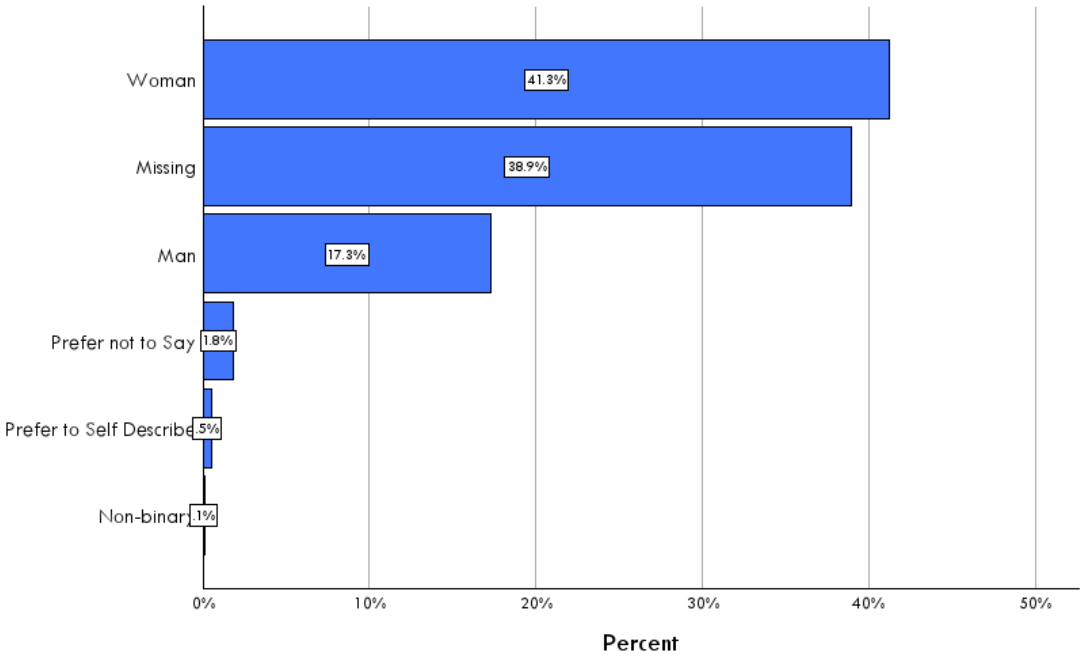

Figure 69. Gender

47. With which of the following do you identify? Select one or more.

This question and options were used because they mirrored Federal guidelines for collecting this information. The fact that respondents could select more than one of the choices complicated interpretation.

Another factor that complicated interpretation was the fact that 1,365 people did not respond to this item. The population projections assumed that respondents from each race and ethnicity subgroup were equally likely to leave this survey item without a response. If that assumption was not true, then the projections were estimates at best.

Table 38. Race

	Responses		Percent of Cases	Population Projection**
	N	Percent*		
American Indian or Alaska Native	43	1.2%	1.3%	2,566
Asian or Asian origin	146	4.1%	4.3%	8,712
Black or African American	243	6.8%	7.1%	14,500
Hispanic, Latino, or Spanish origin	243	6.8%	7.1%	14,500
Native Hawaiian or other Pacific Islander	25	0.7%	0.7%	1,492
Middle Eastern or North African	18	0.5%	0.5%	1,074
White	2547	71.8%	74.4%	151,980
Multiracial	61	1.7%	1.8%	3,640
Prefer to self-describe	41	1.2%	1.2%	2,446
Prefer not to respond	181	5.1%	5.3%	10,800
Total***	3548	100.0%	103.7%	

* The percentage was based on the number of people who responded to this question.
** Projected population = (Frequency/3,422) x 204,191, where 204,191 = number of active therapists in total population. Projected total does not equal the sum across degree due to cases with missing data.
***Respondents were allowed to select multiple responses.

48. Are you a member of the AARC?

Approximately 42% of respondents gave an affirmative response to this item, which projects a population of 85,311. However, the AARC reported that it had 42,383 members as of August 2024, so AARC members were oversampled among respondents. Frequencies can be found in Appendix C Table 92.

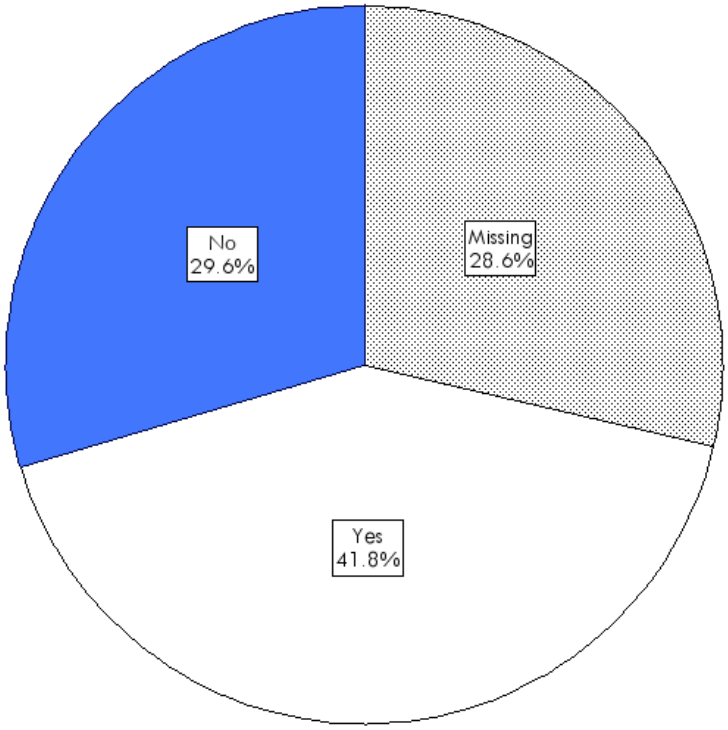

Figure 70. AARC Membership

Summary of Oversampled Populations

Results of this report caused us to conclude that therapists from the following subgroups were overrepresented in these results:

- AARC members
- Certified Asthma Educators
- Directors of respiratory care from acute care hospitals
- Therapists who primarily worked in education settings

Summary of Yes-No Responses

This survey relied on several questions in which respondents were prompted to select "Yes" or "No." Some chose not to respond, which represented a third response. Table 39 summarizes these

responses by giving a high and low estimate of the percentage of "Yes" responses that were reported for each question.

The high estimate was the valid percent value, which assumed that those who left the question without a response were equally likely to have selected "Yes" or "No." The low estimate assumed that respondents skipped the question when it did not apply to them rather than select "No." The truth most likely lies somewhere between the low and high estimate for each question, which was why we summarized them here. Lastly, we rank-ordered these responses from high to low based on the high estimate.

Table 39. Low and high estimates for affirmative responses to survey items limited to Yes/No options

	Estimates of the percentage for the percentage for which this was true	
	Low	High
In your role do you provide direct patient care?	69.7	90.3
Are you a member of the AARC?	41.8	58.5
Do you work an additional respiratory care-related job?	16.6	19.0
Within the last year, has your employer expected you to deliver therapy to multiple patients in different rooms or locations simultaneously?	29.7	47.5
Do you hold a Baccalaureate or graduate degree in a health-related field?	26.2	34.5
Are you employed as a temporary / travel therapist at [your secondary employment] location?	16.6	19.0
Are you pursuing an academic degree that is higher than one you have already earned?	13.7	18.1
Does the employer for your primary job require that you maintain a National Board for Respiratory Care (NBRC) credential as a condition for your continued employment?	2.5	13.2
Are you employed as a temporary / travel therapist at [your primary employment] location?	5.0	5.0

Compensation Factors

Although this study was done in 2024, questions about annual compensation asked therapists to respond based on the previous full year, which was 2023. Survey functionality limited responses for wage from the primary job to values of 0 to 400000 but a few responses about total

compensation were far removed from most of the other survey respondents, which caused them to be considered outliers. In cases where the provided 2023 annual salary was less than $500 or not provided at all, a new value was calculated, when possible, by using responses from other survey questions. The values provided for hourly rate and hours per week at the primary job were multiplied by 52 (weeks/year) to calculate an estimated annual salary.

Even after including these recalculated values, there remained 794 respondents who chose not to provide a total compensation value, some for whom a new salary value could not be calculated, and a few very high values. The resulting distribution of 3,993 values strongly deviated from characteristics that are associated with a normally distributed set of values.

Because analyses that followed relied on the assumption that the dependent variable (total compensation from the primary job in 2023) was normally distributed, we removed the extreme values. We retained 3,966 cases after removing cases that were (1) missing a value, (2) showing a value less than $1,000, or (3) showing a value greater than $270,000.

After removing outlying cases, the fact that the mean value exceeded the median value in Table 40 and the right tail of the histogram was longer than the left tail in Figure 71, indicated that perfect normality still had not been achieved. However, comparing information in the first row of 20 and Figure 26 (with outliers included) to Table 40 and Figure 71 (after outliers were excluded) indicated to us that the distribution of the total compensation variable had moved enough toward normality to proceed.

Table 40. Descriptive statistics for total compensation in 2023 from primary job

N							
Valid	Missing	Mean	Std. Error of Mean	Median	Std. Deviation	Minimum	Maximum
3966	821	$77,441.28	$509.62	$75,000.00	$32,094.107	$1,000	$260,000

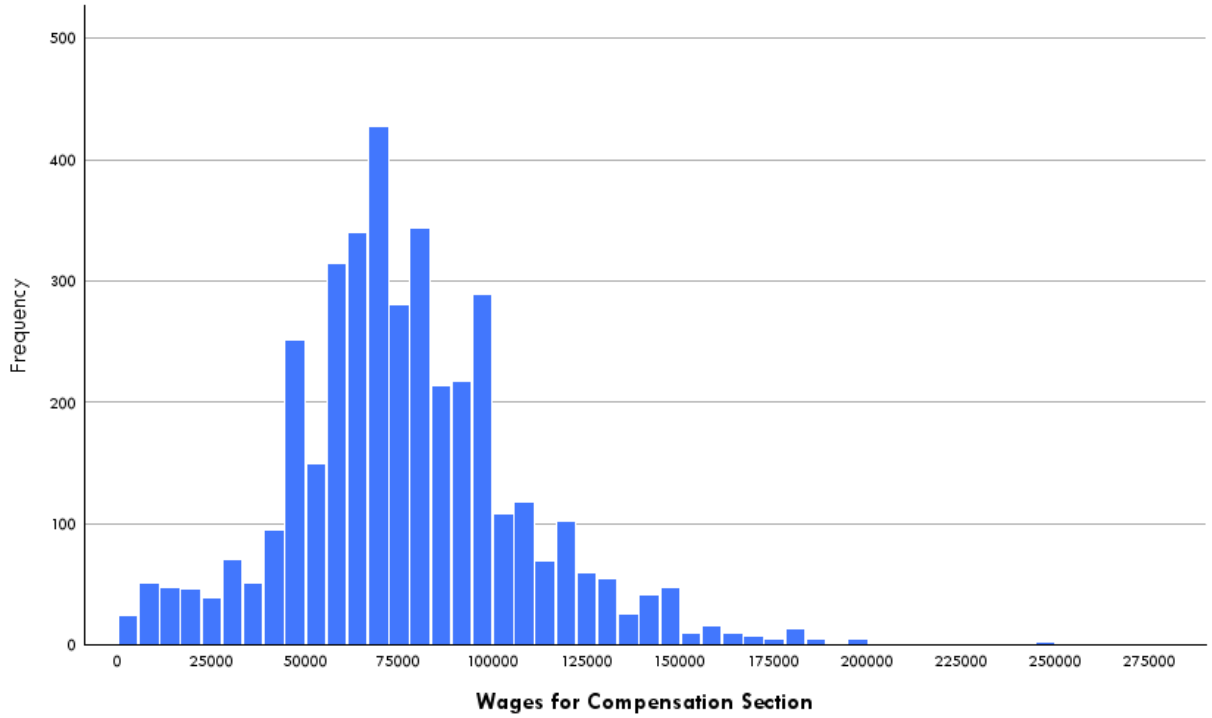

Figure 71. Distribution of compensation after removing outlying cases

Factors Potentially Related to Compensation

The intent behind this phase of the study was to identify those factors that shared a systematic relationship with 2023 total compensation, but to also narrow down the list to those factors that really mattered. To begin the narrowing process, there were 18 bivariate correlations with total compensation that were statistically significant ($p<.05$) in Table 41. Three factors (whether care is delivered by protocol, whether employer requires maintenance of a credential, pursuing a higher academic degree) fell away from consideration at this stage because their bivariate correlations with total compensation did not reach the significance threshold.

Table 41. Correlations of potential 2023 total compensation predictors sorted by strength

		Correlation (R)	Sample Size
1	Hours worked each week at primary venue	.356	3961
2	Total experience as a respiratory therapist since training	.230	3956
3	Experience with current primary employer	.219	3954
4	Whether the CRT-NPS or RRT-NPS credential had been achieved	.202	3966
5	Highest academic degree achieved	.196	3452
6	Age	.188	3954
7	Satisfaction with primary job	.173	3359

8	Whether respondent was an AARC member	.150	3263
9	Whether the RRT-ACCS credential has been achieved	.132	3966
10	The degree earned from respiratory therapy school	.099	3205
11	Whether the RRT credential had been achieved	.083	3966
12	Whether the CPFT credential had been achieved	.077	3966
13	Whether the AE-C credential has been achieved	.073	3966
14	Whether the RPFT credential had been achieved	.065	3966
15	Whether employer provides a work prioritization system	.044	2894
16	The year one plans to leave the workforce	-.074	3902
17	Typical number of patients receiving mechanical ventilation cared for by one therapist	-.082	2414
18	Whether employer requires simultaneous patient care	-.082	2876
	Factors Falling Below the Threshold for Significant Correlations (p>.05)		
19	Whether care is delivered by protocol	.001	2978
20	Whether employer requires maintenance of an NBRC credential	-.014	3471
21	Whether respondent was pursuing a higher academic degree	-.023	3454

We sought next to find those factors that together explained a significant amount of variability in 2023 total compensation. We used a multiple regression statistical model to assess which of the significant predictors from Table 41 would continue to explain variability in 2023 total compensation while controlling for the factors that had already entered the model. If two factors were redundant in explaining variability, then the weaker factor would be left out of the model according to the selection criterion built into the software.

Results of this process cut down the number of factors as shown in Table 42. The net effect was an explanation of 30% of variability in 2023 total compensation. The last study of human resources had explained 26% of variability in 2019 compensation.

The long list of potential predictors of 2023 total compensation was narrowed to a shorter list of 12 factors by the multiple regression procedure. Evaluation of information in Table 43 yielded some potentially useful observations about total compensation in 2023. While evaluating these points, it may help to recall that the dependent variable was one year's worth of compensation.

- Each hour worked in a typical week added $1,083
- Each year of total work experience as a respiratory therapist added $480
- The CRT-NPS or RRT-NPS credential was associated with an additional $8,755
- Each increment of increased job satisfaction was associated with an additional $2,378
- Each step up on the academic degree scale was associated with an additional $3,038

- The RRT-ACCS credential was associated with an additional $7,758
- Each year of work experience with one's current primary employer was associated with an additional $230 dollars
- AARC membership was associated with an additional $3,155
- The RRT credential was associated with an additional $4,114
- The availability of a prioritization system was associated with a decrease of $2,797
- Therapists who reported that their employers required that they give simultaneous care to multiple patients was associated with $2,757 less than their counterparts who worked under no such policy
- Each additional patient receiving mechanical ventilation under the care of a therapist was associated with $361 decrease in pay

Table 42. Multiple regression result for 2023 total compensation

		Proportion of Shared Variance (R^2) after entry	Significance linked to the R^2 change
1	Hours worked each week at primary venue	.151	<.001
2	Total experience as a respiratory therapist since training	.236	<.001
3	Whether the CRT-NPS or RRT-NPS credential had been achieved	.256	<.001
4	Satisfaction with primary job	.270	<.001
5	Highest academic degree achieved	.279	<.001
6	Whether the RRT-ACCS credential has been achieved	.284	<.001
7	Experience with current primary employer	.288	<.001
8	Whether respondent was an AARC member	.290	.005
9	Whether employer requires simultaneous patient care	.293	.016
10	Whether the RRT credential had been achieved	.294	.012
11	Whether employer provides a work prioritization system	.296	.015
12	Typical number of patients receiving mechanical ventilation cared for by one therapist	.297	.029
	Factors that did not increase R^2 further		
13	Whether the AE-C credential has been achieved		
14	Whether the CPFT credential had been achieved		
15	Whether the RPFT credential had been achieved		
16	The degree earned from respiratory therapy school		

We planned to control for the influence of these variables and compare differences between average 2023 compensation among two sets of subgroups described in the next section. Our

purpose was to determine whether any of the subgroup factors contributed uniquely to 2023 total compensation explanation beyond what was explained by the factors listed in Table 42.

Table 43. Multiple regression coefficients for each significant factor

Factor	Regression Coefficient	Details about underlying data
Hours worked each week at primary venue	1083.21	Whole numbers, for example, 20, 36, 40
Total experience as a respiratory therapist since training	480.35	Whole or fractional numbers, for example 5, 6.5
Whether the CRT-NPS or RRT-NPS credential had been achieved	8,755.11	Whole numbers 0 = No 1 = Yes
Satisfaction with primary job	2,377.68	Whole numbers between 0 = Unsatisfied and 5= Completely satisfied
Highest academic degree achieved	3,038.15	Whole numbers 1 = Some high school, no degree 2 = High school diploma/GED 3 = Some college, no degree 4 = Associates degree 5 = Baccalaureate degree 6 = Master's degree 7 = Doctorate degree
Whether the RRT-ACCS credential has been achieved	7,758.25	Whole numbers 0 = No 1 = Yes
Experience with current primary employer	230.15	Whole or fractional numbers, for example, 5, 6.5
Whether respondent was an AARC member	3,155.27	Whole numbers 0 = No 1 = Yes
Whether employer requires simultaneous patient care	-2,756.67	Whole numbers 0 = No 1 = Yes
Whether the RRT credential had been achieved	4,113.56	Whole numbers 0 = No 1 = Yes

Factor	Regression Coefficient	Details about underlying data
Whether employer provides a work prioritization system	-2797.04	Whole numbers 0 = No 1 = Yes
Typical number of patients receiving mechanical ventilation cared for by one therapist	-361.41	Whole numbers, for example, 0, 4
Constant in the equation	-769.11	

Regions

Four geographic regions had been defined earlier in this report and were used in this section to assess whether total compensation differed among them. An inspection of the "Observed mean" column of Table 44 indicated that compensation did differ within this sample, but this set of values was influenced by factors other than just region. A series of alternate explanations about why the observed means were different could have been proposed. For example, it could have been that respondents from one region tended to have more experience than those from another region so the observed difference in compensation between two regions could have been attributed to experience differences, not differences associated with working in two regions.

We controlled for twelve of the alternate explanations about variance in total compensation by using an ANCOVA model to isolate whether geographic region truly exerted its own influence on total compensation. The column within Table 44 that described estimated means shows the values that could be attributed to the region factor after controlling for the twelve covariates. The F value (68.186) associated with the ANCOVA result ($p<.001$, df 15, 2184) yielded an observed power of 1.0. (If a difference truly existed, then we would have detected it.) The effect size (eta squared) value was .32 indicating that the region factor had added to the explanation of variance beyond what had been explained ($R^2=.30$) by the twelve covariates. Post-hoc analyses using the least significant difference technique indicated that estimated means for the Northeast and West were significantly different than the means from South and Midwest. Likewise, the means for the South and Midwest were significantly different than means from the Northeast and West.

