Introduction and Background

Neonatal-pediatric respiratory care is recognized as a unique and complex area of practice as evidenced by the creation of the Neonatal-Pediatric Specialty (NPS) examination and credential by the National Board for Respiratory Care. Respiratory therapists (RT) work in a growing number of pediatric facilities. Additionally, respiratory therapists staff delivery rooms and neonatal intensive care units. While the number of practicing neonatal/pediatric respiratory therapists is currently unknown, the Neonatal-Pediatric section of the American Association of Respiratory Care (AARC) currently has over 2,000 members and 12,488 practitioners hold the NPS credential (NBRC, New Horizons, January 2015).

Neonatal/Pediatric respiratory care encompasses the treatment of a range of patients from extremely low birth weight premature newborns to adolescents with a wide range of cardio-respiratory diseases of diverse etiologies. The care of the neonatal/pediatric patient thus requires mastery of a wide range of pediatric anatomy and physiology, disease etiology and pharmacology, and diagnostic and therapeutic equipment and procedures. Respiratory therapy education programs are required to cover basic neonatal / pediatric care and neonatal-pediatric content is included on both the National Board for Respiratory Care’s (NBRC) entry-level and advanced practitioners credentialing exams. Yet, much of the training of neonatal-pediatric practitioners is done “on-the-job”. The variety and complexity of the neonatal-pediatric environment requires substantial orientation of new staff to meet the requirements of basic competency – the delivery of care safely and effectively.
Despite significant medical advancements in the 21st Century, dramatic inequalities in healthcare currently persist across the globe. This inequality is due in part to a stagnant medical educational system. The apprenticeship model, which once revolutionized respiratory education, is now failing to keep up with an increasingly interconnected world. As a result, expert knowledge is bottlenecked within the walls of institutions. Post-graduate education is further disrupted by various state license or NBRC continuing education requirement and decreasing opportunities for on-the-job learning as education is often seen as inefficient. These deficiencies in the medical education system have culminated in a global shortage of effective pediatric care. Indeed, nearly ten million children under the age of five die each year across the globe from preventable causes with respiratory disorders being the number one reason for hospitalization and respiratory failure in children. Over the last decade, however, innovative Internet-based technology has emerged which effectively scales knowledge-exchange across the world. The rise of this technology leads to the opportunity for a fundamental revision of methods for medical learning and knowledge exchange.

Overview of the OPENPediatrics Project

By fusing world-class medical expertise with the power of the Internet, OPENPediatrics has created an interactive virtual training and knowledge exchange platform to enhance the quality of pediatric critical care and revolutionize the existing education model. Designed by experienced physicians, nurses and respiratory therapists at Boston Children’s Hospital, in collaboration with IBM Interactive, OPENPediatrics is the first global health initiative to utilize innovations in cloud-based technology for advancements in medical education. OPENPediatrics is changing the existing medical educational paradigm by offering asynchronous interactive learning and various avenues for knowledge sharing outside the walls of select institutions. Those accessing the website or the online platform will find free access to academically rigorous and peer-reviewed lectures, simulators, and protocols. Using these materials to encourage active learning and information exchange, this platform has already begun to create a global community of pediatric practitioners.

OPENPediatrics Content

Staff at Boston Children's Hospital collaborated with experts from the Harvard School of Graduate Education, MIT’s OpenCourseWare, the Harvard School of Public Health, and the Harvard Kennedy School of Government to develop the conceptual foundation of the program’s content. The content was developed based on David Kolb’s theory of adult education, which suggests learning is more effective when content is presented in four distinct learning steps: concrete experience, reflective observation, abstract conceptualization, and active experimentation. Users will experience this educational model through four main features of the OPENPediatrics Platform: World Shared Practice Forum, Guided Learning Pathways, Groups and The Library.
The Library on OPENPediatrics includes the full extent of the platform’s content. The educational material is available in many different forms, including didactic and procedural lectures and demonstrations by experts, protocol summaries, medical and drug dosing calculators, and virtual ventilator simulators. The library is freely available at any time and provides a searchable collection of foundational knowledge. The World Shared Practice Forum is a monthly video lecture delivered by a physician, respiratory therapist or nurse on a critical issue in pediatric care. This forum connects a global community of care, allowing healthcare teams from around the world to communicate via a discussion forum, comment on and ask questions of the video, and gain knowledge of international best practices. This function facilitates asynchronous learning and knowledge exchange across geographic borders and time zones by allowing users to add comments at anytime, anywhere, throughout the life of the video.

