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Spotlight Article

Intermountain Health

Respiratory Care Clinical Services

“If you can’t breathe, nothing else really matters!”

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**Primary Children’s Medical Center
Salt Lake City, Utah**



**Intermountain Medical Center
Murray, Utah**



SCL Health (now Intermountain Health)



**St. George Hospital
St. George, Utah**

Mission, Vision, and Values

The mission of Intermountain Health Care's nonprofit hospitals and clinics is to provide quality care to those with a medical need, regardless of ability to pay. Our services must be high quality, cost-effective, and accessible, achieving a balance between community needs and available resources. It is our intent to be a model health care system. Intermountain Health strives to be a national leader in nonprofit health care delivery.

History of Intermountain Health

1970s Origins: The LDS Church Hospital System

Intermountain Health, Inc. grew out of the hospital system of The Church of Jesus Christ of Latter-day Saints (LDS). Although the Episcopalians built St. Mark's Hospital, Utah's first permanent hospital, in 1872, the LDS Church had built its two main facilities by the early 1900s: the LDS Hospital and the Primary Children's Hospital (Figure 1), both in Salt Lake City, Utah.

After World War II, the Church acquired other facilities, including some, like Provo's Utah Valley Hospital, which had originated as community hospitals. In 1970 the church integrated its health care system by forming the LDS Health Services Corporation. In the early 1970s that nonprofit corporation operated 15 hospitals with more than 2,000 beds, one of the nation's largest hospital chains. In 1974, however, the church surprised many by announcing that it would quit the hospital business, "because the operation of hospitals is not central to the mission of the Church." In 1975, the Church gave its hospitals to a new nonprofit entity called Intermountain Health Care (IHC).

Life Flight

Life Flight originally began service in 1972 with just fixed-winged aircraft, but on July 6, 1978, it performed its first patient transport by helicopter, becoming the seventh helicopter (rotor wing) [air medical service](#) in the United States (Fig. 5).



Figure 5. Intermountain Health Life Flight

Intermountain currently operates one [Agusta A109K2](#) helicopter and five Agusta [AW109 SP Grand](#) helicopters. In addition to servicing Utah, Life Flight transports patients from Arizona, Idaho,

Montana, Nevada, Wyoming, and other locations in the [Western United States](#). Life Flight and its staff are [Commission on Accreditation of Medical Transport Systems](#) (CAMTS) certified. The multi-disciplinary transport staff include registered nurses, registered respiratory therapists, and physicians.

Diversification and Restructuring in the 1980s

While continuing to add more hospitals and horizontally integrate its chain under centralized leadership, IHC in the early 1980s constructed or purchased several facilities for ambulatory patients who did not need hospitalization. Included were surgical centers for elective surgery, InstaCare Centers or clinics near residential areas, and occupational health centers. In 1983 IHC created its Home Health Agency to provide nursing care, physical therapy, medical social work, intravenous therapy, and other services to patients at home.

Early Awards and Recognitions

In 1997, IHC received the following awards or honors. A National Research Corporation survey found that IHC was the top-rated HMO in the Salt Lake City area. After examining 500 U.S. firms, the magazine *PC Week* rated IHC as Utah's number one company in the use of computers and information technology. In addition, IHC received the Smithsonian Computerworld Award for its use of the Internet in quality care tracking systems. The American Hospital Association's *Hospitals and Health Networks* magazine, after studying more than 630 systems, named IHC one of the nation's top eight integrated health care systems.

Intermountain Health (formerly Intermountain Healthcare) is a not-for profit healthcare system and the largest healthcare provider in the Intermountain West of the United States. Intermountain Health provides ambulatory and acute health services, along with other medical services, through 385 clinics and 33 hospitals (4,700 licensed beds) in Utah, Idaho, Nevada, Montana, Kansas, Colorado and additional affiliations in other areas. It also offers integrated managed care under the insurance brand "SelectHealth." Intermountain Health is headquartered in Salt Lake City, Utah, and has more than 42,000 employees. Intermountain and Colorado-based SCL Health announced that they completed their merger on April 1, 2022. The combined system employs more than 64,000 people and operates 33 hospitals.

In 2009, Intermountain Healthcare was identified as a healthcare model by President Barack Obama, "We have long known that some places, like the Intermountain Healthcare in Utah, offer high-quality care at a cost below average." According to the Kaiser Family Foundation, Utah's per capita spending on healthcare is 44% below the national average.

In 2018 in response to drug shortages and pricing scandals, Intermountain Healthcare and other hospitals formed a generic drug manufacturer, Civica Rx, to produce generic drugs that are in short supply or highly-priced. In early 2022, Intermountain Healthcare created program for those suffering from long-haul COVID-19 symptoms.

Intermountain Health completed a merger with SCL Health on April 1, 2022, expanding the healthcare systems reach into Utah, Idaho, Colorado, Kansas, and Montana. The organization changed its name from Intermountain Healthcare to Intermountain Health in 2023.

Intermountain Health is governed by a system-level Board of Trustees and led by Rob Allen, president and CEO, and by an Enterprise Leadership Team (ELT) and a subset of ELT leaders referred to as the President's Leadership Council (PLC).

There are three regions (canyons, desert, and peaks) each governed by a region board and led by a region president and Region Executive Team (RET). Headquarters are in Salt Lake City, Utah, with region offices in Salt Lake City, Utah, Broomfield, Colorado, and Las Vegas, Nevada. Through alignment, collaboration and communication, regions harness the strength of a shared strategy and the expertise of caregivers across the system to deliver extraordinary care to our communities.

What Makes Intermountain Health Unique?

What makes Intermountain Health unique among health systems is the organization's willingness to dedicate resources, both financial and human, to health care innovation. This includes the Healthcare Delivery Institute and Advanced Training Program (ATP) course, innovation and growth, Ventures, Castell, Simulation Center, and Supply Organization. Intermountain **Healthcare Delivery Institute/ATP Course**

The Intermountain Health Delivery Institute is a formal effort to transform healthcare. Intermountain Health has offered, for over twenty years, an ATP course with the key aim of educating clinical leaders in clinical quality improvement.