Table 44. Total compensation for geographic regions

Region	States	Observed Mean	Estimated Mean after Controlling for Covariates*	Observed Std. Deviation	Observed N
Northeast	MA, RI, NH, ME, VT, CT, NJ, NY, PA	$84,200	$83,810	$33,286	257
South	DC, DE, MD, VA, WV, NC, SC, GA, FL, AL, TN, MS, KY, LA, AR, OK, TX	$73,176	$72,450	$27,879	907
Midwest	OH, IN, MI, WI, IL, IA, MN, SD, ND, MO, KS, NE	$73,639	$74,094	$26,595	561
West	MT, CO, WY, ID, UT, AZ, NM, NV, CA, HI, OR, WA, AK	$81,062	$82,155	$33,677	460

*Covariates were listed in Table 42

Job Titles

Some job title subgroups (Disease Manager/Patient Educator, Quality/Compliance Coordinator/Manager, Informatics Specialist, Sleep Technologist, ECMO/ECLS Specialist, Rehabilitation Specialist, Research Coordinator/Associate, Academic Educator, Salesperson) were small, containing less than 25 respondents who also provided wage and other covariate information. The groups were combined into an 'Other' category for further analysis. These small groups also prevented the application of a two-way analysis of covariance (ANCOVA) model to permit assessment of potential interactions between regions *and* job titles.

As we had done for comparisons of total compensation by regions, we applied the same method to make comparisons among job titles. Differences between observed and estimated means again reflected the influence of the twelve covariates in Table 42. After removing responses from the smaller subgroups, the F value (56.984) associated with the ANCOVA result ($p<.001$, df 18, 2199) yielded an observed power of 1.0. The effect size value was .32.

Post-hoc comparisons among remaining job titles were more complicated than observed when making comparisons among geographic regions because there were seven groups to compare instead of four. The following statements summarize these results:

- The Manager/Director group had a significantly different mean than the mean for
    - Staff Therapists
    - Clinical Specialists
    - Pulmonary Function Technologists
    - Others

- The Supervisor group had a significantly different mean than the mean for
    - Staff Therapists
    - Clinical Specialists
    - Pulmonary Function Technologists
    - Others
- The Staff Therapist group had a significantly different mean than the mean for
    - Managers/Directors
    - Supervisors
- The Clinical Specialist group had a significantly different mean than the mean for
    - Managers/Directors
    - Supervisors
    - Pulmonary Function Technologists
- The Pulmonary Function Technologist group had a significantly different mean than the mean for
    - Managers/Directors
    - Supervisors
    - Clinical Specialists
    - Flight/Transport Therapists
- The Flight/Transport Therapist group had a significantly different mean than the mean for
    - Pulmonary Function Technologists
- The Other group had a significantly different mean than the mean for
    - Managers/Directors
    - Supervisors

Table 45. Total compensation for job titles

	Observed Mean	Estimated Mean after controlling for covariates*	Observed Std. Deviation	Observed N
Manager/Director or a Dept, Program, or System	$103,365	$88,969	$30,151	128
Supervisor	$94,845	$86,570	$30,318	142
Staff Therapist	$71,861	$74,582	$27,609	1609
Clinical Specialist	$84,268	$78,540	$33,292	106
Pulmonary Function Technologist	$71,316	$69,249	$25,838	60
Flight/Transport Therapist	$86,579	$80,989	$34,462	28
Other	$76,159	$72,436	$29,900	127

*Covariates were listed in Table 42

Total Compensation Scenarios

Early Career

The utility of the information described above became more apparent when observing the ways in which various clusters of specific factors could be incorporated into a predictive model. The first such scenario starts in Figure 72. Our intent was to represent a therapist one year after earning an Associate's degree and starting a job as a respiratory therapist. We chose to assume the individual had worked for the same employer. We built in the expectation that the individual had achieved the RRT credential during the first year of employment. We also assumed that the individual was mostly, but not entirely satisfied with his or her working conditions, that the employer provided a prioritization system and 3 patients receiving mechanical ventilation were typically assigned to each therapist.

We did not expect that the compensation value that was displayed in Figure 72 was universally relevant because the value represented the contributions of therapists' responses from all regions and all job titles. We had demonstrated significant main effects for both of these factors. An opportunity to refine the first estimate was illustrated in Figure 73. After building in the assumption that the therapist in this scenario worked in the southern region and remained in a staff therapist job, we arrived at a refined estimate shown at the bottom of Figure 73. After one year of employment and achieving the RRT credential, we confidently expected that a typical staff therapist from the southern region would receive about $51,000 in total compensation. However, another therapist who shared the same characteristics, but worked in the Northeast or Western region would be expected to receive $10,000 to $11,000 more in total compensation.

Prediction of Annual Compensation in 2023 =				
Regression coefficients	**Factors**	**Enter your numbers here**		**Product**
1083.211	Hours worked each week at primary venue	36	$	38,996
480.350	Total experience as a respiratory therapist since training	1	$	480
8755.106	Whether the CRT-NPS or RRT-NPS credential had been achieved	0	$	-
	0=no; 1=yes			
2377.675	Satisfaction with primary job	4	$	9,511
	0=very unsatisfied, ready to quit; 5=very satisfied			
3038.150	Highest academic degree achieved	4	$	12,153
	1=some high school, but no degree; 2=high school/GED; 3=some college, but no degree; 4=associates degree; 5=bachelors degree; 6=masters degree; 7=doctorate degree			
7758.252	Whether the RRT-ACCS credential has been achieved	0	$	-
	0=no; 1=yes			
230.145	Experience with current primary employer	1	$	230
3155.273	Whether an AARC member	0	$	-
	0=no; 1=yes			
4113.558	Whether the RRT credential had been achieved	1	$	4,114
	0=no; 1=yes			
-2756.668	Whether employer requires simultaneous patient care	0	$	-
	0=no; 1=yes			
-361.408	Number of patients receiving mechanical ventilation assigned to each therapist	3	$	(1,084)
-2797.035	Whether employer provides prioritization system	1	$	(2,797)
	0=no; 1=yes			
(769.106)	Regression model constant			(769.106)
		Subtotal	**$**	**60,833**

Figure 72. Total compensation scenario after first year of employment

Compensation factors to refine the prediction

Factor	Group Means ($)		Mean across groups	Enter your group mean*	Difference
Region	Northeast	$83,810	$ 78,127	$ 72,450	$ (5,677)
	South	$72,450			
	Midwest	$74,094			
	West	$82,155			
Job title	Manager/Director	$88,969	$ 78,762	$ 74,582	$ (4,180)
	Supervisor	$86,570			
	Staff Therapist	$74,582			
	Clinical Specialist	$78,540			
	Pulmonary function technologist	$69,249			
	Flight/Transport Therapist	$80,989			
	Other	$72,436			
	Difference (Amount by which one could adjust the compensation prediction)				**$ (9,857)**
	Best estimate of 2023 Compensation				**$ 50,975**

Figure 73. Refinements to the one-year prediction

After a Decade

We envisioned a therapist with ten years of total experience while providing respiratory care, but there was a job change after the first four years. We assumed that the therapist was very satisfied in his or her job and had achieved a Bachelor's degree (either initially or after starting work as a therapist). We built in an expectation that the therapist occupied a job as a clinical specialist and had achieved the RRT-NPS credential (while likely working mostly or entirely with children). The facility for which they worked had a prioritization system available to assist with patient care, simultaneous patient care was required, and therapists were typically assigned to 5 patients who were receiving mechanical ventilation. We anticipated that the individual was a member of the AARC and worked in one of the states included in the northeast region. The models predicted that this individual would earn almost $86,000 in total compensation as illustrated in Figure 75 but could be $10,000 to $12,000 less when in the Midwest or Southern regions.

Prediction of Annual Compensation in 2023 =				
Regression coefficients	**Factors**	**Enter your numbers here**		**Product**
1083.211	Hours worked each week at primary venue	36	$	38,996
480.350	Total experience as a respiratory therapist since training	10	$	4,804
8755.106	Whether the CRT-NPS or RRT-NPS credential had been achieved	1	$	8,755
	0=no; 1=yes			
2377.675	Satisfaction with primary job	5	$	11,888
	0=very unsatisfied, ready to quit; 5=very satisfied			
3038.150	Highest academic degree achieved	5	$	15,191
	1=some high school, but no degree; 2=high school/GED; 3=some college, but no degree; 4=associates degree; 5=bachelors degree; 6=masters degree; 7=doctorate degree			
7758.252	Whether the RRT-ACCS credential has been achieved	0	$	-
	0=no; 1=yes			
230.145	Experience with current primary employer	6	$	1,381
3155.273	Whether an AARC member	1	$	3,155
	0=no; 1=yes			
4113.558	Whether the RRT credential had been achieved	1	$	4,114
	0=no; 1=yes			
-2756.668	Whether employer requires simultaneous patient care	1	$	(2,757)
	0=no; 1=yes			
-361.408	Number of patients receiving mechanical ventilation assigned to each therapist	5	$	(1,807)
-2797.035	Whether employer provides prioritization system	1	$	(2,797)
	0=no; 1=yes			
(769.106)	Regression model constant			(769.106)
		Subtotal	**$**	**80,153**

Figure 74. Total compensation scenario after a decade of employment

Compensation factors to refine the prediction

Factor	Group Means ($)		Mean across groups	Enter your group mean*	Difference
Region	Northeast	$83,810	$ 78,127	$ 83,810	$ 5,683
	South	$72,450			
	Midwest	$74,094			
	West	$82,155			
Job title	Manager/Director	$88,969	$ 78,762	$ 78,540	$ (222)
	Supervisor	$86,570			
	Staff Therapist	$74,582			
	Clinical Specialist	$78,540			
	Pulmonary function technologist	$69,249			
	Flight/Transport Therapist	$80,989			
	Other	$72,436			
	Difference (Amount by which one could adjust the compensation prediction)				**$ 5,461**
	Best estimate of 2023 Compensation				**$ 85,614**

Figure 75. Refinements to the one-decade prediction

Limits on Inferences about Total Compensation

The strength behind using a regression-based approach was our ability to narrow down a list of 21 potential factors that could have affected compensation to a list of 12 factors that really mattered. Redundant factors were weeded out. We verified two factors (region and job title) that can be confidently used to refine an initial estimate from the 12 factors.

Weakness from this approach lay in the kinds of inferences that we could anticipate some could try to make of these study results. After studying Figure 74, an employee could go to their employer and state, "I am very satisfied in my job, not just moderately satisfied, so you should pay me $2,378 dollars more per year." Another employee could ask their employer, "If I become an AARC member, will you give me a $3,155 dollar raise?" Our response to both inquiries is that those generalizations of study results cannot be supported. Regression models measure associations between variables, the degree to which values move up and down together. What these models do not measure is cause and effect.

It is true that this study found that compensation within the sample tended to go up with job satisfaction. What remains unknown is whether more satisfied people perform better on the job. Higher performance levels are likely to be valued with more compensation. Alternatively, more compensation could encourage increased job satisfaction. However, results of this study cannot tease out whether the high compensation or the high performance came first.

Likewise, when considering AARC membership, we cannot say that every membership-holder received a direct compensation boost because he or she was a member. Potential alternative explanations include compensation and performance increased for members with (1) a stronger professional commitment, (2) an established communication network with other professionals, and (3) being better informed of trends and current practices. In other words, membership could have helped performance and so secondarily influenced compensation.

A similar mystery is linked to the factors for which a positive response will yield a subtraction from the annual compensation total. One such factor hinged on whether the employer expected respiratory therapists to provide care for more than one patient at a time. Therapists who reported that their employers followed this policy also tended to report receiving less compensation. However, this does not confirm that therapists get paid less because of this policy. Neither would it be justified for an employer to use results of this study to reduce compensation because they had just changed their policy to permit simultaneous care. We expect that it is most likely that this response was an indicator of economic stresses. Doing more with less could manifest in a policy that permits simultaneous care and results in lower compensation for everyone who works at the institution.

Travel / Temporary Therapists

The COVID pandemic caused a shift in the way therapists were employed as individuals traveled to hot spot locations where additional support was needed. To meet demand, acute care hospitals had to offer highly paid temporary contracts, and many therapists left permanent positions to take on these lucrative travel positions.

A wage analysis was conducted to examine changes to wages of traveling/temporary therapists over time. Similar wage data has been gathered over many iterations of this study in which survey respondents were asked to provide information about their primary work setting and annual wage data from the previous year. Prior studies asked respondents to indicate the number of hours worked in a variety of settings like Acute Care, DME, and Education programs with Registry (temporary/travel agency) being offered as a stand-alone location. The wage data for individuals who indicated that Registry was their primary work setting in the 2014 and 2020 studies was compared to the 2024 wage data for individuals who worked primarily in an acute care setting and who also indicated that their position was a travel/temporary role.

As seen in Table 46, significant differences exist between the reported temporary/travel therapist wages as time passed. Wages rose for all types of respiratory therapist roles between 2013 and 2023, but as seen in Tables 47 and 48, the increase in mean wages was significantly higher for Travel/Temporary therapists between 2013 and 2019 and the difference only increased during the COVID pandemic and into last year.

Table 46. Differences in wages for Travel / Temporary Therapists over time

(I) Year	(J) Year	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
2013	2019	-12318.35*	6097.97	.044	-24320.0650	-316.6291
	2023	-33096.61*	5127.29	<.001	-43187.8843	-23005.3371
2019	2013	12318.35*	6097.97	.044	316.6291	24320.0650
	2023	-20778.26*	5042.25	<.001	-30702.1745	-10854.3528
2023	2013	33096.61*	5127.29	<.001	23005.3371	43187.8843
	2019	20778.26*	5042.25	<.001	10854.3528	30702.1745

*. The mean difference is significant at the 0.05 level.

Table 47. Comparison of wages for Travel / Temporary Therapists and All Therapists over time

Year	N		Mean	Std. Error of Mean	Median	Std. Deviation	Minimum	Maximum
	Valid	Missing						
	Temporary / Travel Therapists							
2013	63	0	$42,706.70	$3247.83	$46,000	$25,778.82	$3,000	$150,000
2019	66	0	$55,025.05	$3616.95	$50,500	$29,384.21	$3,000	$150,000
2023	165	0	$75,803.31	$3048.39	$75,000	$39,157.32	$1,000	$200,000
	All Therapists							
2013	11373	0	$56,127.77	$206.39	$54,000	$22,010.05	$1,000	$151,000
2019	8206	0	$63,226.67	$280.43	$60,000	$25,403.74	$1,000	$170,000
2023	3966	0	$77,441.28	$509.62	$75,000	$32,094.11	$1,000	$260,000

Table 48. Percent change in mean wage over time

	Temporary / Travel Therapist Wages	All Therapist Wages
2013 – 2019	22.4%	11.2%
2019 - 2023	27.4%	18.4%

Appendix A. Human Resource Survey of Respiratory Therapists

2024 AARC Human Resource Survey of Respiratory Therapists

* 1. Have you been paid for your work in the respiratory care profession within the past six months?

- ◯ Yes
- ◯ No

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2. **What is the zip code of the work setting where you spend most of your time?**

3. **What is your age in years?**

4. **For how many years have you practiced as a respiratory therapist since completing your training?**

5. **Which of the following best describes your military status?**

- ◯ Active duty
- ◯ Reserve duty
- ◯ Discharged
- ◯ Never served

6. **Acknowledging that you may work for more than one employer, your primary employer is defined as the one where you spend a majority of your work hours.**

How many years have you worked for your primary employer?

Please provide a number between 0.0 and 65.0, e.g., 5.5 not 5 1/2 years.

7. **What is your best guess about the year you will leave the respiratory therapy workforce?**

2024 AARC Human Resource Survey of Respiratory Therapists

Primary Job

8. At which of the following locations do you spend most of your respiratory care-related work time?

- ◯ Acute care hospital
- ◯ DME / Home care
- ◯ Long-term care / Rehab / SNF
- ◯ Education program
- ◯ Manufacturer / Distributor
- ◯ Outpatient facility
- ◯ Physician's office
- ◯ Professional / Trade Association

9. Approximately how many hours per week do you spend doing respiratory care-related work at this location?

Please provide a number between 1 and 90.

10. Are you employed as a temporary / travel respiratory therapist at this location?

- ◯ Yes
- ◯ No

11. What do you estimate were the total wages you earned at this job in 2023?

Please round your response to the nearest whole number and type your response without a dollar sign ($) or comma, e.g., 65000.

* 12. Do you work an additional respiratory care-related job?

- ◯ Yes
- ◯ No

2024 AARC Human Resource Survey of Respiratory Therapists

Secondary Job

13. At which of the following locations do you work this additional job?

- ◯ Acute care hospital
- ◯ DME / Home care
- ◯ Long-term care / Rehab / SNF
- ◯ Education program
- ◯ Manufacturer / Distributor
- ◯ Outpatient facility
- ◯ Physician's office
- ◯ Professional / Trade Association

14. Approximately how many hours per week do you spend doing respiratory care-related work at this additional job?

Please provide a number between 1 and 90.

15. Are you employed as a temporary / travel respiratory therapist at this location?

- ◯ Yes
- ◯ No

16. What do you estimate were the total wages you earned at this job in 2023?

Please round your response to the nearest whole number and type your response without a dollar sign ($) or comma, e.g., 65000.

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2024 AARC Human Resource Survey of Respiratory Therapists

Compensation

17. **What is your hourly base wage at your primary respiratory care job?**

Please type your response without the dollar sign ($), e.g., 24.00 or 36.15.
If salaried, divide annual compensation by 2080.

18. **If you are eligible for a differential, please specify the additional $ per hour earned at your primary job using the table below:**

Please type your response without the dollar sign, e.g., 2.25._
If you are not eligible for a differential, proceed to the next question.

Evening shift	
Night shift	
Weekend	
Holiday	
On-call	

19. **If you received a bonus last year, what was the amount?**

Please type your response without the dollar sign, e.g., 2000.
If you did not receive a bonus, proceed to the next question.

20. **By what percentage was your base wage increased when you last received a raise for your current position?**

Please type your response without the percentage sign, e.g., 2.5 not 2.5%.

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Satisfaction

21. **Using the following scale, please indicate your satisfaction with your primary job.**

0 - Unsatisfied, I am ready to quit this job

5 - Completely satisifed, I want to stay at this job

22. **With which of the following are you LEAST satisfied about your primary job?**

- ◯ Compensation and benefits
- ◯ Department administration and supervision
- ◯ Involvement in operational decisions
- ◯ Involvement in patient care decisions
- ◯ Opportunities for advancement
- ◯ Range of respiratory care services
- ◯ Workload
- ◯ None of these

23. **With which of the following are you MOST satisfied about your primary job?**

- ◯ Compensation and benefits
- ◯ Department administration and supervision
- ◯ Involvement in operational decisions
- ◯ Involvement in patient care decisions
- ◯ Opportunities for advancement
- ◯ Range of respiratory care services
- ◯ Workload
- ◯ None of these

24. **If you have changed employers within the last five years, what was the strongest reason?**

- ◯ Compensation and benefits
- ◯ Department administration and supervision
- ◯ Involvement in operational decisions
- ◯ Involvement in patient care decisions
- ◯ Layoffs
- ◯ Opportunities for advancement
- ◯ Range of respiratory care services
- ◯ Relocation
- ◯ Workload
- ◯ None of these

25. Which of the following shift durations do you work?

Select all that apply.