The Respiratory Care guided learning pathways in currently in beta testing and offers an opportunity for users to expand their knowledge of topics relevant to their practice in critical care. The learning pathways are comprised of 10-20 short lessons, which each begin with a video, summary, and, if applicable, a simulator, and conclude with a post-test. These learning pathways allow educators to track the progress of their learners in detail, and provide a place for employing the flipped classroom in medical education.

The last main feature of the site is the Groups section, in which any user of OPENPediatrics can join or create his own private or public group. Groups allow users to foster communities and connect with global colleagues. Users can create or join groups related to specific subspecialties, geographical locations or medical interests. These groups allow participants to share documents and exchange ideas with global colleagues. A video chat capability is also available through the group feature, which allows users to host a live videoconference with up to 9 colleagues.

**Physician Leaders**

Three experienced physicians and educators lead the OPENPediatrics project: Dr. Jeffrey Burns, Dr. Traci Wolbrink and Dr. John Arnold. Dr. Burns, the Program Director, is also the Chief of Critical Care at Boston Children's Hospital and an Associate Professor of Anesthesia at Harvard Medical School. Associate Program Director Dr. Wolbrink serves as an Attending at Boston Children’s Hospital and an Instructor of Anesthesia at Harvard Medical School. Dr. Arnold is the Medical Director for Respiratory Care and ECMO at Boston Children’s Hospital and Professor of Anesthesia at Harvard Medical School and serves as the physician lead of the respiratory care curriculum.

**Respiratory Therapy Leaders**

Three experienced respiratory therapist and educators, Craig Smallwood, RRT, John Thompson, RRT-NPS, FAARC and Brian Walsh, MBA, RRT-NPS, ACCS, AE-C, FAARC.

**John Thompson, RRT, FAARC** is a respiratory therapist and the former director of respiratory care at Boston Children's Hospital for over 40 years. Mr. Thompson continues to offer his expertise to OPENPediatrics as a consultant on the respiratory care module.
Craig Smallwood, RRT is a respiratory therapist and researcher at Boston Children’s Hospital with over six years of experience. Craig graduated from Northeastern University with a Bachelor of Science degree in Respiratory Care. Presently, Craig is pursuing his PhD in Biomedical Engineering where his research focuses on lung imaging, mechanical characteristics of surfactant under different conditions and breathing dynamics. Craig has authored or coauthored two book chapters and 12 peer reviewed publications ranging from gas exchange measurement to novel lung imaging methodologies.

Brian Walsh, MBA, RRT-NPS, ACCS, AE-C, FAARC is a respiratory therapist and research coordinator at Boston Children’s Hospital with over 18 years of experience in neonatal and pediatric respiratory care. Brian graduated from Old Dominion University with a Bachelor of Health Sciences degree, Liberty University with a Master’s in Business Administration and is currently a PhD candidate at Rush University where his research focuses on computer decision support for mechanical ventilation. Brian is the editor for Neonatal and Pediatric Respiratory Care, 4th edition. He has authored or coauthored over 25 manuscripts.

The OPENPediatrics Team

In addition to the Respiratory Care Team and Physician Leaders, the OPENPediatrics Team consist of two directors, a manager, a program coordinator, three videographers, two medical illustrator and animator, two medical editor, administrative assistant, data analysis, research data coordinator and voice-over artist.

Version 1 Release

OPENPediatrics was field-tested as a prototype application on four continents from 2009-2010, and beta tested in over 85 countries, across six continents from September 2012 to April 2014. Based on feedback from this extensive testing, the first version of OPENPediatrics was released on April 1, 2014. The new version has expanded user-access to the program, and the number of users grew by 250% in the first eight months following the launch of Version 1. The program is currently used by healthcare providers in over 120 countries across six continents, and is
growing every day. The increased ease of access and networking capabilities will expand the OPENPediatics community and allow it to better serve global pediatric practitioners.