➤ Innovation & Growth

<https://intermountainhealthcare.org/about/transforming-healthcare/awards-and-recognition/Ventures>

Intermountain Ventures supports Intermountain Healthcare's mission and vision through proof-of-concept pilots, spinouts, strategic investments, and new commercial business partnerships.

➤ Castell

Castell, Intermountain Healthcare's a new comprehensive health platform company, is focused on elevating value-based care capabilities with providers, payers, healthcare systems, and accountable care organizations. Castell will

deliver impactful solutions that help other organizations accelerate their transition from volume to value-based systems of care, improve outcomes, and keep costs more affordable.

➤ **Intermountain Simulation Center**

The Intermountain Simulation Center provides a realistic training environment for healthcare teams using advanced technology to simulate complex medical situations.

➤ **Supply Chain Organization**

Our Supply Chain Organization is known for its innovative procedures and practices, helping Intermountain get the best value for dollars it spends and allowing the organization to devote more resources to patient care.

Shared Services

We are an operating company. This means the strategy for the entire organization is set by the Enterprise Leadership Team and our Board of Trustees. There are three regions that deliver care based on the organizational strategy. The regions are also supported at a system level with shared services. This structure allows us to share knowledge and best practices, operate efficiently, and create a consistent experience while meeting the unique needs of local communities.

Examples of Shared Services include human resources, legal, supply chain, marketing and communications, finance and others, who support each region to help deliver our strategy and mission.

Shared Clinical Services

Integrated, shared clinical services examples include but are not limited to Respiratory Care and Sleep, Laboratory, Imaging, Nutrition, and Pharmacy.

Respiratory Care and Sleep Clinical Services

Respiratory Therapists serve patients suffering from acute and chronic cardiopulmonary diseases. Of the 64,000 employees at Intermountain Health, only 800 are Respiratory Therapists which elevates the expertise of the profession as a highly educated and skilled workforce. Respiratory Care Clinical Services reports directly to a RRT who is the Assistant Vice-President, Steve Abplanalp (Figure 7). [Intermountain Health Sleep Services](#) offers 25 sleep centers in Utah, Idaho, Montana, and Colorado.

Meet Our RRTs (Produced by Intermountain Health)

<https://www.youtube.com/watch?v=XoN9TcFENS4>

Duties and Responsibilities

Services our respiratory therapists provide include general respiratory care and expanded practice roles. The demand for our services and the roles we fill are growing almost daily. We focus on our unique expanded roles by providing a few examples below:

- RCS General Services
- Life Flight (adults, peds, neo)
- Twenty-one RRTs cover medical flight transports for adult, pediatric, and neonatal transports based at several hospitals.
- Organ procurement team members (lung harvesting)
- Cardiac Cath Lab

System clinical program operation council members (e.g., critical care, sleep, newborn ICU, Women and Children's, Hospitalist, emergency medicine) who actively consult on best-practices and hold conferences.

Expanded Respiratory Care Roles

Pulmonary Disease Navigators

In 2016, the organization's formal implementation of outpatient pulmonary disease navigators (PDNs) was deployed. When comparing 30-day readmission rates from 2017 to 2022, readmissions were decreased from 18.2 to 7.1%. Under the direction of the Respiratory Therapy Clinical Services System Medical Director, Dr. Peter Crossno. His work is currently underway to place PDNs in physician clinics.

Significant work has occurred for COPD patients including the use of technology to assist patients with their care engagement. It was reported in two abstracts that 19-24% of COPD patients respectively could not overcome inhaler resistance to trigger adequate medication delivery. PDNs included screening to assess this by including such screening in the Ambulatory COPD and Asthma Protocols.

System Quality Consultants

Three RRTs hold positions in the System Quality department. They attend preparatory internal surveys for gap identification and closure to assure high patient quality of care prior to hospital accreditation.

System Clinical Research (Director and IRB Manager)

Two RRTs fill key roles in system clinical research. In 2022, the former system administrator of respiratory care retired to assume the newly created role of

system director of research for respiratory care. The manager of the corporation's institute research board is an RRT.

TOSH Opioid Home Monitoring Study

During 2019-2021, a study created and led by Respiratory Care was implemented to monitor high-risk opioid patients at home following orthopedic surgery. The study team received a \$60,000 grant from the Intermountain Health Medical Research Foundation. The study was key in the earlier identification of Opioid Induced Respiratory Depression in terms of diagnosed opioid induced hypoxic events. The manuscript was submitted to the *Journal of Anesthesia and Analgesia* in mid-August 2023.

iCare Study

This a healthcare innovation study developed and being led by respiratory care clinical services after 10 years of proven improved outcomes utilizing the PDN program, vetted ambulatory COPD and asthma protocols, clinical improvement processes published in abstract format, and with the organization's executive leader support. This study has been six years in the making and includes \$4 million support funding. Respiratory care system leaders partnered with key vendors and their products to integrate the remote patient monitoring devices on an artificial intelligence platform. The primary objective is to earlier identify COPD and adult asthma exacerbations and provide more timely care to avoid overutilization of healthcare resources. PDNs will be leading the process.

The HFNC in COPD Impending Respiratory Failure Study is in the preliminary stages of creation and is again a respiratory care clinical services led initiative.

Student Study Interns are utilized and coordinated with the college and university respiratory care programs. This has been an ongoing, formal process for over 20 years and assists with staff recruitment.

Advanced Care Planning Discussion Facilitators

A respiratory care clinical service leader was the first respiratory therapist to complete the Gunderson Health's Respecting Choices course in Wisconsin. Intermountain Health is active in the documentation and honoring of patient healthcare wishes. With RRTs present from the diagnosis of chronic lung disease throughout the disease trajectory, RTs are unique qualifiers for advanced care planning discussions.