- ☐ 4-hour
- ☐ 8-hour
- ☐ 10-hour
- ☐ 12-hour
- ☐ 16-hour
- ☐ Other (please specify)

26. **Which of the following is *closest* to the title for your primary job?**

- ◯ Manager / Director of a Department, Program, or System
- ◯ Supervisor
- ◯ Staff Therapist
- ◯ Clinical Specialist
- ◯ Department Educator
- ◯ Disease Manager or Patient Educator
- ◯ Quality / Compliance Coordinator/Manager
- ◯ Informatics Specialist (e.g., Clinical Analyst, Information Specialist)
- ◯ Other (please specify)
- ◯ Pulmonary Function Technologist
- ◯ Sleep Technologist
- ◯ ECMO / ECLS Specialist
- ◯ Rehabilitation Specialist (e.g., Cardiac, Pulmonary)
- ◯ Flight / Transport Therapist
- ◯ Research Coordinator or Associate
- ◯ Academic Educator (e.g., PD, DCE, faculty)
- ◯ Industry Clinical Specialist, Representative, or Salesperson

2024 AARC Human Resource Survey of Respiratory Therapists

Credentials

27. **Does the employer for your primary job require that you maintain a National Board for Respiratory Care (NBRC) credential as a condition for your continued employment?**

- ◯ Yes
- ◯ No

28. **Which of the following NBRC credentials have you earned that are not expired?**

Select all that apply.

- ☐ Adult Critical Care Specialist (RRT-ACCS)
- ☐ Certified Asthma Educator (AE-C)
- ☐ Certified Respiratory Therapist (CRT)
- ☐ Certified Pulmonary Function Technologist (CPFT)
- ☐ Neonatal/Pediatric Specialist (CRT-NPS or RRT-NPS)
- ☐ Sleep Disorders Specialist (CRT-SDS or RRT-SDS)
- ☐ Registered Pulmonary Function Technologist (RPFT)
- ☐ Registered Respiratory Therapist (RRT)

29. **If you hold an unexpired nursing credential, which of the following do you hold?**

Select all that apply.

- ☐ Licensed Practical Nurse (LPN)
- ☐ Registered Nurse (RN)

30. **What additional certifications have you completed?**

Select all that apply.

- [ ] Advanced Cardiac Life Support (ACLS)
- [ ] Basic Cardiac Life Support (BCLS)
- [ ] Neonatal Resuscitation Program (NRP)
- [ ] Pediatric Advanced Life Support (PALS)
- [ ] Smoking Cessation or Tobacco Treatment specialist

31. **Which of the following other credentials have you earned that are not expired?**

Select all that apply. Please omit academic degrees, fellowship designations, AHA instructor status, and certificates that do not lead to credentials behind your name (e.g., ACLS, PALS).

- [ ] Certified Cardiographic Technician (CCT)
- [ ] Certified Case Manager (CCM)
- [ ] Certified Hyperbaric Technologist (CHT)
- [ ] Certified Neonatal-Pediatric Transport (C-NPT)
- [ ] Certified Procurement Transplant Coordinator (CPTC)
- [ ] Emergency Medical Technician (EMT)
- [ ] Paramedic
- [ ] Registered Cardiovascular Invasive Specialist (RCIS)
- [ ] Registered EEG Technologist (R.EEG.T)
- [ ] Registered Electrophysiology Technologist (R.EP.T)
- [ ] Registered Polysomnographic Technologist (RPSGT)
- [ ] Registered Vascular or Cardiac Ultrasound Credential (RDMS, RDCS, RVT, RVS)
- [ ] Smoking Cessation specialist
- [ ] Other (please specify)

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Training

32. **Which of the following best describes how you entered and became licensed to be employed in the respiratory care field?**

- ◯ On-the-job training, CRT and RRT not earned at entry
- ◯ In a program that prepared me for the CRT credential only
- ◯ In a program that prepared me for the RRT credential

33. **If you earned a college degree when you became eligible for your respiratory therapy credential, what type of degree was it?**

- ◯ Associate
- ◯ Bachelors
- ◯ Masters
- ◯ Not applicable

34. **What is the highest academic level you have achieved?**

- ◯ Some high school, but no diploma
- ◯ High school diploma or GED
- ◯ Some college, but no degree
- ◯ Associates degree
- ◯ Bachelors degree
- ◯ Masters degree
- ◯ Doctorate degree

* 35. **Do you hold a Baccalaureate or graduate degree in a health-related field?**

- ◯ Yes
- ◯ No

2024 AARC Human Resource Survey of Respiratory Therapists

Health-Related Field

36. **In what field of study is your highest health-related degree?**

- ◯ Biology / Chemistry
- ◯ Health Sciences
- ◯ Healthcare Administration
- ◯ Healthcare Management
- ◯ Health Informatics
- ◯ Medicine
- ◯ Mid-Level Provider
- ◯ Nursing
- ◯ Psychology / Mental Health
- ◯ Public Health
- ◯ Respiratory Therapy
- ◯ Other (please specify)

2024 AARC Human Resource Survey of Respiratory Therapists

Pursuing Degree

* 37. **Are you pursuing an academic degree that is higher than one you have already earned?**

- ◯ Yes
- ◯ No

38. **Does your employer offer a program that discounts, reimburses, or forgives tuition?**

- ◯ Yes
- ◯ No
- ◯ I don't know.

Higher Academic Degree

39. **What best describes your goal for pursuing a degree higher than one you have already earned?**

- ◯ Enhance my respiratory care career
- ◯ Change to a new career outside respiratory care

2024 AARC Human Resource Survey of Respiratory Therapists

Direct Patient Care

40. In your role, do you provide direct patient care?

- ◯ Yes
- ◯ No

2024 AARC Human Resource Survey of Respiratory Therapists

Clinical Work Assignments

41. **If you work in a setting where therapists are assigned to the management of mechanical ventilation, approximately how many patients receiving mechanical ventilation are assigned to each therapist?**

42. **If you work in an acute care hospital, please indicate the typical percentage of time you spend in each area when providing direct patient care.**

Provide numeric responses excluding the percent sign, e.g., 15 not 15%. Your responses must sum to 100.

Adult ICU	
Pediatric ICU	
Neonatal ICU	
General medical and surgical floor	
Emergency Department	
Telemedicine/telehealth	
Pulmonary rehabilitation	
Pulmonary function lab	
Sleep lab	
Other	

43. **What is the typical percentage of time spent caring for patients with the following diseases/disorders?**

Provide numeric responses excluding the percent sign, e.g., 15 not 15%. Your responses must sum to 100.

Pulmonary (for example, COPD, asthma, cystic fibrosis, interstitial)	
Sleep	
Cardiac	
Neuromuscular	
Non-pulmonary (for example, trauma, surgical)	
Other	

44. **Within the last year, has your employer expected you to deliver therapy to multiple patients in different rooms or locations simultaneously?**

- ◯ Yes
- ◯ No

45. **For approximately what percentage of recent shifts have you been unable to complete all work assigned to you?**

* 46. **Does your employer provide a system that helps you to prioritize your work assignments when providing direct patient care and there is not enough time to complete them all?**

- ◯ Yes
- ◯ No
- ◯ I don't provide direct patient care.

2024 AARC Human Resource Survey of Respiratory Therapists

Prioritization System

47. Briefly describe the prioritization system, including whether it involves software.

48. **How often do you use the prioritization system?**

- ◯ Every day
- ◯ Once a week
- ◯ Once a month
- ◯ Less than once a month

2024 AARC Human Resource Survey of Respiratory Therapists

Protocols

49. **Do you deliver respiratory care by protocol when providing direct patient care?**

- ◯ Yes
- ◯ No
- ◯ I don't provide direct patient care.

A protocol is defined as initiation or modification of a patient care plan following a predetermined structured set of physician orders, instructions or interventions in which the therapist initiates, discontinues, refines, transitions, or restarts therapy as the patient's medical condition dictates.

Avoid confusing 'protocols' with programs that discontinue therapy without a reorder, flag therapy to be reordered, or modify therapy by standing order.

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Optional Questions

50. **With which of the following do you identify?**

- ◯ Man
- ◯ Woman
- ◯ Non-binary
- ◯ Prefer to self-describe
- ◯ Prefer not to say

51. With which of the following do you primarily identify?
Select one or more.

- ☐ American Indian or Alaska Native
- ☐ Asian or Asian origin
- ☐ Black or African American
- ☐ Hispanic, Latino, or Spanish origin
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Middle Eastern or North African
- ☐ White
- ☐ Multiracial
- ☐ Prefer to self-describe (please specify)
- ☐ Prefer not to respond

2024 AARC Human Resource Survey of Respiratory Therapists

AARC Membership

52. **Are you a member of the AARC?**

- ◯ Yes
- ◯ No

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2024 AARC Human Resource Survey of Respiratory Therapists

Drawing Registration

For submitting a completed survey, you can receive a copy of the report describing the results.

Your survey responses will not be associated with your personal information.

53. **Please provide your contact information to receive the report.**

Name:	
Email Address:	
Phone Number:	
AARC Member #:	

2024 AARC Human Resource Survey of Respiratory Therapists

Conclusion

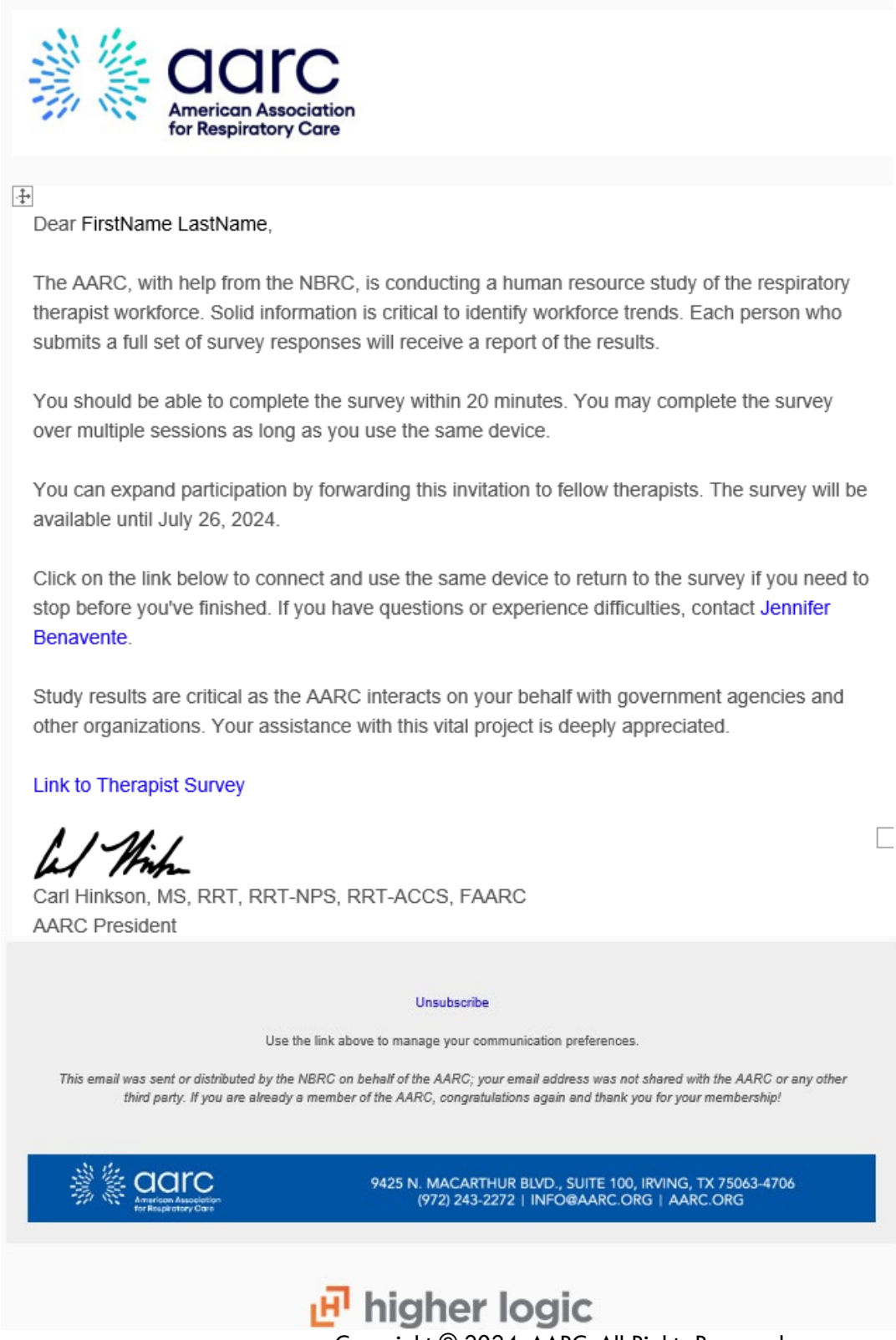
Thank you for completing the AARC Human Resource Survey for Respiratory Therapists.

Please forward the link to the survey to other respiratory therapists by clicking on the link below.

Send Email to Colleagues

Appendix B. Email and Postcard Invitations and Social Media Posts

Email invitation – June 15



aarc
American Association for Respiratory Care

Dear FirstName LastName,

The AARC, with help from the NBRC, is conducting a human resource study of the respiratory therapist workforce. Solid information is critical to identify workforce trends. Each person who submits a full set of survey responses will receive a report of the results.

You should be able to complete the survey within 20 minutes. You may complete the survey over multiple sessions as long as you use the same device.

You can expand participation by forwarding this invitation to fellow therapists. The survey will be available until July 26, 2024.

Click on the link below to connect and use the same device to return to the survey if you need to stop before you've finished. If you have questions or experience difficulties, contact Jennifer Benavente.

Study results are critical as the AARC interacts on your behalf with government agencies and other organizations. Your assistance with this vital project is deeply appreciated.

Link to Therapist Survey

Carl Hinkson, MS, RRT, RRT-NPS, RRT-ACCS, FAARC
AARC President

Unsubscribe

Use the link above to manage your communication preferences.

This email was sent or distributed by the NBRC on behalf of the AARC; your email address was not shared with the AARC or any other third party. If you are already a member of the AARC, congratulations again and thank you for your membership!

aarc
American Association for Respiratory Care

9425 N. MACARTHUR BLVD., SUITE 100, IRVING, TX 75063-4706
(972) 243-2272 | INFO@AARC.ORG | AARC.ORG

higher logic

Emailed reminder – August 2

Dear FirstName LastName,

If you have already completed the AARC Human Resource survey, we thank you! If you haven't yet, please read on.

The AARC, with help from the NBRC, is conducting a human resource study of the respiratory therapist workforce. Solid information is critical to identify workforce trends. Each person who submits a full set of survey responses will receive a report of the results.

You should be able to complete the survey within 20 minutes. You may complete the survey over multiple sessions as long as you use the same device.
You can expand participation by forwarding this invitation to fellow therapists. The survey deadline has been extended to **Friday, August 16**.

Click on the link below to connect and use the same device to return to the survey if you need to stop before you've finished. If you have questions or experience difficulties, contact Jennifer Benavente.

Study results are critical as the AARC interacts on your behalf with government agencies and other organizations. Your assistance with this vital project is deeply appreciated.

Link to Therapist Survey

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Unsubscribe

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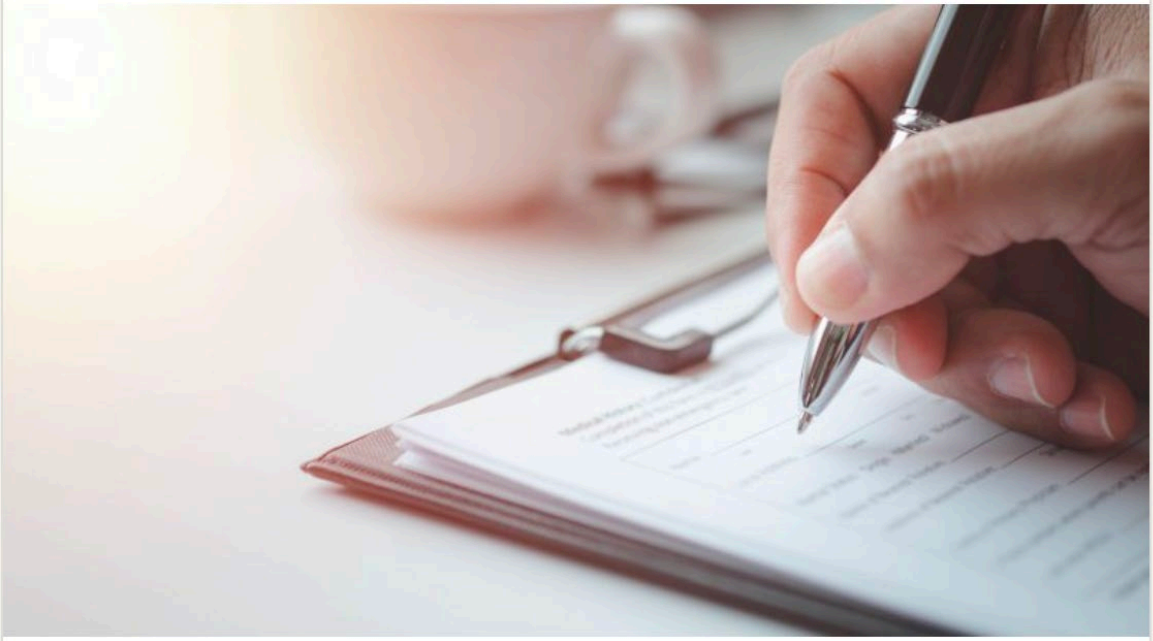
This email was sent or distributed by the NBRC on behalf of the AARC; your email address was not shared with the AARC or any other third party. If you are already a member of the AARC, congratulations again and thank you for your membership!

