A Day in the Life of an APRT

Mindy Conklin MRT, RRT, RRT-ACCS

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Disclosure

"VAPOTHERM – Co-Host of RT Sidebar & Consult"

Objectives

1. Daily practice of an APRT
2. Competencies needed to practice as an APRT

WHAT IS AN ADVANCED PRACTICE RESPIRATORY THERAPIST?

The Advanced Practice Respiratory Therapist (APRT) is a practitioner trained to provide a scope of practice that exceeds that of the registered respiratory therapist (RRT). After completing a Bachelor of Science degree in respiratory therapy and obtaining the National Board for Respiratory Care (NBRC) Registered Respiratory Therapist (RRT) credential, the aspiring APRT must successfully complete a Commission on Accreditation for Respiratory Care (CoARC) accredited graduate-level education and training program that prepares graduates to provide advanced, evidence-based diagnostic and therapeutic clinical practice and disease management. As part of a physician-led team, APRTs are trained to provide diagnostic and therapeutic patient care services in multiple settings across the health care spectrum, including critical care, acute and sub-acute in-patient care, and outpatient care such as preventative, ambulatory, and chronic care

Advanced Practice Standards - CoARC - Commission on Accreditation for Respiratory C

Advanced Practice Respiratory Therapist Scope of Practice Form
VA Maryland Health Care System (VAMHCS)

1. Advanced Practice Respiratory Therapist (APRT) SCOPE OF PRACTICE

Clinical APRT in the Department of Veterans Affairs are privileged through a Scope of Practice (SOP). The SOP includes core elements or duties of APRT clinical practice.
Core duties are the medical acts that are included in the standard curricula of the COARC accredited APRT education program.
https://coarc.com/accreditation/advanced-practice-standards/

2. COLLABORATING PHYSICIAN ROLE

The collaborating physician and designated alternate collaborating physician(s) are identified on the team signatures page at the end of this SOP. The APRT will practice as a physician extender, licensed (Respiratory Care Practitioner) RCP under the clinical and administrative oversight of the Chief of Pulmonary Medicine, designee, or Clinical Center Director. The physician who can provide clinical oversight, consultation, and patient care management assistance if needed by the APRT in person, by phone or other electronic means. A physician contracted by VA to provide clinical services at VA medical facilities may be appointed as a APRT's collaborating physician. The clinical duties or procedures assigned to the APRT must fall within the collaborating physician's delineation of privileges at VAMHCS. The degree of involvement of the collaborating physician in the APRT's clinical activities varies depending on the APRT's practice setting, clinical competence, complexity of patients treated and the nature of the assigned duties. In the collaborating physician's absence from the facility, they will need to notify the APRT and the alternate collaborating physician to assume collaborating physician responsibilities until they return to duty.

- APRTs obtain medical histories, and record progress notes
- Assess, treat and counsel patients
- Order, and interpret lab tests, imaging studies, diagnostic and therapeutics procedures
- Develop care plans, order, and provide care and then evaluate and modify care based on each patient's response.

My Snapshot as an APRT

- Practice Patterns within Pulmonary Division and Sleep Medicine
- My clinics: APRT Pulmonary , APRT Sleep
- Patient encounters- 3550 Encounters, 1000 unique Encounters
- Prescribing Habits – 3700 Prescribed Agents, Holter monitor, Echos, Sleep Studies- PSG, HSATs, PAP systems, IVAPS, Hi-FLOW/Supplemental Oxygen, Pulmonary Function Test, Lung Transplant Work-up, Labs, Mechanical Ventilator.

Case Series 1

- An adult patient with history of COPD, PH, HTN, HFpEF, OSA, RA, with known prolonged exposure to chicken droppings.

- Presents to clinic with an increase in SOB and 40lb weight loss. Pt states dyspnea had increased over the last 9 months with a productive cough – yellow/green sputum.

- Was recently discharged from OSH on 3L O2

Labs/Images Results

CT CHEST: Stable appearance of upper lobe predominant areas of groundglass and fibrotic lung changes. Consistent with hypersensitivity pneumonitis. Diagnosis ILD

PFTs demonstrate preserved FEV1/FVC ratio. TLC is preserved and RV is elevated at 148% of predicted. DLCO is severely reduced at 40% of predicted.