**Ventilator Simulator**

One of the most exciting and engaging aspects of the learning platform is the virtual ventilator. The virtual ventilator is an online mechanical ventilator simulation. It's a novel training tool that allows the user to take care of virtual patients in an immersive environment without having to actually be in the intensive care unit; training can happen on any computer with an Internet connection. This cutting edge tool incorporates real-time changes in vital signs, ventilatory parameters, patient appearance, arterial blood gases, chest X-rays and more. Users are required to interpret physiologic, imaging and ventilator data, formulate diagnoses and make changes to best treat their patients. Additionally, users will get near real-time feedback on their performance. Paying close attention to the scores you get as you treat patients helps users to identify those areas that need improvement. We’ve even added an award system that gives you medal if you score high enough overall. Go for the gold! Through a novel, immersive, feedback oriented simulation system; the virtual ventilator is revolutionizing how clinicians learn mechanical ventilation throughout the world.
Currently, anyone can go to [www.virtualventilator.org](http://www.virtualventilator.org) for the ventilator simulator or navigate to the system by logging into [www.openpediatrics.org](http://www.openpediatrics.org). Simply sign up for free and start using the virtual ventilator or gain access to available content. If you are an educator at a college, university or hospital and are interested in how you can incorporate this as part of your curriculum we would love to help. Please email Craig Smallwood at [craig.smallwood@childrens.harvard.edu](mailto:craig.smallwood@childrens.harvard.edu) for questions regarding the ventilator simulator or Brian Walsh at [brian.walsh@childrens.harvard.edu](mailto:brian.walsh@childrens.harvard.edu). We are always updating our content as well. Look for the next version of the ventilator that will include all new neonatal and adult content!
CoBGRTE Approved as Associate Member of CAAHEP

By Thomas A. Barnes, EdD, RRT, FAARC and
David C. Shelledy, PhD, RRT, FAARC, FASAHP

In Kansas City at their annual business meeting on April 20, 2015 the Commission for Accreditation of Allied Health Educational Programs (CAAHEP) voted to approve the application for associate organization status for CoBGRTE. The application to CAAHEP was based on the CoBGRTE Task Force on Accreditation White Paper recommendation that “The further development of baccalaureate and graduate respiratory care education will depend on the development of a new accreditation agency that can advance respiratory care education in a manner consistent with current and future needs of the profession. This agency would accredit only baccalaureate and graduate degree respiratory care educational programs.” The CAAHEP associate member status for CoBGRTE is consistent with the direction provided by the board to study and explore development of independent specialized accreditation of baccalaureate and graduate respiratory care educational programs.

History of CAAHEP

Allied Health Accreditation: The Early Years
In 1904 the American Medical Association (AMA) created the Council on Medical Education (CME) whose objective was to restructure American medical education. In 1908 the CME asked the Carnegie Foundation for the Advancement of Teaching to survey medical education and they chose Abraham Flexner to conduct the survey. The publication of the Flexner report led to the accreditation process created for medical schools in the early 1900s. The medical school accreditation process provided a model for the accreditation activities of many other professional associations. This pattern was followed in the 1920s, when the AMA responded to the need for inspection and certification of laboratory facilities, and later for inspection of other specialized training and practice facilities.

Early in the 1930s and continuing into the 1940s, several national bodies requested the collaborative aid of the AMA in establishing accreditation processes for their educational programs: the American Occupational Therapy Association in 1933; the American Society of Clinical Pathologists in 1934 for medical technology; and the American Physical Therapy Association in 1935. “Essentials” (accreditation standards) were adopted for all three professions during the mid- to late 1930s.

1966: AMA Allied Health Department Created
The demand for additional well-trained professionals assisting physicians in the delivery of health care prompted the AMA, in the late 1960s, to recommend creation in August 1966, of the Department of Allied Medical Professions and Services. In November 1967, the Department was moved to the newly created Division of Medical Education.
1967: Allied Health Advisory Committee Established
The Council on Medical Education, recognizing the value of and need for advice and counsel from allied health professional associations and educational institutions, recommended to the AMA Board of Trustees the establishment of a national advisory committee on allied health.  

1968, 1970: Special Advisors Recommended, Panel of Consultants
To facilitate communication between the AMA and organizations that represented selected members of the health team, the Allied Health Advisory Committee recommended to the Council on Medical Education that representatives of each of the medical specialty and allied health organizations meet with the Advisory Committee twice annually as a Panel of Consultants. The Joint Review Committee for Respiratory Therapy Education, the successor group to the Board of Schools came into being on January 15, 1970 as a recommending body to the AMA Panel of Consultants.