Sample social media posts

American Association for Respiratory Care (AARC)
41,912 followers
1mo •

Help us shape the future of respiratory therapy! The AARC needs your input for our latest HR study. Your voice matters—take the survey today! **https://lnkd.in/gGTSE8gJ #Healthcare #RespiratoryTherapy #AARCResearch #TakeTheSurvey**



The AARC is launching a new human resource study, and we need your help! By participating, you'll contribute to vital strategic planning, government relations, and programming. Our past studies, including the 2017 education survey, have made significant impacts. Join us in shaping the future—take the survey now! **https://lnkd.in/gGTSE8gJ #AARC #RespiratoryTherapy #HealthcareResearch #TakeTheSurvey**

Appendix C. Frequency Tables

Table 49. Respondents by State

Return to Figure 2

		Frequency	Percent	Valid Percent	Cumulative Percent	Population Reported from State Agency/Chapter
Valid	AL	83	1.7	1.9	1.9	3,216
	AK	10	.2	.2	2.2	150
	AZ	109	2.3	2.5	4.7	4,328
	AR	75	1.6	1.7	6.4	2,232
	CA	363	7.6	8.4	14.9	21,198
	CO	84	1.8	2.0	16.8	6,174
	CT	43	.9	1.0	17.8	1,590
	DE	26	.5	.6	18.4	880
	DC	10	.2	.2	18.7	925
	FL	249	5.2	5.8	24.5	15,191
	GA	166	3.5	3.9	28.3	6,243
	HI	12	.3	.3	28.6	860
	ID	23	.5	.5	29.1	2,923
	IL	142	3.0	3.3	32.4	5,121
	IN	136	2.8	3.2	35.6	5,692
	IA	53	1.1	1.2	36.8	4,418
	KS	51	1.1	1.2	38.0	2,072
	KY	94	2.0	2.2	40.2	4,100
	LA	82	1.7	1.9	42.1	3,631
	ME	21	.4	.5	42.6	1,017
	MD	63	1.3	1.5	44.1	3,279
	MA	62	1.3	1.4	45.5	2,915
	MI	143	3.0	3.3	48.8	5,489
	MN	45	.9	1.0	49.9	2,278
	MS	52	1.1	1.2	51.1	2,762
	MO	148	3.1	3.4	54.5	5,620
	MT	9	.2	.2	54.8	521
	NE	34	.7	.8	55.5	1,382
	NV	27	.6	.6	56.2	1,948
	NH	19	.4	.4	56.6	824

		Frequency	Percent	Valid Percent	Cumulative Percent	Population Reported from State Agency/Chapter
	NJ	71	1.5	1.7	58.3	3,649
	NM	22	.5	.5	58.8	1,443
	NY	152	3.2	3.5	62.3	7,685
	NC	165	3.4	3.8	66.2	6,147
	ND	16	.3	.4	66.5	698
	OH	230	4.8	5.4	71.9	9,374
	OK	66	1.4	1.5	73.4	2,684
	OR	60	1.3	1.4	74.8	2,180
	PA	130	2.7	3.0	77.8	7,848
	RI	25	.5	.6	78.4	593
	SC	72	1.5	1.7	80.1	2,167
	SD	13	.3	.3	80.4	614
	TN	120	2.5	2.8	83.2	5,278
	TX	370	7.7	8.6	91.8	14,638
	UT	44	.9	1.0	92.8	2,548
	VT	11	.2	.3	93.1	695
	VA	86	1.8	2.0	95.1	4,902
	WA	67	1.4	1.6	96.6	3,718
	WV	41	.9	1.0	97.6	2,122
	WI	82	1.7	1.9	99.5	3,071
	WY	15	.3	.3	99.8	431
	PR	5	.1	.1	100.0	2,727
	Guam	2	.0	.0	100.0	NA
	Total	4299	89.8	100.0		204,191
Missing	System	488	10.2			
Total		4787	100.0			

Table 50. Distribution of respondents by region

Return to Figure 3

		Frequency	Percent	Valid Percent	Cumulative Percent	Population Reported by State Agencies/Chapters
Valid	Northeast	534	11.2	12.4	12.4	26,816
	South	1820	38.0	42.4	54.8	80,397
	Midwest	1093	22.8	25.5	80.3	45,829
	West	845	17.7	19.7	100.0	48,422
	Total	4292	89.7	100.0		
Missing	Outside US	7	.1			2,727
	System	488	10.2			
	Total	495	10.3			
Total		4787	100.0			204,191

Northeast – MA, RI, NH, ME, VT, CT, NJ, NY, PA
South – DC, DE, MD, VA, WV, NC, SC, GA, FL, AL, TN, MS, KY, LA, AR, OK, TX
Midwest – OH, IN, MI, WI, IL, IA, MN, SD, ND, MO, KS, NE
West – MT, CO, WY, ID, UT, AZ, NM, NV, CA, HI, OR, WA, AK

Table 51. Distribution by census division

Return to Figure 4

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 - New England	181	3.8	4.2	4.2
	2 - Middle Atlantic	353	7.4	8.2	12.4
	3 - South Atlantic	878	18.3	20.5	32.9
	4 - East North Central	733	15.3	17.1	50.0
	5 - West North Central	360	7.5	8.4	58.4
	6 - East South Central	349	7.3	8.1	66.5
	7 - West South Central	593	12.4	13.8	80.3
	8 - Mountain	333	7.0	7.8	88.1
	9 - Pacific	512	10.7	11.9	100.0
	Total	4292	89.7	100.0	
Missing	Outside US	7	.1		
	System	488	10.2		
	Total	495	10.3		
Total		4787	100.0		

1 – ME, VT, NH, MA, RI, CT; 2 – NY, PA, NJ; 3 – WV, VA, MD, DC, DE, NC, SC, GA, FL; 4 – MI, OH, IN, IL, WI; 5 – ND, SD, MN, NE, IA, KS, MO; 6 – KY, TN, MS, AL; 7 – OK, AR, LA, TX; 8 – MT, ID, WY, NV, UT, CO, AZ, NM; 9 – WA, OR, CA, AK, HI

Table 52. Year of intended departure from respiratory therapist workforce

Return to Figure 9

		Frequency	Percent	Valid Percent	Cumulative Percent	Projected cumulative number form 2024 population that will have left the profession
Valid	2023	8	.2	.2	.2	408
	2024	131	2.7	3.1	3.3	6,738
	2025	243	5.1	5.7	9.0	18,377
	2026	310	6.5	7.3	16.2	33,079
	2027	223	4.7	5.2	21.5	43,901
	2028	189	3.9	4.4	25.9	52,885
	2029	169	3.5	4.0	29.9	61,053
	2030	409	8.5	9.6	39.5	80,655
	2031	82	1.7	1.9	41.4	84,535
	2032	110	2.3	2.6	44.0	89,844
	2033	58	1.2	1.4	45.3	92,499
	2034	248	5.2	5.8	51.1	104,342
	2035	254	5.3	6.0	57.1	116,593
	2036	81	1.7	1.9	59.0	120,473
	2037	52	1.1	1.2	60.2	122,923
	2038	55	1.1	1.3	61.5	125,577
	2039	78	1.6	1.8	63.3	129,253
	2040	293	6.1	6.9	70.2	143,342
	2041	24	.5	.6	70.8	144,567
	2042	30	.6	.7	71.5	145,997
	2043	25	.5	.6	72.1	147,222
	2044	180	3.8	4.2	76.3	155,798
	2045	184	3.8	4.3	80.6	164,578
	2046	31	.6	.7	81.3	166,007
	2047	36	.8	.8	82.2	167,845
	2048	35	.7	.8	83.0	169,479
	2049	37	.8	.9	83.9	171,316
	2050	221	4.6	5.2	89.0	181,730
	2051	12	.3	.3	89.3	182,343

		Frequency	Percent	Valid Percent	Cumulative Percent	Projected cumulative number form 2024 population that will have left the profession
	2052	20	.4	.5	89.8	183,364
	2053	15	.3	.4	90.1	183,976
	2054	100	2.1	2.3	92.5	188,877
	2055	77	1.6	1.8	94.3	192,552
	2056	15	.3	.4	94.7	193,369
	2057	10	.2	.2	94.9	193,777
	2058	6	.1	.1	95.0	193,981
	2059	10	.2	.2	95.3	194,594
	2060	67	1.4	1.6	96.8	197,657
	2061	5	.1	.1	97.0	198,065
	2062	6	.1	.1	97.1	198,269
	2063	6	.1	.1	97.2	198,474
	2064	23	.5	.5	97.8	199,699
	2065	35	.7	.8	98.6	201,332
	2066	5	.1	.1	98.7	201,537
	2067	3	.1	.1	98.8	201,741
	2068	4	.1	.1	98.9	201,945
	2069	2	.0	.0	98.9	201,945
	2070	9	.2	.2	99.1	202,353
	2071	1	.0	.0	99.2	202,557
	2074	4	.1	.1	99.2	202,557
	2075	4	.1	.1	99.3	202,762
	2078	1	.0	.0	99.4	202,966
	2080	1	.0	.0	99.4	202,966
	2090	2	.0	.0	99.4	202,966
	2099	1	.0	.0	99.5	203,170
	2100	23	.5	.5	100.0	204,191
	Total	4263	89.1	100.0		
Missing	System	524	10.9			
Total		4787	100.0			

Table 53. Setting of primary job

Return to Figure 10

		Frequency	Percent	Valid Percent	Cumulative Percent	Population Projection*
Valid	Acute care hospital	3206	67.0	76.2	76.2	136,753
	DME/Home care	188	3.9	4.5	80.7	8,019
	Long-term care/Rehab/SNF	308	6.4	7.3	88.0	13,138
	Education program	137	2.9	3.3	91.3	5,844
	Manufacturer/Distributor	36	.8	.9	92.1	1,536
	Outpatient facility	207	4.3	4.9	97.0	8,830
	Physician's office	99	2.1	2.4	99.4	4,223
	Professional / Trade association	26	.5	.6	100.0	1,109
	Total	4207	87.9	100.0		
Missing	System	580	12.1			
Total		4787	100.0			

*Projected population = (Frequency/4,787) x 204,191, where 204,191 = number of active therapists in total population. Projected total does not equal the sum across job title due to cases with missing data.

Table 54. Hours worked per week at Primary job in Acute Care Hospital

Return to Table 9

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	15	.5	.5	.5
	2	3	.1	.1	.6
	3	2	.1	.1	.6
	4	6	.2	.2	.8
	5	3	.1	.1	.9
	6	1	.0	.0	.9
	8	16	.5	.5	1.4
	10	7	.2	.2	1.7
	12	58	1.8	1.8	3.5
	13	3	.1	.1	3.6
	15	6	.2	.2	3.8
	16	10	.3	.3	4.1
	17	1	.0	.0	4.1
	18	6	.2	.2	4.3
	20	36	1.1	1.1	5.4
	24	207	6.5	6.5	11.9
	25	10	.3	.3	12.2

	Frequency	Percent	Valid Percent	Cumulative Percent
26	6	.2	.2	12.4
28	8	.3	.3	12.7
30	53	1.7	1.7	14.3
32	50	1.6	1.6	15.9
33	1	.0	.0	15.9
34	2	.1	.1	16.0
35	14	.4	.4	16.4
36	1316	41.3	41.3	57.7
37	32	1.0	1.0	58.7
38	44	1.4	1.4	60.1
39	2	.1	.1	60.2
40	764	24.0	24.0	84.1
41	1	.0	.0	84.2
42	21	.7	.7	84.8
43	1	.0	.0	84.8
44	16	.5	.5	85.4
45	45	1.4	1.4	86.8
46	6	.2	.2	87.0
48	179	5.6	5.6	92.6
49	3	.1	.1	92.7
50	89	2.8	2.8	95.5
52	8	.3	.3	95.7
55	7	.2	.2	95.9
56	1	.0	.0	96.0
60	66	2.1	2.1	98.0
65	1	.0	.0	98.1
68	1	.0	.0	98.1
70	2	.1	.1	98.1
72	25	.8	.8	98.9
75	3	.1	.1	99.0
76	1	.0	.0	99.1
80	19	.6	.6	99.7
84	3	.1	.1	99.7
85	1	.0	.0	99.8
88	1	.0	.0	99.8
90	6	.2	.2	100.0

	Frequency	Percent	Valid Percent	Cumulative Percent
Total	3188	100.0	100.0	

Table 55. Hours worked per week at Second job in Acute Care Hospital

Return to Table 9

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	14	3.4	3.4	3.4
	2	1	.2	.2	3.7
	3	6	1.4	1.5	5.2
	4	17	4.1	4.2	9.4
	5	2	.5	.5	9.9
	6	22	5.3	5.4	15.3
	8	33	7.9	8.1	23.4
	9	1	.2	.2	23.6
	10	4	1.0	1.0	24.6
	11	1	.2	.2	24.9
	12	167	40.0	41.1	66.0
	13	1	.2	.2	66.3
	15	2	.5	.5	66.7
	16	4	1.0	1.0	67.7
	18	4	1.0	1.0	68.7
	20	9	2.2	2.2	70.9
	21	1	.2	.2	71.2
	24	50	12.0	12.3	83.5
	25	2	.5	.5	84.0
	30	2	.5	.5	84.5
	34	1	.2	.2	84.7
	36	41	9.8	10.1	94.8
	37	2	.5	.5	95.3
	38	3	.7	.7	96.1
	40	11	2.6	2.7	98.8
	45	1	.2	.2	99.0
	48	3	.7	.7	99.8
	60	1	.2	.2	100.0
	Total	406	97.4	100.0	
Missing	System	11	2.6		
Total		417	100.0		

Table 56. Hours worked per week at Primary job in DME/Home Care

Return to Table 10

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2	1.1	1.1	1.1
	4	2	1.1	1.1	2.1
	5	4	2.1	2.1	4.3
	6	1	.5	.5	4.8
	10	7	3.7	3.7	8.6
	14	1	.5	.5	9.1
	16	2	1.1	1.1	10.2
	20	3	1.6	1.6	11.8
	24	7	3.7	3.7	15.5
	25	1	.5	.5	16.0
	26	1	.5	.5	16.6
	28	1	.5	.5	17.1
	30	10	5.3	5.3	22.5
	32	3	1.6	1.6	24.1
	35	3	1.6	1.6	25.7
	36	8	4.3	4.3	29.9
	38	1	.5	.5	30.5
	40	95	50.8	50.8	81.3
	41	1	.5	.5	81.8
	42	1	.5	.5	82.4
	44	2	1.1	1.1	83.4
	45	9	4.8	4.8	88.2
	48	2	1.1	1.1	89.3
	50	9	4.8	4.8	94.1
	55	1	.5	.5	94.7
	56	1	.5	.5	95.2
	60	2	1.1	1.1	96.3
	70	2	1.1	1.1	97.3
	75	1	.5	.5	97.9
	80	4	2.1	2.1	100.0
	Total	187	100.0	100.0	

Table 57. Hours worked per week at Second job in DME/Home Care

Return to Table 10

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	6	9.8	9.8	9.8
	2	5	8.2	8.2	18.0
	3	1	1.6	1.6	19.7
	4	9	14.8	14.8	34.4
	5	5	8.2	8.2	42.6
	6	2	3.3	3.3	45.9
	8	7	11.5	11.5	57.4
	10	7	11.5	11.5	68.9
	12	3	4.9	4.9	73.8
	14	1	1.6	1.6	75.4
	15	1	1.6	1.6	77.0
	16	3	4.9	4.9	82.0
	20	5	8.2	8.2	90.2
	24	1	1.6	1.6	91.8
	40	4	6.6	6.6	98.4
	50	1	1.6	1.6	100.0
	Total	61	100.0	100.0	

Table 58. Hours worked per week at Primary job in Long Term Care/Rehab/SNF

Return to Table 11

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	1	.3	.3	.3
	4	2	.7	.7	1.0
	6	1	.3	.3	1.3
	8	2	.7	.7	2.0
	12	9	3.0	3.0	4.9
	15	1	.3	.3	5.3
	16	3	1.0	1.0	6.3
	20	4	1.3	1.3	7.6
	22	1	.3	.3	7.9
	24	21	6.9	6.9	14.8
	30	11	3.6	3.6	18.4
	32	10	3.3	3.3	21.7

		Frequency	Percent	Valid Percent	Cumulative Percent
	33	1	.3	.3	22.0
	35	4	1.3	1.3	23.4
	36	111	36.5	36.5	59.9
	37	2	.7	.7	60.5
	38	1	.3	.3	60.9
	40	72	23.7	23.7	84.5
	42	1	.3	.3	84.9
	44	3	1.0	1.0	85.9
	45	4	1.3	1.3	87.2
	47	1	.3	.3	87.5
	48	15	4.9	4.9	92.4
	50	13	4.3	4.3	96.7
	55	1	.3	.3	97.0
	60	5	1.6	1.6	98.7
	70	1	.3	.3	99.0
	72	2	.7	.7	99.7
	80	1	.3	.3	100.0
	Total	304	100.0	100.0	

Table 59. Hours worked per week at Second job in Long Term Care/Rehab/SNF

Return to Table 11

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2	1.7	1.7	1.7
	2	1	.8	.8	2.5
	4	7	5.9	5.9	8.5
	5	1	.8	.8	9.3
	6	9	7.6	7.6	16.9
	8	10	8.5	8.5	25.4
	10	5	4.2	4.2	29.7
	11	1	.8	.8	30.5
	12	42	35.6	35.6	66.1
	14	1	.8	.8	66.9
	16	1	.8	.8	67.8
	18	1	.8	.8	68.6
	20	5	4.2	4.2	72.9
	22	2	1.7	1.7	74.6

		Frequency	Percent	Valid Percent	Cumulative Percent
	23	1	.8	.8	75.4
	24	20	16.9	16.9	92.4
	25	1	.8	.8	93.2
	30	3	2.5	2.5	95.8
	36	3	2.5	2.5	98.3
	40	1	.8	.8	99.2
	48	1	.8	.8	100.0
	Total	118	100.0	100.0	

Table 60. Hours worked per week at Primary job at Education Program

Return to Table 12

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2	1.5	1.5	1.5
	4	2	1.5	1.5	2.9
	5	2	1.5	1.5	4.4
	6	1	.7	.7	5.1
	8	1	.7	.7	5.9
	9	1	.7	.7	6.6
	10	4	2.9	2.9	9.6
	12	1	.7	.7	10.3
	15	1	.7	.7	11.0
	16	3	2.2	2.2	13.2
	20	6	4.4	4.4	17.6
	24	3	2.2	2.2	19.9
	25	1	.7	.7	20.6
	30	8	5.9	5.9	26.5
	32	2	1.5	1.5	27.9
	35	5	3.7	3.7	31.6
	36	4	2.9	2.9	34.6
	40	58	42.6	42.6	77.2
	45	4	2.9	2.9	80.1
	46	1	.7	.7	80.9
	50	16	11.8	11.8	92.6
	60	8	5.9	5.9	98.5
	65	1	.7	.7	99.3
	80	1	.7	.7	100.0

	Frequency	Percent	Valid Percent	Cumulative Percent
Total	136	100.0	100.0	

Table 61. Hours worked per week at Second job at Education Program

Return to Table 12

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	4	3.9	4.0	4.0
	2	2	1.9	2.0	6.1
	3	3	2.9	3.0	9.1
	4	9	8.7	9.1	18.2
	5	3	2.9	3.0	21.2
	6	6	5.8	6.1	27.3
	7	1	1.0	1.0	28.3
	8	14	13.6	14.1	42.4
	9	2	1.9	2.0	44.4
	10	16	15.5	16.2	60.6
	12	9	8.7	9.1	69.7
	14	1	1.0	1.0	70.7
	15	4	3.9	4.0	74.7
	16	6	5.8	6.1	80.8
	17	1	1.0	1.0	81.8
	18	1	1.0	1.0	82.8
	19	2	1.9	2.0	84.8
	20	7	6.8	7.1	91.9
	24	2	1.9	2.0	93.9
	25	1	1.0	1.0	94.9
	30	1	1.0	1.0	96.0
	35	1	1.0	1.0	97.0
	40	2	1.9	2.0	99.0
	50	1	1.0	1.0	100.0
	Total	99	96.1	100.0	
Missing	System	4	3.9		
Total		103	100.0		

Table 62. Hours worked per week at Primary job in Manufacturer/Distributor

Return to Table 13

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	5	3	8.3	8.3	8.3
	15	1	2.8	2.8	11.1
	24	2	5.6	5.6	16.7
	30	3	8.3	8.3	25.0
	35	1	2.8	2.8	27.8
	40	18	50.0	50.0	77.8
	50	5	13.9	13.9	91.7
	55	2	5.6	5.6	97.2
	60	1	2.8	2.8	100.0
	Total	36	100.0	100.0	

Table 63. Hours worked per week at Second job in Manufacturing/Distribution

Return to Table 13

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	4	23.5	23.5	23.5
	2	2	11.8	11.8	35.3
	4	2	11.8	11.8	47.1
	5	3	17.6	17.6	64.7
	8	1	5.9	5.9	70.6
	10	1	5.9	5.9	76.5
	12	3	17.6	17.6	94.1
	20	1	5.9	5.9	100.0
	Total	17	100.0	100.0	

Table 64. Hours worked per week at Primary job at Outpatient Facility

Return to Table 14

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	1	.5	.5	.5
	8	2	1.0	1.0	1.5
	9	3	1.5	1.5	2.9
	10	4	2.0	2.0	4.9
	12	2	1.0	1.0	5.9
	16	5	2.4	2.4	8.3
	19	1	.5	.5	8.8