-Histoplasmosis negative
-TB negative
HIV negative

6 min walk- At rest : On oxygen @ 4 lpm oxymizer
O2 saturation: 91% HR 98
Ambulation on oxygen
Liter flow 6 lpm oxymizer 200 feet
O2 saturation 87-89% % HR103

Diagnosis/Plan

- ILD 2/2 RA vs ILD 2/2 Hypersensitive Pneumonitis with rapid progress
  - Start trial of immunosuppression to determine if we are able to holt the autoimmune process
  - Increase Prednisone to 60mg Daily
  - Start CellCept - repeat EKG in 1 month
  - Start PPI GERD
  - PJP prophylaxis- Bactrim and Dapsone
  - Start Calcium and Vitamin D
  - Start Lung Transplant work up

Case Series 2

- An adult patient with history GERD, Asthma, Chronic Respiratory Failure 2/2 ALS, s/p trach and peg. Presents to clinic to establish care. Pt is non-verbal and ventilator dependent. Spouse is POA, is also an ICU nurse. Pt is DNRCC

- Chief complaint: Establish care & recurrent aspiration pneumonia

- HPI: Pt was diagnosed with ALS in 2021- with rapid progression. Pt had multiple aspiration events. On arrival, pt was febrile 102, with copious yellow thick secretions. Pt has had multiple rounds of Leviquin within the last several months. Continues to be febrile & produce tenacious secretion.

Case Series 3

- An adult presents to sleep clinic to rule out OSA. PMH: HTN, Former smoker, obesity, A-fib and GERD
- Chief Complaint: Snoring, daytime sleepiness
- The Epworth Sleepiness Scale: 19
- STOP BANG 8 - High risk for Moderate to Severe OSA
- Plan: Sleep Study
- Results of HSAT: Mixed Apnea
  Severe OSA AHI 66 RDI 66 and CSA AHI 36

Case Series 4

- A patient presents to pulmonary clinic for evaluation for lung transplant.

Pt with a PMH very severe COPD, DM, CKD, HTN, Former smoker and obesity BMI 37. Currently on 2L O2 and NIV for chronic respiratory failure. Patient in triple therapy.

CT Chest

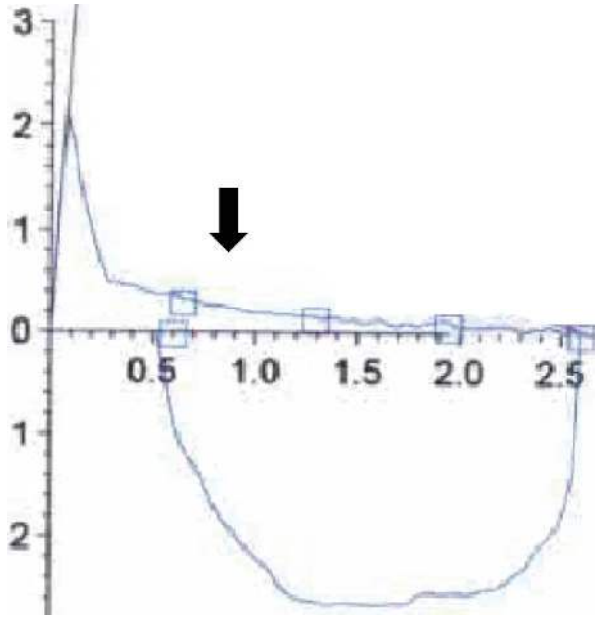
- Severe centrilobular emphysema. Left basilar atelectatic changes. Stable right apical solid nodule measuring up to 5 mm.

PFT Results

- FVC 48
- FEV1 19
- FEV1/FVC% 40
- FEF25-75% 9

- TLC 90
- VC 49
- RV 149

- DLCO 23



Case Series 5

- Patient presents to pulmonary clinic with cc worsening dyspnea on exertion, mucus plugging and chronic Wheeze. Pt with PMH asthma, former smoker, oral cancer, HTN, CAD s/p T4aN2c SCC of the left FOM s/p awake tracheostomy, anterior composite resection, bilateral neck dissection, left osteocutanous fibula free flap, STSG and saphenous vein Graft. Patient with #4 cuffless Shiley

- Previous visit started treatment for Asthma- Duoneb Q6, Albuterol Q2 prn, Pulmicort and Guaifenesin. AirVo, Cough assist, and Chest vest for airway clearance.

Descriptive Analysis of RT Guided Tobacco Cessation Outreach and Treatment

Mindy Conklin MRT, RRT-ACCS, RRT [1], Janaki Deepak MD[2];
[1]Pulmonary, VA Maryland Health Care System, Baltimore, MD, United States, [2]Pulmonary and Critical Care, Univ of Maryland, Baltimore, MD, United States.