1971-1976: Committee on Allied Health Education and Accreditation (CAHEA) Formed
The American Medical Association, Association of Schools of Allied Health Professions and the National Commission on Accreditation sponsored in 1971 a Study of Accreditation of Selected Health Educational Programs (SASHEP) supported by a grant from The Commonwealth Fund. In this report the SASHEP Study Commission presented specific recommendations for creation of a new organization to be responsible for the selected health educational programs that were the primary focus of the study. Inhalation therapy technician and the Joint Review Committee for Inhalation Therapy Education were among the 15 selected health educational programs that served as the focus of the SASHEP.

In December 1976, the AMA House of Delegates approved a Council on Medical Education recommendation to establish a 14-member accrediting body that included two Council on Medical Education members and two public members, along with broad representation from the communities holding interests in accreditation. This new body, the Committee on Allied Health Education and Accreditation (CAHEA), was staffed by the AMA Division of Allied Health Education and Accreditation (DAHEA). In 1976, CAHEA accredited over 2,700 programs in 26 professions enrolling 52,000 students. By 1992, these numbers had grown to 2,900 programs in 28 professions enrolling 98,000 students.

1992 – 1993: Transition to a New System
At the October 1992 meeting of CAHEA, the AMA announced its intent to support the establishment of an agency that would assume the accreditation responsibilities of CAHEA. The proposed new agency would be an independent body in which the AMA would participate as one sponsor among equals. A task force was formed to design an agency to assume the accreditation role of CAHEA.

The AMA responded to requests from numerous collaborating organizations and review committees by agreeing to continue to support CAHEA until July 1, 1994. The extension ensured
continuity in the transition period and sufficient time for establishing the proposed new agency or agencies.  

1994: CAAHEP Created
The Commission on Accreditation of Allied Health Education Programs (CAAHEP) was incorporated as a nonprofit organization on July 1, 1994, assuming the allied health accrediting functions that had been performed by CAHEA. The AMA continued to be CAAHEP’s primary sponsor through a 3-year transition period, ending on December 31, 1996.  
The JRCRTE, was dissolved in 1996 and the Committee on Accreditation for Respiratory Care became its successor organization, as a recommending body to CAAHEP, which provided the actual accreditation of respiratory care educational programs. In 2008, the CoARC began the process of becoming an independent accrediting body: the Commission on Accreditation for Respiratory Care.  

Today, CAAHEP accredits approximately 2,104 educational programs that prepare health professionals in 24 different professions. While CAAHEP has the final authority for making accreditation decisions, the day-to-day work is done by 24 committees on accreditation (CoAs), one for each of the professions in which CAAHEP accredits programs. Each committee on accreditation is responsible for reviewing self-studies, performing on-site reviews, and making recommendations to the CAAHEP Board of Directors for final action.  

CAAHEP’s membership is composed of organizations, with member organizations divided into three categories. The first category of membership is committees on accreditation. Sponsoring organizations are the second category of membership. These organizations are generally the professional associations representing the various allied health disciplines and they may sponsor one or more committees on accreditation in addition to sponsoring CAAHEP. Finally, the third category of membership is that of associate member. Each member organization appoints a Commissioner to represent its interests within the CAAHEP system.  
The Commission is the ultimate governing authority of CAAHEP. The Commission meets once each year to examine critical issues; vote on any proposed Bylaws amendments or changes to the CAAHEP Vision and Mission Statements; vote on applications from new sponsoring or associate member organizations; approve recognition of allied health disciplines for the purpose of participating in the accreditation review process; and otherwise set the major policy directions for the coming year.  