	Frequency	Percent	Valid Percent	Cumulative Percent
20	8	3.9	3.9	12.7
21	1	.5	.5	13.2
24	10	4.9	4.9	18.0
25	2	1.0	1.0	19.0
26	1	.5	.5	19.5
28	2	1.0	1.0	20.5
30	7	3.4	3.4	23.9
32	8	3.9	3.9	27.8
34	2	1.0	1.0	28.8
35	4	2.0	2.0	30.7
36	20	9.8	9.8	40.5
37	1	.5	.5	41.0
38	7	3.4	3.4	44.4
40	99	48.3	48.3	92.7
45	3	1.5	1.5	94.1
48	3	1.5	1.5	95.6
50	4	2.0	2.0	97.6
55	1	.5	.5	98.0
70	1	.5	.5	98.5
72	1	.5	.5	99.0
78	1	.5	.5	99.5
80	1	.5	.5	100.0
Total	205	100.0	100.0	

Table 65. Hours worked per week at Second job at Outpatient facility

Return to Table 14

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	1	2.9	3.1	3.1
	2	1	2.9	3.1	6.3
	5	1	2.9	3.1	9.4
	8	4	11.8	12.5	21.9
	10	3	8.8	9.4	31.3
	12	5	14.7	15.6	46.9
	16	2	5.9	6.3	53.1
	20	3	8.8	9.4	62.5
	24	6	17.6	18.8	81.3

		Frequency	Percent	Valid Percent	Cumulative Percent
	40	5	14.7	15.6	96.9
	42	1	2.9	3.1	100.0
	Total	32	94.1	100.0	
Missing	System	2	5.9		
Total		34	100.0		

Table 66. Hours worked per week at Primary job in a Physician's office

Return to Table 15

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	2	2.0	2.0	2.0
	9	1	1.0	1.0	3.0
	10	1	1.0	1.0	4.0
	15	1	1.0	1.0	5.1
	16	5	5.1	5.1	10.1
	20	5	5.1	5.1	15.2
	21	1	1.0	1.0	16.2
	24	3	3.0	3.0	19.2
	30	12	12.1	12.1	31.3
	32	5	5.1	5.1	36.4
	34	1	1.0	1.0	37.4
	35	4	4.0	4.0	41.4
	36	6	6.1	6.1	47.5
	37	1	1.0	1.0	48.5
	38	2	2.0	2.0	50.5
	40	39	39.4	39.4	89.9
	42	2	2.0	2.0	91.9
	44	1	1.0	1.0	92.9
	45	3	3.0	3.0	96.0
	50	3	3.0	3.0	99.0
	55	1	1.0	1.0	100.0
	Total	99	100.0	100.0	

Table 67. Hours worked per week at Second job in a Physician's office

Return to Table 15

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	4	5	17.9	18.5	18.5
	5	2	7.1	7.4	25.9
	6	1	3.6	3.7	29.6
	7	1	3.6	3.7	33.3
	8	5	17.9	18.5	51.9
	9	1	3.6	3.7	55.6
	10	1	3.6	3.7	59.3
	12	5	17.9	18.5	77.8
	16	3	10.7	11.1	88.9
	20	1	3.6	3.7	92.6
	30	1	3.6	3.7	96.3
	40	1	3.6	3.7	100.0
	Total	27	96.4	100.0	
Missing	System	1	3.6		
Total		28	100.0		

Table 68. Hours worked per week at Primary job for a Professional / Trade association

Return to Table 16

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	1	3.8	3.8	3.8
	4	1	3.8	3.8	7.7
	5	1	3.8	3.8	11.5
	16	1	3.8	3.8	15.4
	24	1	3.8	3.8	19.2
	30	1	3.8	3.8	23.1
	32	1	3.8	3.8	26.9
	36	2	7.7	7.7	34.6
	40	13	50.0	50.0	84.6
	48	2	7.7	7.7	92.3
	50	1	3.8	3.8	96.2
	59	1	3.8	3.8	100.0
	Total	26	100.0	100.0	

Table 69. Hours worked per week at Second job for a Professional / Trade association

Return to Table 16

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	3	20.0	20.0	20.0
	2	1	6.7	6.7	26.7
	4	1	6.7	6.7	33.3
	5	1	6.7	6.7	40.0
	8	1	6.7	6.7	46.7
	10	3	20.0	20.0	66.7
	12	1	6.7	6.7	73.3
	20	1	6.7	6.7	80.0
	25	1	6.7	6.7	86.7
	30	1	6.7	6.7	93.3
	40	1	6.7	6.7	100.0
	Total	15	100.0	100.0	

Table 70. Job satisfaction

Return to Figure 36

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	176	3.7	5.0	5.0
	1	175	3.7	5.0	10.0
	2	309	6.5	8.8	18.8
	3	874	18.3	24.9	43.7
	4	1006	21.0	28.7	72.3
	5	971	20.3	27.7	100.0
	Total	3511	73.3	100.0	
Missing	System	1276	26.7		
Total		4787	100.0		

Table 71. Area of lowest job satisfaction

Return to Figure 37

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Compensation and benefits	1096	22.9	29.7	29.7
	Department administration and supervision	638	13.3	17.3	47.0
	Involvement in operational decisions	124	2.6	3.4	50.4
	Involvement in patient care decisions	140	2.9	3.8	54.2
	Opportunities for advancement	396	8.3	10.7	64.9
	Range of respiratory care services	133	2.8	3.6	68.5
	Workload	483	10.1	13.1	81.6
	None of these	679	14.2	18.4	100.0
	Total	3689	77.1	100.0	
Missing	System	1098	22.9		
Total		4787	100.0		

Table 72. Area of greatest job satisfaction

Return to Figure 38

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Compensation and benefits	587	12.3	15.9	15.9
	Department administration and supervision	367	7.7	10.0	25.9
	Involvement in operational decisions	179	3.7	4.9	30.7
	Involvement in patient care decisions	905	18.9	24.5	55.3
	Opportunities for advancement	97	2.0	2.6	57.9
	Range of respiratory care services	518	10.8	14.0	72.0
	Workload	402	8.4	10.9	82.9
	None of these	632	13.2	17.1	100.0
	Total	3687	77.0	100.0	
Missing	System	1100	23.0		
Total		4787	100.0		

Table 73. Strongest reason for employment change

Return to Figure 39

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Compensation and benefits	460	9.6	16.1	16.1
	Department administration and supervision	333	7.0	11.7	27.8
	Involvement in operational decisions	17	.4	.6	28.4
	Involvement in patient care decisions	27	.6	.9	29.4
	Layoffs	69	1.4	2.4	31.8
	Opportunities for advancement	144	3.0	5.1	36.9
	Range of respiratory care services	37	.8	1.3	38.2
	Relocation	265	5.5	9.3	47.5
	Workload	167	3.5	5.9	53.3
	None of these	1330	27.8	46.7	100.0
	Total	2849	59.5	100.0	
Missing	System	1938	40.5		
Total		4787	100.0		

Table 74. Job titles

Return to Figure 40

		Frequency	Percent	Valid Percent	Cumulative Percent	Population Projection*
	Manager/Director or a Dept, Program, or System	350	7.3	9.5	9.5	14,929
	Supervisor	226	4.7	6.1	15.6	9,640
	Staff Therapist	2242	46.8	60.8	76.4	95,633
	Clinical Specialist	196	4.1	5.3	81.7	8,360
	Department Educator	60	1.3	1.6	83.3	2,559
	Disease Manager/Patient Educator	56	1.2	1.5	84.8	2,389
	Quality/Compliance Coordinator/Manager	12	.3	.3	85.1	512
	Informatics Specialist (e.g., Clinical Analyst, Information Specialist)	9	.2	.2	85.4	384
	Pulmonary Function Technologist	219	4.6	5.9	91.3	9,342
	Sleep Technologist	39	.8	1.1	92.4	1,664
	ECMO/ECLS Specialist	27	.6	.7	93.1	1,152
	Rehabilitation Specialist (e.g., Cardiac, Pulmonary)	69	1.4	1.9	95.0	2,943
	Flight/Transport Therapist	34	.7	.9	95.9	1,450
	Research Coordinator/Associate	8	.2	.2	96.1	341
	Academic Educator (e.g., PD, DCE, faculty)	84	1.8	2.3	98.4	3,583
	Industry Clinical Specialist, Representative or Salesperson	30	.6	.8	99.2	1,280
	Other	29	.6	.8	100.0	1,237
	Total	3690	77.1	100.0		
Missing	System	1097	22.9			
Total		4787	100.0			

* Projected population = (Frequency/4,787) x 204,191, where 204,191 = number of active therapists in total population. Projected total does not equal the sum across job title due to cases with missing data.

Table 75. NBRC credential maintenance requirement by employer

Return to Figure 41

		Frequency	Percent	Valid Percent	Cumulative Percent	Projected Population*
Valid	Yes	2960	61.8	81.5	81.5	126,560
	No	671	14.0	18.5	100.0	28,622
	Total	3631	75.9	100.0		
Missing	System	1156	24.1			
Total		4787	100.0			

* Projected population = (Frequency/4,787) x 204,191, where 204,191 = number of active therapists in total population. Projected total does not equal the sum across NBRC credential maintenance requirement due to cases with missing data.

Table 76. Respiratory therapy training/education

Return to Figure 42

		Frequency	Percent	Valid Percent	Cumulative Percent	Population Projection*
	On-the-job training, CRT and RRT not earned at entry	171	3.6	4.7	4.7	7,294
	In a program that prepared me for the CRT credential only	462	9.7	12.8	17.6	19,707
	In a program that prepared me for the RRT credential	2971	62.1	82.4	100.0	126,729
	Total	3604	75.3	100.0		
Missing	System	1183	24.7			
Total		4787	100.0			

* Projected population = (Frequency/4,787) x 204,191, where 204,191 = number of active therapists in total population. Projected total does not equal the sum across credential training due to cases with missing data.

Table 77. Degree earned when eligible for credential

Return to Figure 43

		Frequency	Percent	Valid Percent	Cumulative Percent	Population Projection*
Valid	Associate	2750	57.4	76.5	76.5	117,302
	Bachelors	567	11.8	15.8	92.2	24,186
	Masters	33	.7	.9	93.2	1,408
	Not applicable	246	5.1	6.8	100.0	
	Total	3596	75.1	100.0		
Missing	System	1191	24.9			
Total		4787	100.0			

* Projected population = (Frequency/4,787) x 204,191, where 204,191 = number of active therapists in total population. Projected total does not equal the sum across degree due to cases with missing data.

Table 78. Highest academic level achieved

Return to Figure 44

		Frequency	Percent	Valid Percent	Cumulative Percent	Population Projection*
Valid	HS diploma/GED	22	.5	.6	.6	938
	Some college but no degree	130	2.7	3.6	4.2	5,545
	Associates	1760	36.8	48.7	52.9	75,073
	Bachelors	1243	26.0	34.4	87.3	53,021
	Masters	415	8.7	11.5	98.8	17,702
	Doctorate	44	.9	1.2	100.0	1,877
	Total	3614	75.5	100.0		
Missing	System	1173	24.5			
Total		4787	100.0			

* Projected population = (Frequency/4,787) x 204,191, where 204,191 = number of active therapists in total population. Projected total does not equal the sum across degree due to cases with missing data.

Table 79. Baccalaureate or Graduate degree in health-related field

Return to Figure 45

		Frequency	Percent	Valid Percent	Cumulative Percent	Population Projection*
Valid	Yes	1252	26.2	34.5	34.5	53,404
	No	2381	49.7	65.5	100.0	101562
	Total	3633	75.9	100.0		
Missing	System	1154	24.1			
Total		4787	100.0			

* Projected population = (Frequency/4,787) x 204,191, where 204,191 = number of active therapists in total population. Projected total does not equal the sum across degree due to cases with missing data.

Table 80. Field of health-related Baccalaureate/Graduate degree

Return to Figure 46

		Frequency	Percent	Valid Percent	Cumulative Percent	Population Projection*
Valid	Biology / Chemistry	46	1.0	3.7	3.7	1,973
	Health Sciences	150	3.1	12.0	15.7	6,434
	Healthcare Administration	189	3.9	15.2	30.9	8,107
	Healthcare Mgmt	81	1.7	6.5	37.4	3,474
	Health Informatics	11	.2	.9	38.3	472
	Medicine	9	.2	.7	39.0	386
	Nursing	13	.3	1.0	40.1	558
	Psychology/Mental health	23	.5	1.8	41.9	987
	Public Health	37	.8	3.0	44.9	1,587
	Resp Therapy / Cardiopulmonary Sciences	600	12.5	48.2	93.1	25,737
	Health Education	9	.2	.7	93.8	386
	Other	77	1.6	6.2	100.0	3,303
	Total	1245	26.0	100.0		
Missing	System	3542	74.0			
Total		4787	100.0			

* Projected population = (Frequency/1,245) x 53,404, where 53,404 = projected number of active therapists holding a health-related baccalaureate/graduate degree in total population. Projected total does not equal the sum across degree due to cases with missing data.

Table 81. Presently pursuing higher academic degree

Return to Figure 47

		Frequency	Percent	Valid Percent	Cumulative Percent	Population Projection*
Valid	Yes	656	13.7	18.1	18.1	27,982
	No	2969	62.0	81.9	100.0	126,644
	Total	3625	75.7	100.0		
Missing	System	1162	24.3			
Total		4787	100.0			

* Projected population = (Frequency/4,787) x 204,191, where 204,191 = number of active therapists in total population. Projected total does not equal the sum across degree due to cases with missing data.

Table 82. Goal for pursuing higher academic degree

Return to Figure 50

		Frequency	Percent	Valid Percent	Cumulative Percent	Population Projection*
Valid	Advance my RT career	339	7.1	52.2	52.2	14,594
	Change my career	311	6.5	47.8	100.0	13,388
	Total	650	13.6	100.0		
Missing	System	4137	86.4			
Total		4787	100.0			

* Projected population = (Frequency/650) x 27,982, where 27,982 = projected number of active therapists pursuing a higher academic degree in total population. Projected total does not equal the sum due to cases with missing data.

Table 83. Employer offers tuition reimbursement

Return to Figure 51

		Frequency	Percent	Valid Percent	Cumulative Percent	Population Projection*
Valid	Yes	2241	46.8	62.1	62.1	95,591
	No	806	16.8	22.3	84.5	34,380
	I don't know	560	11.7	15.5	100.0	23,887
	Total	3607	75.3	100.0		
Missing	System	1180	24.7			
Total		4787	100.0			

* Projected population = (Frequency/4,787) x 204,191, where 204,191 = number of active therapists in total population. Projected total does not equal the sum across degree due to cases with missing data.

Table 84. Provide direct patient care

Return to Figure 52

		Frequency	Percent	Valid Percent	Cumulative Percent	Population Projection*
Valid	Yes	3250	67.9	90.3	90.3	138,630
	No	349	7.3	9.7	100.0	14,887
	Total	3599	75.2	100.0		
Missing	System	1188	24.8			
Total		4787	100.0			

* Projected population = (Frequency/4,787) x 204,191, where 204,191 = number of active therapists in total population. Projected total does not equal the sum across degree due to cases with missing data.

Table 85. Patients receiving mechanical ventilation assigned to therapists

Return to Figure 52

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	102	2.1	4.1	4.1
	2	84	1.8	3.4	7.4
	3	145	3.0	5.8	13.2
	4	385	8.0	15.4	28.6
	5	428	8.9	17.1	45.7
	6	480	10.0	19.2	64.9
	7	165	3.4	6.6	71.5
	8	321	6.7	12.8	84.3
	9	25	.5	1.0	85.3
	10	190	4.0	7.6	92.9
	11	5	.1	.2	93.1
	12	75	1.6	3.0	96.1
	13	6	.1	.2	96.3
	14	16	.3	.6	97.0
	15	23	.5	.9	97.9
	16	12	.3	.5	98.4
	17	2	.0	.1	98.4
	18	7	.1	.3	98.7
	19	2	.0	.1	98.8
	20	10	.2	.4	99.2
	21	1	.0	.0	99.2
	22	2	.0	.1	99.3
	25	17	.4	.7	100.0
	Total	2503	52.3	100.0	
Missing	System	2284	47.7		
Total		4787	100.0		

Table 86. Expectation to deliver therapy to multiple patients in different locations simultaneously

Return to Figure 64

		Frequency	Percent	Valid Percent	Cumulative Percent	Population Projection*
Valid	Yes	1424	29.7	47.5	47.5	60,741
	No	1572	32.8	52.5	100.0	67,054
	Total	2996	62.6	100.0		
Missing	System	1791	37.4			
Total		4787	100.0			

* Projected population = (Frequency/4,787) x 204,191, where 204,191 = number of active therapists in total population. Projected total does not equal the sum across degree due to cases with missing data.

Table 87. Frequencies for percentage of recent shifts respondents have been unable to complete all assigned work

Return to Figure 65

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0%	1376	28.7	48.2	48.2
	10%	608	12.7	21.3	69.6
	20%	237	5.0	8.3	77.9
	30%	133	2.8	4.7	82.5
	40%	57	1.2	2.0	84.5
	50%	74	1.5	2.6	87.1
	60%	30	.6	1.1	88.2
	70%	35	.7	1.2	89.4
	80%	68	1.4	2.4	91.8
	90%	71	1.5	2.5	94.3
	100%	163	3.4	5.7	100.0
	Total	2852	59.6	100.0	
Missing	System	1935	40.4		
Total		4787	100.0		

Table 88. Availability of work prioritization system

Return to Figure 66

		Frequency	Percent	Valid Percent	Cumulative Percent	Population Projection*
Valid	Yes	1241	25.9	40.2	40.2	53,370
	No	1784	37.3	57.8	98.0	76,097
	I don't provide direct patient care	62	1.3	2.0	100.0	2,645
	Total	3087	64.5	100.0		
Missing	System	1700	35.5			
Total		4787	100.0			

* Projected population = (Frequency/4,787) x 204,191, where 204,191 = number of active therapists in total population. Projected total does not equal the sum across degree due to cases with missing data.

Table 89. Use of prioritization system

Return to Figure 67

		Frequency	Percent	Valid Percent	Cumulative Percent	Population Projection*
Valid	Every day	669	14.0	59.5	59.5	25,836
	Once a week	97	2.0	8.6	68.1	4,138
	Once a month	82	1.7	7.3	75.4	3,498
	Less than once a month	276	5.8	24.6	100.0	11,773
	Total	1124	23.5	100.0		
Missing	System	3663	76.5			
Total		4787	100.0			

* Projected population = (Frequency/4,787) x 204,191, where 204,191 = number of active therapists in total population. Projected total does not equal the sum across degree due to cases with missing data.

Table 90. Use of protocols to deliver respiratory care

Return to Figure 68

		Frequency	Percent	Valid Percent	Cumulative Percent	Population Projection*
Valid	Yes	2358	49.3	69.1	69.1	100,581
	No	752	15.7	22.0	91.1	32,077
	I don't provide direct patient care	303	6.3	8.9	100.0	12,925
	Total	3413	71.3	100.0		
Missing	System	1374	28.7			
Total		4787	100.0			

* Projected population = (Frequency/4,787) x 204,191, where 204,191 = number of active therapists in total population. Projected total does not equal the sum across degree due to cases with missing data.

Table 91. Gender

Return to Figure 69

		Frequency	Percent	Valid Percent	Cumulative Percent	Population Projection*
Valid	Man	971	17.3	28.3	28.3	41,418
	Woman	2315	41.3	67.6	95.9	98,747
	Non-binary	7	.1	.2	96.1	299
	Prefer to Self Describe	30	.5	.9	97.0	1,280
	Prefer not to Say	103	1.8	3.0	100.0	
	Total	3426	61.1	100.0		
Missing	System	2184	38.9			
Total		5610	100.0			

* Projected population = (Frequency/4,787) x 204,191, where 204,191 = number of active therapists in total population. Projected total does not equal the sum across degree due to cases with missing data.