Telemedicine

TeleCritical Care

RRTs at the telemedicine desk required five years of work to gain approval and implementation. With the business model for TeleCritical Care ready five years previously, the onslaught of the COVID pandemic was the open door needed to gain the implementation of this new job title. Initially, twenty-four RRTs covered shifts at the TeleCritical Care desk covering all the system intensive care units while still working at their primary hospitals. As the pandemic drew to a close and with over 8,000 documented interventions, physicians and executive leaders supported the continued use of RRTs at the desk. Currently, six full-time RRTs and four PRN RRTs cover the required shifts. Additionally, these RRTs oversee the end tidal carbon dioxide (ETCO₂) protocol utilized for higher risk opioid prescribed patients in hospitals across the system. Finally, they will also provide after-hours oversight for patients enrolled in the iCARE study.

iCARE Study

Once launched, RRTs at the TeleCritical Care desk will provide call services for COPD and adult asthma patients after hours.

Internal Process Controllers (IPC)

This unique system role has oversight for the establishment of best practice be it equipment/supply acquisition, system best clinical practice creation and implementation, as well as oversight for auditing and monitoring compliance. Currently, three system positions exist with oversight for equipment/supplies, respiratory care, and sleep services.

Formal System Leadership Mentors (multi-disciplinary)

Two respiratory care system leaders serve on the corporation's formal mentorship committee where they mentor individuals from all disciplines to include nurses, RTs, physicians, etc.

HCCA Certified Healthcare Compliance Senior Consultants (CHC)

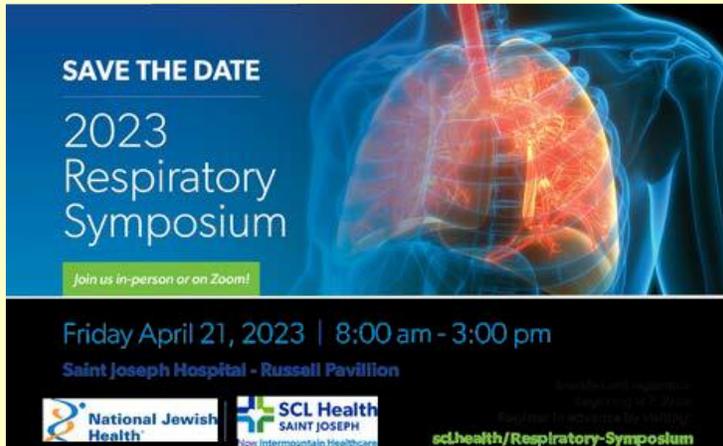
Three system leaders serve as senior Health Care Compliance Consultants assuring state and federal health care regulations are followed.

State Healthcare Consultants (CMS/HHS)

As Utah State health care policies are created or revised, select members of the system Respiratory Care leadership team serve as consultants. In 2018, RTs at Intermountain Health co-created SCRO04 (Parker's Bill) which raised the awareness of the need for home monitoring for patients taking opioids post-

operatively at home. The bill passed without a single dissenting vote. Additionally, Intermountain Health RRTs were instrumental in the passing of raising the tobacco purchase age to twenty-one. Additionally, Utah was one of the first states to pass legislation for e-cigarette legislation. System respiratory care leaders were active participants in the creation of the language and lobbying for its passage.

Intermountain Health Conference Planning Committees



RRTs in the organization assume roles to assist with the agendas for Intermountain Health Conferences.

Extraordinary Care

RTs received organizational recognition for their roles during the COVID pandemic.

https://www.youtube.com/watch?v=oknDL_oJJI&list=PLIWYdYatjvoOxCv48DiELgPhfzT_qqc5E&index=14

Respiratory therapists at Intermountain Health realize the importance of focusing care to match patient needs and are empowered to care holistically for patients. Two key examples include a professor of music was intubated and mechanically ventilated patient during the COVID pandemic. His nurse, Ciara Sase, and the respiratory therapist at McKay-Dee Hospital in Ogden, Utah, provided the opportunity for the patient to play his violin “concert” for staff and patients in the ICU. Tommy Stirland RRT at St George Medical Center created a beautiful portrait for the parents of a NICU patient who had passed away.



The Respiratory Care Clinical Service Line has received several accolades and recognitions, one of which cannot yet be reported here. However, perhaps a few of our patients say it best.

Betty Lawson's Story
August 26, 1927 – October 29, 2015



"I lived to be 88 years old because of this program and my Respiratory Therapists. I thank them with every fiber of my being. In my eyes, RTs are the ROCK STARS"!

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Professional Positions Posted

***STIMIT-Dräger, *Georgia State University, *University of North Carolina-Charlotte, *University of Nebraska Medical Center, *Massachusetts College of Pharmacy and Health Sciences, *Thomas Jefferson University, *Stony Brook University, *University of Missouri, *Liberty University, *St. Catherine University, *University of North Carolina-Wilmington, *Augusta University, *Upstate Medical University-Syracuse, *Norton Healthcare, *University of Virginia Health System**



INTERVIEW

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**1. Tell us about your early days as a respiratory therapist.
What events/circumstances brought you into the
profession?**

Both of my parents were smokers and had used coal to heat their homes as children. Due to this, my mother suffered throughout my entire childhood with multiple pneumonias, chronic bronchitis, and asthma. A career in the medical field had always interested me with the key goal of being the best resource to care for my mother. As I searched to determine a career path during my freshman year at college, a close friend of mine told me about respiratory therapy. Although I had a career counselor/sponsor for medical school, I chose respiratory therapy. What intrigued me most was the specialization that RT offered. From the words of a movie (*Jerry Maguire*), respiratory therapy “had me at hello!”

**2. Who were your mentors?
What/how did they contribute to your career?**

There is a difference between mentors and sponsors. A *mentor* is someone you generally ask for help to guide you on your path. I have had several of those. However, the guidance a mentor provides is usually focused and time limited. *Sponsors* are those who see your potential and provide career guidance as well as “selling” you and your skills to others (AKA “managing up”). They see in you potential and assist in helping you sharpen or obtain leadership characteristics while promoting you to others. Your relationship with them can last for years.