VA MARYLAND HEALTH CARE SYSTEM

Significance

•Three out of ten veterans are current everyday smokers

•Smoking results in chronic diseases such as heart disease, cancer, and chronic obstructive pulmonary disease, leading to hospital admissions for disease exacerbation and respiratory failure

•Nationally 20% 30-day readmission rate for COPD exacerbation

•Respiratory Therapists can engage and enhance the tobacco cessation efforts

METHODS

- Workgroup of RT's, Advanced Practice Respiratory Therapist (APRT) and a Pulmonologist developed a plan to increase tobacco education outreach for inpatients with a segway to outpatient tobacco treatment referral
- Over 4 months, a daily list of inpatients smokers was made available to RTs who then outreached these veterans with a health flyer
- APRT tobacco treatment clinic was developed and implemented within the VAMHCS by a pulmonologist and the APRT
- Veterans were referred to Tobacco clinic by pulmonary providers

RESULTS

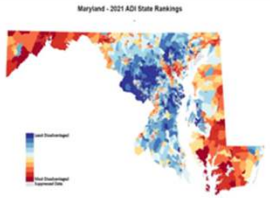
RT's Inpatient Tobacco Cessation Outreach

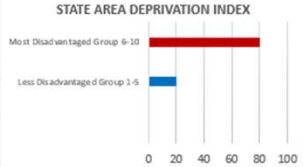
Demographic Information	Variable	N	Cohort
Age (years), mean	63	360	
Gender	M/F	322/22	
Race	Caucasian	87	24%
	Black	247	68%
	Other	26	8%
Pack Year, mean	33	360	
State Area Deprivation Index	Group 1-5	61	17%
	Group 6-10	299	83%
Outpatient Tobacco Cessation Counseling	1	360	0.2%

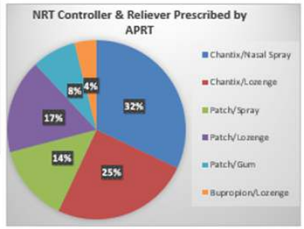
APRT Tobacco Treatment Clinic

Demographic Information	Variable	N	Cohort
Age (years), mean	64	89	
Gender	M/F	86/3	
Race	Caucasian	34	38%
	Black	53	60%
	Other	2	2%
Pack Year, mean	39		
State Area Deprivation Index	Group 1-5	18	20%
	Group 6-10	71	80%

- Two-month follow-up data on 24 veterans seen in APRT tobacco treatment clinic shows 13 of 24 (54%) quit and 11 of 23 (46%) reduced cigarette use by 50%







CONCLUSIONS

- This pilot study shows that point of care tobacco cessation education by RT's is a good start but falls short. Only 1 of 360 veterans completed outpatient tobacco cessation counseling
- APRTs can have a significant impact on tobacco cessation and harm reduction
- Treat with Controller and Reliever
- Additional data collection is necessary to determine the impact of tobacco cessation and harm reduction on hospital admissions and healthcare utilization

References:
Kind AJH, Buckingham W. Making Neighborhood-Disadvantage Metrics Accessible - The Neighborhood Atlas. *New England Journal of Medicine*, 2018. 378: 2456-2458. DOI: 10.1056/NEJMp1802313. PMCID: PMC6051533.
University of Wisconsin School of Medicine and Public Health. 2021 Area Deprivation Index. Downloaded from https://www.neighborhoodatlas.medicine.wisc.edu/ March,31 2021.
Disclaimer: The contents here do not represent the views of VA or the United States Government.
This material is the result of work supported with resources and the use of facilities at the VA Maryland Health Care System, Baltimore, Maryland

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- 72 yr old
- 30 pk yr with moderate COPD
- Tobacco Treatment:
  Chantix, Nicotine Lozenge
- >1 year Tobacco/Smoke Free

APP INTERSECTION

Column

Advanced practice respiratory therapist: The new advanced practice provider

BY MINDY CONKLIN, MRT, RRT, RRT-ACCS

With the physician shortage continuing to increase across the nation, the need for trained providers continues to be a void in the health care system. Advanced practice providers (APPs) have played an integral part in filling this gap for years. The success of these providers has, in turn, opened the door for a new role within the respiratory care profession: the advanced practice respiratory therapist (APRT).