Table 92. AARC Member

Return to Figure 70

		Frequency	Percent	Valid Percent	Cumulative Percent	Population Projection*
Valid	Yes	2000	41.8	58.5	58.5	85,311
	No	1416	29.6	41.5	100.0	60,400
	Total	3416	71.4	100.0		
Missing	System	1371	28.6			
Total		4787	100.0			

* Projected population = (Frequency/4,787) x 204,191, where 204,191 = number of active therapists in total population. Projected total does not equal the sum across degree due to cases with missing data.

Appendix D. Compiled Comments from Survey Respondents

"What kind of shift do you typically work?" Other responses

- 11 hours (2 responses)
- 12 and 8 hours shifts
- 12 hour day shift
- 12.3
- 12.5 (2 responses)
- 13 (5 responses)
- 13.5 (3 responses)
- 14
- 16 hours per week
- 2
- 2 hours per day
- 2 hrs, 2x per week
- 20-25 hours/week part-time status since COVID-19
- 24 hour shifts (8 responses)
- 4 9's, 3 9's, 1 8 hour in 2 weeks
- 5
- 5 days a week. Start by 8 am end when finished
- 5 hours a week
- 5.5 hour
- 6 to 8
- 6-8 hours
- 6-hour (12 responses)
- 6.5-hour
- 7 (2 responses)
- 7-9 hour/5 days per week to equal 36
- 7.5
- 9 hour alternative work schedule
- 9-hour
- 9-hour
- 9-hour (18 responses)
- 9.5
- Ã—3, 8 hr office days, Ã—2, 8 hr@home
- and on call
- As needed
- Depends from day to day. 12 hours is never real and always longer.
- depends on provider hours. Peds Pulm clinic/PFT lab
- Flexible schedule
- Flexible schedule, work with RCP students
- I am on call unless I am on PTO
- I am PRN
- I make my own schedule
- I try to work 8 hrs but itâ€™s always more
- Monday thru Friday
- On call (4 responses)
- On call 24hrs
- on call for ecmo 1 week a month
- On call for Transport 72 hours plus
- on call post hours
- On call some weekends
- Per diem
- plus on call 36 hours a week
- PRN
- PRN worker
- Remote
- scheduled for 10 but usually 12
- Self scheduling
- Some 24
- Something covering for just 2 hours
- teach 1 class fall and spring semesters
- Teach 4 days a week.
- Teach at college part time- retired program director
- teach online
- Teaching part time
- Teaching Schedule Varies
- Variable
- varies
- varies
- Varies
- varies 8-16 hours
- Varies due to educational location (8-12 depending on day)
- Weekends
- Whatever calls for
- When needed

“What is the title for your primary job?” Other Responses:

- Administrator
- Anesthesia respiratory therapist
- Biologic coordinator
- Blood Gas Lab
- Blood Gas Lab Coordinator
- Cardiac clinic technologies
- CEO
- Clinic Intake Administrator
- Clinical Editor in a Clinical Decision Support Company
- Contractor
- DIAGNOSTIC TECH
- DME
- EEG
- EEG tech, Broncos, EBUS, ION
- Equipment Coordinator (2 responses)
- Hyperbaric Specialist (2 responses)
- Interventional Pulmonary Respiratory Therapist (2 responses)
-
- Moo
- NICU Outreach and Development Coordinator
- no longer employed
- Pulmonary Special Diagnostic Therapist
- Recruiting
- Referral Response Coordinator
- RN (3 responses)

“Other Credentials Earned“ Other Responses

- AACVPR (2 responses)
- AACVPR-cardiac and pulmonary rehab
- Advanced Emergency Medical Technician (AEMT)
- AHA ACLS instructor
- Aha cpr instructor
- AHA Instructor BLS, ACLS and PALS
- AHA Instructor, Training Center Instructor
- ALA/NYSTS
- ASTEP (2 responses)
- BLS instructor (4 responses)
- CADS
- CALA
- CCRP (Certified Cardiac Rehab Professional)
- CCRP, PRC
- Certificate in Pulmonary Rehabilitation, AARC/AACVPR"
- Certified Cardiopulm Technologist
- Certified Clinical Research Coordinator
- Certified COPD educator
- Certified Extremely Low Birth Weight (C-ELBW) (2 responses)
- Certified Flight Paramedic (FP-C)
- certified gerontologist nurse / licensed respiratory therapist
- Certified Healthcare Simulation Educator-Advanced (CHSE-A)
- Certified Hyperbaric Technician
- Certified in pulmonary rehab
- Certified Lactation Counselor
- Certified Pharmacy Technician
- Certified phlebotomist
- Certified Professional Coder
- Ces-A
- CES-A & CES-P (Certified ECMO Specialist Adult/Pediatric via AMSECT)
- Chaplain
- CHEC II (Emergency Preparedness)
- CHES
- CMTE
- CNA (5 responses)
- CNA, MA
- Community Health Educator
- COPD Educator (5 responses)
- CPH
- CPHQ
- CPPS
- CSE (Clinical Sleep Educator)
- D-Tech
- E-AEC
- ECMO Specialist (6 responses)
- Ecmo tech
- Embalmer
- Emergency medical responder
- EMR
- FEMA certifications

- HACP (2 responses)
- Healthcare Administration
- Interventional Pulmonology Assistant
- Interventional Pulmonology Assistant
- Lean six sigma green belt certified
- Lean Six Sigma QI Certification
- LPN
- MA-C, XRT
- Mlt
- NIOSH-Certified Pulmonary Techician
- NRP
- Nrp instructor, advanced burns life support,A3, practical problem solving
- NRP provider & instructor
- OHC-Occupational Hearing conservationist
- PBMS, PBMT, RABT RPT
- Pfccs
- Pharmacy Technician (2 responses)
- PITLS
- PSG
- PTCB
- Pulm Rehab Certification
- PULMONARY DISASE SPECIALIST
- Pulmonary Rehab Certification (2 responses)
- Pulmonary rehab specialist
- Pulmonary Rehabilitation Certificate
- Pulmonary rehabilitation specialist
- Registered Sleep Technician (RST)
- Registered Yoga Teacher
- Research
- RST
- S.T.A.B.L.E. (3 responses)
- S.T.A.B.L.E., TNCC, ATLS
- Sleep Disorders Specialist NBRC
- STABLE, ACLS, BLC, PALS, NRP
- Stress Test technician
- TPATC
- Trauma Nurse Certified & CARES Serious Mental Illness
- WHE

"Other Science Field" Other Responses

- 2 bachelors degrees
- Acupuncture and Traditional Chinese Medicine
- Adult Education and curriculum development
- Allied Health (3 responses)
- allied health education track
- Alternative and complimentary health
- Applied Behavior Analysis
- applied physiology
- Behavioral Science
- Bioethics & Health Policy
- Biomedical Sciences
- biophysics
- BS-Cardiopulmonary Science and BS- Allied Health Leadership
- Business
- Business Administration (4 responses)
- Business management (2 responses)
- Cardiac rehab
- Chiropractic (2 responses)
- Clinical research
- Community Health Education
- Corporate Communications
- Economics
- Education (7 responses)
- Emergency Management
- English
- Executive Leadership Organizational Change
- Exercise Physiologist
- Exercise physiology
- Exercise Science
- Exercise Science (I used in Cardio Pulmo Rehab)
- FINANCE
- Gerontology
- health and wellness, BA
- Health Promotion
- Healthcare Administration and Education
- Healthcare Quality
- Higher Education
- Law (2 responses)
- Master of Arts (Education)
- Master of business administration
- Master of Legal Studies (health care)
- Masters in Health Occupation Education
- MBA (4 responses)
- MBA in Healthcare
- Nutrition
- Occupational therapist
- Organizational Leadership (3 responses)
- Pastoral Counseling
- PhD in college student development
- Physical Education
- Physical Therapy
- Physiology
- Pre law
- PsychBiology (NeuroScience)

- Public Administration
- Public Health, Sociology and Psychology
- Speech and language pathology
- Speech Pathology
- Strategic Leadership

Prioritization System Descriptions

- â€œpriority systemâ€□ charting
- Ents first, trach patients, treatments. We work as a team. Your partner always assists you as needed.
- #1. priority- special car nursery calls (We are usually only called for a possible code situation.) #2. - codes and RRT calls #3. - Emergency room calls #4. - RN calling for patient whoâ€™s condition has changed for the worse and she wants direction, or PRN medication. #5. - scheduled floor treatments (medâ€™s) #6. _ scheduled floor therapy (non-med.) This is my priority system that I worked out. #3 and #4 can be interchangeable depending on the circumstances discussed with the DR or RN.
- 1. Precipitous deliveries 2. Pediatrics 3. Critical patients in ED 4. Critical patient in ICU 5. Medical Surgical patients RTC 6. Medical Surgical patients TID 7. PFT patients 7. Walk in OP
- 1st Priority- treatments/ procedures 2nd Priority- equipment checks
- 1st, expand time between rounds, then treatments. Then, acuity based, mechanical ventilation higher priority,
- A pals list
- A policy stating to Proritize critical patients and then q4 treatments and it steps down in acuity.
- A scoring system based on acuity, using disease, age group, O2 requirements
- A scoring system to show which of is most critical
- Ability to chart therapist unavailable
- Access to our work schedule, prioritize our own patients.
- Acuity (4 responses)
- Acuity based on assessment. No software
- acuity based, does not include software
- Acuity based. Respiratory Care Assessment triage score.
- Acuity by triage
- Acuity level, ED over inpatient and outpatient based on acuity level.
- Acuity of patient
- Acuity staffing points
- Acuity system that identifies high points for more acute patients
- Airways first, nebulizer, then routine oxygen
- Airways, treatments, device checks, puffs.
- Alert house supervisor that we are unable to give scheduled treatments until further notice.
- algorhythm for prioritization
- All patients on respiratory modalities are seen, if they are stable and not on mechanical ventilation or on heated humidity then they will only get seen once per shift unless we are called to the room
- all scheduled things get bumped ex Q4 is now a Q6 see vent pt once a shift skip breathing tx's as able
- Allowed to check non-invasive less often (q6-q12). Supervisors are supposed to come assist but they never do. With good staffing, 4 or less vents. Weâ€™ve been short staffed for 4 years now, the most vents Iâ€™ve had were 12 neonate in one day, with 14 total patients.
- Altera
- Always see emergencies first, the new admissions, medicare part B on the long term side and then see stable patients who need care. We use Point click care.
- An example would be in the ER pediatric treatments are prioritized over adult treatments and level one traumas are prioritized over treatments
- An hour is given in the PFT lab for each patient. We use epic.

- Another coworker will help out. No software
- Anything stat whether on Floors or ER would take the priority, then per pt. need..... I work at a small hospital
- Ask for assistance
- Ask for help
- Ask nursing to do MDI'S, omit BID,then one of a TID then one or two of the QID /Q4.
- Asking colleagues for help or starting rounds earlier to account for unpredicted emergencies
- Assessment base priority
- Assessment that gives number value. Higher the number higher acuity. See higher acuity first and ability to adjust therapy with protocols for those who need less or more therapy accordingly
- Assigned by points system and shift buddy or float to help
- Assignments are broken down by zone and additional help is added to areas that are heavy
- At peak loads, we're expected to skip those patients for whom treatments are NOT indicated.
- based on accuity and staffing
- Based on acuity
- Based on acuity, ICU pts first, followed by step down, followed by floors. Pts with medications at higher ordered frequencies are prioritized over lower frequencies. Airway clearance without medication is lowest priority
- Based on clinical condition, cardiac and respiratory issues first, then pediatrics, etc. No software.
- based on daily staffing
- Based on patient acuity (2 responses)
- Based on protocols
- Based on RVU's & patient's condition.
- based on staffing we can evaluate and hold routine treatments or increase the duration between from Q4 to Q6
- Based on the assessment skills of our therapists and the professional displayed. Our team of therapists can use their clinical judgement from our policy on what patients must be completed per physican orders.
- Based on therapists evaluations of patients respiratory needs . Whether the pt is here for acute resp care or just because they do their nebs at home
- Based on treatment evaluation.
- Based on triaging the patient's need for care
- Based on workload unit acuity and the number of therapists for a shift if the percent is 86% or higher we operate at our standard (vent checks q4), less than 86% we operate on a prioritization plan where routine/acute tracheostomy, NIV, oxygen checks are q6 in all areas. Below 65% staffing non-ICU acute care patients become checks Q12 (ICUs stay Q6) this is so RTs in non-ICU areas (step down/ med surg) are able to go help busy areas or ICUs
- Bases on staffing and volume
- Basic Triaging, if overwhelmed, ICU takes priority, then ER, then floor. Triage floor patients based on necessity of treatment
- Basically sickest patients get seen first
- BDP score help us the change the modalities
- Board with point system.
- Brief charting, and co-workers help each other
- Bronchoscopy lab- work overtime until all cases completed
- Broncodialator protocol. Triage
- Calendar
- Call another RT for help
- Call charge for assistance
- Call charge therapist for additional assistance
- Call charge, call supvisor, chart against if no one available
- Call for help
- call for help all work must be done

- Call for help from other staff members
- Call for help from supervisor. Triage pts
- Call for help when needed. Other therapist help when you canâ€™t finish your work.
- Call other therapist to help, call charge therapist then call Shift Lead/Supervisor
- Call shift manager and they reassign that task to another person which I really do not find this to be a system
- Call team lead if you canâ€™t get to patient if stuck in a code. Go do treatment after therapist is done if patient is stable.
- Call the other therapist for assistance.
- Call the supervisor for help when required, if not based on acuity
- Call your supervisor ask for assistance, Use Teammate help, then limit care to the most acute patients.
- Called Surge, medications and trachs first , then other therapy if time.
- Calling for help from a lead shift person. Prioritize sickest patients first.
- Calling leads or RCs for help
- Can alter delivery times in Epic
- Care flow sheets is on excel spreadsheet
- Cerna
- Cerner (8 responses)
- Cerner is used for patient care at my facility. Itâ€™s outdate but we use it. We also use the chips on the board with the patient names/ room numbers and treatment on them.
- Cerner med-department includes stretching protocols
- Cerner Task List
- Change frequency of checks. Triage the sick patients. Not using software
- Changing scheduled times or start an hour before or after scheduled times
- Charge sheets and epic
- Charge therapist
- Charging then ICU rounds
- Chart preparation
- chart therapist not available to all non essential treatments
- Check and balance system using computer software
- Check ventilated pts, give txs to severe pts, evaluate less severe pts and adjust med schedule. Adjust staff as needed, bring in off duty staff.
- Checking on each patient and delivering needed treatments in timely manor.
- Checklist
- clinical triage
- Clinician care based on protocol.
- CODE BLUE, MRT, VENT PATIENTS,
- Code, Rapid Response, NICU, ICU, Peds, General Med/Surg
- Codes
- Codes and traumas, babies, icu, floors, rehab
- Codes first then ICUs Ed then Peds then floors
- Codes, ED, Critical Careâ€¦
- CODES, RAPIDS, STATS VENTS, NPPV, CONT. AEROGEN- FLOLAN, SABA TRACHS, HFNC Q4HRS TXS, Q6, QID, TID, ETC TXS CPT, PEP
- Codes/ rapids, Er/ icu/ floors
- Common sense
- complete most critical treatments, complete ventilation checks and critical blood gases first.
- Computer programs specific work list
- Computer system
- Computerized
- Computerized list of task

- computerized worklist / with RT deciding priority
- Computers
- Contact 2nd acuity or charge RT
- Contacting a charge or float therapist to assist with duties
- Continuous education is provided
- count system based on therapies ordered for each patient
- Cristal care patients always come first
- Critical access
- Critical care & Pulmonary; med-surg; on call
- Critical care and emergency room first and med surge floors last
- Critical care and medications only no incentive spirometer or flutter done allowed to spread vent checks to Q6 although I never do
- Critical care areas are priority, patients on vents, bipaps or other equipment and then any patient that calls for therapy
- Critical care first. (8 responses)
- Critical care mechanical vent patients, scheduled nebulizer treatments. Codes, Trauma, rapid response always take priority.
- Critical care patients 1st then move on to less critical patients
- Critical Care, Emergency and Floor therapy last
- Critical care, er, floor therapy
- Critical care/ emergency department first then based on need, ie. chronic respiratory patients, post op , etc
- Critical or noncritical status, Acuity, treatment frequency,
- Critical patients first, then less critical. Sometimes nurses on the floors will do the DPI's
- Critical patients first. Triage or do Q6 machine checks
- Critical patients take priority and then we can always reschedule tx times if we are unable to see everyone
- Critical pt first
- Critical staffing . Oxygen checks are once a shift vs every 4 , vent checks can be every 6 vs every 4 . Cpt can be skipped if necessary
- Critical vs routine
- Cut list to certain assigned therapies
- Daily assessments
- Deal with emergencies first then finish what you can
- Deductive reasoning skills
- Delegation to other therapists or canceling treatments
- Deliveries, Emergency, Critical Care, Non-Critical Care
- Department algorithm.
- departmental policy
- Determine acuity based on report and prioritize accordingly.
- Direct patient care then charting
- Discretionary,no softwear
- Do the best you can ,some days only have 2 Rt in a 9 story hospital
- Do vent check q6 instead of Q4, adults only
- Does not include software, we are just trained to "triage" patient care when we are unable to complete all assignments.
- Does not include software. Patient condition determines priorities.
- Does not include software. Time management skills
- Does not involve software. Prioritize workload.
- Doing non emergency treatments last or miss if the work load is heavy.
- During report we're given priorities.
- Duties by priority..code blue, vents, aerosol, o2

- Each patient has an evaluation done and a priority ranking assigned based on set criteria.
- ED, ICU, all else
- ED, ICU, then floor patients
- ED, ICU/IMC, Scheduled therapies, PRN requests, sleep disorded breathing.
- Education software and RT protocol
- Electronic charting
- Electronic Medical Re
- Electronic Process control boards
- Emergencies first and chronic
- Emergency triage plan where checks are â€œallowedâ€□ to be q6 for ventilators and 1 for bcpap pts. Some patients like HFNC are unseen. Not safe.
- Emergency, floor, ventilator patients
- Emergency, Treatment, Ventilator management, oxygen. No software for triage
- Emergent & urgent needs first, treatments second then rounds. Software only used for charting
- Emergent cases then routine.
- Emergent Patients first, STAT, MRT,and Home evaluation needs to be done in 1hr.
- EMR systems
- Epic (29 responses)
- EPIC Microsoft programs
- Epic and time standards. Department productively at 130-140%
- Epic charting system/ipass communications comments section of epic software
- Epic computer system. Lack of staff is the main problem for numbers. Hospitals donâ€™t want to pay what we are worth.
- EPIC offers sorting orders and and different icons
- Epic system (5 responses)
- EPIC system show tasks. I prioritize.
- Epic work list (5 responses)
- Epic work list with times due but not all of our treatments show up there consistently
- Epic work list, offloading routine treatments to nursing to focus on intubations, codes, etc
- Epic workflow
- Epic,schedule
- Epic/Printed assignments/dry erase board
- ER ICU MEDICAL FLOOR
- ER Icu Ocular Cvicu Med surge
- ER , Peds , ICU, General
- Er 1st ICU 2nd Med surge 3rd Out patient 4th
- Er is priority over med surg
- ER monitor
- Er most Critical Patient first. Next ICU then General Floor care
- ER patients first then regular treatments
- ER pts 1st,codes
- Er, icu then floors
- Er, icu, floor
- ER, ICU, Nursery, and Rapid Response take priority everything else is completed based on severity in the event that there is not enough staff
- ER, ICU, then general therapy, last rehab
- ER/ICU Access IV Floors access Long term/long dwell access
- Every patient gets complete care each check even if the number of checks do not meet the expected frequency
- Evidence- based scoring assessment performed by therapists, documented in EMR
- Excel based workload board