Between annual meetings, the organization is governed by the Board of Directors (elected by and from the Commission), who represent the following constituencies: sponsoring organizations, committees on accreditation, educational institutions, and the general public. In addition to hiring the executive director, approving the budget, and overseeing CAAHEP office operations, the Board of Directors acts four times a year on accreditation recommendations submitted by the committees on accreditation.
CAAHEP Accredited Programs by Profession

Advanced Cardiovascular Sonography
Anesthesia Technology
Anesthesiologist Assistant
Cardiovascular Technology
Cytotechnology
Diagnostic Medical Sonography
Emergency Medical Technician-Paramedic
Exercise Physiology
Exercise Science
Intraoperative Neurophysiologic Monitoring
Kinesiotherapy
Lactation Consultant
Medical Assisting
Medical Illustration
Neurodiagnostic Technology
Orthotic and Prosthetic Technician
Orthotist/Prosthetist
Perfusionist
Personal Fitness Trainer
Polysomnographic Technology
Recreational Therapy
Specialist Blood Bank Technology/Transfusion Medicine
Surgical Assistant
Surgical Technologist

REFERENCES

Call for Graduation Photos

CoBGRTE wants to publish in The Coalition Chronicle group photos of 2015 graduates and faculty members. Please send in the photographs as large jpg files with a short article about the graduation ceremony and student accomplishments. Use the “Contact Us” page at http://www.cobgrte.org/contactus.html to receive further instructions.

Four Reasons: Why I am a CoBGRTE Member

Lanny Inabnit, MSc, RRT-ACCS, NPS, RCP
University of North Carolina - Charlotte

1. CoBGRTE provides a platform for communicating and delineating information related to furthering the education of our profession.

2. The resources obtained allow one to network with others on a similar mission.

3. CoBGRTE also lobbies for the progression of our profession and provides a voice for those seeking this advancement.

4. CoBGRTE provides guidance to those who wish to develop practices that will aid in the advancement of our profession.

Gregg Marshall Promoted to Full Professor

Gregg Marshall, PhD, RRT, RPSGT, RST, Chair of the Department of Respiratory Care & REM Sleep Center at Texas State University has been promoted to Full Professor. Dr. Marshall has been a faculty member at Texas State since 1980 serving as Department Chair for 11 years and Director of Clinical Education for 23 years. He is the founder and developer of the Sleep Center at Texas State. He was awarded a PhD in Education/Curriculum & Instruction in Higher Education from University of Texas at Austin, received a Master of Science in Health Professions and Healthcare Administration from Texas State University-San Marcos, and a Bachelor of Science degree in Biology from Baylor University. Dr. Marshall has been a member of the CoBGRTE Board of Directors since 2012 and is Chair of the Program Standards Committee.
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Interested in writing or reviewing? Contact our Publisher, Cathy Espanet, at espanet@jblearning.com.
The California Society for Respiratory Care (CSRC), as an affiliate of the American Association of Respiratory Care (AARC), is a non-profit professional organization, whose mission is to represent and support our members through public and legislative advocacy, educational opportunities, and to continuously strive for excellence in the cardiopulmonary profession. By these means, the CSRC is committed to health, healing and disease prevention in the California community.

CSRC Mission Statement

The California Society for Respiratory Care (CSRC), as an affiliate of the American Association of Respiratory Care (AARC), is a non-profit professional organization, whose mission is to represent and support our members through public and legislative advocacy, educational opportunities, and to continuously strive for excellence in the cardiopulmonary profession. By these means, the CSRC is committed to health, healing and disease prevention in the California community.

CSRC Vision Statement

The California Society for Respiratory Care strives to be the elite provider of education, consumer information and the benchmark for professionalism.

CSRC Core Values

Professionalism
Advocacy
Commitment
Excellence
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Indiana Respiratory Therapy Consortium
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Wheeling Jesuit University
Texas State University
University of South Alabama
Long Island University
University of North Carolina – Charlotte
Louisiana State University Health Science Center – New Orleans
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Youngstown State University
Rutgers University - North
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Texas Southern University
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East Tennessee State University
University of Virginia Medical Center
University of Dammam
Seattle Central College
Florida Southwestern State College
Utah Society for Respiratory Care
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Southern Connecticut State University
Washington Adventist University
Rutgers University - South
Northern Kentucky University
If you haven’t already decided to become a CoBGRTE member after visiting www.cobgrte.org, the following are 10 reasons why you should join the coalition.

**Ten 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 55 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. Join colleagues to collectively develop standards for baccalaureate and graduate respiratory therapist education.
8. Develop public relations programs to make potential students aware of baccalaureate and graduate respiratory therapist programs.
9. Help to publicize, among department directors/managers, the differences between respiratory therapists with associate, baccalaureate and graduate degrees.
10. Help to support maintaining a roster and web site for all baccalaureate and graduate respiratory therapist programs.

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