The implementation of this new role is bringing forth a major shift in the profession of respiratory care. The APRT is a skilled and qualified practitioner trained by academic and clinical education to provide a scope of practice that exceeds that of the registered respiratory therapist (RRT). The pathway to becoming an APRT includes obtaining a baccalaureate degree in respiratory care, obtaining the National Board for Respiratory Care (NBRC) RRT credential, completing one year of experience as an RRT, and completing a graduate APRT education program where students focus on adult or neonatal/pediatric populations. The current Commission on Accreditation for Respiratory Care (CoARC) accredited APRT graduate program requires a minimum of 1,200 clinical hours.

As with other APPs, APRTs work in a physician-led team to provide diagnosis and treatment to patients with cardiopulmonary disease in multiple areas of a hospital setting, including acute care, critical care, and long-term care. APRTs are also prepared to provide outpatient services such as pulmonology, sleep medicine, interventional pulmonology, cardiology, pulmonary rehab, and neuromuscular patient management. APRTs can be integrated into the interdisciplinary team in the ICU to help manage patients suffering from COPD exacerbations to sepsis to respiratory failure. APRTs bring significant value to the team with proficiency in management and liberation of patients on mechanical ventilation. APRTs are a great asset to the team by adding their expertise in point-of-care ultrasound, line placements, airways, bronchoscopy, and overall knowledge of pulmonary diseases and disorders.

Having an APP who is specialized in cardiopulmonary care is valuable to patients and facilities alike. APRTs have demonstrated the determination and knowledge needed to provide excellent medical care to patients. As a result, patients value the expertise these specialized APPs display in pulmonology, and they have confidence they are receiving outstanding care. Daniel Thacker, MRT, RRT, RRT-ACCS, a practicing APRT at the VA Maryland Health Care System, states, "We are seeing a myriad of patients in various stages of pulmonary diseases and disorders. From tobacco treatment programs to sleep medicine clinics, our expertise as APRTs has made our treatment and care of patients very successful. Beyond direct patient care, we are also proving ourselves beneficial to the research conducted within our facility, thus further utilizing our education and expertise to the highest potential."

The rise of the APRT marks a pivotal advancement in respiratory care, addressing the growing need for specialized providers in health care. With advanced training and expertise in cardiopulmonary care, APRTs are enhancing patient outcomes across diverse settings and becoming integral members of health care teams. As physician shortages continue, APRTs are well-positioned to fill critical gaps, improving both patient care and team efficiency for the future of health care. •

All references are available online at chestphysician.org.

THE OHIO STATE UNIVERSITY

Education Requirements

The Ohio State University's MRT Program Curriculum

AUTUMN YR 1	SPRING YR 1	SUMMER YR 1
HTHRHSC 7900: Evidence Based Practice I: Critical Analysis of Measurement and Diagnostic Tests (1) **NURSING 7450**: Pathophysiology of Altered Health States (5) **RESPTHR 7700**: Ethical Issues in Advanced Practice (2) **RESPTHR 7895**: Seminar: Evidence for Respiratory Care I (1)	**HTHRHSC 7910**: Evidence Based Practice II: Critical Analysis of Intervention Research & Systematic Review (1) **NURSING 7410**: Advanced Health Assessment (3) **NURSING 7470**: Advanced Pharmacology in Nursing Practice (4) **RESPTHR 7895**: Seminar: Evidence for Respiratory Care II (1)	**RESPTHR 7800**: Advanced Practice in Respiratory Care (3) **RESPTHR 8189**: Advanced Clinical Practice I (4) **RESPTHR 7895**: Seminar: Updated and Current Developments I (2)
9 credits	**9 credits**	
AUTUMN YR 2	**SPRING YR 2**	
RESPTHR 7800: Advanced Practice in Respiratory Care (3) **RESPTHR 7895**: Seminar: Updates and Current Developments II (1) **RESPTHR 8289**: Advanced Clinical Practice II (7)	**RESPTHR 7895**: Seminar: Professional Practice Issues (2) **RESPTHR 8389**: Advanced Clinical Practice III (7)	
11 credits	**9 credits**	**TOTAL CREDITS: 47**

Master of Respiratory Therapy (osu.edu)

Clinical Rotation

- **Required- a minimum 1000 clinical hours**
- **Pulmonary Outpatient Clinic – 100 hours**
- **Sleep Outpatient Clinic- 140 hours**
- **Interventional Pulmonary Clinic- 28 hours**
- **Inpatient Pulmonary Consults -184 hours**
- **Interventional Pulmonary – 48 hours**
- **Medical ICU- 300 hours**
- **Surgical ICU 200 hours**

MRT Admission Requirements

- (CoARC) accredited Respiratory Therapy Program
- NBRC- RRT
- Minimum of 1 year working as RRT

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QUESTIONS?

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