- Excel spreadsheet with all therapies
- Experience and internal knowledge in identifying the greatest need and when to ask for help.
- First come first serve for scheduled pts. Frequent add ons.
- Flight RRT. One patient at a time in a helicopter, ambulance, or airplane.
- Floor therapy triage
- Focus on critical care patients first. ICU / ED. Surgical procedures then Med surge/ prn assessments.
- From more acute to less if needed.
- From sickest to least
- get extra staffs
- Get help from other respiratory therapist
- Get on the floors, scan patients and try to see all your patients and talk more to patients and less to nurses to ensure rounds are conducted on all my patients.
- give medication treatments first and only if there are a lot and tell Patient to do their flutter txs on their own
- Go to more critical patients first then floor care/ treatments
- Go to the most needed patients
- Google spreadsheet with weighted procedures
- Green Yellow Red stop light system with prioritization of work.
- Grouping treatments and reaching out to others and removing some less needed treatments, no
- Guideline and handout to staff
- Health Connect
- Help from other staff
- Help from other staff and nursing to get the job done.
- high modality (vents) to low modality (IS)
- High risk deliveries normally come 1st in building. Triage the rest if necessary.
- Higher acuity patients first
- Higher acuity therapies are defined as well as lower acuity therapies
- Hospital department workflow policy
- I always see the sickest patients first.
- I can rely on my coworkers and my team leader to help me care for infants on respiratory adjuncts while I handle deliveries or caring for particularly acute patients.
- I have coverage to help with other duties if I have more patient load.
- I have my own system that works for me
- I perform PFT's, and my patients are scheduled.
- I preform PFT's and assist with bronchoscopy. If we have staff shortage, bronchs take priority over PFT's
- I prioritize my workload myself
- I prioritize myself.
- I schedule my patients
- I scheduled my own patients since I am involved in home medical service
- I starts with the easiest job
- I take care of the worst patients first. If there's an emergency, I may not be able to get to my stable patients, so I chart acute priority.
- I think the AARC failed this profession after covid.
- I triage based on vent dependen, artificial airway and he or risk of respiratory failure
- I work DME
- I work ER so I do the most critical first
- I work in outpatient clinic within acute care hospital. Spirometry 1st, 2nd ,patient education , treatments,
- icentra
- ICU ER Floor patients
- ICU ER Pediatrics
- ICU and Tele 1st

- Icu er stats and patient calls take priority then scheduled treatments and care then prn and night time CPAP
- ICU patients then general floors
- Icu then floor therapy
- ICU, ED, Nsy, and general floor therapy
- ICU, ER before general
- ICU, ERT, RT driven protocols
- Icu, floors, call team lead if unable to get to a patient
- Icu, pulmonary, first
- ICUs, ER and IMCs pts take priority.
- IDK
- If help is needed call supervisor
- If our workloads average out to a certain number than q4 turn to q6, q6 becomes q8, q12 isn't seen unless getting another treatment. Vents are checked twice a shift rather than 3x. If workloads cross another threshold, q4 is q8, q6 is seen once, anything else is not done. Vents are checked once and as needed. Routine transports (say daily CTs) are pushed to the next shift.
- If there is not enough staff the manager emails nursing to let them know they will have to do nebulizers in their area.
- If there is not enough therapist or too much work for the amount of therapist that's available, then we prioritize the patient in terms of what care they receive. Firstly, we always see invasive/non-invasive ventilators, Airway Clearance therapies (IPV, Vest, PD&V), trach patients, breathing treatments. If we can't get to it, then oxygen checks, low acuity lung expansion/airway clearance, and cpap patients are reasonable to be able to skip - unless the patients call.
- Immediate care, room computer charting,
- Impending Death. No software used.
- In Epic I have a worklist that provides time that therapies & treatments are due
- IN our clinic- patient care comes first but computers in every room to use when appropriate
- in policy form
- In the PFT lab if we have a full outpatient schedule and cannot get to an inpatient that day it is pushed to the next morning or we stay late. No software is used.
- In-patients, clinic patients we will work into our out-patients schedule. Rev Cycle is the software
- Independent, Therapists professional discretion
- inform the lead, if no other help is available triage patients knowing some will be missed
- Informal, airways first, maintenance treatments last
- Inpatient are squeezed into outpatient schedule. Sometimes need to stay late (without call pay)
- Intubated patients, respiratory support cpap hhfnc can be Q6 if needed otherwise Q4.
- Invasive vents, pediatric, Non invasive, sleep
- It does not involve software it's based on the number of stat calls you received
- It does not involve software, We triage patients
- It doesnâ€™t involve software and prioritizes acording to patient needs and acuity.
- It goes by acuity. Triage all BID stable patients. Go see high flow and Trach mist on the floors. Then see all your critical ICU patients that are .oat important.
- It involves coworkers that would be able to help
- It is a policy. No software. It prioritizes critical procedures such as mechanical ventilation first and then in descending order to low priority procedures such as incentive spirometry
- It is an excel spreadsheet in which the charge enters all known therapies including ventilators and patient transports. It is based off the AARC safe staffing guidelines where each therapy has a point value. The goal is for each RT to have 40-50 points in 12 hours. This tool also tells the charge how many RTs are needed per shift. If we are short at least 20% of the needed RTs we are able to only give treatments to the patient's who have been deemed acuity 1, 2 or 3 based on an evaluation system we are supposed to use on each new therapy. This system takes into account shortness of breath at baseline, current shortness of breath and COPD history.
- It is based on acuity. And we decide.

- It is based on basic assessment and RT protocol of each patient.
- It is considered a code red, so the required treatments are changed to less frequency. Example Q4 to Q8.
- It is the software.
- It is understood that ICU patients are priority--then routine assignments are divided between then number of therapists, excluding manager/supervisor.
- It's subjective to patient disease
- Itâ€™s a flow chart, critical icu, copd exac, etc
- Itâ€™s a nursing system, not set up for respiratory directly. Itâ€™s very time consuming and our lab tops are slow. I spend more time on the computer than being with my patients.
- Itâ€™s a SOP where we stop O2 checks, incentive spirometers, acapellas, and switch from Q4 to Q6 ventilator checks,
- Itâ€™s epic and it works great.
- Its software
- Job duties are classified as "tasks." The tasks are fairly easily classifiable on an informal scale of perceived necessity, depending on the specific needs of the individual patient. Therapists get better at doing this with accumulated experience of course.
- Just basic knowledge of your more critical patients
- Leadership divides assignment based on experience and competence. If for any reason there might be any possibility that patient care is not the standard of excellence, our culture and policy supports us by Teamwork and communication and helping each other out in addition to escalating to delegated Charge Senior RRT and Supervisors which always gaurantees our commitment to excellence in safe patient care. The Prioritization system ultimately upholds the Patient care standard of excellence and is a testament to what a culture of dedication and excellence accomplishes together consistently every shift, every patient, everybody. The system allows for time and upholds safety and quality of care.
- Life support, peds/nicu, priority nebs, nebs, o2 therapy
- List in order of how to prioritize patients
- List of task through Epic
- List printed off on computer with times due and orders
- Lot
- Lower priority patients are designated PRN. Only software involved will be the ability to select PRN instead of Q6 or some other routine schedule.
- Magnets on board, cards
- Mainly take priority with higher acuity patients and working as a team to help each other. Generally allowing nurses to complete scheduled nebs when applicable as well.
- Make a note RT is not available and cancel treatments
- Make sure all RVUs are fair for everyone and ask for help when needed
- Mechanical ventilation, treatmens, codes
- Meditech (3 responses)
- meditech charting
- Modified therapy. It involves stretching treatments and therapies. If you have 80 RVUs, youâ€™d stretch back to 70 RVUs. So you would stretch 10 RVUs. We try to avoid stretching meds, so you could stretch a vent round from Q4 to Q6, etc. it all depends on the assignment. You cannot stretch CF patients. We also have Charge therapists who check on staff and help out to alleviate the workload.
- monthly ventilator checks
- More acute first
- More critical (ER) is priority over neb treatments or floor therapy if we have an emergency. There is a place to mark TNA due to emergency or whatever the reason on EPIC application
- more patient care, less computer work
- Most acute first Less acute last
- Most acute get cared for first.
- Most acute to less acute, work areas priority, and priority with tasks to be performed
- Most critical first (3 responses)

- Most critical patients come first, followed by NICU, ICU then Floor care. Outside of traumas or codes start in ED then work your way down to the floor care.
- Most critical patients first (ventilators, tracheostomy, etc.) then routine scheduled treatments
- Most critical patients get priority
- Most critical patients, then prn
- Most critical pts e.g Ventilator, ECMO, Nitric oxide, Oscillator Special procedures e.g intubation, transport to MRI, Mini-bal Bipap Airway clearance (IPV, Vest, cough assist) Hi-flow nasal cannula/Heated trach collar Continous nebulizer Nasal cannula and masks
- Most emergent first
- Most severely resp compromise first and then triage. No software.
- My workplace has triage system when there is a shortage on staff.
- need to triage patients
- New evals, lung transplant/high oxygen requirements
- Nexus and brightree
- Nicu, ER, medsurg
- NICU, ICU, ER, Floor TX
- NICU, PICU, ICU, ER and RAPID RESPONSE are priority. Scheduled txs next if able otherwise nursing is responsible for them and PRN in non emergent pts.
- No formal system: we determine priorities of patient care. One clinical RT works the shift for entire hospital.
- No prioritizing
- No soft ware, it all depends on most critical, and out patient scheduling. We schedule our own and are left to ourselves. One therapist is on duty at a time and on call that night
- No software (7 responses)
- No software Commonsense and experience
- no software - based on individual needs
- No software -reschedule or telephone until able to see patient
- No software but we have a tier system or who to see first.. however we are not allowed to document in the chart why we were unable to perform the treatment so it looks like we just skip therapies/treatments. Code-ecmo 1st Out of hospital transports for critical care team Ed Picu/nicu Pulmonary patients (so even if the treatments are unwarranted we have to do the q2 nebs they put the patients on for 1-2weeks straight because theyâ€™re pulmonary patients and that department doesnâ€™t listen to us or assess their patients. Then do any vent/cpap/bipap Lastly any chronic treatments or just scheduled we can skip. Again we canâ€™t really use this thought because we as each employee isnâ€™t covered because we canâ€™t write why we were unable to perform treatment anywhere so it looks like we just skipped them. And itâ€™s a pediatric hospital so if the treatment doesnâ€™t get done, no one goes in to explain to the family why they couldnâ€™t get done they just call us and we have to go do the treatment anyways.
- No software I do Q4 , Q6 tx and skip the PEP and IS when I have time I do the QD and BID
- No software involved. Just prioritizing patient care by acuity - higher acuity gets seen first. Lower acuity gets seen last or â€˜prioritizedâ€™ if the work load is too high.
- No software involved. Triage the most important
- no software judgement
- No software just common sense the more critical the patient the most priority
- No software just prioritize workload
- No software triage your patients
- no software-- priority of care based on our critical thinking of urgency based on patient status.
- no software-scheduled services before PRN
- No software, common sense
- no software, documentation location to chart "triage"
- No software, high acuity to low acuity
- No software, high census peotocols
- No software, judgement and can write off txs

- No software, priorities of care allows us to relegate certain floors to be only critical calls only and the charge nurses play a much greater role assisting respiratory patients.
- No software, red yellow green triage, based on report green get skipped, yellow have their frequency stretched so Q4 goes to Q6, red continue therapy as ordered.
- No software, shift handoff and communication with other ancillary staff
- No software, triage
- no software, triage patients by acuity scoring
- No software, triage policy
- No software, we do a huddle before every shift and a list of how to do report, plus the charge therapists give report to each other.
- No software. It is determined by need vs prn status
- no software. just call for help
- no software. Patient acuity: ER, ICU, Med Surg
- No software. Prioritize by modality.
- no software. you triage pts and do what is best
- No software. Decrease the frequency of ventilator checks, treatments and therapies. Also reduced charting.
- No software. Deferment protocol
- No software. ICU, ER first
- no software. just clinical judgment
- No software. Most critical patients first.
- No software. Nebs and vent checks first, I tend to skip O2 checks which are done by nurse techs and prn checks because theyâ€™re part of set orders for most physicians. For example, patient admitted for toe nail infection, prn breathing tx and O2 will come through.
- No software. Prioritization focuses on patients in ICU, ED and pediatric/neonates in order of highest acuity. Routine and maintenance therapy can be written off if all extenders (teammates, coordinator, and director) have been exhausted. Those extenders may be called in to assist with workload as well.
- No software. Prioritize ER, then ICU/ventilated patients, then scheduled treatments, with consideration for MET/RRT calls, PRN treatment calls, etc
- No software. Rounds are spread apart.
- No software. See most acutely ill patients, then triage the remaining. Try reaching out to other therapists and supervisor on duty for help prior to charting therapy not done
- No software. Triage. Codes first, nicu, er, icu . Triage within these departments. Let nursing supervisor know that tx need to be fine by nurses on med floors.
- No software. Ventilator, non-invasive checks are stretched from q4 to q6
- no system clinically assess
- No system, just prioritization. Can't go back to fix my answer
- No system. We are first assist in cases
- Non emergent treatment can be done by nursing.
- non software
- Not able to do my administrative duties for that day
- Not seeing patients for incentive spirometry or flutter.
- Not sure
- Notify charge therapist which will pull staff from other areas to help when busy at the code or a workload
- Notify supervisory
- Number of therapist vs number of patients decides
- Number rating system from 1-5
- Nursing provides HHN and MDI txs when RT unavailable
- Our department goes on priority. We need to go to codes, complete lung transplant therapies and respond to urgent calls. If patients are stable and have routine therapies, they might be skipped.
- Our department has float RRTs that assist with procedures, transports and heavy workloads
- Our schedules are built out in Epic. Each test is schedule for a certain period of time.

- Our shift starts 15 minutes before nurses. This helps so we can get a good start before nurses start their rounds. We use computer charting and most of our respiratory therapy device's values show up automatically. We can use this system to see orders, overhead monitors, lab results, X-rays, doctors notes and whomever is apart of the care team. We can also contact anyone on the care team through this software as well.
- our software system helps provide prioritization
- Out patients only and they are scheduled.
- Oxygen checks are cut off the top. Then vent checks Q4 to Q6, and scheduled treatments if we are called for them.
- P. C. C.
- Paper algorithm
- Paper list of pts, report gives the information on the pt needing to been seen first/sickest
- patient assessment, charting
- Patient board
- patient care
- Patient demographics, diagnosis. and current orders or protocols to maintain.
- Patient List, assignment sheets, daily communication binder
- patient need
- Patient triage via assessment of need No software
- Patients are protocoled, the higher acuity receives a higher number
- Patients care
- Patients that need therapy right away
- PCC
- Personal and professional judgment
- Phased triage system to prioritize acute care
- Physician orders and RVU's
- Point Click Care
- Point system (3 responses)
- Point system based on acuity
- Point system based on minutes
- Points system, triage plant
- Policies describe prioritization
- Policy and q6h report
- Policy listed the priority of different intervention as well as having lead therapist and additional resource therapist to help.
- Policy Procedure
- Policy stating priority service areas and how to document â€œtriagedâ€☐ treatments during low staffing or when higher acuity situations are prioritized
- policy that lists the priorities in order
- Policy to prioritize care.
- Policy: Location by priority Neonatal and deliveries, ICU, Pediatrics, Med/Surg, ED. ED has the trained staff to do anything RT does.
- Pressure changes are completed first then emails are answered and lastly new patient triggers are worked.
- Print off of all scheduled therapies from Epic program
- Printed out schedule for the day.
- Printing patient lists with workload.
- Prior to patient arrival: Set up room Set up table for patient hook up Review patient chart Load information into Nihon Kohden Register patient upon arrival (Using EPIC) Show patient to room Describe what to expect before, during and after study. Collect questionnaire (5 pages) Pre hook up paperwork Once patient is in bed: Calibration are conducted prior to beginning study During study document: O2/position(s)/HR/TX/Mask(s)/record observations Fill out patient data forms Post-study paperwork D/C

paperwork including time patient left lab Strip soiled linen in bedrooms and from tables Clean wires and belts Make beds with clean linen, dress pillow and tables for next shift.

- Prioritization based of severity/need, seek help from manager, call in additional staff. No software used.
- Prioritization is a system I carry inside myself; not given by my employer. It is not something you can offer, assessment and ability to triage and multitask is a skill every RT should have. Most do. If anything taught me the skill it was the pandemic
- Prioritization is based on patient acuity and frequency of ordered treatments with most acute and most frequent therapy seen first.
- prioritization system is mainly therapist ran, it's our responsibility to inform nurses whether or not we'll be there to help with treatments, I usually tell charge if I can't get to an area of my assignment.
- Prioritize based on acuity. Reduce frequency of therapy and assessments when implemented. No software. Has not been needed
- prioritize critical care areas, q4 done two times, q6 done once
- Prioritize the critically ill.
- Prioritize the more crucial patients
- Prioritize the most critical patients.
- Prioritizing care based on patient need not software
- Priority
- Priority
- Priority from reports from outgoing rt; however itâ€™s the responsibility of the shift rt to prioritize workload, vents, floor care, in house transport for procedure/testing, labs. Lead therapist MUST be notified so that help can be provided. All patients on PRN treatments must be assessed atleast once a shift.
- priority is based on severity of symptoms, obviously critical care units, ED and codes take priority always
- Priority is given to patients on mechanical ventilator and administration of medications. CPT is held if we are in triage.
- Priority is vents, then airways, then Bipap/AVAPS, then HHF, then treatments
- Priority patient, Trauma 1 patient, stat CT, Breathing treatments, and regular checks
- Priority status - no software
- PRN, BID, QID, TID times
- PRNs are left to the end scheduled meds take priority
- Protocol system that uses a points-based algorithm to determine acuity
- Protocols (6 responses)
- Protocols and peer assistance
- Protocols charting system
- Protocols to adjust how often patients must be treated based on clinical presentation. No software, just algorithms
- Protouch computer system
- Provides soft ware
- Pts are prioritized by disease and need for treatment
- Pulmonary assessment scoring with protocol
- Push back of timesâ€¦instead of Q4 change to Q6
- Q4 to Q6, Q6 to Q8, BID to QS RVU system based in Cerner (> 80 units = ability to prioritize).
- Q4 turns into q6 checks
- Q4 vent checks go to Q6. Room air and clear sounding patients are not given priority. We see the sickest first.
- Q4, TID, BID,
- R/Y/G Staffing Guidelines ~ Depending on the staffing dictates timing of rounds and what will go to nursing.
- Real time charting
- Red we prioritize by decrease therapy by one per shift per patient
- Red, yellow or green staffing levels. Deprioritize gen care therapy as appropriate
- Reducing the frequency of checking patients ieq4 check to q6 Computer charting
- Report between shifts