Mentors

My mentors stand out clearly as do the reasons I approached them. First, there was my mother who taught me more about life and success than I can fairly report here in this brief reflection. As a professional woman herself, she mentored me in setting goals, sharpening communication skills, and pursuing innovation.

Professionally, she mentored me by sharing her perspectives as a pulmonary patient with chronic lung disease. She taught me to care for others as if they were my family members.

Second, I discovered the power of professional mentorship when I met John Salyer. I made a request to learn how to perform research and specifically how to create, publish, and present abstracts/manuscripts. He co-authored my first abstract. To date, I have published over 70 abstracts while mentoring RT students and professionals. The most valued, mentored professionals “pay it forward”. Research is nothing I had ever planned, but it has become my passion. I became dedicated to questioning what we do, finding improved ways of practicing, and implementing those practices that improve the quality of life for patients. After retiring in 2022 as the System Administrative Director of Respiratory Care, I was hired back two weeks later as the System Director of Research for Respiratory Care after a large, funded research project I had been working on for over 10 years came to fruition.

Third, Karen Burton coached me on communicating with senior leadership. She provided opportunities to create, lead, and report system processes for newborn and pediatric care. Her guidance shaped me more than I have honestly ever been able to express to her. She taught me to avoid “trigger” words for the C-suite (CEO, CIO, CFO, etc.) From her I learned how to express challenging concepts in the SBAR format (situation, background, assessment, and recommendation) long before it was a common practice.

Sponsors

Sponsors can be those to whom we report, those with whom we work on the same level, and those who report directly to us. Does that sound strange? Generally, we think of sponsors as those in positions above us. That is not always the case. Let me explain.

My current direct supervisor, Steve Abplanalp, has been my boss since 2012. He has promoted me by making senior leaders aware of the system projects I have led or am leading. He is quick to give credit where he feels credit is due. I have never known him to grandstand or associate success only to himself. He continually defers to specific individuals or the team. In doing so, he “sponsors” others including me. He removes obstacles to innovation and progress. He has provided countless opportunities for me to have “face time” with senior leaders. Steve has represented what a leader should be.

I have been sponsored by Doug Laher and Garry Kauffman in most of my volunteer positions in the American Association for Respiratory Care. They have provided me opportunities to lead, assured that others were aware of my

contributions, made pivotal suggestions, and promoted me for future opportunities as previous assignments have drawn to a close.

Finally, I have also been sponsored by those who report *to* me. An example is Carrie Winberg. She assumed my former position as the System Administrative Director of Respiratory Care when I retired before being called back as the Director of Research. Though she had a dotted administrative line to me in my former position, her expertise was different than mine. We shared information with others, taught each other new concepts, and promoted each other as we met with our various assigned teams and committees. She was well prepared to take my position as the Administrative Director. This “co-sponsorship” has built credibility with leaders with whom we may not have otherwise individually had the privilege with whom to work.

Whether a mentor or sponsor, my career trajectory has been more than I ever dreamed it could be because of what I learned from my mentors and sponsors. Let me be clear. I am certainly not touting myself as anything more than an extremely grateful recipient of their guidance.

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

My initial education in respiratory therapy was an associate of science degree from Rose State College in Midwest City, Oklahoma. Shortly after obtaining a job in RT, I received my Bachelor of Science in Advanced Respiratory Care from Weber State University in Ogden, Utah. That was followed by my Master of Science in Health Sciences with an emphasis in public health. I have been blessed to work for an organization that promotes advanced degrees in both financial reimbursement for tuition and requiring such degrees in job descriptions for career advancement.

Being the daughter of an educator, I knew the keys to success resided in both the ability to gain a formal education as well as further developing my knowledge of the job to which I had been hired. I was taught to seize the opportunity to learn every aspect of every job in which I worked as well as to “stretch the limits” of that job. Stretching the limits can be defined as not always accepting what always had been done as good enough. It means both giving 110% as well as applying innovation. Innovation requires professionally questioning what we are currently doing, searching literature for comparison outcomes, creating and testing new processes/practices, measuring outcomes, and then revising practices to provide the highest quality of care for the lowest cost.

4. What got you on your path towards leadership roles in the AARC and/or related organizations?

As part of mentoring, John Salyer made it emphatically clear that active participation in our professional organization would prove paramount to success. He was absolutely correct! My active participation began with that first abstract followed by presentation submissions and acceptance for AARC Summer Forums and Congresses. Those events opened the door to being introduced to leaders across the country who sponsored my serving as: President and other Board of Director positions in the Utah Society of Respiratory Care, active participant in the Leadership/Management AARConnect Community, Leadership/Management Section Chair, an AARC Board of Directors member, and member of other AARC committees. Because of these experiences, I have or am serving on Boards of Directors of other professional organizations as well as s on various state committees for healthcare policy reform.

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

Healthcare innovation has never been more needed. The largest lesson for me throughout my 46 years in respiratory therapy is that innovation and pioneering takes time, patience, and a well-vetted plan of progression where “giving up” is never an option even in the face of limited resources. Building networks to accomplish the various steps of the plan is paramount to success. I have learned that publishing what you do, both internally and externally, keeps the goal in sight while raising awareness of your progress to senior leadership. Simply stated, publishing enhances the C-suites continued engagement. Finally, and this is a hard one to learn, innovative trail blazers and ideas are rarely ever initially embraced with kindness and support. Resistance to change is the enemy of innovation. Becoming an expert in the subject area, patience, and the ability to gracefully deflect nay-sayers is a leadership art that is rarely addressed when innovation is being discussed.

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

Be a sponge! Learn to adapt quickly to the rapid pace of changes that will occur at work. Work to master processes and interventions quickly. Come out of your shell, find a mentor and ask them for assistance. Volunteer to teach community health education courses, become a mentor of students, remembering how YOU wanted to be mentored Stay active in the AARC and your state Society, and read a peer reviewed journal article every week. Peer reviewed articles are where the evidence for best practice exists.