- respiratory care protocols
- respiratory driven protocol involving triage numbers
- RN to give updrafts and MDI
- RT lead assigns work load, when we are done, we call around to help everyone else.
- RT Protocol, evaluate and change treatments to PRN based on score
- RT Protocols
- Rt staff below 75%
- RT triage, no software involved
- RVU
- RVUâ€™s
- Schedule adjustments are made for non-critical med-surg floor patients to scale back our workload. If the census is too high, even in after adjustments on med-surg, we alter the frequency of vent checks and make schedule adjustments for critical areas also. No software is used as our patients are separated into areas by acuity.
- Schedule time for appointments of the patients.
- Scheduled appointment times
- Scheduled patient care
- Scheduled therapies first, then BID patients In ICU setting, most critical first
- Scheduled treatments, vents, bipaps first then prioritize the rest
- Scheduling patterns in epic.
- scoring based on current symptoms and past medical hx
- See high acuity patients and patients with complex therapies. Assign low acuity patients to the nurses.
- See non critical vent patients every 6 hours, trach and hfnc once a shift,
- See pulmonary patients first, give scheduled breathing treatments, new patient assessments within the first 48 hours, reach out to nursing if needed for mdis or O2.
- See vented patients first, then treatments with higher frequency next, last priority is high flows, trach masks, and oxygen rounds.
- Self created
- self determination of prioritization
- Self disciplined
- Self scheduling
- Self-controlled triage
- Self-subjective
- SESG / URM (policy stratifies items of higher importance and impact)
- Shift extra people to help with unexpected additions to work load
- Shift lead will provide information
- Shift-wide standardized reductions on frequency, based on RVUâ€™s assigned per therapist
- Sickest and the ones with airway pro
- Sickest first
- Simply take care of critical patients first, make sure all scheduled nebs are given, then worry about O2 checks/IS/other breathing exercises
- Simply, personal discretion and ability to complete at a later visit.
- Small hospital, one RT on duty, Nursing provides assistance if needed and Supervisor can supplement with help or get an RT to do part shift
- Small hospital, small workload
- Software (3 responses)
- Software and established SOP
- Software and manual
- Software and prioritize most acute and or critical patients ie on vents
- Software for medical records

- Software that predicts workload based on time standards
- Software used for organizing and scheduling home visits is Salesforce. Referrals are received electronically and processed using TIMSv8.
- Some direction but mostly common sense.
- Staff determined
- Staff supervisor notified documentation in computer
- Staffing graph based on how well staffed we are, determines what we cover and what nursing takes over if while we are short staffed
- Staggering inhaled medication due times.
- Standing order protocols
- Start with ICU, and if we can make it to the floors great, but otherwise triage
- Stat therapy than Q4
- Stat, urgent, asap, routine
- stay until complete assignment and ask other therapists that have completed work to help.
- stoplight model
- Structured triage protocol, doesn't use software
- supervisor determines green, yellow, or red staffing status. Can prioritize patient ventilator assessments based on acuity. Some patients may only need q12 vent check for the day while higher acuity patients may require q2-q4. PRN checks are only done if patient is calling and requesting a treatment.
- Supervisors out of assignment
- Surge plan (2 responses)
- Surge plan that identifies how often patients are seen and what constitutes the most critical patients to treat
- surge plan, no software
- System wide protocols
- take care of sickest
- Task list
- Task lists by order time
- Task system via charting software
- Tasks are triaged by scheduled tasks. Also co-workers help if needed.
- Tdp
- Team assignments
- Team members assist and help; it's a small facility so we work as a team! Ascension does not work as a team & the workload was horrifying with leads/managers sitting on their asses in the department.
- Teamwork (4 responses)
- Teamwork with the staff we have on any given day.
- Tend to the critical units first: ICUs; ER; PEDS; then whatever else you can. No computer system.
- The computerized system keeps records and treatments accurate and organized.
- The prioritization system does not include designated software and is based on patient acuity levels. Patients on life sustaining/support equipment (i.e. ventilators, BiPAP, high flow) will take precedence, along with emergent cases, procedures and transports, followed by scheduled inhaled medication delivery.
- The question should have been Rep questions, we do not have a priority schedule, just a list
- The sickest and most acute patients get seen first
- The system is ventilator patients and codes come first. Then c-sections. If the baby needs critical intervention they become top priority. No software system.
- The way I do things I go as my patients on ventilators first give treatments, then I go see trach patients and breathing treatment patients!
- Therapist decides what is most important based on what other departments can do with out a therapist
- Therapist decision
- Therapist discretion how to prioritize. No software
- Therapist Diven Protocols
- Therapist driven

- Therapist evaluations
- Therapist help eachother out
- Therapist prioritizes
- Therapist unavailable in charting
- Therapy can be q6 instead of q4 hours depending on acuity of the patient. Also communication with the patients physician.
- There is no writing system. We go by ICU/ER, step down, and then tele
- there is only 1 person on a shift, so the patient with the most need comes first , or a birth or trauma/cardiac pt comes 1st and nursing helps with pt care if needed
- There is the staff with their assignments and then there are 2 Lead Therapists on shift you can call for backup to relieve you and/or help with your assignment. However, if the Leads are already busy there is no other system. I am a part of this group of Leads.
- They go by a point system
- This is a small orthopedic surgical center so it's not always busy. I do have supervisor support I can call if ever needed.
- This prioritization system is used in our respiratory therapy department, not our PFT lab. We need to complete everything in PFT/bronch before we leave.
- Tiered ICU and ED are priority with general floors lowest priority except for emergency situations
- Time allotments for each therapy totaling up to your expected workload for the shift.
- Time management (3 responses)
- Time windows on our delivery tracking system
- Trach patients, Ventilators, floor
- Traige protocol. If treatments are q6 has to be seen atleast once, q4 atleast twice. Vent checks always q2. No software used.
- Training and debriefings
- Training under Leadership.
- Training, not software
- Traumas, Codes, ED, ICU/NICU, Bipaps, floor care with COPD patients first
- Treat critical first, then hourly orders, the ask for help on the rest
- Treating patients first then computer
- Treatment cards so we can prioritize scheduled over prn treatments.
- Treatment counts to divide workload between therapists and prioritize ICU/ER patients.
- Treatment lists for each unit.
- Treatment, charting
- Treatments get advanced to next tierâ€¦q2 goes q3, etc
- treatments spaced out, vent checks deferred and/or spaced out
- Triage (14 responses)
- Triage 1 to 3
- Triage and make sure Q6s get at least 1 treatment.
- Triage and prioritization.
- Triage and protocols
- Triage based on AARC guidelines for severity
- Triage based on care needs
- Triage based on specific work load of each individual. No it does not involve software.
- Triage by protocol, RL if unable to complete therapy.
- Triage by PT needs first, TX frequency next
- Triage by who is more sick
- Triage lesser duties/treatments, no software.
- Triage non essentials
- Triage patient care with rapid response or code blue, then vent checks, svn treatments, suction

- Triage patient level of acute need. Provide care based on time due and at level of request from primary care team. My team works with inpatient and outpatient clinic patients.
- Triage patients 1-3. 1s can not be missed
- Triage patients. Most critical patients first.
- Triage policy (2 responses)
- triage pts based on acuity
- Triage scale
- Triage system and team approach to not urgent care.
- triage system that allows therapist to prioritize vent patients first and foremost. I do work at a LTAC vs acute care
- triage system, no software used just common sense.
- Triage system.
- Triage the patient
- Triage the patients necessities as to who gets treatment first. More critical to less critical
- Triage to Q6
- Triage when count is exorbitant. Prioritize critical care patients ensuring they receive treatment and monitoring. Vent and niv monitoring drops to q6 from q4. We "write off due to workload" anything that we can't complete.
- Triage, does not use software, and is only on single patients
- Triage, q6 checks, supervisor assists if possible. Union form.
- triage, see the most unstable patients first. then the q4s turn into q6.
- Triage; most critical first, push BID treatments to later time
- triage. the sickest first and down the line to patients on maintenance therapy
- Triage. Facility is critical access with a 10 bed ICU, 20 bed med surge, 10 bed ER, 5 OR suites and 2 C-Section suites. I make my own priority list based on patient load and move about the entire facility from there. 1 RT on shift. Prioritize in order based on acuity and run my program from there. The current department manager trusts and has a lot of confidence in knowing I will do my job effectively and with the absolute most care.
- Triage. Most in need to less in need
- Triage. RT missed.
- Triage. Sickest patients get seen. Those that can wait, wait.
- Triaging care by level of importance and omitting treatments when necessary
- Triaging need for services based on acuity and type of condition. I write short respiratory note and explanation in a pharmacy MAR
- Typed list of priority's
- Typed up triage list of what gets done first.
- units take priority and then floors are prioritized by cystic copd, etc.
- Unknown
- Unknown, my area does not get an assignment, but the organization does have a system for the RT Dept
- use Cerner to plan out workflow in a patient care area
- Use clinical judgement as to whether your general floor patients are in great need of sooner treatments than your ICU patients.
- Use of software EMR
- Use software for documentation
- Used rarely. Does not involve software. Critical care patients are seen first, then everyone else. Teamwork, everyone pitches in everywhere they are competent to work.
- Uses the epic work list
- Using epic
- Using our brains to know how to prioritize therapies. We help each other out. We can chart in Epic as a triage if an unpredictably busy night happens.
- Using the EMR system helps prioritize. Checking patients every 2-4 hours

- Using the patient assessment tool, decreasing the frequency in which treatments are delivered based on patient clinical condition.
- Utilization of EMR worklist with details on patient demographics, diagnosis, and protocols required.
- Utilize lead RT
- Vent check software
- vent checks change from Q4 to Q6. other therapists help as well if you can't get to non emergent floor therapy
- Vent patient first before I move to other ones
- Vent patients 1st & non-vent residents 2nd
- Vent sheets
- vent, neb txs before PEP and O2 checks
- Vent/icu pts, ER
- Vented an emergency patient come first, then MedSurg for patients on floors.
- Vented patients first
- Vented patients first, then treatments, then NIV, and last oxygen via NC
- Ventilated or non-invasive vent patients first followed by pts on continuous aerosol generating flow therapy, then scheduled nebulized and non scheduled breathing treatments
- Ventilated patients first, then treatments,then Patients on Oxygen devices
- Ventilator patients first
- Ventilator patients first, then Bipap patients. No software involved.
- Ventilator pts, Open airways with treatments, then non-airways with treatments
- Ventilators 1st, Airvo2 2nd
- Ventilators seen first. F/b trachs, then txs
- Vents are done first
- Vents critical care er
- Vents first, tx floor treatments, oxygen checks lung optimization
- vents first.
- Vents meds Q4 then Q6. Skips daily meds and donâ€™t worry about non med therapists
- Vents to room air. Vent checks can be spread out q6. If there is an asthmatic who needs treatments see them. See all the pts once and the more sick prioritize them.
- Vents, bipap, kids, als,o2..
- Vents, other devices, txs, other therapies
- Vents, tracheostomy or airway patients, bipap or cpap, are all seen first, treatments are done by q4, q6, or bid.
- Vents; Bipaps , patients with airways arepriority Inhaled medication treatments are prioritized over CPT treatments
- Verbal
- Visits by date last seen.
- Waterfall system starting with vents down to simple tasks. Cut out the bottom tasks and get to the top tasks
- We activate high volume status and just don't see low acuity patients.
- We always take care of most critical patients first and then work our way down to the patients with least need.
- We are expected to prioritize ourselves and our workloads, but have a system for asking other therapists for help when we need it.
- We are expected to triage our time and resources to meet the needs of patients that have the highest acuity
- We are given ample time to finish. Itâ€™s up to the therapist to prioritize and manage time wisely
- We are notified via page that we are to start using our triage protocol. The protocol is described on one page that is available physically at our work stations or on share point to view. We check ventilator patients every 8 hours instead of 4, we only give â€œnecessaryâ€□ treatments.
- We are provided enough staff to always complete therapy
- We are to care for the most critical patients first and triage the rest, with communication to charge RN in all areas.

- We call it prioritization protocol...QIDs and Q4WA goes to TID, Bipap check TID instead of Q4, triage pts
- We can always call for assistance if there are other therapist available. Otherwise, we notify the lead that we are unable to complete and make a note in the EMR.
- We can chart a treatment with lack of time in the EMR as the comment if we cannot complete the workload
- We can go longer between vent checks if needed, we skip lung expansion therapy, ie supervised IS if needed
- We change the frequency with which we give treatments and triage patients depending on what crisis level we are in.
- We definitely try to get all our meds out within an hour, if we are sure short we triage everyone and see the sickest ones first. Patients receiving oxygen therapy and track patient we round on at least three times daily. Other therapy's come after that, such rib fracture protocol, smoking cessation, OSA screenings etc
- we do daily evaluations which gives prioritizing numbers to each patient based on their needs. If I was too busy to get my assignments completed, i would skip the ones with the lowest priority number.
- We don't have a system, we have to figure out ourselves/triage
- We enter what we call Trige mode where all therapies that are non emergent are not done or decreased in frequency for example Q8 vent checks rather than Q4
- We focus our work list on most critical first then scheduled treatments. The. Prn
- We follow multiple therapist driven protocols that allow us to adjust therapies
- We follow the assigned clinic flow (in cystic fibrosis and bronchiectasis clinic)
- We get our assignme to printed and we use EPIC to sign in to our patients
- We go by on acuity of care needed per patient. The ones that need the greatest deed are the ones that are done first. For example, if a patient has clear lungs, theyâ€™re not in distress. We consider those patients to be able to miss a treatment. And of course, ventilator patients have the highest acuity of care needed so they come first. We have not had to use the system since the pandemic. We have proper staffing levels every day.
- We handoff MDIs to the RNs
- We have a "duties by priority" guideline that details how to prioritize tasks. No software
- We have a charge RT to call for help & each therapist checks on each other to help if someone is workload becomes overwhelming. We generally prioritize higher acuity & peds/neonatal first. We will delegate minor tasks such as nasal cannula humidity to the RN calling if we are busy.
- We have a float that will go around and help.
- We have a point system, which ICuâ€™s and more critical patients take priority
- We have a policy that we go by to prioritize patients. It also allows us to change frequency of tx's like from Q4 down to Q6.
- We have a printed report and our orders get printed as well as there on Meditech
- We have a schedule of when the patients come in for PFT, ABG, 6 min walk, etc
- We have a system of Lack of Time to chart in our computer charting. I my postiton,I do not use that system. All my pts are treated.
- We have a task list so that I can prioritize Q4 treatments over QID, BID, or Q6 since those can be completed slightly later than they're due.
- We have a triage policy
- We have a work list that tracks treatment and vents. The lead therapist devides the work. When it is overwhelming we ask the RN staff to administer treatments on the units.
- We have an ABC system. A people with lung disease history and acute distress, b people with lung disease but not in distress and c no history no distress
- we have an ER and 1 med surg floor we are to treat ER patients first then floor patients
- We have an established PACE plan that outlines triage criteria based on acuity and interventions .
- We have enough staff and we have a work list
- We have flow sheets, spreadsheets of our vent home patients.
- we have none
- We have protocols for treatments, and we prioritize ventilated patients as first priority
- We have protocols in place where we directly assess the patient with a scoring system to help determine priority

- We have respiratory driven protocols for nebulizer schedules, a PDP is filled out and points are given. At the bottom the total will give a category of what the schedule can be at minium. So critical patients, exacerbations on any floor, open heart, Stat orders, and med surge pts with no pulmonary history last. Only if we are short staffed do we do the prioritizing in that ordered. We do PdP so assess patient Improvement or decline to see if the scheduled nebulizer need frequency adjustment. Those are any time we need to do one and scheduled every 72 hoursby the system also
- We have triage levels and depending on the severity, nurses in certain units will give breathing treatments.
- We have two RTs not in assignments that we can call for help.
- we ignore non critical evaluation protocols and med assessments. no software required.
- we just triage
- We only have 2 patients in the sleep lab.
- We prioritize based on acuity, determined from report.
- We prioritize based on acuity. We donâ€™t use any software to figure out acuity.
- We prioritize based on severity of the medical situation
- We prioritize based on the patients with most urgent needs coming first.
- We prioritize ourselves based on whether short of staff or not.
- We prioritize patient care depending on the acuity of the patient.
- We prioritize patient care in the ICU, NICU, ER, and CVICU
- We run a report from Epic and plug the numbers into a spreadsheet that has time standards that gives us how many therapist are needed.
- We take it upon ourselves to prioritize
- We triage based on acuity, no software involved.
- we triage patients
- We use a triage system. Most critical patients get seen first.
- We use Cerner and have a task list thatâ€™s timed.
- We use common sense. The most critical patient's are seen first.
- We use Epic software and keep an updated list of patients and current therapy/history on a word document
- We use nexus to chart and keep track of all visits
- We use paper charting at an LTACH, but it is well organized.
- we work as one department and once therapist are done with their assignment we go help the others because no one is done until we are all done
- We work together as a team
- We work together to complete all assignments
- We've a policy for prioritization of care.
- Well I just care for my most critical patients first, not really sure I understand this question
- Wellsky
- what other available staff are present to assist or take over when needed. Also acuity of situation
- wheezing priority 1 Short of breath / takes treatments at home- priority 2 Patients with no pulm history- priority 3
- When short staffed emergencies and critical patients take priority.
- When there is staff shortages we prioritize pt on basis of a city. No softwood used
- While on call we use our clinical judgement.
- Whiteboard broke down with treatments and numbers system to determine workload
- Without involving software, RTs at my acute care hospital are expected to prioritize patient care according to their degree of illness.
- Word load check list. Acute pts. Frequency on breathing treatments. Then breathing exercises
- Work list within Epic
- Work load list
- Workflow strategies
- Workload based on RVU's
- Workload. Yes software

- Worksheet. Organize . List of priority locations
- worst patient become priority no software involved
- Written policy
- Written policy of tasks
- Yes
- Yes specialized software
- You eliminate things like IS and CPT in order to give the meds needed
- You prioritize your sickest patients first, ventilators, then other kinds of treatments such as bubble cpap, high flows, or nebulizers
- Your brain

Other Gender responses

- AARC is a medical society, adhere to reality & stop being woke, DEI is critical theory marxism. Stop it. stop pandering to the political left, you look foolish.
- Apache helicopter. Stop asking stupid questions.
- biological male, XY chromosomes, Man, Sir, Mister, Master
- Care provider
- Demigirl
- Dinosaur, more specifically from the early cretaceous
- Gay male
- go fuck yourself
- Human
- Human Being
- I stand up to urinate.
- i was born a male and live as a man without mental disorder
- It
- J
- Not a Communist
- One of a lost group of old Rrts Male
- Only 2 possible answers
- Please get rid of this question. Get real
- Really need to quit with this stupid shit. Itâ€™s either make or female. Period.
- Stegosaurus armatus
- Super Woman
- There are only 2 genders! I am a WOMAN.
- there are only 2 sexes
- This is a stupid question. Identify? Your one or the other
- This is dumb. I'm a man.
- Trans man
- Tyrannosaur
- What I was born as
- Why does it matter???
- Your majesty

Other Race responses

- Indian
- A human shaped patchwork of questionable coping mechanisms
- African ammerican of Hispanic descent
- American
- American
- American
- American af.
- Black
- Black American
- Canadian
- Canadian Goose
- Caucasian
- does race really matter?
- Ethnic Jew
- European
- European
- European
- Gemini
- German/Scottish white is not a race but a color and I am not just a color don't like the term black either. And most Jamaicans don't like being called black either
- Habesha
- Hittites
- Human
- Human
- Human Being
- I am an American citizen. My ancestors came from England, Scotland, France, and Norway.

- It
- Italian-American
- Its not the color or skin but the content of character
- Native American and Spaniard
- No
- Not relevant
- other
- Romanian
- Saudi Arabian
- Scandinavian/Germanic
- Sicilian
- Southeast Asian
- Stupid question again. I am white I donâ€™t identify as white
- Texan American
- Trinidadian American
- White or Anglo American