Most importantly, allow all you do to reflect your deep understanding of the compassion required to be successful in the prevention and treatment of disease. As healthcare professionals, our motto should always be, “The patient first...and always!”

**Perspectives on Medical Simulation for
Respiratory Care Educators**

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My journey as a simulation educator was prompted by my desire to be a better educator for my respiratory care students. As a young faculty member, I was trying to find a way to add value to a team of already accomplished faculty in my program. One day I stumbled on a full body manikin locked in a room on the Macon campus at Middle Georgia State University (MGSU). My curiosity took over as I investigated the manikin’s capabilities. I learned it was not just a basic device for CPR training, but a high-fidelity patient simulator. My research continued as I explored its capabilities and wondered how I could apply this simulator in the RT program’s curriculum. That is how my adventure in simulation began.

With limited resources, I began to build and implement a simulation program within the respiratory therapy department MGSU. Because of the relatively small enrollment compared to other departments, RT program budgets do not typically have the finances to support their own simulation-related equipment, facilities, and staff. However, I was fortunate that my institution has a robust nursing program that already had a high-fidelity simulator which was available. I used that manikin and shared space to build the first simulation program within the School of Health Sciences.... with a support team of one (me).

Besides securing equipment and a facility, this process steered me to expand my abilities as a simulation educator. I logged many hours of professional development, often traveling to free simulation conferences and seminars across the state. Technological challenges forged my discovery of the simulator, simulation software, and troubleshooting. Being from a small department presented challenges of administrative buy-in and navigating new skills of

collaboration. My ability to witness how simulation impacted student learning spurred on the advocacy within me. I soon realized I couldn't grow the simulation process in the Health Sciences School alone. I offered training for interested RT and nursing faculty, which taught me mentorship skills. Building a simulation program from the ground up was a steep learning curve. However, challenges in this process prompted me to seek new resources and learn quickly. In addition, the start-up experience gave me wisdom that I could share with others who were in similar situations. As I've continued to advance in simulation education, I am proud to say that the simulation program at MGSU is now sustainable and continues to grow. With the support of the Dean, Tara Underwood, and Chair, Teri Millier, the RT Program has 6 high fidelity simulators and has expanded to include neonatal/pediatric simulation experiences.

Because of my work and advocacy in simulation, I've become known as a *champion of simulation* in both my institution and respiratory care professional group. This is largely due to the mentorship I received from colleagues in the larger simulation community, mostly nursing and some RTs. I have tried to encourage respiratory educators to incorporate simulation within their curriculum as others have encouraged me. The value that I am able to add to professional conversation is a perspective on its educational value. I understand that many of the academic institutions that offer respiratory therapy programs are small and have limited faculty like mine. So, it is encouraging to see someone that understands that dynamic and offers solutions to the small programs that want to implement simulation no matter what the discipline.

Once introduced to medical simulation in late 2015, I became very curious about the simulation as an educational strategy; I sought out opportunities to learn more about both theory and tactics. Soon I began to wonder, "how is it that I had never been exposed to simulation as a respiratory therapist? I quickly realized that there was a lack of simulation education specifically directed to the RT profession. In addition, there was scant literature published solely in the discipline of respiratory therapy by RTs.¹ So many other professions, nursing, EMT, pharmacy and physicians had incorporated simulation to enhance their education with evidence of its impact on. I was inspired to discover if simulation would be as impactful in respiratory education. This promoted an interest in research and spawned an original research project.

I designed and conducted a retrospective study to determine if the implementation of simulation in the 2016 RT Program curriculum had impacted respiratory therapy students' performance on national board exams at MGSU. The results of the study were significant. An abstract of the study was presented at the International American Association for Respiratory Care (AARC) Conference.²

This initial work was instrumental in opening the doors to other projects, publications, and opportunities to promote simulation within the respiratory community.³

After subsequent collaboration and involvement in simulation activities, I realized that RTs need to have a voice in the larger simulation community. I had discovered that there is limited simulation tech/software that was specifically geared toward respiratory education. Moreover, I want to make sure the respiratory profession and scope of practice is accurately portrayed in medical simulation.⁴ Research has shown that simulation activities help facilitate critical thinking.^{5,6,7,8,9} Therefore, simulation-based education is well suited for our discipline especially since RTs are a critically trained profession. To be heard, you need to be able to identify and interact with the community that you are trying to impact. This led me to take the examination for the Certified Healthcare Simulation Educator (CHSE) credential in 2019 (eligibility for the CHSE requires a minimum of a bachelor's degree). The next step was to achieve the CHSE advanced credential. That required both presenting a body of work in simulation education that has contributed to student learning and the profession (eligibility for CHSE-A requires a minimum of a master's degree) [Certification \(ssih.org\)](https://www.ssih.org).

I continue to be an advocate for simulation and want to share my knowledge with others, especially the respiratory community. Certification is a way to demonstrate competence and earn respect in the larger medical simulation community that brings our discipline to the table. My hope is that my example of attaining the CHSE-A credential will encourage other RT simulation educators to pursue certification. Combining simulation experience with advanced degrees to earn a credential in simulation can also expand career opportunities. More RTs are needed in the simulation community to include simulation centers and interprofessional simulation coordinators, just to name a few. Since I have earned my CHSE-A, it is believed that I may be the first RT to obtain this credential.² And although I am honored that I may be the first, I am more honored to show others that it is attainable. My journey to support medical simulation to help RT students learn continues.

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**CoBGRTE Round Table Dinner & Discussion
at Boat Yard Restaurant
AARC 2023 Summer Meeting
Fort Lauderdale, Florida**

Thomas Barnes, EdD, RRT, FAARC; Kimberly Clark, EdD, RRT, RRT-NPS, FAARC; Douglas Gardenhire, EdD, RRT, RRT-NPS, FAARC; Janelle Gardiner, DHS, RRT, AE-C; Gregg Marshall, PhD, RRT, RPSGT, RST, FAARC; Daneen Nastars, DHS, RRT, RRT-ACCS

CoBGRTE continued last July the tradition of holding a dinner for members and guests to meet, eat, and discuss some of the issues impacting baccalaureate and graduate respiratory therapy education. The Round Table dinner discussion has opportunities to network, recruit new members and discuss topics critical to the advancement of the respiratory therapy education. Visiting with our academic, clinical and industry leaders from across the country supports a collective effort to expand our professional expertise. We learn from each other, solve problems together, and try to advance the profession. Table captains are asked to summarize their discussions. Sharing gives attendees and non-attendees a chance to reflect on the ideas that were exchanged at the dinner. The authors of this article served as table captains at the dinner held on July 16, 2023. Their summary of issues follows below:

Table Captain: Dr. Janelle Gardiner

Question: How are your enrollment numbers? What thoughts do you have on student recruitment?

- Like they are everywhere, enrollment numbers are down.
- We like the idea of becoming more involved in HOSA activities. That is a great recruiting tool to a target audience we know is already interested in health professions.
- We have all of the local high schools visit our university on a tour. They scheduled time to come through our lab. We have the opportunity to show them about the world of respiratory care.
- We take advantage of every opportunity the school or community has to showcase our profession.
- Our students participate in a program for junior high and high school students called Breathe-Zy. The curriculum discusses lung health in fun, engaging ways. We take that opportunity to tell those students about respiratory therapy and our role in lung health.
- We have an open house for the college of health professions. Everyone at the university is invited to come see what is happening in our department.
- The College of Health Professions held a summer camp. It was for junior high and high school students. They had a few days of learning basic healthcare skills (handwashing, vital signs, PPE) and were involved in some simulations.

Question: Talk about faculty recruitment. How can we be sure to hire the right faculty?

- We had some people who were interested in becoming faculty, but they didn't have a Master's degree. They weren't qualified to apply for the position.
- Salary is an issue, especially with recent inflation and rise in housing costs.
- One suggestion is to reach out to hospital therapists - that's how I became involved. The PD of the school sent an email to hospital therapists letting us know that they were hiring adjuncts. Before long I was hired in a full-time position.
- We have to "grow our own". Figure out those who are interested in pursuing a career as an educator and then help them know the path - pursue a graduate degree, etc.



(L to R): Kelly Rose, DCE at Utah Valley University; Thatcher Allred (spouse); Sarah Allred, DCE at Weber State University; Sherri Vasas, PD at Weber State University; John Vasas (spouse); Janelle Gardiner, PD for Graduate Studies (MSRT) at Weber State University.

Question: How does your department mentor faculty for research/scholarship?

- I participate in a Women and Research group. It is university-sponsored mentoring.
- We participate in college research symposiums. That isn't specific to our department, but it is within the college.
- We are trying to get undergraduate students involved in research.
- Our area has a research project going on right now that involves three school's respiratory faculty. They are working with local experienced researchers to design and carry out the study on "Secondary Traumatic Stress in Respiratory Therapy Students."

Question: How do you involve RTs in more research?

- Look for ways to collaborate - with teaching hospitals, partners in industry.
- Look for opportunities within the university.
- Find ways to involve students in our research.
- Have those students who have become involved in research share their experiences with other students (testimonial) to encourage more participation.

Table Captain: Dr. Gregg Marshall – We discussed:

- Recruitment: discussed ways to raise awareness of RT include visiting high school HOSA programs and speaking with students enrolled in microbiology, anatomy & physiology, chemistry, & physics regarding opportunities in healthcare careers.
- Intro course to RC as a means to recruit on campus.
- Lack of qualified RC faculty issue including possible solutions such as “growing your own” faculty from gifted/talented students.
- Use of hospital therapists in preceptor format versus hired clinical instructors---all the pros/cons.
- How CoBGRTE could contribute to advancing faculty knowledge and degrees for entry-level/DA programs.



L-R: Jennifer Anderson, Brian Walsh, Meliza Alvarez, Ellen Becker, Jonathan Waugh, Gregg Marshall

Table Captain: Dr. Douglas Gardenhire

Themes, ideas, and suggestions for improvements in RT Education

- Mentoring faculty: Assistance with objective writing and syllabus design. Support of CoARC documents for self-study and preparing for on-campus review.
- Mentoring students: Scholars, consider more and/or different scholarships categories. New grad mentorship for those talking testing to obtaining work. Skills needed to be a good employee.
- Partnering: Work with HOSA and ASAHP.
- Educator resources page: Consider one central page with all information.
- Recruiting students: EMS, especially for AS programs, Nursing for any level of education, denials. OT/PT CAS denials.
- Survey of PD/DCE/ Faculty to better understand wants and needs of their program.
- Pushing degree advancement. More MSRT programs needed to assist those with the minimum CoARC degree.



Starting long left side front back: Lynda Goodfellow (Georgia State University); Andrea Johnson (Salt Lake City CC); Jessica Ardnt (University of Mary); Becky Byrd (Amarillo College); Right Side Front to Back: Doug Gardenhire (Georgia State University); Chris Sperle (University of Mary); Thomas Lamey (Salisbury University)

Table Captain: Dr. Daneen Nastars

What can CoBGRTE do for you?

The table had some great ideas. We felt mentors for new program directors, directors of clinical education, and faculty would be helpful. The CoBGRTE mentor program should have set guidelines and meet regularly with the mentee. Another suggestion was for CoBGRTE to help respiratory care programs, especially ones in trouble, through guidance and mentors.

Another suggestion was to update the CoBGRTE website to include more direct guidance on resources and who to contact for more information.

One suggestion was for CoBGRTE to have a more inclusive meeting where anyone could attend and possibly join CoBGRTE, and the venue should be onsite.



L-R: Mrs Ransom, Barry Ransom, Wendy Castro, Paul Sweitlik, Daneen Nastars, Karen Schell

What are your recruitment strategies?

The table mentioned getting student denial lists from other programs to recruit or at least inform others about the respiratory care profession.

Rowan University was approached by the “NJ Pathways to Career Opportunities” organization (<https://njpathways.org/about/>), who identified respiratory therapy as one of the “Patient Care” professions (<https://njpathways.org/patient-care/>) in New Jersey experiencing exponential growth.

As a result of several meetings and initiatives, this organizational partner provided funding for and helped us map out pathways from recruitment to employment. Also, in New Jersey, one institution will hire students enrolled in our program as “respiratory assistants.” They will work for no more than 8 hours per week for which they will be paid. In addition, anyone enrolled in the respiratory assistant program will have all tuition paid for and receive \$50,000 in stipends, \$25,000 per year for each of the two years they are enrolled in the BSRT program. At least one other major hospital system is offering a similar program, and a third has asked for our feedback and guidance in developing RT career ladders.

Table Captain Dr. Tom Barnes - We discussed:

- Recruitment/marketing concepts covered on Friday at CoARC workshop.
- Organizing experience of CoBGRTE members to support new programs and programs completing a self-study.
- Developing a "standard" curriculum or guidelines for curriculum for programs offering baccalaureate and graduate education.
- Sharing best practice models for clinical ladders that include baccalaureate and graduate education.
- Ways CoBGRTE could collaborate with associate degree programs with grants, articulation, and research.
- CoBGRTE reaching out to state societies.
- Collaborating on research grants with CoBGRTE institutional members.
- Mentoring faculty members at community colleges and universities.



L-R: Nancy Guyse (Middle Georgia State), Georg, Sergakis (Ohio State), Tom Barnes (Northeastern), Jamy Chulak (UNC-Wilmington), Tom Nietman (UNC-Wilmington), Keith Hirst (Massachusetts College of Pharmacy and Allied Health), Mitch O’Shea (Rowan University), Larrica Clark (Oconee Fall Line Technical College, Not Shown JJ Valdez (Victoria College).

Table Captain Dr. Kimberly Clark

Our table had a robust discussion in which three major themes emerged: 1) competition for clinical placement, 2) program capacity, 3) student recruitment. The COVID-19 pandemic presented many challenges that are still being felt across the country with continued staffing shortages resulting in an increased demand for more RT graduates. Subsequently, more RT programs are starting, but many are in close proximity to existing RT programs. Starting new programs in areas with existing programs increases competition for clinical placement and the staffing shortage at the hospitals exacerbate the problem. The group suggested that may be a disconnect with senior administration agreeing to increase student capacity while RT managers are indicating that they cannot accommodate more students mainly due to the ongoing staffing shortages. The group suggested employers needed more information and education about student capacity to help increase understanding of expectations and limitations.



Photo L to R: Kim Clark (UNC Charlotte), Michael Madison (Third Pole Therapeutics), Crystal Lemelin (Seminole State College of Florida), Megan Koster (Boise State University), Terri Miller (Middle Georgia State University), Nancy Colletti (University of Cincinnati)

Starting new programs also sparked discussion regarding program capacity. While not every program is experiencing decreased enrollment, many programs are not able to fill their seats to capacity each year. The NRBC indicated that enrollment in RT programs have steadily declined by 27% since 2021, with only 10% of RT programs filling to capacity (<https://www.nbrc.org/why-the-world-needs-more-rt-and-how-you-can-help/>). Some states are seeing multiple programs at only 50-60% capacity. The group felt more emphasis could be placed in helping programs increase enrollment rather than starting new associate degree programs. Other concerns were expressed regarding the challenges of finding qualified faculty to fill position vacancies.

With declining enrollments, student recruitment is on everyone's mind. CoARC accredited programs got a funding boost from the NBRC in 2022 with scholarship funds to help with student recruitment and retention (<https://www.nbrc.org/nbrc-invests-more-than-2-million-in-the-future-generation-of-respiratory-therapists/>). The group discussed many ideas and current practices to inform more potential students about the RT profession. Programs were providing presentations to high school students, offering college health 100 level courses to introduce health career options, and conducting "high touch" marketing events. Another strategy was using "parallel planning" in which students apply to more than one health program with an academic plan for each. Nursing programs will often have more student applicants than seats available. Using a parallel planning model provides students with additional options if they are not accepted into the nursing program.

It was an evening of sharing thoughts and ideas about how to address many of the issues facing the RT profession and education programs. We know this is not a quick fix because we are faced with a multipronged problem that will require multiple strategies over the long haul.

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

[BSRT and MSRT Entry Programs](#)

[Graduate Respiratory Therapist Programs](#)

www.CoBGRTE.org

CoBGRTE Scholarships Reminder

The Mission Continues

José D. Rojas, PhD, RRT, RPFT, FAARC
Chair CoBGRTE Scholarship Committee

The CoBGRTE Board of Directors, with steadfast tenacity, continues to make scholarship money available to help support school expenses for members pursuing baccalaureate, graduate, or doctoral degrees. Encourage your friends, colleagues, and students to apply! It is not an onerous process. This year to improve the process for application and distribution, the scholarship committee has made the recommendations outlined below. The process for application is relatively simple and the application has been posted on the CoBGRTE website since April 1, 2023. Don't let this opportunity pass you by! **The application cycle will remain open until October 1, 2023**, and we hope to make announcements of winners and present awards at the AARC Congress.

1. The scholarship cycle: for all awards (NBRC supported, Merit, Malinowski, Smallwood) opened April 1 and closes on 10/1/23. Send your applications early!

2. There are four award categories:

a. Merit Scholarships (\$8,000)

-eligibility (BS and MS entry-level CoBGRTE member, BS and MS degree advancement CoBGRTE members; *Propose to allocate four (4) \$1,000 scholarships for entry-level and four (4) \$1000 scholarships for degree advancement depending on number of applications*)

-required materials (letter of support from faculty/PD/DCE, professional resume, completed application, unofficial transcript, and essay)

b. Smallwood Research Scholarship (\$2,000)

-eligibility: BSRC and MSRC entry-level CoBGRTE member, BSRC and MSRC degree advancement CoBGRTE members.

-required materials: research proposal that includes a budget; proposal should include literature review with hypothesis or research question; project timeline; letter of faculty support; and professional resume.

c. Malinowski Leadership Award (\$2,000)

-eligibility (therapist in a supervisory or lead position; BSRC or MSRC degree advancement or clinical research program; CoBGRTE member)

-required materials (QI project or clinical research proposal; includes a budget; proposal should include literature review/hypothesis or research question/ specific aims/ project timeline; letter of faculty or hospital administration support; professional resume)

d. NBRC-supported faculty awards (\$20,000)

-eligibility (RRT, CoBGRTE member, current faculty member or pursuing faculty position, enrolled in doctoral program)

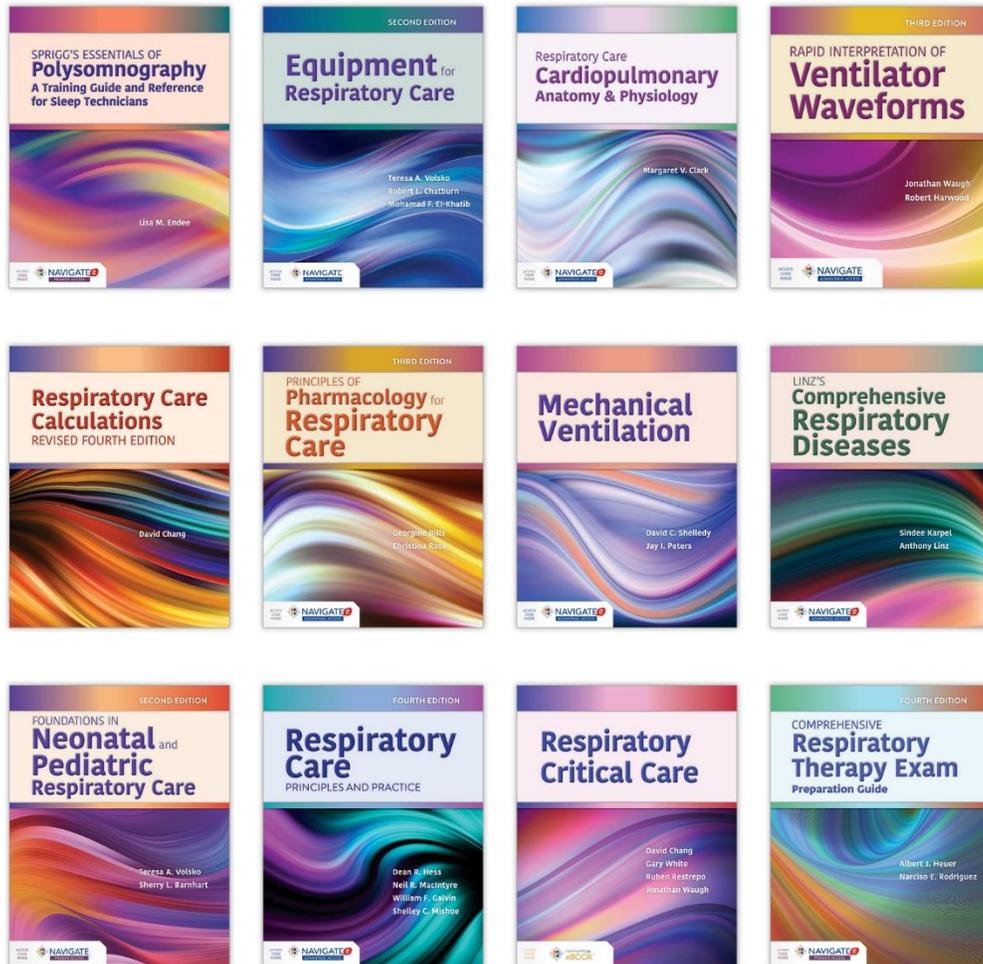
-required materials (proposal for required funds that includes budget/justification; letter of support from Chair/Dean; CV)

-award \$5,000 to \$10,000 based on proposal/need

Members of the CoBGRTE Scholarship Committee

Bruce Adcock, M.Ed, RRT, RRT-NPS, CHSE	Assistant Professor University of Texas Medical Branch
Brian Cayko, MBA, RRT, FAARC Boise State University	Clinical Assistant Professor
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Tyler Weiss, MSc, RRT, RRT-ACCS, AE-C, FCCP Rush University	Assistant Professor
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Visual Learning



- LED highlights: Each lobe of the lungs, 5 cardiac points, 4 quadrants of the abdomen
- Anatomically correct visualization of lobes, fissures, cardiac points and abdomen in relation to torso
- Write on torso (easy wash off): lesson notes

Auditory Learning



- 73 high definition sounds from real clinical cases
- Cardiac, Respiratory and Bowel sounds
- Sounds transmitted directly into any stethoscope (“Bluescope” device)
- Project sounds with external speaker

Haptic Learning



- Tactilely lifelike skin (proprietary silicone)
- Palpable ribs and landmarks
- Rotatable base (anterior/posterior auscultation)
- Correct stethoscope placement produces corresponding sounds

CoBGRTE Institutional Members

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Weber State University
Boise State University
Bellarmine University
Rush University
Salisbury University
The Ohio State University
Northeastern University
University of Texas Medical Branch - Galveston
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CoBGRTE Institutional Members - Continued

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Northern Kentucky University
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University of Nebraska Medical Center
University of Michigan – Flint
Augusta University
West Chester University/Bryn Mar Hospital
Thomas Jefferson University
University of Toledo



If you have not already decided to become a CoBGRTE member after visiting www.cobgrte.org, the following are 15 reasons why you should join the coalition.

Reasons Why You Should Become a CoBGRTE Member

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

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